LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON EDUCATION, EMPLOYMENT AND YOUTH AFFAIRS
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Submission Cover Sheet

Inquiry into Youth Mental Health in the ACT

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Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug policy

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Inquiry into Youth Mental Health in the ACT by the Standing Committee on Education, Employment and Use Affairs

Submission of
Families and Friends for Drug Law Reform

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Families and Friends for Drug Law Reform

1. Families and Friends for Drug Law Reform appreciates the concern of the committee that has moved it to enquire into the state of youth mental health in the ACT and that its broad remit embraces the prevention and early intervention of mental health and addiction challenges and youth suicide prevention including those in the Aboriginal and Torres Strait Islander communities. In the time available we have not had the time to tailor a submission precisely to the committee's terms of reference but in the light of the intense attention we have given in the past year to the interaction between mental health, substance dependency, prison, in the context of COVID-19, to submissions to the Productivity Commission Inquiry into mental health and the scope for the adjustment of drug policy to facilitate the release of people from our overcrowded prison, we are attaching the following annexures. These form integral parts of this submission:

A. Initial submission dated 12 April 2019 of Families and Friends for Drug Law Reform to the inquiry of the Australian Productivity Commission into the Social and Economic Benefits of Improving Mental Health

B. Post draft submission dated 16 January 2020 to the inquiry of the Australian Productivity Commission into the Social and Economic Benefits of Improving Mental Health

C. Submission dated 11 April 2016 of Families and Friends for Drug Law Reform to the inquiry into youth suicide and self harm in the ACT by the Health, Ageing, Community and Social Services Standing Committee.

D. Paper dated 1 June 2020 calling for the initiation in the Australian Capital Territory of heroin assisted treatment to underpin the release of vulnerable prisoners, improve mental health and protect the ACT population from COVID-19

1. Interaction of mental health and drug policy

2. This is not the first time Assembly committees have considered the issues embraced by your terms of reference. Families and Friends have long pointed out the coincidence between poor mental health and illicit drugs, a coincidence that can be ameliorated by less stigmatising and less punitive drug policies that give primacy to a health approach. Such an approach can stabilise people struggling with addiction, providing an opportunity for them to take advantage of complementary psychosocial support to addresses notorious risk factors for ill health and crime.

3. The high level of national concern about mental health is linked to:

- the lingering threat of coronavirus;
- the Black Dog Institute and Mission Australia youth mental health survey;
- the current inquiry into mental health of the Productivity Commission, the final report of which is about to be released;
- public consultations conducted by the National Mental Health Commission to help shape a 2030 vision for mental health and suicide prevention in Australia. Families and Friends participated in the sole ACT consultations held on 21 August 2019 at Forde;
- the current Victorian Royal Commission the terms of reference of which include "how to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches;" and
- the attention to Aboriginal deaths in custody and high indigenous incarceration rate linked to the international black lives matter movement.

4. Families and Friends cannot hide its frustration at the perverse resistance of authorities to connect the obvious and well documented dots that point to the potential for better drug policies to bring about a quantum improvement in mental health in Australia.

5. The work of the Productivity Commission in fulfilling its commission of the Commonwealth Treasurer to "undertake an inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth." In its detailed draft report is a thorough assembly of information on the drivers of mental ill-health and it accurately identified the absolute need to integrate psychosocial support with a stepped model of care varying in intensity from self-management estimated to encompassed 6.4 million people or 26% of the Australian population through five increasing levels of intensity to people requiring "complex care" who are estimated to number 350,000. It is this group of people with complex needs that are of most concern to Families and Friends because it is this group that is characterised by co-occurring substance dependency and other mental health problems. One cannot fault the Productivity Commission's prescription that this complex group requires coordinated care of:

- a range of health providers (GPs, psychiatrists, mental health nurses and adult allied health);
- inpatient services;
- psychosocial support;
- a single care plan;
- a care team; and
- a care coordinator.

It's the full Monty.

6. Full Monty or not, the prescription will inevitably fail because at its core it recommends no more than better and greater coordination of services. As canvassed in our "post draft" submission (annexure B) this is exactly what a succession of mental health strategies going back to the mid-1990s had committed governments to implement and which has seen mental health become a bigger and bigger problem. Even though the concept of coordination is accepted, the commission itself admits "its implementation has proved challenging". The Commission acknowledges that very many of those requiring complex care are embroiled in the criminal justice system whether in contact with the police, prosecution, subject to non-custodial penalties like fines and ultimately imprisonment. A high proportion of these people are indigenous Australians. As consumers of illicit drugs these people are criminals thus redoubling the stigma and discrimination of this population. The Productivity Commission identifies stigma and marginalisation "directed at both those people with mental illness and those who support them" as one of several key factors driving poor outcomes in Australia is mental health system (PC overview 2019 p.6). In spite of this acknowledgement and in spite of the patent intensification of stigma and discrimination brought about by the criminalisation of their behaviour, the Productivity Commission panel made it clear to Families and Friends that it considers consideration of the reform of drug policy as beyond its terms of reference. From our point of view this is made all the more reprehensible by the acknowledgement made off the record to us that "the panel really understood what we were saying".

7. The "challenge" acknowledged by the Commission is how to enfold people with the most complex needs into its stepped model of care. Imprisonment is about the worst possible place for people with mental health problems to be: treating mental health conditions in prison is akin to attempting to treat malaria in a swamp. Recent coronial enquires into deaths in custody of Stephen Freeman and Jonathan Hogan (NSW Coroner's Court 6 May 2020) highlight this. It is just not possible for healing mental health services and support to be provided in a correctional environment.

8. To some extent the ACT Government response acknowledges the inherent impossibility of providing effective mental health care to people in prison. (Annexure D §§62-65). This acknowledgement is evident in the government's embrace of the vacuous idea of "therapeutic jurisprudence" in terms of:

- an ACT drug court,
- detention under reduced security outside the prison perimeter of certain offenders,
- greater recourse to diversion programs,
- restorative justice; and
- justice reinvestment.

Harmful role of the criminal law

9. With the exception of the last two (restorative justice and justice reinvestment) all these measures seek to engage the criminal law as the gatekeeper and ultimate

guarantor: it is the police who net the offender (who are known to be overwhelmingly highly disadvantaged vulnerable people) and the prosecutorial process that snaps in should the offender not comply with the mandatory regime prescribed by the drug court or the terms of parole or bail in the case of diversion. All those measures seek to engage the dynamic of compulsory treatment the benefits of which are at best marginal and in some cases counter-productive (Annexure D §§162-182) – certainly nothing to compare with the track record of respectful person centred care allied to proven pharmacotherapies (discussed below §§ 65-68).

Justice reinvestment

10. Is it credible that someone suffering from schizophrenia or a far more common mental health condition like anxiety accompanying a multitude of personal problems like poverty, homelessness and unemployment would get better by being ordered to do so on pain of separation from what is already probably tenuous family and community support? The answer is no. How is it any different if the person is also wrestling with substance dependency (itself a recognised mental health condition)? In short it is as futile to order someone to overcome their addiction as it is to demand that the person desist from a diet and lifestyle that will lead to a heart attack or life-threatening complication of diabetes such as the amputation of a leg. They would probably double down on their unhealthy lifestyle.

11. The benefits of justice reinvestment are self-evident: the redeployment of resources swallowed up by an ineffective and harmful set of law enforcement measures to address the underlying drivers of the offending behaviour. It works and is effective but only if it is grounded in a realistic assessment of those underlying drivers. It therefore beggars belief that the Minister responsible for all of Mental Health, Justice Health and Corrections should therefore publish in *The Canberra Times* of 5 June an article on the justice reinvestment that makes no reference to the two dominant characteristics of prison populations: co-occurring problems of mental health and substance dependency which the Productivity commission and the 2006 landmark Senate inquiry into health termed the expectation rather than the exception. This inexplicable silence by Mr Rattenbury about the relevance of mental health and substance dependency to justice reinvestment is also reflected in the failure to include among the 25 people he convened for a national forum in December 2018 to discuss the concept, anyone who could speak with knowledge and authority about either mental health or substance dependency. These co-occurring issues are brontosauruses in the room of any discussion about justice reinvestment. It was heartening therefore that the government's announcement on 3 June 2019 about the establishment of a Reintegration Centre outside the prison perimeter, albeit still subject to a coercive regime, should refer to "alcohol, tobacco and other drug rehabilitation" but, alas, not to mental health.

12. A key objective of Justice Reinvestment is to reduce reoffending. How credible then is the intention of the government in its commitment to the concept when it does not even consider a drug treatment that has been described as "one of the most effective measures ever tried in the area of crime prevention"? (Annexure D §113).

2. Suicide

13. The Mission Australia/Black Dog Institute survey draws attention to the "greater risk" of intentional self-harm and suicide that mental health disorders put individuals. To drive the point home the survey mentions that suicide accounts for one third of all deaths among young people aged 15 – 24 years, making it the leading cause of death for this age cohort." Families and Friends would add coincidence of substance dependency and other mental health issues increases the risk even further.

14. In 2016 Families and Friends brought these matters to the attention of the Standing Committee on Health, Ageing, Community and Social Services that was commissioned to enquire into Youth Suicide (Annexure C). One of our members whose opiate dependent daughter took her own life out of desperation at her inability to overcome her addiction was willing to give public evidence. The terms of reference required the committee to examine:

> ". . . the extent and impact in the ACT [of these findings of the Bureau of Statistics], having regard to:
>
> (a) ACT Government and Commonwealth Government roles and responsibilities in regard to youth mental health and suicide prevention, particularly in relation to the recently announced Commonwealth response to the National Mental Health Commission Report and the mental health and suicide commissioning role for the Primary Healthcare Networks as it affects the ACT;
>
> (b) any gaps or duplicate roles and responsibilities;
>
> (c) whether there are unique factors contributing to youth suicide in the ACT, taking into account the small number of young people who have died by suicide in the ACT in recent years, and the impact public investigation may have on families and close friends, that can be identified through submissions and expert witnesses; and
>
> (d) ACT government-funded services, agencies and institutions, including schools, youth centres, and specialist housing service providers' role in promoting resilience and responding to mental health issues in children and young people; . . .
>
> (http://www.parliament.act.gov.au/__data/assets/pdf_file/0010/828172/2016-03-04-Media-Release-call-Public-Submission-HACSS.pdf).

15. Our submission urged the Committee to:

> "carefully consider the effect of criminalisation of drugs on the marginalisation of drug takers and how changes to drug policy would have a direct bearing on the suicide rate.

16. In transmitting its submission to the committee, Families and Friends wrote that "we would very much appreciate the opportunity of appearing before the committee in relation to [the submission]". As it turned out on 9 June the committee

tabled in the Assembly its report. The report contained only cursory reference to our submission. It paid no attention to the issues of substance raised in it.

17. On 16 June Ms Joy Birch, the committee's Labor Party chair wrote expressing the regret of the committee that it was "unable to facilitate a hearing for [us] to appear and to give evidence." The reasons conveyed by Ms Birch were curious: the committee declined to hear us "due to the nature of that submission and a limited time available to the committee for preparing the report into the enquiry."

18. The report and this response invited the conclusion that the committee did not want to consider the association between drug policy and suicide that our submission examined.

19. Given the continuing relevance of the issues raised in that 2016 submission we incorporate it into the present submission as Annexure C in the expectation that unlike its predecessor and the Productivity Commission the present committee will not dodge the issue.

20. The interest of Families and Friends in mental health and suicide prevention is founded upon several harsh realities that we urge the Committee to accept as a basis for its work:

- Co-occurring mental health and substance dependency, particularly on illicit drugs is the expectation rather than the exception (Senate 2006 Chapt .14).
- Substance dependencies are recognised mental health conditions under the International Classification of Diseases (ICD) of the World Health Organization and the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.
- Anxiety, a prevalent mental health condition particularly among vulnerable young people, is a potent risk factor for becoming entangled in illicit drug dependency. For such people substance taking is a form of self-medication (Mattick & O'Brien 2018, pp.124 & 129).
- The criminalisation of drug use exposes drug users to the coercive, stressful processes of the criminal law that constitute recognised risk factors for mental illness or aggravation of existing mental health conditions.
- Risk factors for mental ill-health initiated or intensified by the stressful processes of the criminal law include: isolation from family and other support, deviant peer group school failure, job insecurity (Commonwealth Department of Health and Aged Care, 2000, tables 1 & 2, pp. 15-16, further discussed at Annexure A §§53-58).
- Australian prisons are crowded with some 80% of people with these co-occurring conditions propelling, courtesy of an even higher proportion of co-occurrence, the fast rising number of women ending up in prison (Butler & Allnutt (2003) the table 3, p. 14 & Indig et al., (2010a) p.107).
- Criminalisation of drug users intensifies the risk factors for both mental illness and substance abuse thus creating a feedback loop (Marel et al. 2016 p. 8).
- The criminalisation of drug users initiates and drives intergenerational disadvantage (Annexure A, paras, 123-125).

- Someone with an opioid use disorder is 13 times more likely to attempt suicide than a member of the community at large, intravenous drug users are between 13 and 14 times more likely and mixed drug users (those we would referred to as polydrug users) an astounding 16 to 17 times more likely (Wilcox et al. 2004).

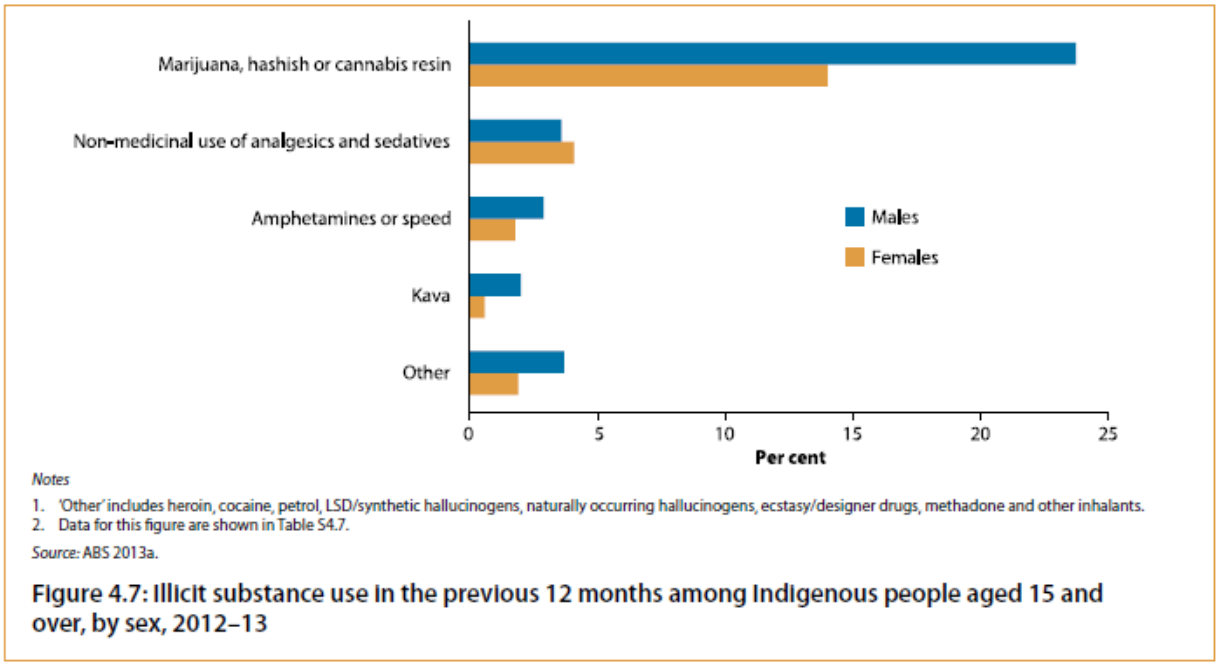
3. Indigenous interaction with the Justice System

21. Families and Friends calls on the committee to consider the destructive role that a criminal law based drug policy plays in enmeshing indigenous Australians in disadvantage and materially contributing to the scandal of black deaths in custody.

22. We suggest a productive approach is to compare the many parallels between the situation of African Americans and indigenous Australians.

Prevalence of illicit drug use in the indigenous community

23. The 2015 report of the health and welfare of Australia's Aboriginal and Torres Strait Islander peoples by the Institute of Health and Welfare summarises illicit drug use in the following chart (AIHW 2015 p. 58):



Notes

1. 'Other' includes heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone and other inhalants.
2. Data for this figure are shown in Table S4.7.

Source: ABS 2013a.

Figure 4.7: Illicit substance use in the previous 12 months among Indigenous people aged 15 and over, by sex, 2012–13

24. "Other than ecstasy and cocaine, Indigenous Australians aged 14 or older used illicit drugs at a higher rate than the general population (Table 8.6). In 2016, Indigenous Australians were: 1.8 times as likely to use any illicit drug in the last 12 months; 1.9 times as likely to use cannabis; 2.2 times as likely to use meth/amphetamines; and 2.3 times as likely to misuse pharmaceuticals as non-Indigenous people. These differences were still apparent even after adjusting for differences in age structure (Table 8.7). There were no significant changes in illicit use of drugs among Indigenous Australians between 2013 and 2016" (AIHW 2016 p. 108).

Wilkes, Gray & Casey 2014

Prevalence of illicit drug use among indigenous prison entrants

25. "Almost two-thirds (65%) of prison entrants reported using illicit drugs during the previous 12 months. Female prison entrants (74%) were more likely to report recent illicit drug use than male entrants (64%), and non-Indigenous entrants (66%) were more likely than Indigenous entrants (63%). Methamphetamine was the most common illicit drug used, followed by cannabis.

"Almost 1 in 6 (16%) prison dischargees reported using illicit drugs in prison, and 1 in 12 (8%) said they had injected drugs in prison" (AIHW 2019 p. vii).

Co-occurring substance dependency and other mental health conditions in the indigenous community.

26. According to an overview of Aboriginal and Torres Strait Islander mental health:

> "Given the high levels of background stress, substance misuse also figures prominently as a background factor to mental illness. It is well recognised that Aboriginal and Torres Strait Islander peoples experience harmful rates of alcohol and other substance use and that this tends to be more pronounced in rural communities. . . .
>
> "Aboriginal and Torres Strait Islander men are hospitalised at over four times the expected rate for population with severe mental illness related to substance misuse, and over double the expected rate for severe chronic mental illnesses such as schizophrenia.35(p112) The rates of hospital admission for severe mental illness in Aboriginal and Torres Strait Islander women is also substantially above expected rates for their numbers in the population" (Parker & Milroy p. 30).
>
> Indigenous adults with high or very high levels of psychological distress were significantly more likely than those with lower levels of psychological distress to:
>
> - assess their health as fair or poor (42% and 20%, respectively)
> - smoke daily (55% and 39%)
> - have used illicit substances in the past 12 months (30% and 18%) (AIHW 2015, p. 72).

Black lives matter in Planet America – a comparison with deaths in custody in Continent Australia

27. To that end we refer the committee to the telling summary of research findings on how the criminal justice system in the United States discriminates against black American citizens. It was broadcast on ABC's *Planet America* on 10 June. A transcript of Licciardello's commentary is reproduced below in italics. It is interspersed with descriptions in plain text of parallel situations in Australia:

28. *There has been a lot of talk in the last two weeks about police shootings of black people. You may have seen stats like these.*

29. *Even though the population is only about 12% black about 26% of people shot*

and killed by police are black and 36% of unarmed people who were shot and killed by police are black, so that's racist right? Well not necessarily because maybe police are around black people a whole lot more than they are around white people. That's why you get studies that find black men are 2 1/2 times more likely than white men to be killed by police. Yet the study still doesn't draw conclusions about racial bias because they say not every person has an equal chance of coming to contact with police and crime rates and policing practices differ across different populations.

30. The following is the latest tally published by the Australian Institute of Criminology of Deaths in police custody and custody-related Operations:

> "Of the 21 deaths occurring in police custody in 2017–18, three were Indigenous deaths and 14 were non-Indigenous deaths. No Indigenous status was recorded in the remaining four cases. Consistent with all years of data on deaths in police custody (1989–90 onward), the number of non-Indigenous deaths exceeded the number of Indigenous deaths" (Doherty & Bricknel 2020)

31. In the year covered (2017-18) "The largest numbers of deaths occurred in New South Wales (*n*=27) and Victoria (*n*=17). There were no deaths in the Australian Capital Territory" (the same) though it was in April 2018 that an ACT coroner issued findings following his inquest into the death in the ACT prison of Stephen Freeman in May 2016.

32. The report went on to analyse shooting deaths in police custody:

> "In 2017–18 there were eight shooting deaths in police custody, three more than in 2016–17 (see Figure 12). Four deaths occurred in New South Wales, and one death occurred in each of Victoria, Queensland, Western Australia and South Australia. All eight shootings involved persons who had been shot by police. Since 1989–90 there have been 139 deaths involving persons shot by police, and a further 104 deaths where persons shot themselves (see Table C33). Of the eight deaths resulting from police shootings in 2017–18:
>
> - seven were of non-Indigenous persons, and the Indigenous status was unknown in one death. Police shootings of non-Indigenous persons have consistently outnumbered those of Indigenous persons since 1990–91;
> - all were of males. In all years but four since 1989–90, all persons shot by police were males;
> - the median age at time of death was 32 years. Forty-nine percent of total police shooting deaths between 1989–90 and 2016–17 were of persons aged between 25 and 39 years;
> - seven were of persons suspected of committing a violent offence as their MSO, and one was of a person suspected of committing an offence recorded as 'other'. Police shootings of persons suspected of committing a violent offence have outnumbered other offence types in all but six years since 1989–90; (Doherty & Bricknel 2020).

33. Australia differs from the United States in the fewer number of police shootings and in the dominant characteristic of those who are shot. It is not on the basis of the colour of the skin of the victims so much as their mental health. Having said that, the greater prevalence of mental illness in the indigenous community and a likely tendency for police to be "around" young indigenous people, suggest that more

mentally disturbed indigenous Australians are victims of this police violence than mentally disturbed nonindigenous Australians.

> "Between 1989 and 2011 . . . police fatally shot 105 people. The victims were almost entirely male and 60% were between 20 and 39 years of age.
>
> "Of those persons shot by police, 42% were suffering a mental illness at the time of the shooting. Schizophrenia was the most common illness (59% of those with a mental illness) suffered. In at least one of the recent Queensland shootings, the person shot was allegedly a sufferer of mental illness" (Goldsworthy 2014).

34. *Also with unarmed people getting shot by police we're talking very small sample sizes and thankfully getting smaller but some studies try to crunch the numbers anyway. This is what they find. When contextual factors are taken into account the racial differences, in shooting numbers disappear.*

35. *But on non-lethal uses of force Blacks and Hispanics are more than 50% more likely to experience some sort of force and contextual factors may reduce but they do not fully explain these racial disparities. You find that all over the criminal justice system. It's not so much the big things as the little things that are demonstrably racially biased and they all add up to create extremely biased outcomes. Let me show you.*

36. *Now shootings are a big deal, even racist police usually need a good reason to shoot someone, but pulling a car over on the other hand? Not so much. What's interesting, a study of 20 million car stops found black drivers have four time the odds of white drivers of being stopped and searched even though they were less likely to be found with contraband after being searched, according to the study.*

37. The Australian Law Reform Commission found that: "Poor relations influence how often Aboriginal and Torres Strait Islander people interact with police and how they respond in interactions with police. Poor police relations can contribute to the disproportionate arrest, police custody and incarceration rates of Aboriginal and Torres Strait Islander people. It may also undermine police investigations." (ALRC 2017 p. 33)

38. *You see it's those kind of decisions when the police have most discretion, and that's where their bias really shows. Like for instance, how the black arrest rates for prostitution are five times higher than the white arrest rates or the black arrest rates for gambling are ten times higher than white arrest rates. That's discretion.*

39. *The biggest discretionary charge, drug possession: black and white people use illegal drugs at about the same rate.*

40. Families and Friends are unaware of data on the actual level of substance dependency within the indigenous community in the ACT but expect from other evidence and surveys elsewhere in the country that the level of problem drug use is higher than in the general community.

41. "Intergenerational trauma and dispossession are risk factors that explain the high prevalence of substance dependency (including alcoholism) in the indigenous community. A Western Australian survey of the psychological well-being of members of the Stolen Generation noted:

> " . . . that members of the Stolen Generations were more likely to live in households where there were problems related to alcohol abuse and gambling. They were less likely to have a trusting relationship and were more likely to have been arrested for offences. Members of the Stolen Generations were more likely to have had contact with mental health services. The survey commented that children of members of the Stolen Generations had much higher rates of emotional/behavioural difficulties and high rates of harmful substance use" (Parker and Milroy 2014, p. 30).

42. Although indigenous people constitute a mere 1.6% of the ACT population, according to ATODA's 2015 Service Users' Satisfaction and Outcomes Survey, a quarter (25.1%) of respondents indicated that they were of Aboriginal and/or Torres Strait Islander descent. This and inmate health surveys (ACT Government Health Directorate, 2011, Young *et al.* 2016 discussed at annex §§132-36) also confirm that these people are further burdened with psychosocial problems that the coercive processes of the criminal law only intensify.

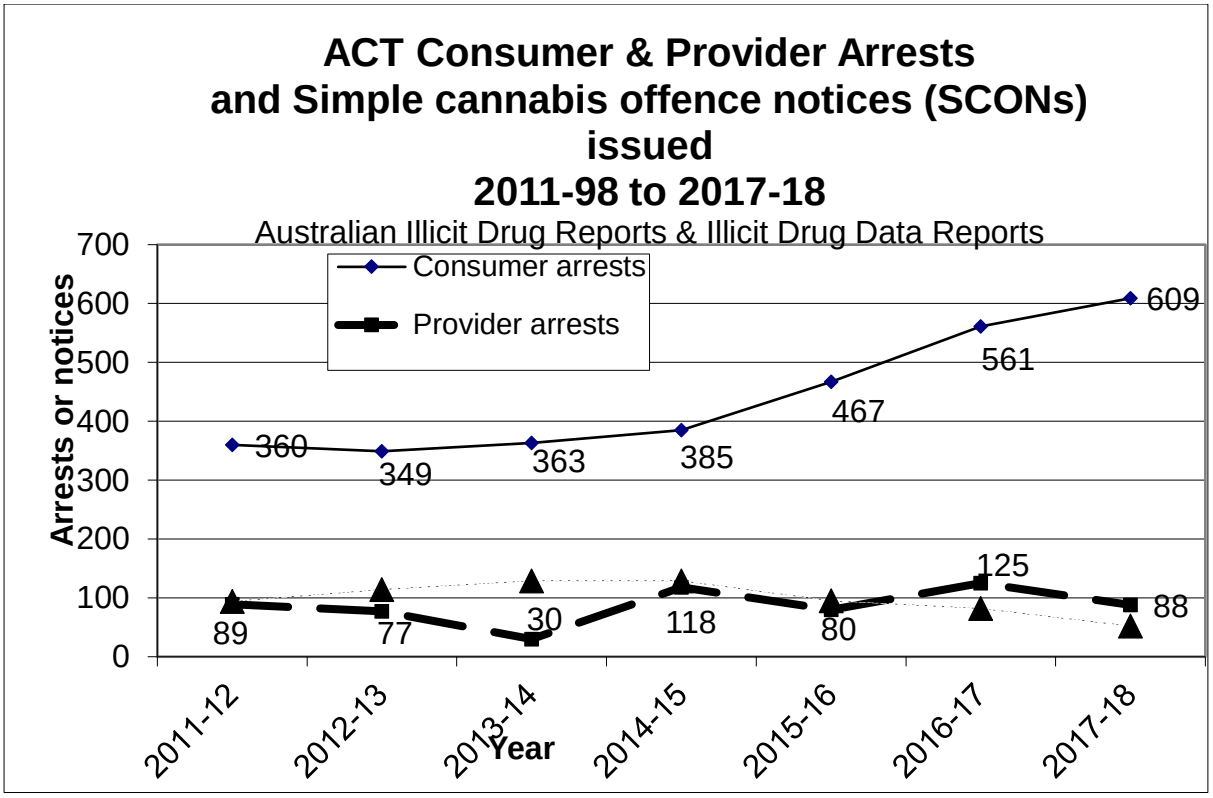
- 19.4% of respondents who attended only mainstream AOD services identified as Aboriginal and/or Torres Strait Islander.
- Nearly three-quarters of the respondents (73.5%) stated that they were unemployed.
- Almost half (45.6%) of the surveyed population identified that they were either homeless or at risk of homelessness.
- 38% of respondents indicated that they are parents (ATODA, Service Users' Satisfaction and Outcomes Survey 2015)

43. *Yet black people are about five times as likely to go to prison for drug possession as white people are. Let's take it further. For any misdemeanour charge carries a potential prison sentence. White people are 75% more likely to have those charges dropped, dismissed or amended than black people are. You see, racial bias doesn't just look like the barrel of a gun. Sometimes it just looks like the fine print of a law journal.*

44. Contradicting the ostensible national policy of harm minimisation, drug law enforcement in Australia including the ACT is overwhelmingly focused on consumers. That is the conclusion that over 80% of arrests for all drug offences are of consumers rather than providers. For each of the seven years from 2011–12 to 2017 – 18 the proportions for the ACT were:

83.61% 85.74% 94.25% 81.33% 87.54% 83.72% 88.25%
(Annual IDDR 2010-12 to IDDR 2017-18 of the Australian Crime Commission and the Australian Criminal Intelligence Commission).

45. The number of consumer arrests and Simple Cannabis Notices issued are a proxy for interactions between young drug users and police.



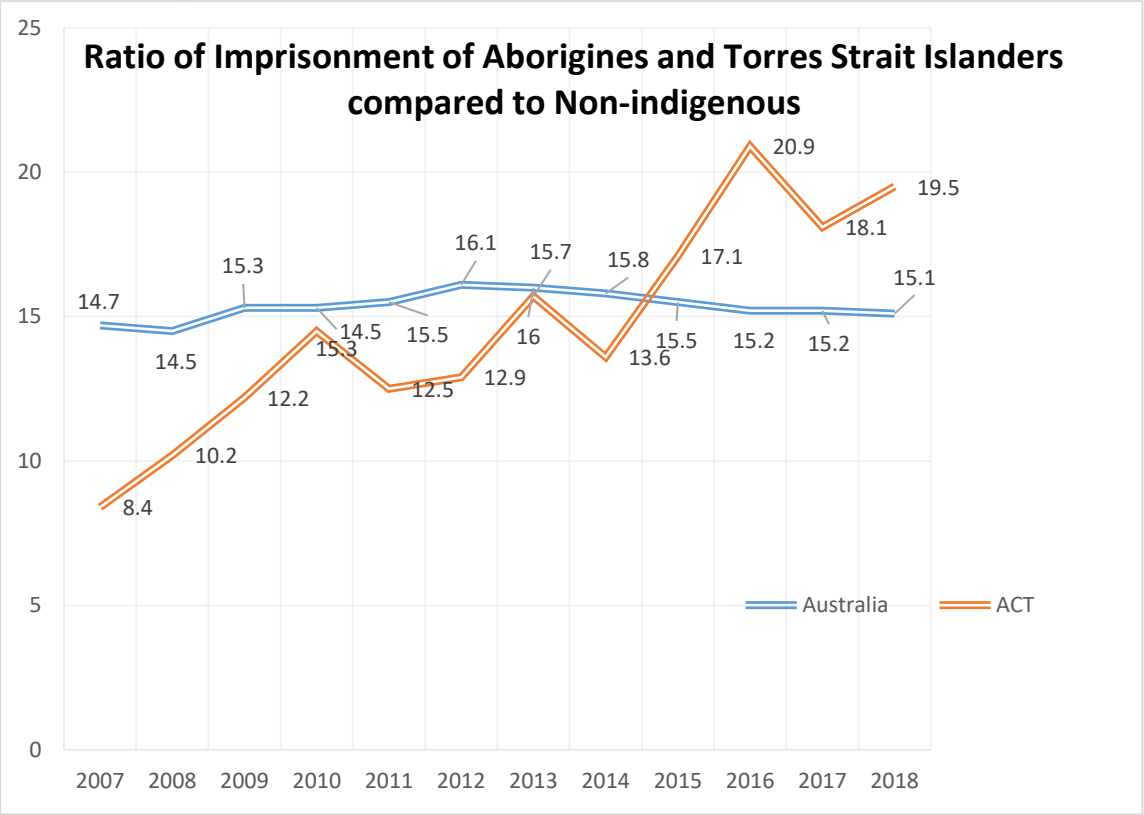
46. *What about more serious crimes, though? Another point of discretion is in setting bail and the average bail for black men charged with violent crimes is set about $7,000 higher than the average bail for white people charged with violent crimes. Bail is set $10,000 higher for black men charged with public order crimes and $13,000 higher for black men charged with, of course, drug crimes and that is all controlled for a bunch of stuff like the seriousness of the crime and the criminal histories etc. but don't think the judges stop there. Oh no, they also sentence black men to federal prison sentences that are 19% longer than white men receive for the same crimes and that's, once again, after controlling for like - everything - but guess what? That gap has grown over the last 20 years or so. In fact when it comes to drug crimes - again - and property crimes, black people are serving 1% more time a year while time served by white people is dropping.*

47. The Australian Law Reform Commission comments that "there is evidence that the law is applied unequally— for example, Aboriginal and Torres Strait Islander young people are less likely to be cautioned and more likely to be charged than non-Indigenous young people" (ALRC 2017 p. 33).

48. *By now you will be unsurprised to hear that nearly half of life and effectively life sentenced prisoners are black, although maybe, black people just commit more of the worst crimes. That could be the case, or maybe they get screwed over more. Black people make up a majority of innocent people wrongfully convicted of crimes and later exonerated. Black sexual assault convictions are 3 1/2 times more likely to be found wrongful than white convictions. Black drug crime convictions, of course, are 12 times more likely to be found wrongful and black murder convictions are seven times more likely to be found wrongful and, out of those, black wrongful convictions are 22% more likely to involve police misconduct than white wrongful convictions. So, where does that all leave us?*

49. *It leaves us with over 2% of adult black males in prison at any one time. We're*

talking about 465,000 black prisoners or about a third of the people in prison and if you compare that to the general population where there is only 12% of black people so the black rate of incarceration is about 2 1/2 times their share in the population, and black 18 and 19-year-olds are about 12 times more likely to be imprisoned than their white equivalents.



SOURCE: Embedded ABS data in Inman & Byrne 2019.

50. When the ACT prison opened, the territory's imprisonment rate was 63.4 per 100,000 of the population. By 2018 – 19 the Productivity Commission reported that it had increased by 132% to 147 per 100,000 (PCrog 2020 table 8A.13). Health surveys show that the detainee population is characterised by co-occurring substance dependency and other mental health issues in combination with severe social disadvantage (ACT Government Health Directorate, 2011 & Young *et al.* 2016 discussed in Annexure at §§133-135).

51. In 2018-19 in the ACT the crude imprisonment rate for the Aboriginal and Torres Strait Islander population was 3,398.6 offenders per 100,000 relevant adult population, compared with 112.2 for the non-Indigenous population. After adjusting for differences in population age structures, the rate per 100,000 for the Aboriginal and Torres Strait Islander population in 2018-19 was 1,602.5, compared with a rate of 107.6 for the non-Indigenous population. Therefore, after taking into account the effect of differences in the age profiles between the two populations, the ACT indigenous corrections rate is 14.9 times greater than for the non-Indigenous population. Rates that do not take age profile differences into account are almost 18.9 times greater (only Western Australia, at 19 times, is worse). In 2004 the Chief Minister could claim the indigenous imprisonment rate was lower than the national average. The ACT thus has now the shameful distinction of an incarceration rate for indigenous Canberrans much higher than the national rate.

52. *By the age of 23, 49% of black males have been arrested compared to 38% of white males which actually, stop! stop! stop!*

53. According to the Australian Institute of Health and Welfare, "Indigenous prison entrants were more likely than non-Indigenous entrants to have an extensive prison history. Almost half (43%) of Indigenous entrants had been in prison at least 5 times before, compared with 25% of non-Indigenous entrants" (AIHW 2019 p. vi).

54. *I know what you're thinking. I've also found it hard to believe that 1/2 of young black men and 38% of young white men had been arrested but arrested doesn't mean charged or convicted, and also I found three studies that were all in the same ballpark, so hey, America arrests a lot of people!*

55. "By the age of 23, more than three quarters (75.6%) of the NSW Indigenous population had been cautioned by police, referred to a youth justice conference or convicted of an offence in a NSW Criminal Court. The corresponding figure for the non-Indigenous population of NSW was just 16.9%. By the same age, 24.5% of the Indigenous population, but just 1.3% of the non-Indigenous population had been refused bail or given a custodial sentence (control order or sentence of imprisonment)" (Weatherburn 2014 p. 5 quoted in ALRC 2017p. 43).

56. *This is a problem because the odds of a black man making it to the middle class are about 60% lower for those who are charged with a crime as a young adult and this affects the whole community. 63% of black people have had an immediate family member incarcerated compared to 42% of white people. Black women between the ages of 25 and 54 outnumber black men of the same age in the general community by a staggering 1 1/2 million. So for every 100 prime aged black women living outside jail there are 83 black men. That's not just in jail, by the way, black men also die early.*

57. The prison health survey of the Australian Institute of Health and Welfare tells us that: "almost 1 in 5 (18%) prison entrants reported that one or more parents or carers had been in prison when they were a child. This was more likely among Indigenous entrants (31%) than non-Indigenous entrants (11%).

58. "Younger prison entrants (27% of those aged 18–24) were almost 3 times as likely as older entrants (10% of those aged 45 and over) to have had a parent or carer in prison during their childhood" (AIHW 2019 p. vii).

59. *But, anyway, I've left the worst to last. You might think this is just a poverty thing. Well not entirely, because this is the curve of incarceration rates for young white men versus how much their parents earned when they were growing up, and this is the same curve for young black men. So, the top 1% of young black men who grew up in millionaire families had the same incarceration rate as young white men who grew up in families earning $36,000 a year, so it's not just a poverty thing, although, look at those incarceration rates for poor young black men, yikes.*

60. Mick Palmer, former Commissioner of the Australian Federal Police, makes the point that drug law enforcement has ruined the life chances of innumerable young people nabbed for using drugs.

> "As a young detective I found myself arresting decent young Australians who had never come to attention of police for any other crime, weren't really ever likely to, who were planning careers in a whole range of areas including

> teaching and police, in defence and the list went on - little tiny quantities were likely to kill these people's careers. What sort of policy is that? Why would we want to do that to people who, again, had never come to notice of police and weren't ever likely to for any other crime or offence?" (Transcribed from Uniting's Fair Treatment documentary *Half a Million Steps*)

61. *Now don't get me wrong, things are getting better. From 2000 to 2016 the rate of black male imprisonment has fallen from nine times the white man's rate to just under six times the white man's rate and black women have progressed even further from about six times the white women's rate to about twice the white women's rate but like I always say, there is a long, long way to go.*

Psychosocial factors

62. Quoting the Aboriginal and Torres Strait Islander Social Justice Commissioner, the Australian Law Reform Commission noted that "there is a strong correlation between having a family member removed and arrest and incarceration. The high rate of imprisonment is occurring in the context of poor health, inadequate housing, high levels of family violence, and high levels of unemployment (ALRC 2017 p. 41). The underlying causes of the disproportionate indigenous imprisonment were tellingly described by the New South Wales deputy coroner in the findings that she made just over a month ago in the course of her inquest into the death by hanging in February 2018 in Junee prison of young ACT indigenous resident, Jonathon Hogan.

> "Almost 30 years after the RCIADIC [Royal Commission into Aboriginal Deaths in Custody], we have failed to appropriately reduce the shockingly disproportionate incarceration of indigenous people or to properly grapple with the underlying factors. The RCIADIC identified indicators of disadvantage that contribute to disproportionate incarceration including: "the economic position of Aboriginal people, the health situation, their housing requirements, their access or non-access to an economic base including land and employment, their situation in relation to education; the part played by alcohol and other drugs - and its effects". The Commission also identified dispossession without the benefit of treaty, agreement or compensation as a factor in over-representation in custody. Decades later, these factors remain at the forefront of our failure to reduce incarceration rates. Despite attempts to "Close the Gap", disadvantage abounds and successive governments have been unable to squarely face the effects of dispossession and move forward with "truth telling" and agreement with Aboriginal and Torres Strait Islander peoples" (NSW Coroner's Court 6 May 2020).

63. The ACT Health and Justice system has much to answer for in connection with Jonathan's death. He apparently simply walked out of the Adult Mental Health Unit to which a magistrate had committed him for an assessment of his mental health condition. Before his return to custody in NSW he reported using methamphetamine daily (IV, smoked) and smoking '10 cones' of cannabis daily. In August 2014 ACT Justice Health had diagnosed him as suffering from schizophrenia.

64. Families and Friends calls on the committee to heed the observations of the New South Wales coroner: that

- "more young Aboriginal citizens like Jonathon must be diverted away from the criminal justice system if we are to reduce the number of Aboriginal deaths in custody nationally" (§14) and
- that justice re-investment as urged by the Australian Law Reform Commission is "one crucial strategy" to achieve this (§14)

Person-Centred Care

65. Families and Friends puts it to the committee that proven pharmacotherapies should be supported by culturally sensitive, person centred care. Person-centred care is a standard of the Australian Commission on Safety and Quality in Health Care which its website describes as:

> "Person-centred care is widely recognised as a foundation to safe, high-quality healthcare. It is care that is respectful of, and responsive to, the preferences, needs and values of the individual patient.
>
> It involves seeking out, and understanding what is important to the patient, fostering trust, establishing mutual respect and working together to share decisions and plan care.
>
> Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.
>
> There is good evidence that person-centred approaches to care can lead to improvements in safety, quality and cost effectiveness, as well as improvements in patient and staff satisfaction. More information about the evidence for person-centred approaches to care can be found in Patient-centred care: Improving quality and safety through partnerships with patients and consumers.
>
> To achieve person-centred care healthcare providers, organisations and policy-makers need to work in partnership with consumers.
>
> Partnering with consumers recognises the value of the consumer voice, and the need for consumer experience and expertise to help shape decisions about health care at the level of the system, service and individual."

66. Person-centred care is modelled in real life at the Crosstown drug treatment clinic in Vancouver (discussed at Annexure D §§168-180) and embodied in the Customer Service Promise that guides the Uniting Medically Supervised Injecting Centre in Sydney.

67. The 2014 landmark study on Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice specifies key initiatives for the progression of mental health services for Aboriginal and Torres Strait Islander peoples as including: "self-determination within Aboriginal and Torres Strait Islander

mental health service development, a holistic approach to mental health, specific services for population sub-groups, improved coordination of service delivery for people within mainstream health services, Aboriginal mental health worker (AMHW) and other staff development, and improved research. (Parker & Helen Milroy 2014, p. 34)

68. In the context of indigenous Canberrans these principles are exemplified by Winnunga Nimmityjah Aboriginal Health Service.

69. In summary, to paraphrase the words of the New South Wales coroner, if there are to be no more deaths in custody, black or otherwise, indigenous Canberrans and those with mental health conditions must be “diverted away from the criminal justice system”. The easiest and most efficient way of doing this is to cease to stigmatise and marginalise these people to divert the freed resources to boosting culturally sensitive drug treatment implementing proven treatments in an environment of person-centred care.

Bill Bush
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Families and Friends for Drug Law Reform
[redacted]

22/06/2020

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Inquiry into
Youth Mental Health in the ACT
by the
Standing Committee on
Education, Employment and Use Affairs

Submission of
Families and Friends for Drug Law Reform

Annexure A Initial submission dated 12 April 2019 of Families and Friends for Drug Law Reform to the inquiry of the Australian Productivity Commission into the Social and Economic Benefits of Improving Mental Health

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SUBMISSION of Families and Friends for Drug Law Reform[1] to the inquiry of the Australian Productivity Commission into the Social and Economic Benefits of Improving Mental Health

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[1] Families and Friends for Drug Law Reform acknowledges with much gratitude the incisive comments and other help of Virginia Hart in the preparation of this submission. Bill Bush.

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SUBMISSION of
Families and Friends for Drug Law Reform
to the inquiry of
the Australian Productivity Commission into
the Social and Economic Benefits of Improving Mental Health

INTRODUCTION

Objective of submission

1. This paper argues that the burden of mental illness in Australia is in a large measure increased by the coincidence of illicit drug abuse and other mental illness. It suggests that the reliance on the criminal law works to create and foster the social and economic conditions that drive mental illness. There is much Australian research that supports these linkages and which show, in the wording of the Treasurer's reference to the Commission that attention to drug policy offers the prospect: "of improving mental health to support economic participation and enhancing productivity and economic growth" (Issues paper, p.iii).

2. The object of this submission is to examine how sectors beyond health including drug policy and justice can contribute to improving mental health and economic participation and productivity. It seeks to identify how much of the current burden of disease attributed to mental health conditions can be attributed to the policy response to illicit drugs rather than the drugs themselves. On this basis it argues that substantial social and economic benefits could be realised by the adoption of a regulatory approach informed by health and familiar psychosocial principles in place of the existing reliance upon the coercive processes of the criminal law. In a final section the paper points to the encouraging experience of other countries that have at least to some extent ceased to rely upon the coercive processes of the criminal law as the primary instrument to limit the availability of drugs.

Drug abuse as a mental health disorder

3. This submission puts the case that the productivity commission should consider that "substance use disorders and autism spectrum disorders fall within the scope of this inquiry" (Issues paper, p. 5). The commission's issues

paper acknowledges this:

> "Almost half of all Australian adults have met the diagnostic criteria for an anxiety, mood or substance use disorder at some point in their lives, and around 20% will meet the criteria in a given year (ABS 2008)" (Issues paper, p. 1).

4. Substance dependence is itself classified a mental health condition and this is recognised around Australia through drug and alcohol services being generally grouped with other mental health services. There is generally joint management of substance dependence and other mental health problems. Addiction or dependence is a health disorder. The generally recognised criteria that are used for dependence on illicit drugs are the same criteria as are used for all psychoactive substances: the International Classification of Diseases (ICD) of the World Health Organization and the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. The different diagnostic criteria are described in the guidelines for management of co-occurring alcohol and other drug and mental health conditions (Marel *et al.* 2016, p. 5):

Drug abuse as a disability

5. While substance dependency is incontrovertibly a mental disorder, it also amounts to a recognised disability within the meaning of the *Disability Discrimination Act*. "A decision of the Federal Court has suggested that it may be unlawful under the Disability Discrimination Act to discriminate against a person solely on the ground that the person has an addiction to or dependence on a prohibited drug (Marsden case 2000).´ The case "concerned an opioid dependent person who was removed from a club and deprived of membership. A Senate inquiry reported that the case " . . . is noteworthy for the recognition that drug addiction falls within the definition of "disability" under the Act. "It is against the law to discriminate against a person because of disability (Senate 2004 paras 1.8-1.11).

6. The Australian Human Rights Commission summarises the legal situation as follows:

> "Drug use can help manage physical or mental disabilities. It is against the law to discriminate against a person because of disability. There are some limited exceptions and exemptions.
>
> > Example: It could be unlawful discrimination if an employer refuses to hire the best candidate for the job because it was discovered that the prospective employee was taking anti-depressant medication to treat depression where the medication did not affect the candidate's ability to do the job.
>
> Some cases of drug addiction are covered by the definition of disability in the *Disability Discrimination Act*.
>
> > Example: It could be unlawful discrimination if a hotel refuses to serve a person who has an addiction to methadone.

> Drug addiction can lead to impairment of physical and mental capacity. The definition of disability under the Disability Discrimination Act includes the total or partial loss of a person's bodily or mental functions. The Act does not exclude disability that has been caused by a drug addiction.
>
> It is not unlawful to discriminate against an employee on the basis of disability if the person cannot perform the inherent requirements of a job after reasonable adjustments have been made" (AHRC).

7. From a medical view substance dependency is a chronic relapsing condition but it can also be viewed as a disability and what is more, a disability that with right policy settings, does not undermine the capacity of dependent people from taking responsibility for their own lives, those dependent upon them and indeed from participation in the economy as responsible taxpaying citizens. Drug policy has been imprisoned by a moral straitjacket that has imposed drug freeness as the absolute priority upon dependent drug users. This priority dooms many drug users to failure. For example, if a drug using parent ordered to "become clean" on pain of losing custody of their children, an unhealthy dynamic is set up with a tug-of-war between the insistence by the state on abstinence and the obligations of love and responsibility that drug using parents feel as much as any others towards their children. The outcome of this dynamic is all too often disastrous. There is no other area of public policy that so intrudes into the autonomy of the citizen than drug policy. The policy seeks to control what the citizen may or may not ingest. Drug policy from this point of view is thus a most extreme form of nanny state overreach. It is also a viewpoint that undermines its own objective by impeding recovery. It does this by reinforcing the alienation and other factors that commonly motivated drug users to dabble with drugs in the first place.

8. There is, for example, much evidence that people addicted to opiates, while receiving maintenance doses of artificial or other opiates, are capable of leading the life of a responsible citizen engaged in society and the economy. Becoming drug free should and can be subservient to the protection of life and well-being. Strong evidence endorses methadone maintenance. It is the best researched treatment for heroin dependency. A Cochrane Review found that:

> "Methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment and decreases heroin use better than treatments that do not utilise opioid replacement therapy" (Mattick *et al.* 2003).

9. Cochrane reviews are intended to provide high quality and independent findings to inform healthcare decision-making. They combine the results of the world's best medical research studies and are recognised as the gold standard in evidence-based health care.

CORRELATION BETWEEN ADDICTION AND OTHER MENTAL HEALTH DISORDERS

10. At one level the position that we put to the commission is counterintuitive. Drug dependency is incontrovertibly closely correlated with mental illness and other health and social problems. This section describes some of these correlations. In doing so, it lays down the foundation for the next section that addresses the

proposition that drug policy itself better explains the correlation rather than any pharmacological effect of the drugs themselves.

Co-occurrence of drug abuse and other mental health conditions the expectation rather than the exception

11. The crossover between substance dependency and other mental health conditions is so common that the Senate Select Committee on Mental Health in 2006 termed it "the expectation not the exception" (Senate 2006 Chapt .14). That Committee lamented that:

> "Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system." (Senate Mental Health (2006) §2.29).
>
> "Population estimates indicate that more than one-third of individuals with an AOD use disorder have at least one comorbid mental health disorder; however, the rate is even higher among those in AOD treatment programs. Additionally, there are a large number of people who present to AOD treatment who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder" (Marel *et al*. 2016, p. xi).

12. Dr Paul Mullen, clinical director of the Victorian Institute of Forensic Mental Health and Professor of Forensic Psychiatry at Monash University has written of the growing recourse to substance abuse by people with mental illnesses:

> "The evidence is mounting that the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing. In one of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995" (Mullen 2001, 17).

Cannabis

13. "Among people with mental illness, particularly psychosis, the rates of cannabis dependence are significantly higher than the general community. Weekly cannabis use has been shown to be 3.3 times more prevalent among people with psychosis than among the general population. People with anxiety and depression also show higher rates of heavy cannabis use.

> "While there is limited data at present, it suggests that heavy cannabis use is also significantly more evident among indigenous populations and that up to one in two cannabis users in remote communities experience adverse mental health effects. . . . There is a significant and growing body of evidence on the relationship between mental illness and cannabis." (MHCA 2006 p. 7).

- "There is a 2 to 3 times greater incidence of psychotic symptoms among those who used cannabis . . ." (*ibid*.).
- "More frequent cannabis use is associated with higher relapse rates for people with psychosis and more severe symptoms were associated with increased risk of cannabis relapse
- Cannabis can induce schizophrenia-like symptoms in otherwise healthy individuals" (MHCA 2006 p. 8).

14. "The need for effective treatment for adults as a prevention mechanism for children is particularly evident for people with psychosis, given that 59 per cent of women with psychosis are mothers and 25 per cent of men with psychosis are fathers. . . .there is a population of adults who are heavily dependent on cannabis and have serious mental illness. There do not appear to be effective treatments available for this group in Australia at this time" (*Ibid*.).

Crystal methamphetamine

15. There is a strong correlation between use of ice and mental health issues. The most common mental health issues experienced by methamphetamine users are psychosis, depression and anxiety. In addition, in 2013, fewer than 60 per cent of users reported moderate, high or very high levels of psychological distress, compared with around 40 per cent of all illicit drug users and 30 per cent of the general population" (PMC 2015 p. 34).

16. One of the key clinical differences between psychostimulants—such as ice—and other illicit drugs is that psychostimulants can induce psychosis. People experiencing psychosis are unable to distinguish what is real—they lose contact with reality. Psychosis induced by methamphetamine is primarily characterised by persecutory delusions and hallucinations. Users have reported that the persecutory delusions often take the form of a feeling that others wish to harm or threaten them. Users have also said that the hallucinations often involve hearing voices that make insulting remarks or command them to do certain things.

17. In a survey of people who use methamphetamine at least monthly, McKetin and colleagues found that around one in four had experienced psychosis in the past year. This prevalence of psychosis is 11 times higher than the general Australian population. Methamphetamine-induced psychosis can last from a few hours to a few days and subsides when the drug is no longer in the body. However, some people experience more chronic symptoms, especially those with a pre-existing psychotic disorder. Mood disorders and anxiety are also associated with methamphetamine use. Darke and colleagues say that, compared with psychosis, depression and anxiety can be "more common, more chronic and potentially more debilitating". . . .There are links between chronic methamphetamine use and damage to the brain. In particular, chronic users of the drug have been found to have abnormalities in brain function, including depleted levels of the neurotransmitter dopamine. Neurotransmitters are chemicals in the brain that transmit information. Dopamine is important in regulation of movement, cognitive processes such as attention, working memory and motivational behaviour (*ibid* pp 34-35).

18. Patients suffering from these florid conditions induced by methamphetamines are a challenge to treat and manage and, in mental health units, can disrupt the recovery of others experiencing similar psychoses who are not drug users.

Violence

19. Psychotic symptoms and heavy alcohol consumption increased the risk of violent behaviour. However, the increase in violence also occurred independently of

psychotic symptoms and alcohol consumption, which suggests a direct relationship between methamphetamine dose and violent behaviour (PMC 2015 p. 36).

Misuse of prescription pain medications

20. According to a survey of the Australian Bureau of Statistics of drug induced deaths in 2016 “Prescription painkillers such as oxycodone, morphine and codeine . . . were present in over 30% of deaths” (ABS 2016). The misuse of prescription painkillers bears in several ways upon mental health and illicit drug policy:

a) people who have developed a dependency on licit opiates used to medicate their physical pain are likely to turn to illicit sources if they are unable to secure the medication through legitimate channels;
b) there is a large increase in overdoses (including many fatal) of prescription medications;
a) we can expect Australia to follow the trend in the United States where misuse of addictive pain killing opiates has contributed to an epidemic of “’diseases of despair’ referring to the interconnected trends in fatal drug overdose, alcohol-related disease, and suicide” (Dasgupta, Beletsky & Ciccarone 2017) and related “deaths of despair”. There, “health appears to be a more significant issue for prime age men’s participation in the labor force than for prime age women’s. There, many prime age men who are out of the labour force are afflicted with despair that exacerbate “many of the physical, emotional and mental health-related problems” (Krueger 2017);
b) there is a long history of inadequate pain medication for those who have become dependent on illicit opiates;
c) there is a dire shortage of pain treatment specialists in the ACT as indicated by the long waiting lists.

21. The predicament of those seeking pain relief will be aggravated by the imposition of restrictions on over the counter medications. In the United States, clamping down on outpatient opioid analgesic prescriptions has seen the “national overdose death rate [surge] 38% during those years.” There is a likelihood that the well intentioned restrictions on access to pain killers will have unintended consequences such as has occurred in the United States where those seeking pain relief have had recourse to “illicitly manufactured fentanyl and its analogs which are increasingly present in counterfeit pills and heroin” (Dasgupta, Beletsky & Ciccarone 2017).

Mental disorders as predictors of drug abuse

Depression:

22. While “there is good evidence to suggest that early onset drug use may lead to an increased risk of depression, even after controlling for a wide range of potentially confounding (or common) variables" “there is no strong evidence from community-based cohort studies to suggest that depression independently increases the risk of drug dependence later in life" (Degenhardt 2008 pp. 139 & 141)

Anxiety

23. The common co-occurrence of anxiety and substance use disorders points to anxiety being a potent risk factor for abuse of sedative drugs like benzodiazepines, opioids, cannabis and alcohol (Mattick & O'Brien 2018, p.124. "Epidemiological studies indicate that anxiety disorders and alcohol and drug disorders commonly co-occur. These disorders, alone and together, have serious health and social consequences (*ibid*., p.129).

Schizophrenia

24. Substance abuse problems are becoming more prevalent among persons with schizophrenia increasing from 8.3% in 1975 to 26.1% in 1995 (Wallace *et al.* 2004, 721).

Co-occurrence of chronic intractable and costly social problems

25. "Clients with comorbid mental health conditions often have a variety of other medical, family, and social problems (e.g., housing, employment, welfare, legal problems)" (Marel *et al.* 2016 p. xi).

> "Given the multitude of problems with which clients present to treatment, the goal of any service should be to improve clients' quality of life across all domains, including health, social welfare and housing, employment, criminal justice, and of course, AOD and mental health. As such, these Guidelines adopt a holistic health care approach to the management and treatment of comorbidity, which is based on the adage 'Treat the person, not the illness'. It is essential to consider the whole person, taking into account psychological, physical, and sociodemographic perspectives when consulting with clients with comorbid mental health conditions (Figure 1)" (Marel *et al.* 2016 p.4).

26. As will be touched on in more detail below, many people experiencing the following problems also suffer from a substance abuse disorder:

a) imprisonment
b) crime
c) homelessness
d) child protection
e) suicide
f) poverty
g) unemployment
h) welfare dependence
i) Indigenous disadvantage.

27. This submission will also consider the extent that drug policy:

a) fosters and intensifies risk factors for mental illness among populations not otherwise at significant risk.
b) recruits those suffering from mental disorders.
c) perpetuates and aggravates mental disorders in those already experiencing them.

d) aggravates and reinforces the very risk factors that led to drug use in the first place and undermines protective factors that are known to guard against drug use.

Drug law reform as a means of ameliorating the burden of disease attributed to mental ill health.

28. This submission urges the commission to consider the likelihood that a drug policy framework that places health and social welfare, will substantially lessen the overall burden of mental illness. At the very least there exists a significant body of evidence in support of a health and social welfare. The very least possibility should be accorded serious consideration. Not only would it be likely that a health and social with welfare approach reduce the burden of mental ill health but could be expected to reduce the burden of other social problems known to precipitate or aggravate mental illness.

DRUG POLICY AS A DRIVER OF MENTAL ILLNESS

29. It is thought that the strong association of mental illness with substance abuse arises because each influences the other. As the comorbidity guidelines put it: " . . .the relationship between comorbid conditions is one of mutual influence" (Marel *et al.* 2016 p. 7). This section suggests how this takes place by reference to what is known of risk factors and the social determinants of health and well-being. It groups the influencing factors under five headings:

1) Drug policy stimulates the supply of illicit drugs;
2) it is known from personality factors that a large percentage of youth is at risk of illicit drug use and that these factors are also predictors of mental health disorders;
3) Drug abuse intensifies risk factors for mental disorders;
4) The coercive processes of the criminal law mandated by prohibition aggravate or even trigger mental ill-health; and
5) Mental illness intensifies the risk factors for drug abuse thus creating a vicious circle thereby bequeathing drug abuse and social disadvantage to subsequent generations.

This paper now looks in turn at each of these factors.

DRUG POLICY STIMULATES THE SUPPLY OF ILLICIT DRUGS

30. If illicit drugs were not available people wouldn't be using them and there would not be the clustering of mental health problems that so characterises those who abuse them. In this world of the imagination there would also be no concentration of risk factors associated with drug abuse that drive other risk factors for mental illness. Put in other words, the burden of mental health disease would be very substantially lightened if law enforcement were successful in eliminating or at least substantially reducing the supply of illicit drugs.

31. It is a paradox that a trade prohibited by the criminal law actually stimulates that trade but it is a paradox that can be appreciated when one considers:

a) the extent that the supply of prohibited substances has actually flourished under prohibition;

b) the extent that new drugs or more potent variants of existing drugs have come to market under prohibition; and

c) the obstacles in the way of it ever being likely that law enforcement could suppress such a lucrative black market trade.

The illicit drug trade has flourished under prohibition

32. With its prime focus on supply reduction, the acid test of prohibition is its success in substantially reducing the availability of the prohibited drugs. In that it has been a lamentable failure. The following potted history of the advent of illicit drugs in Australia while they were banned shows at the very least prohibition has been ineffective.

Cannabis

33. In 1938 *Smith's Weekly* reported the "first appearance in Australia" of cannabis (Manderson 1993 p. 63). The 2016 household survey found that 10.4% of the population over 14 years old (over 2 million Australians) had used it in the last year.

Heroin

34. Australia consumed 5 kg of heroin (all of it legal) on the eve of the ban on its importation in 1953 (Manderson 1993 p. 63). By the end of the century the National Crime Authority estimated Australians were using 350 kg per million (all of it illegal) (NCA 2001 p. 21).

Crystal methamphetamine

35. Initially at least, purified potent crystalline methamphetamine was not manufactured in Australia. It was imported (McKetin & McLaren 2004, 4). The first mention in the *Australian illicit drug report* of the more potent forms of methamphetamine imported from South East Asian being found in Australia was in the report of 1996-97 (AIDR 1997, 56). "There are already signs," it noted, "of this occurring:

- there has been an increase in the number and size of seizures of ice (crystalline methylamphetamine hydrochloride);
- amphetamines in tablet form, manufactured overseas, are starting to appear in larger quantities in Australia;
- there has been an increase in the number of Customs seizures of amphetamines" (AIDR 1997, 56).

At the time "most ice available in Australia [was] believed to be imported from the Philippines" (AIDR 1997, 62).

36. A year or two after that first appearance, the then Commissioner of the AFP told a *Herald Sun* journalist that Asian crime syndicates had carried out marketing research that showed a bigger demand for amphetamine-like substances in the form of swallowed pills than for an injected drug like heroin:

> "'They are making speed pills that look like ecstasy and in many cases they attempt to pass it off as ecstasy. Some people might think these tablets are

sexier than heroin. And the syndicates have their market research which tells them that these days people are more prepared to pop a pill than inject themselves,' he said" (Mr Keelty quoted in Moor 2001b, p. 1).

37. The failure of supply reduction to limit the availability of drugs to users can also be gauged by different market indicators. Price, purity, reports of ease of availability, level of seizures and such like all shine light on the state of the black market. If law enforcement were successful one would expect to see low levels of seizure, rising price, decreasing levels of purity and reports of reduced availability. Instead one sees the opposite: just as a large fish catch points to a healthy fish stock, so reports by users of easy availability and high level of law enforcement seizures point to a flush drug market and thus law enforcement failure rather than the success of which law enforcers and politicians like to boast. A declining or steady retail price and steady or rising reports of purity of seized drugs also confirm a fully supplied black market. In submissions to the Joint Parliamentary Committee on the Australian Crime Commission, Families and Friends for Drug Law Reform examined in detail these market indicators and criticised the Drug Harms Index devised by the Australian Federal Police (FFDLR 2005 & FFDLR 2006). The Drug Harms Index uses as a marker of success the notional harm avoided by every unit of an illicit drug that has been seized. The only trouble is again that this index claims as law enforcement success, seizure of greater quantities and seizure of new more harmful drugs – both markers that are really proof of failure.

Cocaine

38. The 2016 household survey reported that "Recent cocaine use has been increasing since 2004, and is at the highest rate in 15 years": Recent usage of cocaine grew from 0.5% of the population in 1993 to 2.7% in 2016. 9% of the population (about 1.9 million people) have used it at some point in their lifetime. This represented a significant increase from 8.1% reported in the 2013 household survey (AHS 2016pp 51 & 53).

Size of the drug black market

39. In 2012 the Bureau of Statistics researchers came up with an estimate of the total value of domestic and imported drugs in 2010 at $7.574 billion (Gajewski and Cullen 2012). Using a different approach, the Australian Crime Commission estimated that in 2013 – 14 illicit drugs constituted $4.4 billion of the cost to Australia of serious and organised crime. The amount was said to take "into account health impacts, money lost to the economy through international payments made for illicit importations, and estimates of the size of the illicit drug markets and lost productivity output of drug users" (ACC 2015).

New and more potent drugs brought to market

40. As this submission explores below, the presence of prohibition and demand is only part of the story. The psychology of drug users and user dealers and the practical limitations facing law enforcement such as the wealth at the disposal of staggeringly wealthy criminals to corrupt and otherwise smooth the way to enable their evil trade, served as additional stimulants of it. One evidence of this is the agility and responsiveness of the market demand and how it may even expand and diversify product offerings. This is illustrated by some developments in the drug market in Victoria.

41. It is instructive to compare with the latest surveys the early surveys of drug users (the illicit drugs reporting system (IDRS)) and (the ecstasy and related drugs reporting system (EDRS). These surveys have been coordinated for many years by the National Drug and Alcohol Research Centre at the University of New South Wales. The first Victorian IDRS was undertaken in 1997 and in 2003 the first EDRS or Party Drug Initiative (PDI), as it was initially termed. The 2015 surveys depicted a much more complex drug scene. The 2015 survey reported "a significant rebound in the percentage of daily heroin users" compared to 1998 when "heroin continues to be readily available in Melbourne." Cocaine in 1998 was barely detectable (p. 39) whereas in 2015 67% of participants reported a lifetime cocaine use and 9% reported having used that drug in the previous six months (p. 21). In 1998 crystal methamphetamine was unknown. Amphetamines was reported in the form of "speed" (page 33). By 2015 there had been a switch from speed powder so that "participants most commonly reported recently using crystal methamphetamine or ice (69%). In 2015 cannabis was "ubiquitous" and "among recent users, hydroponically grown cannabis was smoked most" (EDRS Vict 2015, pp. 9 & 22). A majority of participants in the 2015 EDRS survey commented that both hydroponic and bush cannabis were ‘easy ‘or ‘very easy’ to obtain (page 46). The 1998 survey noted only "a continuing trend towards hydroponic production" (p. 45). Potency was stable. The 1998 survey identified other drugs used by participants, most notably benzodiazepines. By 2015 both the IDRS and EDRS surveys reported a significantly larger range of other drugs (EDRS Vict 2015, table 2 p. 8), an emerging street market for the antipsychotic medication quetiapine, use of pharmaceutical stimulants (p. 32) and use of new psychoactive substances and synthetic cannabinoids (IDRS Vict 2015 p. 34).

42. What must be among the most egregious examples of criminal entrepreneurship and nefarious influence was revealed to the *Herald Sun* in June 2001 by the then Commissioner of the Australian Federal Police. This was at the time of the so-called heroin drought when a substantial reduction in heroin supply was accompanied by a surge in import of high potency methamphetamine. The Commissioner revealed that Asian organised crime gangs had “done market research that tells them that these days people are more prepared to pop a pill than inject themselves" (Moor 2001b) and that as a result they made, “a business decision by Asian organised crime gangs to switch from heroin production as their major source of income to the making of methamphetamine, or speed, tablets.” The Commissioner stressed that there had been “a conscious” decision “to move the market away from heroin into something that is far easier to put into the marketplace” (Moor 2001a). The general manager, Australian Federal Police National Operations, confirmed the accuracy of this report in evidence he gave on 16 August 2002 to the House of Representatives Family and Community Affairs Committee inquiring into substance abuse in Australian communities (McDevitt 2002, 1,221). There is a continuing debate whether the 2000 – 2001 heroin drought was brought about by law enforcement effort but the decision to swap drug exports to Australia has not been challenged.

43. The advent of an attractive new drug like crystal methamphetamine repeated in Australia what has happened in many other countries and with many other drugs. Time and again prohibition has motivated organised criminals to replace existing drugs with more potent new ones which produce far greater harm. This occurred during alcohol prohibition in the United States when more concentrated spirits

displaced less potent and bulkier beers or in Pakistan and hill tribe villages in Indochina where heroin rapidly displaced traditional opium smoking (Seccombe 1995).

> "The consequence of an illicit market governed almost exclusively by the need to maximise profits, is that it becomes increasingly dominated by the more concentrated, potent and risky drug products and preparations that offer the greatest profits—injected heroin, crack cocaine, and methamphetamine for example" (Transform Drug Policy Foundation 2009, p. 38).

Illicit drugs are attractive to a large proportion of the population and particularly to young adults

The psychological drivers of illicit drug use

44. To state the obvious often overlooked in the analysis of drug policy, drug use is a human behaviour motivated principally by psychological factors. An insight into these factors is provided by the identification in household surveys of the "Motivations/factors that influence decision to use illicit drugs." (AHS 2013, p.68). The Howard government also commissioned important research into the factors leading young people to take drugs. This research revealed that illicit drugs are potentially attractive to a wide range of young people of normal personality types (Blue Moon Research & Planning Pty Ltd (2000)). The following account is drawn from pp. 1-30 of this report and in particular pp. 27-29. There are those who tend to be outward looking and those who tend to be inward looking. Within each group there are some who will be very likely to try drugs - the thrill seekers in the outward looking group and the reality swappers of the inward lookers who feel the need of the support that they think drugs will provide them. Considered rejectors (outward lookers) and cocooned rejectors (inward lookers) are never likely to have any truck with drugs. But there are within the extremes of each of the inward and outward groups (the careful curious and the risk controllers) who may well try drugs.

OUTWARD LOOKING ↓	INWARD LOOKING ↓
Considered Rejectors	Cocooned Rejectors
Careful Curious	Risk Controllers
Thrill Seekers	Reality Swappers

Reality Swappers of the introspective group are not particularly happy or secure in their lives, and they do not feel in control of things. They are inclined to try drugs, to avoid pain, or particularly in the case of stimulants, seek to compensate themselves for their perceived inadequacies – in other words as a form of self medication to compensate for social awkwardness and other perceived shortcomings of their personality.

45. At the other end of the scale among the outward lookers were “thrill seekers” who were prepared to take risks. Comprising 20% of 15-24 year olds, they “. . . enjoyed the excitement of drugs, the ‘buzz’, the sense of risk, the excitement and the belief that drugs were ‘cool’. Their curiosity and pursuit of excitement could tempt them to trial ‘hard’ drugs, despite their awareness of the potential dangers.” Among the less confident inward lookers were “reality swappers” comprising 16% of 15-24 year olds. They “believed that the reality they experience while on drugs was better than the ‘straight’ world. They believed they lacked the self-respect, love and interests that their peers enjoyed. Moreover while they often acknowledged that their problems were increased because of the drugs they took, the only relief they knew was through drug-taking.” The heaviest drug users were likely to come from these two groups.

46. The 37% of “thrill seekers” and “reality swappers” “showed a moderate level of use or potential use of illegal drugs”. In short, among the young population there is a large proportion of personality types with a moderate or high potential risk of using illicit drugs. Those in the household survey citing curiosity as the reason they first used an illicit substance (66%), those wanting to do something exciting (19.2%) and wanting to enhance an experience (13.3%) are probably “thrill seekers”. Some of the personality qualities such as preparedness to experiment and take risks that predispose young people to use are qualities that are generally admired. It is important that drug policy be informed by what is known that moves people to take up drugs. In fact, drug policy continues to be fashioned and implemented on the false assumption that the threat of the consequences of being caught will deter the uptake and use of drugs.

47. It is important to take into account all these psychological factors in framing a public policy response. What has been achieved in the reduction of tobacco smoking which has never been made illegal has lessons. Furthermore, it is said of the Dutch that despite their liberal ways, their success in keeping drug use significantly lower than in Australia is achieved by transforming drug use from something daring and cool to something boring.

48. Appreciation of the psychology underpinning the attraction of illicit drugs helps counter the objection that to move away from prohibition of the possession of small quantities of drugs for personal use would send the wrong message and lead to greater drug use. The author of this submission has just heard a presentation by Dr Caitlin Hughes of the National Drug and Alcohol Research Centre at the University of New South Wales citing multiple surveys that have shown this fear is unfounded. In fact, potent psychological factors are at play as the law presently stands

Why law enforcement is incapable of suppressing drug use.

Retail level drug trade – impossibility of suppression

49. For all the very considerable effort that is put into drug law enforcement, it is a fantasy to believe that it would ever be successful in suppressing the drug trade at the retail level. Many of the reasons for the resilience of the retail drug trade have been addressed but for convenience reasons 12 of them are summarised below:

> (i) With two willing parties to drug transactions, drug dealing is not reported. Transactions in the marketing of illicit drugs are unlike most crimes where there is a willing perpetrator and unwilling victim. In the trading of drugs both parties have a strong interest in keeping the transaction secret. This sets drug

dealing apart from the victims of most crimes. In other words, the drug trade exists under the radar.

(ii) The direct peer to peer marketing system of the retail and other lower levels of the drug trade (Windle & Daniel Briggs 2015) replicate the persuasive person-to-person retailing strategy of enterprises like Amway which in 2016 engaged "107 million people around the world . . . with direct selling, driving more than US $182.6 billion in direct retail sales. Based on 2016 revenues, Amway, Avon, Herbalife, Vorwerk and Mary Kay are the top five global direct selling companies (Amway). [This] shows, a highly effective marketing strategy";

(iii) Consensual direct marketing schemes of addictive substances are highly resistant to police penetration.

(iv) Higher prices brought about by drug law enforcement fail to deter most dependent users whose demand for substances to which they are addicted is largely inelastic.

(v) The very high profit margins allow criminal enterprises to outspend law enforcement agencies in hiding their tracks and facilitating their trade by money laundering, corruption and violence to intimidate witnesses and competitors (ACC 2015 pp. 8 & 9). Thus, money laundering, violence and corruption support and conceal "serious and organised activity" (ACC 2015 p. 5). It is therefore very hard to detect and catch those near the top of the distribution pyramid. In the words of a retired Tasmanian Police Commissioner and member of the Board of Control of the Australian Bureau of Criminal Intelligence, Mr John Johnson:

> "I don't think [police action is] having any effect on the supply in Australia. I think that [what] we do quite regularly when we catch some of the Mr Bigs is that we make life much easier for some of the other Mr Bigs who haven't been prosecuted and caught. We've put their competition in prison and left the world open for them and they're extremely difficult to catch and they go on with their business . . . ." (APGDLR 1997).

(vi) Motivated by the prospect of quick and easy money, there is an endless supply of middle level dealers prepared to run the risk of apprehension in return for wealth. The addicted user who deals to feed a habit is the disposable bottom layer of the distribution pyramid, the cannon fodder of the drug war. At most, local policing merely displaces the market.

(vii) There is only a small chance that drug users will ever be arrested. For a deterrence to be effective, it should be swift and certain. Drug law enforcement is neither (Kleiman, 2009). Based on the most recent Australian usage and arrest rates, there is less than a 2% chance of ever being caught;

(viii) Drug law enforcement and drug dealers both aim to maximise the price of drugs: law enforcement in order to put them out of reach of drug users and dealers in order to maximise their profit. In other words, the objectives of law enforcement and dealers coincide, ensuring a continuing supply of drugs.

(ix) In addition to deterrence, drug law enforcement aims to put drugs out of reach of consumers by raising their price. Given that demand from dependent

drug users is relatively inelastic, raising the price of drugs, far from moderating demand and thus supply, serves as an incentive to supply. The Australian Crime Commission is well aware that profit attracts further supply:

> " . . . the price paid for methylamphetamine in Australia is among the highest in the world, making the importation of the drug and its precursor chemicals an attractive target for transnational crime groups" (ACC 2015, p.3);

(x) law enforcement is never able to seize more than a small proportion of the profits of the drug trade. The Australian Bureau of Statistics has supported research into the estimation of the size of the Australian illicit drug trade. This study estimated that in 2010 the trade in illicit drugs was worth $7,574 million of which "cannabis" represented $4,889 million (Cullen & Gajewski 2012 p. 12). Even if all the $93.3 million that the AFP confiscated in 2016 – 17 (AFP 2016-17 p. 30) represented drug proceeds, this would be a mere 1.23 percent of the estimated annual value six years before of the black market economy for all illicit drugs and 1.91 percent of the cannabis market.

(xi) For risk taking young people the illicit status of certain substances is a challenge that they rise to. Drugs have the attraction of forbidden fruit. Other countries with a better grasp of adolescent psychology have successfully made illicit drugs boring.

(xii) Other less confident young people try drugs to avoid pain or, in the words of the household survey, to "improve [their] mood/to stop feeling unhappy" – This is a form of self medication combating unhappiness or social awkwardness.

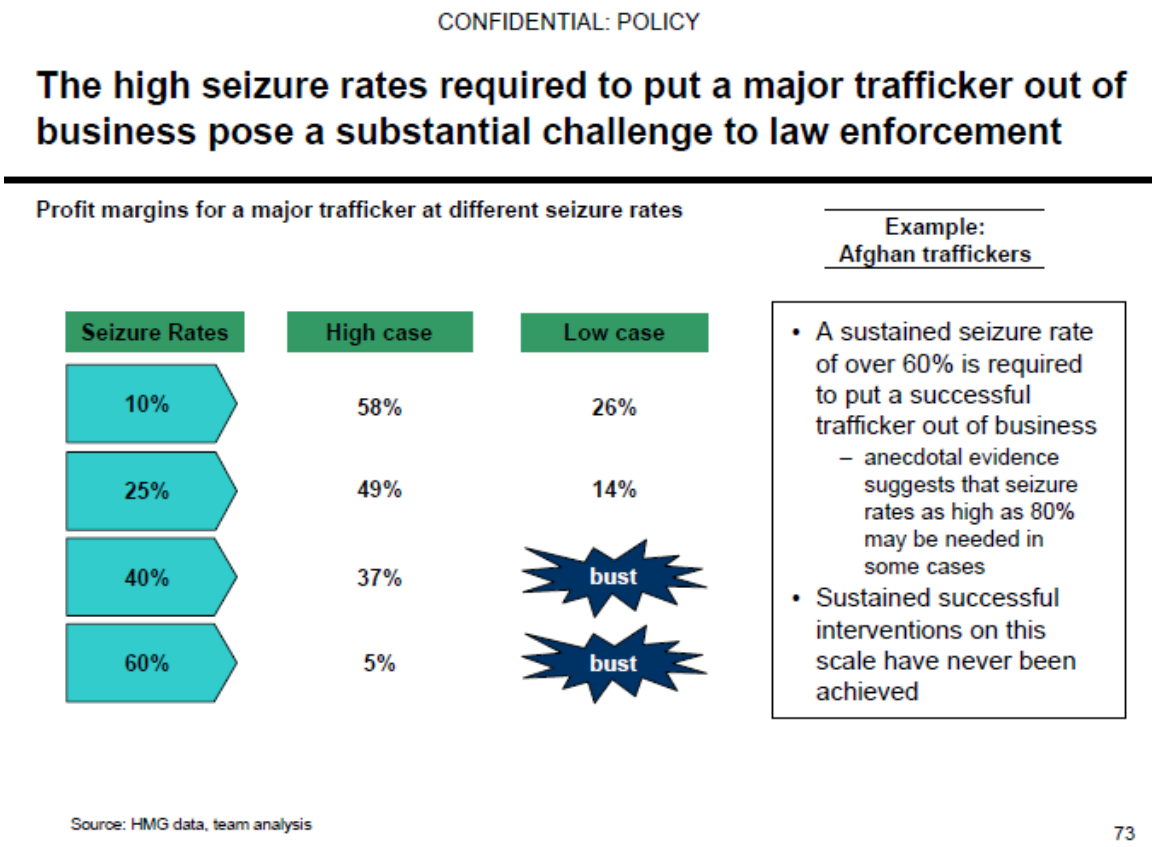
Wholesale level drug trade and production – impossibility of suppression

50. The resilience of the wholesale drug trade is ensured not only by the massive wealth which it can deploy to corrupt and otherwise facilitate its prosperity but also its malleability and adaptability. What law enforcement agencies have singularly failed to do is to identify what it would take to fatally wound the illicit wholesale drug market. The only serious effort that we are aware of to take this step was reported in a confidential briefing paper prepared in 2003 at the instance of the Home Office for the British Cabinet. The paper was leaked by *The Guardian* in 2005. To put a drug dealer out of business requires seizures at a sustained high level that have never been achieved. As the Home Office paper put it:

> "A sustained seizure rate of over 60% is required to put a successful trafficker out of business. Anecdotal evidence suggests that seizure rates as high as 80% may be needed in some cases. Sustained successful interventions on this scale have never been achieved."

51. And it would indeed need to be higher than 80% in the case of cocaine where, as the Australian Crime Commission commented, "Organised criminals can achieve profit mark-ups of more than 6,100 per cent compared with the wholesale cocaine price in Mexico" (ACC 2011).

Figure 1: Seizure rates required to put a major trafficker out of business



SOURCE: United Kingdom 2003, p. 73.

DRUG POLICY AS A DRIVER OF KNOWN RISK FACTORS FOR MENTAL ILLNESS

52. American studies have found that:

> "*. . .two thirds* of the common vulnerability to different types of illicit drug use disorders was explained by shared environmental factors. This is not surprising, given that there is a wealth of evidence that a number of factors are common to both mental disorders and substance use disorders. For example, social disadvantage is more common among persons who are problematic substance users . . . ; who meet criteria for mood disorders and anxiety disorders . . .; and who meet criteria for psychotic disorders, and there is evidence to suggest that this is not merely because of social drift after developing the disorder . . . . For all these groups of disorders, studies have shown that there are higher rates of separation and divorce, and a lower likelihood that persons will be married or in a defacto relationship . . . .
>
> There is also a number of other factors that have been similarly associated with substance use disorders and with mental disorders, such as parental psychiatric illness and family dysfunction . . . It is possible that these social factors serve to increase the apparent 'comorbidity' of mental disorders" (Degenhardt, Hall & Lynskey 2003 pp. 18-19).

53. The relationship between mental illness and drug abuse can be bidirectional as in the case of anxiety and sedatives. “The relationship between the different anxiety disorders and drug disorders is likely to be complex and bidirectional. One disorder can frequently mimic, and exacerbate and worsen, the symptoms of the other, and, as such, have an impact on prognosis and treatment. People with co-occurring drug use and anxiety disorders often have a more severe level of disability over time, and a poorer treatment response” (Mattick & O’Brien 2008 p. 129).

Alienation and stigmatisation

54. Harsh, discriminatory attitudes to drug users are widespread and intense. A visiting American television judge told a cheering audience in Brisbane that we should "Give 'em dirty needles and let 'em die" (*Courier Mail,* 17/11/99, p.12). In sentencing a woman in Adelaide on a prostitution charge a Magistrate told her:

> “We dicks pay for your life. It’s your choice to be a junkie and die in the gutter. No one gives a shit, but you’re going to kill that woman who is your mother, damn you to death.” (*Advertiser*, 1/5/03, p. 7)

55. Research commissioned by the Injecting and Illicit Drug Users League revealed a pervasive stereotypical portrait of “junkies”:

> “[They] look thin, gaunt, pale with bad teeth and track marks. Likely to be unemployed and possibly homeless, living off their family, or in a run down place with others. There is a strong likelihood that the person is a criminal who will steal (or other illegal/ immoral activities) to get money for drugs. They are not to be trusted and are irresponsible and selfish in their behaviour to others, as they are addicted to their drug and are only concerned with fulfilling their addiction” (Parr & Bullen 2010, p.23).

56. The survey found that drug users are shunned. "Almost all respondents among the general public expressed reluctance to be around the person they suspect may inject drugs." There was fear of what the drug users are or may do and a "secondary fear of ‘guilt by association’ meaning that by being around some one who injects drugs, the individual might be subject to the same type of stigma and/or discrimination.” The general public has "little empathy overall for people who inject drugs believing they choose to start and then to continue to inject drugs, so therefore, should deal with negative consequences."

The stigma serves to deter dependent drug users burdened by other serious mental health problems from accessing treatment and psychosocial support. In a paper on the mental health needs of clients of the medically supervised injecting centre in King’s Cross, “qualitative research suggests substantial barriers to accessing treatment among MSIC clients, including unwillingness precipitated by stigma and discrimination”(Goodhew 2016).

57. The pervasiveness of stigma is apparent at another level. It impedes even access to medicinal cannabis for research and treatment. The criminalisation of drug use has also undermined the potential medical use of the drug that may now be prescribed around the country.

- Criminalising cannabis has impeded research on its medical benefits; and
- Criminalisation has distorted the focus of research with research effort directed at the identification of its harms rather than its likely benefits.

- It has led to the existing cumbersome, bureaucratic procedure that impedes access to the drug across Australia. The illegality of cannabis creates stigma, disapproval and judgement that constrains the legal channel for access to it.
- It contributes to the refusal of doctors to educate themselves about the benefits of cannabis for their patients.

In the words of Dr David Caldicott there has been "a century of missed scientific research to be conducted before allowing access" (Volteface 2018)

58. In spite of the legalisation of access to cannabis through the medical profession, its criminalisation still impedes access to it by by those who stand to benefit from it. We are aware that the stigma in New South Wales has constrained the public advocacy of a group representing people suffering from conditions like epilepsy for which cannabis is recognised by medical science as therapeutic.

Homelessness

59. There is “empirical evidence that a lack of social capital and/or behavioural problems, such as mental ill health and substance misuse, are more prevalent among the homeless” (Johnson, Scutella, Tseng, & Wood 2015 p. 7).

> “ . . .the availability of housing and housing status (including homelessness) consistently appears as a risk factor for injection initiation across a range of settings. For example,Roy *et al*. found that homelessness was the key risk factor for injection initiation among street-involved youth in Montreal. They further posited a causal pathway to injection initiation, as they note that the risk of injection initiation has been shown to be associated with the level of social integration of people who use drugs into society, and that a lack of access to housing impacts an individual’s capacity for social integration. Similarly, in a study of injection initiation in three Australian settings, Abelson *et al.* hypothesized that homelessness was a proxy measure for social and family disadvantage, which placed people at higher risk of initiation. Indeed, the fact that much of the observational research on injection initiation is restricted to samples of street youth who experience entrenched and chronic housing instability is evidence of the strong role that housing status is assumed to play in heightening injection initiation risk” (Werb *et al.* 2018).

Homelessness and mental illness

60. Mental illness is much more common among homeless people than in the general community. A study of a large number of people in inner-city hostels in Sydney found that at least 75% had at least one significant mental health disorder. “A 1998 study reported that about 75% of homeless people contacted through inner-city hostels in Sydney had at least one significant mental disorder (as defined by formal diagnostic tests). The prevalence was higher for women (81%) than men (73%).” In contrast, the expected prevalence rate in the Australian population of at least one mental disorder is just 18%. (Forell, McCarron & Schetzer 2005, p. 51). The Homelessness Task force noted that: “About one third of SAAP clients required intensive and/or ongoing assistance with mental health issues (FAHCSIA 2008, p. 8). More recent assessments of the situation report increasing prevalence of mental illness among the homeless:

> "The Australian Government's national approach to reducing homelessness identifies untreated mental health as one of the main pathways into homelessness, and has given priority to this vulnerable group (COAG 2009).Specialist homelessness agencies support many people with mental health issues, providing a range of health, housing and general services. Clients with a current mental health issue . . . make up the fastest growing client group in the [Specialist Homelessness Services] SHS population. Increased rates of identification, greater community awareness and reduced stigma about mental health have all potentially driven the increase in self-identification and reporting of mental illness among SHS clients. On average, this client group has grown at a rate of 13% per year since 2011–12 (Table 6.2.1). The increase has been faster for females, growing at an average rate of 14% per year since 2011–12. The equivalent growth rate for males over this period was 11%.The rate of service use by clients with a mental health issue has increased 50% in 5 years, from 20 people per 10,000 population in 2011–12 to 30 people in 2015–16.Similar to the general SHS population, the majority of clients with a current mental health issue were female (58%) in 2015–16" (AIHW 2017).

61. A British survey found ". . . a staggering 76% of interviewees who lived on the streets or in hostels, had some form of mental health problem –either diagnosed by a doctor (65%) or self identified (11%)" (St Mungo's 2009 p. 4).

> "Homelessness and inappropriate housing expose people with mental illness to a wide range of risk factors for their mental and physical health and wellbeing. These include violence and abuse, harmful alcohol and other drug use, poor nutrition and sleep, severe social isolation, lack of amenities for self-care, disease, and even exposure to the elements. All of these are major stressors that are highly likely to compromise mental and physical wellbeing and pose additional challenges for providing continuing care" (Rickwood 2005 p. 36).

62. Rickwood attributes the high coincidence of mental illness and homelessness in part at least to deinstitutionalisation of mental health services. "Of major concern is the level of homelessness experienced by people with mental illness. An unintended consequence of the deinstitutionalisation that has taken place over the period of the National Mental Health Strategy has been an increase in the number of people with mental illness who are homeless or inadequately housed. Data collated by the AIHW on supported accommodation programs show that mental illness, directly and indirectly, is a major contributor to homelessness" (Rickwood 2005, p. 36).

63. For all that, a large survey of those likely to enter homelessness came up with the surprising finding that "individuals diagnosed with bipolar or schizophrenia are at a lower risk of homelessness than those without similar diagnosed conditions" (Johnson, Scutella, Tseng, & Wood 2015, p. 45). The survey does not make clear whether these personal characteristics were considered separately (*ibid*., appendix 2 pp.54-59 & table 1). One wonders whether their co-occurrence or their co-occurrence with incarceration may have altered the situation. The authors speculated that the explanation of their finding may be because "those diagnosed are more likely to be receiving treatment and care (even institutionalised care), thereby lowering the chances of experiencing homelessness compared to those

undiagnosed but with other risk factors" (*ibid.,* p. 26). They noted that that "implies that those diagnosed but not receiving treatment and support are more likely to become and remain homeless". They added that "If, this is indeed the case it emphasises the crucial role that health services play in the prevention of homelessness among people with a severe mental illness". (*ibid.,* pp. 45-46). This possibility reinforces the thesis of this paper that mental health is to improve if those who abuse drugs are no longer treated as criminals. As things stand the criminal law or the threat of its application tends to disrupt treatment.

> "The risks of homelessness are significantly greater for those recently incarcerated, which includes those coming out of juvenile justice, adult prison or remand. The recently incarcerated variable has a relatively large marginal effect at 9.7 percentage points, despite it only affecting 3 per cent of the sample" (*ibid*., p. 26).

64. The survey of Johnson and others is consistent with the 2018 figures of the Australian Bureau of Statistics of the main reasons why people experience, or are at risk of, homelessness. Mental health and "substance use" issues are each dwarfed by reasons like financial difficulties, relationship/family breakdown, domestic and family violence and housing crisis (AIHW 2018). These surveys and the high prevalence of mental health problems among the homeless, point to homelessness being a potent driver of both substance dependency and other mental illnesses. Particularly when these conditions co-occur, the burden upon agencies working to support the homeless is rendered vastly more complex, thus straining already scarce resources.

Homelessness as a multiplier of other problems

65. Just as homelessness is a consequence of a range of earlier "problems", of "risk factors" or of "determinants" uncompensated by "protective factors," so the experience of homelessness can intensify existing problems or precipitate new ones. In this way human beings can be caught up in a vortex of disadvantage that increasingly plays out in their own life and in the life of their children and others dependent on them. In this way, disadvantage is guaranteed to echo down generations. Two disadvantages commonly intensified or precipitated by homelessness are mental ill health and crime.

Substance dependence as a compounder of disadvantage of the homeless

66. The high level of mental health and other health problems among the primary homeless lead commentators to suggest that street homelessness should be viewed as a health rather than a bricks and mortar problem (St Mungo's 2009 p. 4). Society is indeed conflicted in how it should respond to primary homelessness: the law has it that a large proportion of rough sleepers are criminals. This is not so much because of the law on street offences (see Forell, McCarron & Schetzer 2005, pp. 108-09) but because of the high proportion of homeless people afflicted with a substance abuse disorder. It is noteworthy that the substances of greatest impact are not so much stereotypical alcohol as illicit drugs.

> " . . . Homeless people as a group are more likely to encounter the law than other groups because of their greater involvement in illicit drug taking. Further, their lack of financial resources may also mean that homeless people use illegal means to get sufficient money to support their addiction" (Forell, McCarron & Schetzer 2005, p. 111)

67. The Commonwealth's Homelessness Taskforce, which noted that 12 per cent of Supported Accommodation Assistance Program (SAAP) clients reported a mental health problem other than a substance use one, added that:

> "19 per cent reported a substance use problem and another 5 per cent reported both a mental health and a substance use problem. The majority of these clients were men aged between 25 and 44 years".

68. Much higher prevalence has been detected in a particularly large Victorian survey. This survey was conducted in 2005-06 of 4,291 homeless people in Melbourne. It found that 43 per cent had substance use problems (Johnson & Chamberlain 2007 p. 5). The drugs concerned were predominantly illicit rather than alcohol or prescription medications:

> "The most common drug was heroin, but a minority identified alcohol or other prescription drugs. This is consistent with recent findings indicating that drugs have displaced alcohol as the most abused substance among the homeless, particularly among the young" (Johnson & Chamberlain 2007 p. 5)

69. Substance dependence is regarded as a risk factor for homelessness as well as many other disadvantages but the large Melbourne study suggests that homelessness is itself an even more potent risk factor for substance abuse:

> "We identified that 1,940 people, or 43 per cent of the sample, had substance use issues. Table 2 shows that two-thirds (66 per cent) of them developed substance use problems after they became homeless. Our data confirm that substance use is common among the homeless population, but for most people drug use follows homelessness. Drug use is an adaptive response to an unpleasant and stressful environment and drug use creates new problems for many people" (Johnson & Chamberlain 2007 p. 8).

70. Here we have another of those self perpetuating vortices of disadvantage. Disadvantage and other risk factors lead to homelessness. Homelessness is likely to lead to the mental disorder of substance dependence. The substance concerned is likely to be an illicit drug like heroin. Criminal prosecution and imprisonment is a likely consequence of abuse of illicit drugs. Imprisonment is likely to compound or create other mental health problems and remove chances of employment and stable housing. Is there any way of breaking this downward cycle of disadvantage?

71. Rickwood emphatically believes that establishing people in stable accommodation does:

> "Appropriate accommodation not only removes the risks associated with unsuitable accommodation or homelessness, but also provides a base from which a person can focus on their recovery. It enables people to develop links with organisations and services within their community, and allows them to channel their energy into other factors supportive of their ongoing wellbeing (such as education or employment)" (Rickwood 2006 p. 36).

72. Substance dependence is often the most urgent issue in the lives of many rough sleepers whose resulting chaotic lifestyle sabotages their dreams and best of intentions. Effectively addressing this can bring stability that facilitates them securing and maintaining housing.

73. We have seen that submitting drug users to the processes of the criminal law is implicated in many of the social disadvantages that they experience. Treating

someone as a criminal serves to marginalise them, to push them on to the edges of society. Johann Hari in the conclusion of his book, *Chasing the Scream,* writes of his former partner:

> "You confront the addict, shame him into seeing how he has gone wrong, and threaten to cut him out of your life if he won't get help and stop using. It is the logic of the drug war, applied to your private life. I had tried that way before. It always failed. Now I could see why. He coped with his childhood by cutting himself off. He obsessively connected with his chemicals because he couldn't connect with another human being for long. So when I threatened to cut him off – when I threatened to end one of the few connections that worked, for him and me – I was threatening to deepen his addiction." (Hari 2015 p. 293).

74. At the end of his long journey towards enlightenment Hari concludes: "The opposite of addiction isn't sobriety. It's connection. It's all I can offer. It's all that will help him in the end. If you are alone, you cannot escape addiction. If you love, you have a chance. For a hundred years we have been singing war songs about addicts. All along, we should have been singing love songs to them." (Hari 2015 p. 293).

School dropout

75. The illegality of drugs moves many educational authorities to take far more punitive action in cases of drug use than they do in the case of tobacco and alcohol. This reaction can generate risk factors for mental illness. While there is no strong evidence that depression independently increases the risks of drug dependence later in life, (Degenhardt p.141) "early onset cannabis use and alcohol use (but not tobacco) are both associated with an increased risk of major depression by the age of 27 years (*ibid.*, 139).

76. Current Education Department guidelines for NSW public schools mandate immediate suspension and referral to the police. "Suspension is to occur immediately if the substance is being represented by the student as an illegal substance, or on confirmation that the substance is, in fact, illegal" (NSW DOEC 2015). Punitive policies are also adopted by private schools. An angry Prof. David Penington declared himself to be "simply appalled at the Prime Minister's statement praising PLC (Pymble Ladies College) in Sydney for expelling nine girls for allegedly handling marijuana. We know a large number of those girls in that school will have used it, and to say that expulsion is part of the solution is fundamentally wrong. One of the risk factors of going to heroin is leaving school early, or having been dismissed from school early. We've got political leadership not willing to listen to the facts" (Prof. David Penington quoted in *The Age* (Melb) 1st Edition Friday 28 May, 1999 pp. A16-A17).

77. Use and other involvement with illicit drugs are significant reasons for suspension and dropout from schools. In 2012, for example, 749 students were suspended for up to 20 days for "Possession or use of a suspected illegal substance." These suspensions do not include drug dealing. Anecdotal evidence suggests that a significant proportion of the 8,692 students who were suspended for "Serious criminal behaviour related to the school" were participating in the distribution of drugs to their peers. Adolescents are attracted to this by the ready money. Most suspensions occur to students in years 7 to 10 (NSW DOEC 2013).

78. A study of school dropout across the United States found that “prior use of cigarettes, marijuana, and other illicit drugs increases the propensity to drop out and the earlier the initiation into drugs, the greater the probability of premature school leaving." (Mensch & Kandel).

DRUG ABUSE INTENSIFIES RISK FACTORS FOR MENTAL DISORDERS

Crime

79. The Senate Select Committee on Mental Health made much of the co-occurrence of substance abuse and mental illness among people caught up in the criminal justice system. It termed this “the expectation not the exception”. That committee lamented that:

> “Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system.” (Senate 2006 §2.29).

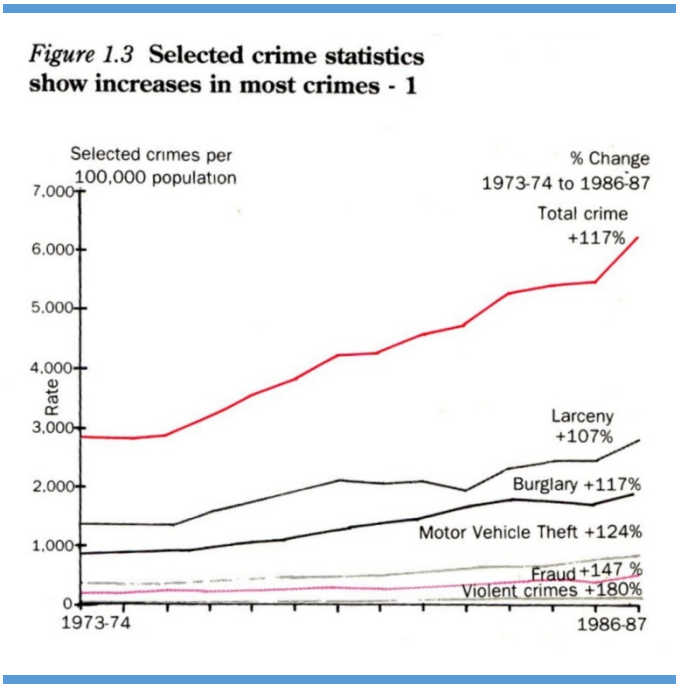
80. The report pointed out the increase in dual diagnosis which was seen as flowing from the failure to meet mental health needs and the increased focus on law and order to control behavioural problems:

> “In recent years the rising incidence of co-morbidity, as it is also termed, has supported a substantial increase in the number of people with mental illness in gaol. Predominating among these are young men and Indigenous people, a disproportionate number being women. Submissions to this inquiry took the view that this trend is a direct consequence of the failure to adequately respond to the mental health needs of people with dual diagnosis, combined with an increased focus on law and order models to control perceived behavioural problems.” (Senate 2006, §5.36).

81. The most common crimes then tended to be those committed by people seeking to raise the funds to support their habit or committed under the influence of drugs. A 1990 study pointed out that short-term trends (1973 – 74 to 1986 – 87) indicated that the:

> “Total numbers of crimes have increased.
>
> - Per capita rates of crimes reported to police generally show increases….
> - Among the violent crimes, serious assaults increased by 236% ,…. And robbery by 78%
> - Property crimes, of which stealing accounts the half, increased by 89%”. (Mukherjee, Neuhaus & Walker (1990) p.7).

Chart 1: Crime statistics 1973 – 74 to 1986 – 87
Total crime, Larceny, Burglary, Motor vehicle theft, Fraud and violent crimes



Source: Mukherjee, Neuhaus & Walker (1990) p. 7.

82. An evaluation by the Burnett Institute of drug policies in the ACT prison reported that:

> "Nearly four in five respondents with a history of drug use reported that they were under the influence of alcohol and/or drugs when they committed the offence for which they were imprisoned. Similar proportions reported that their current imprisonment episode was related to their alcohol and/or drug use. These data are indicative of the close relationship between crime and drug use and in turn the potential benefit of effective drug and alcohol policy and service provision on reducing crime and incarceration rates" (Stoové & Kirwan, 2010, p. 123).

83. In 2002 the Institute of Criminology had commented that crime was still rising: "in terms of property crime the evidence is one of significant increases over the past 20 years, particularly for break and enter and motor vehicle theft" (Makkai (2002) p. 111).). In 2010 Australia was still experiencing "high levels of property crime" (AIC 2012 p. 5.)

84. The increasing association between crime on the one hand and the combination of substance abuse and other mental disorders on the other is a point made by Dr Paul Mullen. The growing association between mental health, illicit drug use and crime was also stressed in much evidence put to the Mental Health Council's landmark *Not for service* report. For example, the Victorian Network for Carers of People with a Mental Illness made the point that:

> "During the past decade, there has been a 50% expansion in the Australian prison system yet those close to grassroots services argue that much of the recent increase in the Australian prison population can be explained by unmet mental health needs, subsequent illegal use of drugs as a form of self-medication, and the eventual intervention of the criminal justice system" (MHCA 2005 p. 436)

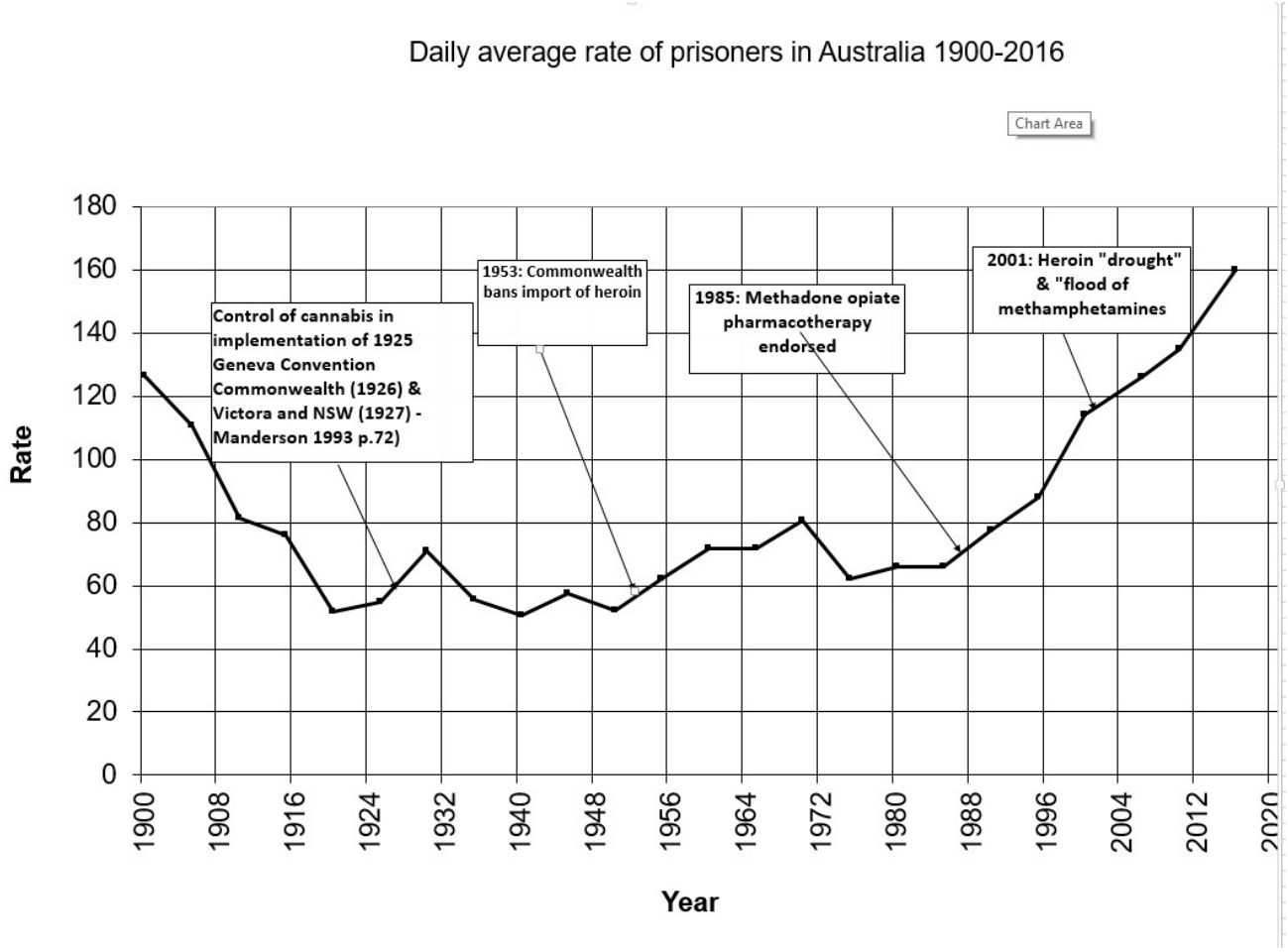
85. In this way, the use of illegal substances has become a common pathway by which people with a pre-existing mental health problem end up in the criminal justice system. Often abuse of a substance starts as a form of self-medication to alleviate symptoms of a mental health condition. Substance abuse can thus mask other mental health conditions.

Prisons

The growth in imprisonment

86. For 80 years of the 20th century to the early 90s Australia had an incarceration rate of below 80 prisoners per 100,000 of the population. As the following chart shows, the century was book ended by much higher incarceration rates. In 1900 we incarcerated 126.8 Australians for every 100,000 of the population and this incarceration rate was falling while in 2000 the rate was 108.39 and rising sharply.

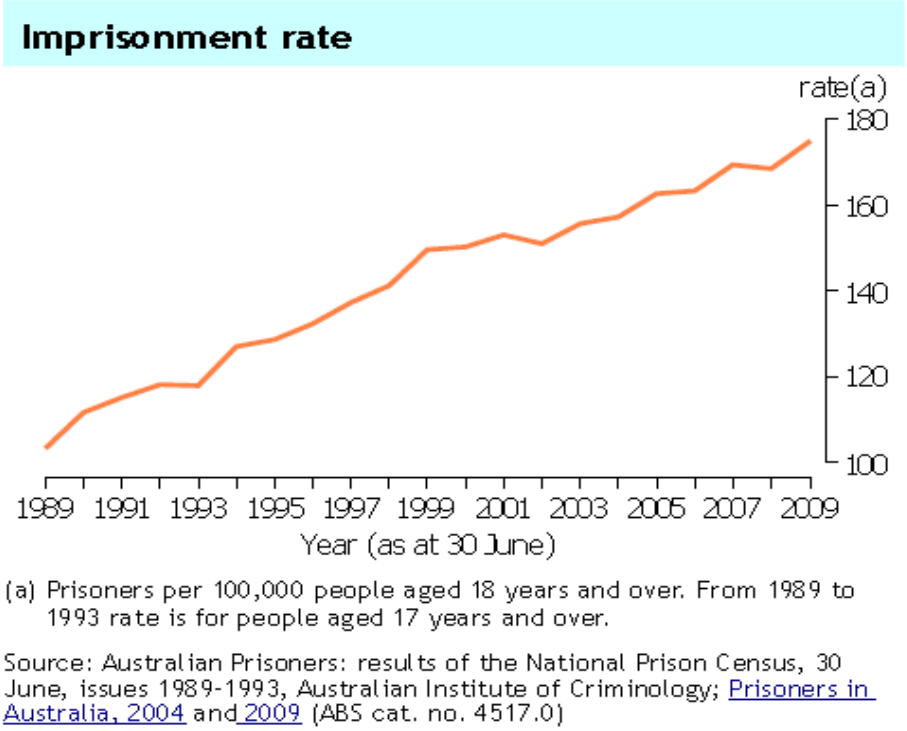
87. The rate of increase may have slackened somewhat in the last few years but prisons remain a huge and costly burden on the government, the people in them, their families and the broader community. According to the latest report on corrective services of the Productivity Commission, in 2011-12, on average, 29,213 people per day were held in Australian prisons – an increase of 1.7 per cent from the 2010-11 (p. 8.5). Nationally, 18.9 per cent of the total prisoner population (excluding periodic detainees) were held in privately operated facilities (Productivity Commission (2013a) p. C.5).



SOURCE: The Cambridge handbook of Australian criminology (2002), table 1.3, p. 16 & ABS, Australian crime: facts & figures 2004, p. 92 & World Prison Brief (http://www.prisonstudies.org/country/australia visited 3/4/2019)

88. The former Institute of Criminology remarked that: “Between 1984 and 2005, the overall imprisonment rate increased from 88 to 163 per 100,000 adult population.” (AIC 2007, p. 84). The Bureau of Statistics reckons that an imprisonment rate of 175 prisoners per 100,000 adults on 30 June 2009 represents an increase "by around two-thirds" since 1989 (ABS 2010 p. 1). This amounts to an increase of 85% or, as the Institute of Criminology puts it, “an average 5% a year since 1984” (AIC 2007, p. 84). If the Cambridge Handbook of Australian criminology is to be believed, the incarceration rate in 1985 was 66.06 per 100,000 rather than 88 (Graycar & Grabosky (2002), table 1.3 p. 16) thus producing an even more alarming surge in imprisonment at the end of the century of 147%. As of 30 June 2018 there were 42,974 people in Australian prisons. This constituted a rate of 221 per 100,000 (ABS 2019).

Chart 2: Imprisonment rate 1989 – 2009



SOURCE: ABS (2010) p. 1.

89. This surge led to a boom in prison-building, for Australia had outgrown its capacity which had dated from an earlier boom in prison-building between 1852 and 1880 (Graycar & Grabosky (2002), p. 17).

90. Unlike the trend in recent years when incarceration rates continued to rise while crime rates were falling (AIC 2012), the tick-up in the prison population from the 1970s matched an increase in the crime rate.

91. It has been suggested that a reason that prisons have come to house so many people with mental disorders is because of the closure from the 1960s of mental asylums in a process termed deinstitutionalisation. In 2006 the Senate Select committee on mental health reported that: "Australia had around 30,000 acute care psychiatric beds in the 1960s. The number of public beds had fallen to around 8,000 at the time of the development of the National Mental Health Strategy (NMHS), and is now around 6,000" (Senate 2006,para. 8.4). In our opinion any impetus of deinstitutionalisation to fill prisons with people who are mentally ill is supercharged by drug policy. This is the most credible explanation of the high prevalence of co-occurring substance abuse disorders and other mental health conditions.

92. The consequence of this deinstitutionalisation without adequate complementary community care was highlighted in the grand survey of lived experience of consumers, carers and others in the *Not for Service report* [MHCA 2005]:

> "this report concludes that government promises to establish adequate, networked, community based services to replace institutional care have not materialised. Reverberating through this report are the voices of consumers, advocates, families, workers and politicians who give accounts of

> homelessness, lack of inpatient and community services, over-reliance on pharmaceutical treatment, undue confinement, imprisonment in gaols, and suicide" (Savy 2005).

93. Ten years later Dr Sebastien Rosenberg observed that "Australia's mental health system is in crisis" and that:

> "One key reason for this is the "missing middle". Most of Australia's asylums were closed by the 1990s, though the Australian Institute of Health and Welfare reports there are still 1,831 acute and sub-acute beds operating in specialist psychiatric hospitals (as opposed to general hospitals), costing more than half a billion dollars annually.
>
> "It is widely accepted that on closing the asylums, Australia failed to invest in an alternative model of community mental health care. This means that for people seeking mental health assistance, there are few alternatives between the GP's surgery and the hospital emergency department.
>
> "These alternatives reflect the financial demarcation between the federal government, which pays for primary care, and the states and territories, which manage hospitals. Nobody currently "owns" or has responsibility for community mental health services" (Rosenberg 2015).

Inefficacy of prisons as a crime prevention measure

Recidivism

94. Sending people to prison inflicts a pain or harm upon them, namely it deprives them of the fundamental right to freedom. Furthermore, doing so comes at a very high economic cost to the community. The infliction of such harm could be justified, only, if at all, if it made the community safer but there is reason to believe that it has the opposite effect. This effectiveness is, of course, achieved while an offender is incarcerated – imprisonment thus disables those detained from committing crimes in the community while they are detained. On the other hand the community has a right to expect much more from its prisons.

95. The Australian Bureau of Statistics neatly summarises the effect that imprisonment is intended to have and goes on to doubt their efficacy:

> "Imprisonment aims to prevent crime and enhance community safety by removing offenders from the public arena and acting as a deterrent to potential offenders, as well as meeting society's need for reparation or retribution for crimes committed.[1] However, while a period of imprisonment may deter some people from re-offending, in others it may foster further criminal behaviour" (ABS 2010b p. 1)

96. The fact of the matter is that the threat of imprisonment is an ineffective means of deterring offending in the first place and, worse than that, there is strong evidence that imprisonment in the Australian system increases the likelihood of reoffending by those who graduate from a prison. All too often imprisonment is justified in the eyes of politicians and the public as simply a means of making people suffer in revenge for a crime that they may have committed.

97. As a means of reducing crime there is little room for doubt that incarceration as practised in Australia is a very inefficient social intervention. This is evident from

the following table and chart of recidivism (expressed as the rates of Prisoners released who returned to prison) in the 2019 *Report of Government Services* compiled by the Productivity Commission (PC Rog 2019).

Table 1: Prisoners released who returned to prison under sentence within two years (per cent)

Table CA.4 **Adults released from prison who returned to prison with a new sentence within two years - time series (per cent) (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2017-18	%	50.8	43.7	42.7	38.5	37.1	46.3	44.2	55.9	45.6
2016-17	%	51.3	43.6	40.2	37.8	36.2	44.3	38.6	57.1	44.8
2015-16	%	50.7	42.8	39.7	38.1	36.9	39.8	41.0	58.3	44.6
2014-15	%	48.1	44.1	40.9	36.2	38.1	39.9	38.7	59.5	44.5
2013-14	%	45.8	39.5	39.8	39.0	38.4	39.3	41.9	59.1	43.0

Adults released from prison who returned to corrective services with a new correctional sanction within two years - time series (per cent) (a), (c), (d)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2017-18	%	55.8	58.2	53.7	45.3	45.7	55.5	69.9	58.7	54.2
2016-17	%	55.8	57.7	51.1	44.9	45.0	55.0	58.5	60.1	53.4
2015-16	%	55.1	55.6	49.8	45.7	46.1	49.8	61.3	61.0	52.6
2014-15	%	52.9	53.7	49.1	42.7	46.0	50.0	59.8	61.6	51.3
2013-14	%	50.3	48.7	48.0	45.2	48.7	49.4	62.9	61.4	49.9

(a) Refers to all prisoners released following a term of sentenced imprisonment including prisoners subject to correctional supervision following release, that is, offenders released on parole or other community corrections orders. Data include returns to prison resulting from the cancellation of a parole order.

(b) Includes released prisoners who returned to prison only or who returned to both prison and community corrections.

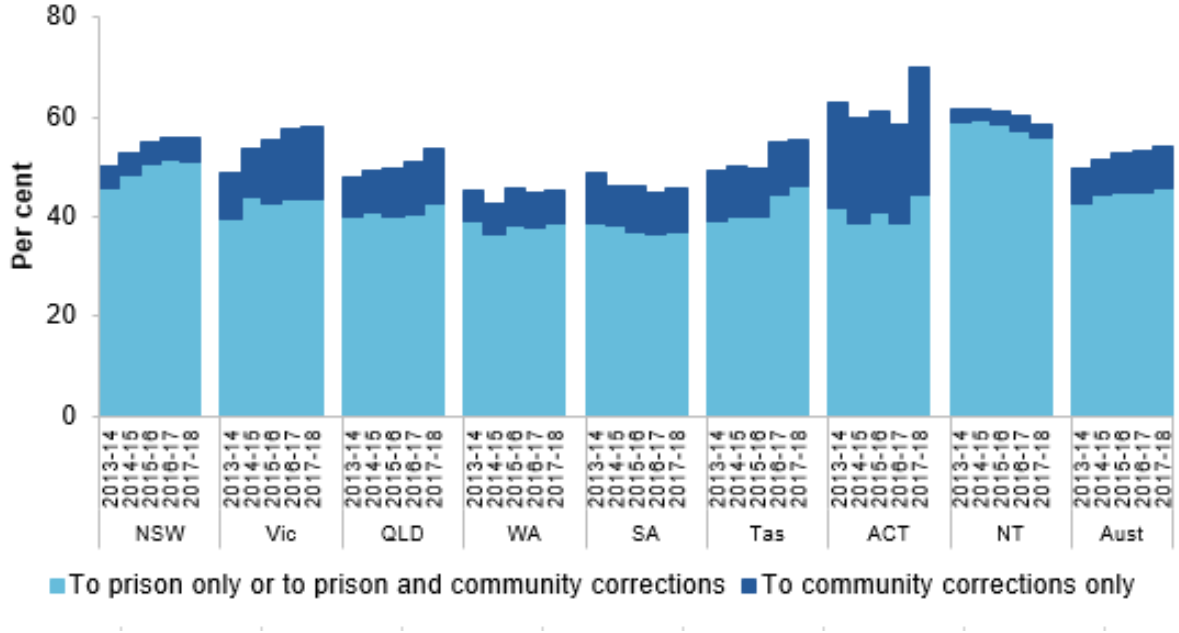
(c) Rates for SA from 2013-14 onwards reflect legislative changes introduced in August 2012 that provides opportunity for parole to be cancelled for a breach of any condition, resulting in return to prison to serve the remaining sentence(s). Previously, breaches of only certain types of conditions would result in cancellation of parole.

(d) Includes a prison sentence or a community corrections order.

Source: Australian State and Territory governments (unpublished).

SOURCE: PC Rog 2019

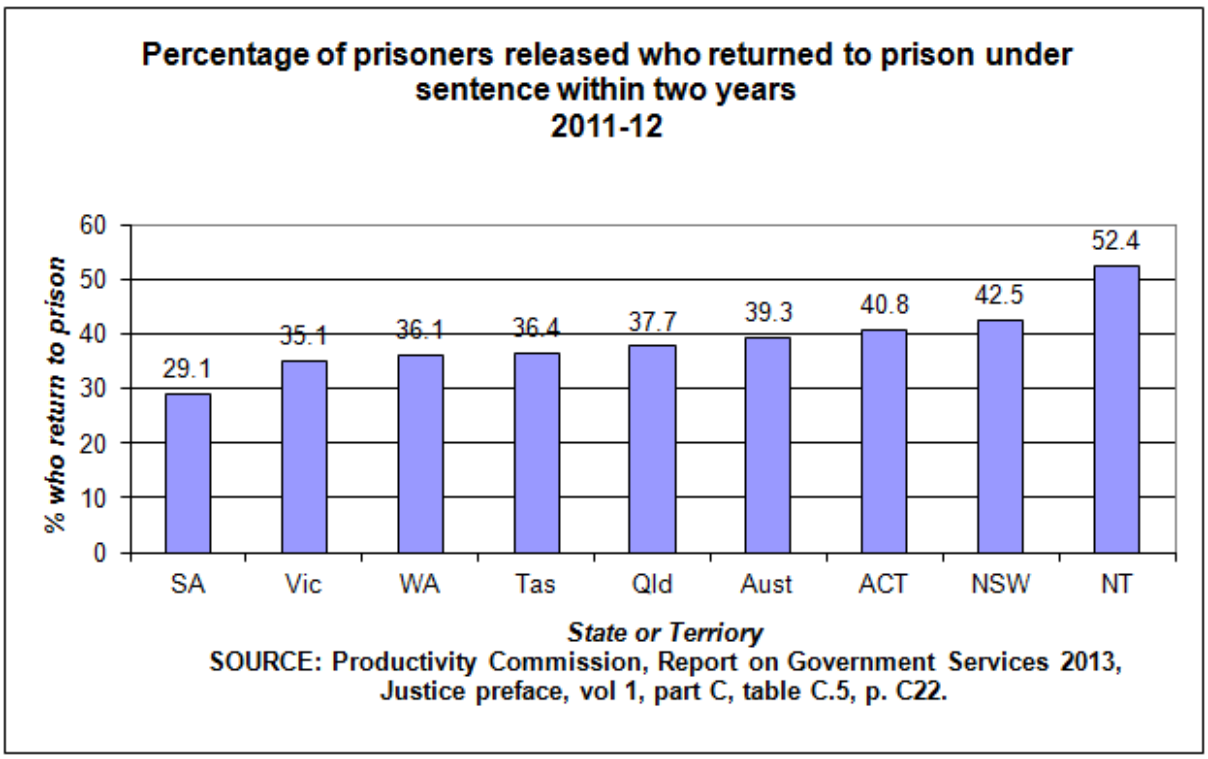
Prisoners returned to corrective services with a new correctional sanction within two years of release (per cent) visited



SOURCE: https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/justice visited 4/18/2019.

98. The rate of return to prison varies greatly between jurisdictions. The rate in the Northern Territory at 55.9% (the highest) is almost half as big again as that of South Australia at 37.1% (the lowest). Clearly some Australian prison systems perform better than others. It is concerning that, as the following chart shows, just six years ago the rate of return of prisoners should have been so much lower. The trend is in the wrong direction.

Chart 3: percentage of prisoners released who returned to prison under sentence within two years 2011 – 12.



99. Analysis by the Bureau of Statistics also throws doubt on the the utility of prison. It followed a cohort of people released from prison between 1994 and 1997 and measured whether they had returned to prison within 10 years of their release. It found that two in five of those released had been reimprisoned within 10 years (ABS 2010, p. 3).

100. The rate of re-imprisonment for those who had earlier served time for property offences – crimes that are particularly associated with illicit drug use – was even higher:

> "Members of the 1994–1997 release cohort who had been in prison for burglary or theft had the highest reimprisonment rates (58% and 53% respectively)" ABS 2010a p. 4).

101. Perhaps the gravest indictment of imprisonment revealed in the ABS study was that the more one has been in prison the more likely one is to reoffend: "reimprisonment was strongly associated with already being a recidivist prisoner, as opposed to being in prison for the first time . . . Younger prisoners were more likely than older prisoners to be reimprisoned following release. Within 10 years of being released, the reimprisonment rate for the teenager group (those aged 17–19 years when released) was 61%, compared with 23% for those aged 35 years and over." (ABS 2010a p.2).

102. This study lends credence to the folk wisdom that prisons are colleges of crime.

Harms associated with imprisonment

103. Prisons inflict not just the intended harm of deprivation of liberty, but also aggravate and even create many of the problems that were a factor in people being sent to prison in the first place. Not least among these is the presence of illicit drugs. These are present in prison to such an extent that non-drug users known to commence drug use while in prison: "prison environments have been identified as sites of injection initiation" (Werb *et al.* 2018 & Gore, Bird & Ross 1995).

104. The overwhelming majority of people in Australian prisons suffer from both a substance abuse disorder and a dependency upon an illicit drug, possibly in combination also with an alcohol disorder. It is the expectation that prisoners will have some other mental health disorder in combination with a substance abuse problem. The detailed 2003 mental health survey by New South Wales Justice Health showed that of 63.7% of men and 74.5% of women had a substance use disorder. In the same group some 22% of men and 37% of women suffered from alcohol dependence or alcohol use (Butler & Allnutt (2003) the table 3, p. 14). The 2009 New South Wales inmate health survey suggested that even more inmates were using illicit drugs:

> "The proportion of IHS participants who reported having ever used an illicit drug increased from 71% in 1996 to 81% in 2001, and then increased again slightly to 84% in 2009 (Table 5.6.1). Reported lifetime prevalence of illicit drug use increased steadily among men (from 69% to 80% to 86%), while decreasing slightly among women, from 82% in 1996 to 78% in 2009" (Indig *et al.,* (2010a) p.107).

105. The health survey in 2010 of the new ACT prison revealed that 79% of inmates had been under the influence of alcohol or other drugs at the time of committing the offence that led to their imprisonment, that 67% had ever injected

drugs and that 53% were currently on a methadone maintenance program - a pharmacotherapy appropriate for opiates dependent drug users (ACT Health 2011 table 9, p. 11).

106. The findings of the Drug use monitoring program (DUMA) of police detainees which has been undertaken since 1999 at a number of sites around Australia by the Institute of Criminology have been summarised as follows:

> "In its most recent annual report the AIC presented findings that two in every three offenders (66%) detained by the police tested positive to at least one drug, not including alcohol; female detainees were more likely to test positive (73% vs. 65%) and almost half (47%) of those who had been charged with an offence in the preceding 12 months reported having taken drugs at the time of that prior offending. The findings from the DUMA program leave little doubt that substance misuse is more prevalent among offenders than in the general community" (Payne & Gaffney (2012)).

107. The Institute of Criminology also confirms the results of the inmate health surveys such as those mentioned above:

> Among incarcerated offenders, the results are much the same. In a survey of adult male prisoners in 2001, the AIC's Drug Use Careers of Offenders (DUCO) study found that 62 percent of adult male prisoners reported being under the influence of alcohol or illegal drugs at the time of the offence that later resulted in their incarceration (Payne & Gaffney (2012)).

COERCIVE PROCESSES OF THE CRIMINAL LAW MANDATED BY PROHIBITION AGGRAVATE MENTAL ILL-HEALTH

108. Drug users, having been detected, become entangled in the stressful, coercive processes of the criminal law, notably arrest, incurring fines and possibly even imprisonment. This stress typically aggravates existing mental health problems and precipitates others where they did not exist.

Child Protection

109. The ineffectiveness of drug treatments leaves an increasing number of children exposed to greater risk of becoming mentally ill or disordered themselves by virtue of the addiction of their parents, other adults or their peers. In particular, the substance dependence of parents is a risk factor directly associated with their children developing a mental illness or disorder. It also contributes to other recognised risk factors of mental illness or disorder such as low birth weight, neglect and school drop out (DOHAC 2000, 16). It is patently clear, as this brief survey illustrates, that illicit drug use is intimately associated with child neglect and abuse either directly or through its known links to other potent risk factors for those harms.

110. A 2004 Report to the ACT Government recognised and paid particular attention to this group.

> "Of particular relevance to this Review is the identification of a number of client groups requiring special attention, many of which also find themselves as clients of child protection services:
>
> - families, the fastest growing group of clients, some of whom are experiencing second- and third-generation poverty, joblessness,

homelessness and/or domestic violence as a result of inadequate interventions;

- accompanying children, many of whom have experienced trauma (such as witnessing domestic violence), live in insecure accommodation, and are enduring the effects of situational factors such as drug and alcohol use, problem gambling and mental health problems"(Vardon 2004 p.46)

111. It is patently clear, as this brief survey illustrates, that illicit drug use is intimately associated with child neglect and abuse either directly or through its known links to other potent risk factors for those harms.

Suicide

112. The Bureau of Statistics has pointed out that accidental poisonings including drug overdoses are among the leading causes of death for the youngest cohort (ABS 2016): "'The link between drug and alcohol abuse has been identified as a significant risk factor in suicide, this is particularly unsettling for a country battling with alcohol binge drinking and recreational and prescription drug abuse problems.' . . . Ryan McGlaughlin, CEO of Suicide Prevention Australia added 'The research suggests that the risk of suicide among drug users is between four and fourteen times that of the general population; due to the effects of drug abuse on psychological, social and health factors'" (SPA 2011).

113. The link between drug use and suicide is confirmed in a meta analysis of 64 studies. The analysis published in the reputable peer reviewed journal, *Drug and Alcohol Dependence* utilised the statistical concept of standardized mortality ratios that reveal the extent to which death in a study population exceeds the rate of the population at large:

> " . . . standardized mortality ratio (SMR) is a relative index of mortality, expressing the mortality experience of a given study population relative to that of a comparison ("standard") population. In this study, the SMRs were used to estimate whether risk for suicide among those with specific alcohol or drug use disorders were at greater risk than expected in the general population. SMRs were calculated by dividing the observed number of suicides by the expected number of suicides and multiplying by 100, in order to yield results without decimals as . . . " (Wilcox *et al.* 2004, p. S13).

114. The meta-analysis showed that while alcohol use disorder was a high risk factor for suicide, it was far exceeded by risk factors associated with the consumption of illicit drugs. Someone with an alcohol use disorder was almost 10 times more likely to attempt suicide than a member of the community at large (being just a heavy drinker raises one's risk of suicide by 3.5 times), the risk factor for those with an opioid use disorder was 13 more times more likely, intravenous drug users were between 13 and 14 times more likely and mixed drug users (those we would refer to as polydrug users) an astounding 16 to 17 times more likely (Wilcox *et al.* 2004).

MENTAL DISORDERS AS AN INTENSIFIER OF RISK FACTORS FOR DRUG ABUSE

Schooling

115. "Depressive disorder may lead to difficulties in completing study and work commitments, which may in turn lead to difficulties finding employment, increasing the risk of AOD misuse [41-43]" (Marel *et al.* 2016 p. 8)

THE FEEDBACK LOOP: DRUG POLICY AS A AN INTENSIFIER OF RISK FACTORS FOR BOTH MENTAL ILLNESS AND SUBSTANCE ABUSE

Schooling

116. "Research has shown that the presence of early onset AOD [Alcohol and Other Drugs] use reduces the likelihood of completing high school, entering tertiary education, and completing tertiary education. This poor level of education may lead to later life difficulties (e.g., unemployment) that may lead to other problems, such as depression. Similarly, the reverse is possible, whereby a depressive disorder may lead to difficulties in completing study and work commitments, which may in turn lead to difficulties finding employment, increasing the risk of AOD misuse" (Marel *et al.* 2016 p. 8).

Impact on treatment services of co-occurrence of drug abuse and mental illness

117. The evidence points to a high and still increasing level of comorbid substance abuse and mental illness or disorders.

> "The use of illicit drugs such as cannabis and psychostimulants such as amphetamines and cocaine is . . . higher amongst young adults with severe mental illness compared to either the general population or to other psychiatric comparison groups" (Baker *et al.* 2004, 155).

This is putting more pressure on the health system and families than they can bear.

> "Hospital morbidity data show a dramatic rise in the number of psychotic disorders due to psychostimulant use from 200 in 1998-99, to 1,028 in 1999-2000 and a further but smaller increase to 1,252 in 2000-01" (*ibid*., 156).

118. Drug users are particularly difficult to connect with mental health and indeed other health services:

> "Despite high rates of mental health problems, [people who inject drugs] PWID often encounter multiple barriers to accessing relevant services, ranging from clinician attitudes to the systems within which they work. Early evaluation of MSIC found that of those PWID registered to use the service, only 42 % were clients of local services targeted to their needs . . ." (Goodhew *et al.* 2016)

119. A vivid picture of the complexity of the needs of hard to reach populations of drug users is found in the following description of a survey of many of the clients of the Sydney medically supervised injecting centre (MSIC):

> "The broad population of [people who inject drugs] PWID is characterised by low educational attainment and employment rates and high rates of incarceration and unstable housing. Such attributes are exaggerated among MSIC's clients, of whom 92 % report unemployment and 65 % report unstable housing. Additionally, PWID commonly have limited social networks, as rejection by non-using friends often leads to social isolation, a well-documented risk factor for poor mental health. Such social determinants of health are associated with mental health problems, and consistent with these associations, PWID have documented elevated rates of mood, anxiety, personality and psychotic disorders; posttraumatic stress disorder (PTSD);

> and suicidality and self-harm. Trauma exposures such as being witness to serious injury or death, being involved in a life-threatening accident, being threatened with a weapon, being held captive or kidnapped and being sexually abused as a child are commonly experienced by people with substance dependence. These traumas usually occur before the onset of substance abuse disorders and increase the risk of later mental health problems" (Goodhew *et al.* 2016)

120. Professor Kavanagh of the Mental Health Centre at the Royal Brisbane Hospital has warned that "effective management of comorbidity is likely to be critical to the cost-effectiveness of services." There are, he has written, "particularly high proportions [of comorbidity] seen in services for more serious problems (such as in-patient wards) and in younger patients. If these patients are not effectively treated, this will have a substantial impact on the overall effectiveness of the service. In practice, management of comorbidity becomes 'core business' for the service, whether or not this is recognised" (Kavanagh 2001, 64).

121. In order to cope with crises, scarce resources are being siphoned away from already chronically under funded services providing low and medium level interventions – that is, from most cost effective to least cost effective interventions. Of course, this deprivation of resources from where needs are low or medium leads more people into crisis thus compounding the health, social and fiscal problems. Rosenberg speaks of a ""missing middle":

> " . . . for people seeking mental health assistance, there are few alternatives between the GP's surgery and the hospital emergency department.
>
> "These alternatives reflect the financial demarcation between the federal government, which pays for primary care, and the states and territories, which manage hospitals. Nobody currently "owns" or has responsibility for community mental health services.
>
> "The federal government has been ramping up investment in primary mental health care. This has been principally through the Better Access program, now costing taxpayers more than A$15 million per week, mostly in payments to psychologists. Apart from a small sample of selected consumers in 2010, we know little about the merit of this spending other than it has continually increased since the program was introduced in November 2006.
>
> "In relation to hospitals, costs increase but the rate of access to care does not. People often refer to the grim term 'the revolving door', when people are admitted with acute symptoms of mental illness and are at risk of harm to themselves or others. They are commonly stabilised, provided with some medication and then discharged with little or no ongoing community support. They can become unwell again quickly and need re-admission" (Rosenberg 2015).

122. The link between drug dependence and mental illness or disorders is not confined to the pharmacological effects of the drug concerned. The Commission should not therefore rest content with a platitudinous recommendation that illicit drugs, because they have deleterious effects, should be made less available.

Drug abuse as an initiator and driver of intergenerational disadvantage

123. Illicit drugs are potentially attractive to a wide range of young people of normal personality types without any particular additional risk factors (Blue Moon 2000). Drug law enforcement, far from eliminating or even reducing supply of those drugs, stimulates their availability. Most of those who try drugs will cease using them as they grow older but a small proportion will become dependent on them. Those who do or who are unlucky enough to be among the few caught by the police, are likely to accumulate a set of risk factors that they would not otherwise acquire. They may, for example, be expelled from school, thus truncating their education. In securing their supply of drugs or while arrested or imprisoned they will find themselves mixing with a deviant criminal peer group. They may even be enticed to deal in drugs in order to finance their own supply. Their relationship with their families and "straight" friends" will be stretched to a breaking point. The net result of this is that their own children will probably grow up in an environment populated by many, many more risk factors than they did. Dependence on illicit drugs thus adds to the risk factors that make it more likely that adolescents will acquire a mental illness and engage in crime. Like a snowball, young people endowed with a surfeit of risk factors and paucity of protective ones are likely to acquire more and more risk factors as they roll through life. They are particularly at danger at points of transition such as leaving school and family breakup.

124. Risk factors for mental illness involving use of illicit drugs and linked to child neglect and abuse are increasingly being amplified down generations. Put in another way, drug abuse is a risk factor for mental illness and the policy response to it drives other risk factors for mental illness which in combination resonate down generations. A small proportion of people who use drugs become addicted. Their own addiction will be a risk factor in itself and will also contribute to a larger set of risk factors for their own children, not least of mental disorders, because:

(a) substance abuse by parents is a risk factor for adverse mental health outcomes during the infancy and childhood of children of these parents (DHAC 2000, pp. 49, 74).

(b) substance abuse by children is a risk factor for other negative outcomes like school failure which amplify the risk of the children developing a mental disorder (DHAC 2000 p. 16).

(c) Substantial substance abuse in a neighbourhood is a risk factor for violence and other crime in that neighbourhood which in turn amplifies the risk of those in the neighbourhood developing a mental disorder (DHAC 2000 p. 16).

125. In the first generation of drug using parents, it is likely that grandparents will be around to help out. A further generation on and there are likely to be more risk factors impinging on the children. In that second generation of drug using parents there are likely to be fewer protective factors such as the influence of grandparents able to provide support. This has long been a serious problem in the ACT. The then director of Marymead, an ACT family support service, said in 2001:

> "[W]e're now certainly seeing second generation families. Of course, there are children who are resilient, who will break out of the lifestyle of drug abuse but there are others who have not been able to escape that and it's really quite difficult to imagine how they're going to find their way out of that" (Mickleburgh 2001).

Economic impact of co-occurrence drug abuse and mental illness

126. Existing health services strain to engage and cope with the needs of people who are struggling with both a drug dependence and other serious mental health conditions. Those people will often be severely disadvantaged and stand in acute need of other health services for their physical conditions and social services such as housing. The more complex a person's needs, the more difficult and costly it is for existing services to meet them. This part briefly surveys aspects of drug policy that hold out the promise of substantial financial benefit and better outcomes. The survey is limited to situations where attempts have been made to estimate costs of existing policy and hint at possible savings. Needless to say, in most if not all situations not even that level of rudimentary estimation is available.

MONEY SPENT ON DRUG LAW ENFORCEMENT IS BOTH WASTEFUL AND A DRIVER OF MENTAL ILLNESS

Loss of revenue and cost of combating organised crime

127. As opposed to tobacco and alcohol, Governments receive no revenue from illicit drugs. The turnover of the illicit drug market is outside the GST regime.

> Twenty-two years ago *Access Economics* estimated the annual Australian turnover of the criminal drug trade was $7 billion (Access Economics 1997). In its 2005 yearbook, the UN Office of Drugs and Crime estimated the illicit drug market for Oceania to be US$16bn which represented 5% of its estimate of the World Drug Market of US$322bn (UNODC 2005 vol. 1, p. 128). The Oceania figures overwhelmingly represent those of Australia (only figures from Australia and New Zealand were included [in that region]) (UNODC 2005 vol. 2 pp. 254ff).

128. Drugs constitute the lion's share of the estimated annual cost of organised crime to Australia which was said in 2010 to be some $15 billion a year (McClelland & O'Conner (2010)).

129. Not only has drug policy been ineffective in quarantining the Australian population from illicit drugs, it has, as discussed earlier, actually stimulated their supply. Given both the drugs themselves and the ineffective measures taken to reduce their accessibility are drivers of mental illness, the money would be far better spent on other strategies that reduced the burden of mental ill health.

> "Substantial funds have been devoted to drug prevention in Australia. According to the Australia Institute of Health and Welfare (AIHW), the Australian government spent $142.2 million on the prevention of hazardous and harmful drug use in 2000 – 01. This represents 15% of the total national expenditure ($987 million) on core public health activities, making drug prevention the fourth most highly funded public health activity, after organised immunisation, communicable disease control and selected health promotion (Spooner and Hetherington 2004, p. 5).

Treatment more effective in supply reduction than drug law enforcement

130. Treatment is recognised as more effective in reducing the availability of illicit drugs than law enforcement. It does so by reducing the demand from consumers at the local retail level. Drug users who are unable to finance their habit will typically resort to property crime or deal in drugs. If confined to supplying their drug using peers dealing can be regarded as more honourable than scamming funds from their family (Braithwaite 2001 p.228) or property crime. Attracting dependent drug users into treatment thus removes them from the person to person illicit distribution system. In the words of Swiss criminologists:

> "Drug trafficking is by far the most frequent offence committed by drug-addicts, but the rate is very much reduced by drug prescription programs. Since new users tend to be recruited by addicts in their own social networks, getting drug-addicts out of crime (and drug trafficking) might contribute to slowing down the recruitment of new users of illegal drugs" (Killias, Aebi & Ribeaud 2005, pp. 187-98).

131. With the co-occurrence of substance dependence and other mental health issues being the expectation rather than the exception, drug policy should be at the centre of strategies to engage in treatment this population, which is notoriously hard to engage. A comparative study of the 92 drug consumption rooms (DCR) and supervised injecting facilities (SIFs) currently operating in 11 countries including Australia point to the crucial role that these can play in the engagement of difficult-to-reach drug users with a plethora of mental health and other needs (Belackova *et al.* 2019). The latest European Drug Report describes the opportunities that low threshold services like drug consumption rooms provide to engage severely dependent, alienated drug users not only with mental and other health services but also a range of social services that can address the many and varied risk factors for those health conditions:

> "Supervised drug consumption facilities are spaces where drug users can consume drugs in hygienic and safer conditions. This intervention aims both to prevent overdoses from occurring and to ensure that professional support is available if an overdose occurs. These facilities typically provide access to a wide range of medical and social services, as well as referral to drug treatment, and are able to attract hard-to-reach populations of users. Individual facilities supervise large numbers of consumptions, which otherwise would have taken place in the streets or in other risky circumstances. There is growing evidence of their benefits, which include reductions in risk behaviour, overdose mortality and transmission of infections, as well as increased drug users' access to treatment and other health and social services. At the same time, they can help to reduce drug use in public and improve public amenity in areas surrounding urban drug markets. Such facilities now operate in 56 cities in 6 EU countries and Norway; 78 facilities in total. In Germany, where such facilities have been operating since the early 1990s, legal regulations have recently been revised to allow them to supervise lower-risk types of use, such as snorting, smoking and inhaling. In addition, two of the 16 Federal states have begun to permit their use by people in substitution treatment" (EMCDDA 2018, p. 79).

132. The following studies support effectiveness of treatment leading to reduced availability of illicit drugs include:

- A highly regarded study on the control of cocaine undertaken by the Drug Policy Research Center of RAND in California found that "the least costly supply-control program (domestic enforcement) costs 7.3 times as much as treatment to achieve the same consumption reduction." The study compared the relative effectiveness of treatment with various forms of law enforcement in achieving a reduction in the number of users, the quantity of the drug consumed and the societal costs of crime and lost productivity that arise from use of the drug. The study estimated that "the costs of crime and lost productivity are reduced by $7.46 for every dollar spent on treatment." Described in other terms, domestic law enforcement, the most efficient form of law enforcement, "costs 4 times as much as treatment for a given amount of user reduction, 7 times as much for consumption reduction, and 15 times as much for societal cost reduction." (Rydell & Everingham 1994 pp. xv-xvi).
- Controlled trials of comprehensive methadone maintenance and comparative observational studies have all shown that this treatment is more effective than either placebo or no treatment in retaining people in treatment and in reducing opioid use. Larger comparative observational studies have confirmed this (Ward, Mattick & Hall 1992, 20-21 & 39).
- The drug trafficking by those admitted to the Swiss program of heroin assisted treatment declined from that committed in the six months before compared to the 6 months after admission by 57% (Killias, Aebi & Ribeaud 2005, p. 196 & Uchtenhagen *et al.* 1999 pp. 64-69). The flow on effect of this reduction is probably reflected in a large reduction in the recruitment of new heroin users. Since the introduction there of prescription heroin in 1995, a study reported in *The Lancet* of the canton of Zurich has shown a large decline in the recruitment of new heroin users:

  > "The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%" (Nordt & Stohler 2006).

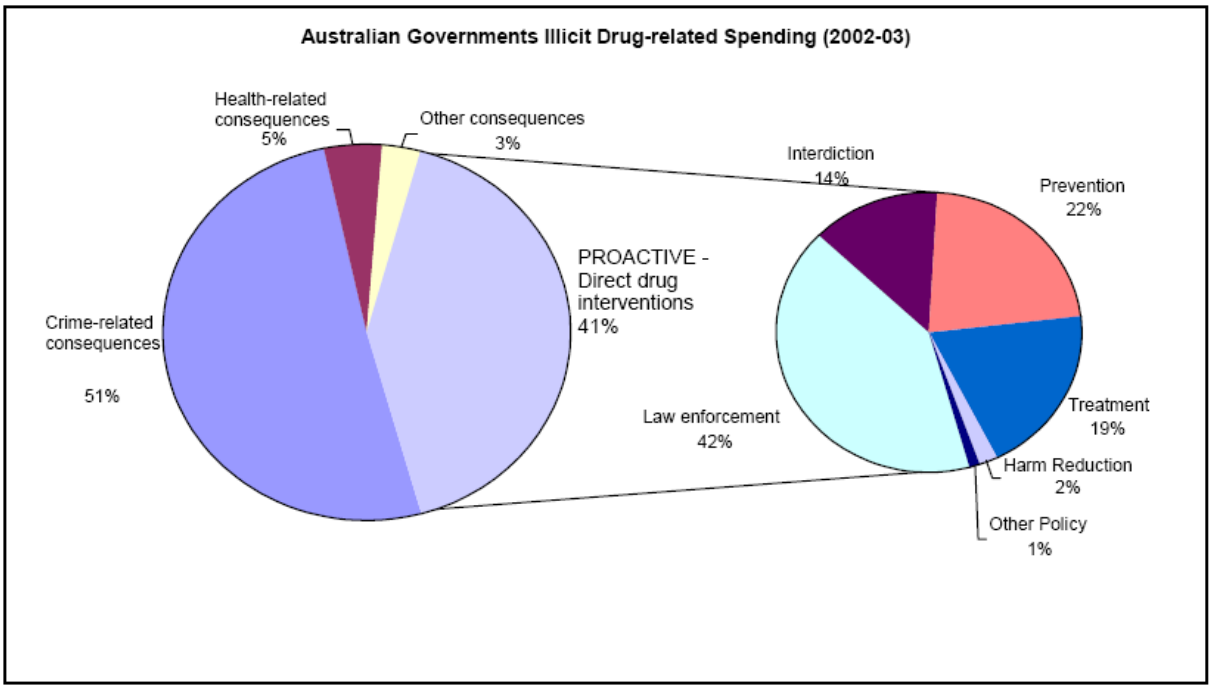
133. Treatment is recognised as more effective in reducing consumption of illicit drugs than law enforcement by reducing the demand from consumers and of suppliers at the local retail level. Typically illicit drug users deal in drugs in order to pay for their habit. Attracting them into treatment thus removes them from the illicit distribution system.

> "The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%" (Nordt & Stohler 2006).

134. In defiance of the knowledge that a health approach is far more effective than drug law enforcement in reducing the availability of drugs, Australian governments, under the pretence of taking a "balanced approach", persist in dispensing the lion's share on law enforcement. Different estimates have been made over the years of Australia's "drug budget". Using 2002-03 figures, research of the Drug Policy Monitoring Project estimated that the annual expenditure of Australian governments was $3.2bn (Moore 2005)

Of this, direct spending on drug interventions amounts to $1.3bn or 41% and the consequences of illicit drug use amount to $1.9bn or 59%.

Law enforcement including interdiction costs absorbs by far most of the direct spending (56%), prevention 22%, treatment only 19% and harm reduction a mere 2%.



SOURCE: Moore 2005.

Crime-related costs also form a huge proportion of the consequential costs of government expenditure amounting to 51% of the entire government expenditure (direct and indirect) related to illicit drugs.

135. Estimates have also been commissioned by the Commonwealth Department of Health. Methodologies have evolved or varied so that different surveys are not directly comparable. Using 1998 – 99 figures the social costs of illicit drugs were given as $m5,107.0 (Collins & Lapsley 2002 p. ix). Five years later utilising 2004-05 figures the same authors produced an estimate of $m6,915.4 in tangible social costs (Collins & Lapsley 2008, table 33).

136. The Australia Institute of Health and Welfare (AIHW), estimated that in 2000 – 01 the Australian government spent $142.2 million on prevention of hazardous and harmful drug use. This represented 15% of the total national expenditure of $987 million on core public health activities (Spooner and Hetherington 2004, p. 5).

137. Illicit drugs are utilised regularly by only a small proportion of the population. The resulting costs are disproportionately high compared to the costs of, say, alcohol, which is used regularly by a much larger proportion of the population.

138. While government budgetary health costs of illicit drugs ($258.9m) are just 16% of those of alcohol ($1,555.3m), the government budgetary crime costs of illicit drugs of ($2,212.3m) are 2.27 times the crime costs of alcohol ($974.6) (Collins & Lapsley 2008, pp. 68-69 & 72-73 utilising 2004-05 figures).

139. State and territory governments bear by far the majority of the spending (84.1%, or $2,264.8 million) while the Federal Government accounts for 15.9% ($427.0 million) (Collins & Lapsley 2008, pp.72-73). In 2003 Business incurred $3,523 million of a total of $6,154 million of tangible costs of illicit drug use, Government $2,048 million and individuals ($583 million) (Collins & Lapsley 2007).

Greater engagement in and more effective treatment.

140. Removal of the threat of detection and prosecution of drug users (what has been termed Damocles sword, Braithwaite 2001) would probably lead to less disruption to users in treatment and less deterrence of drug users seeking treatment. Existing diversion and drug courts have the criminal law as the gatekeeper and ultimate enforcer of treatment. Substantial doubt hangs over the usefulness of compulsory treatment given the importance of personal commitment to overcome an addiction: "Overall, there is limited empirical evidence demonstrating the effectiveness of compulsory AOD treatment" (Pritchard, Mugavin & Swan 2007). Dependency alone without any threat of current criminal sanctions is a powerful incentive to seek treatment. A lot of money is at stake. According to a 2013 estimate of the cost under current drug policies:

> "The total estimated health expenditure on AOD treatment in Australia for 2012/2013 was AUD$1 212 877 157. This represents $52.92 per person (estimated resident population, 2012/2013) and 0.08% of GDP (Table 1).
>
> "The highest proportion is state/territory AOD treatment grant funding (41.2%), followed by public hospitals (15%), then private hospitals (10.8%), followed by the Commonwealth AOD treatment grants (10.7%). . . . As can be seen, the state/territory government contribution is 50.7%, compared with 31.4% for the Commonwealth and 17.8% for private expenditure. When only government funding is considered, the split between Commonwealth and state/territories is 38% and 62%, respectively" (Ritter, Chalmers & Berends 2015).

Harm reduction interventions (such as needle syringe programs) were excluded from that estimate (*Ibid*., p.398).

Extra burden on welfare agencies required to serve people with complex needs involving substance dependency alone or in combination with other mental health problems

141. Mental illness aggravated or even brought about by measures mandated by existing drug policy are just one of the unintended consequences of that policy. This paper has already touched upon crime, school dropout, child protection and suicide, welfare dependency and homelessness as other harms traceable to the disruption brought about by drug policy. Indeed it is likely that the abuse of illicit substances and the policies adopted to combat that abuse are deeply implicated in virtually all of Australia's most intractable and costly social problems. In the United States drug policy has had economy wide impacts most notably exemplified by the world's highest incarceration rate of 693 per 100,000 (World Prison Brief 2014) (a rate that is declining while Australia's is rising) but also in a decline in the workforce participation rate. The paper turns briefly to these two phenomena.

Workforce participation

142. Government is concerned about the impact of drug abuse on workforce participation. The former Minister for Social Services, Mr Porter, claimed "that

unemployed people are over three times more likely to use meth/amphetamines, and 1.5 times more likely to use cannabis, when compared with employed people". He makes no mention of unemployment being a potent risk factor for substance abuse or of the unemployed who have become addicted to pharmaceutical opiates in the course of treatment of chronic pain.

143. The Ice Task Force observed that:

> "Many regional areas face economic challenges, such as high unemployment, that contribute to social problems like illicit drug use. As at April 2015, Cairns and outback Queensland faced youth unemployment of over 20 per cent, and youth unemployment in western New South Wales was over 22 per cent. This compares with an overall youth unemployment rate of around 14 per cent for Australia" (PMC 2015 p.104).

144. The minister's reaction shows that he does not understand addiction. He sees it as viable applying financial pressure on drug users to leverage them into employment. Yes, unemployment may contribute to drug abuse but this will be largely because of the anxiety that comes with unemployment and poverty, a condition that cutting off Social Security will only intensify. The end result is likely to be an even more complex drug problem, the burden of which is likely to be borne by the parents and other family members of drug users.

145. An indication of the extent of the evolving problem of analgesics is given by a survey of the Australian Bureau of Statistics of drug induced deaths. These have increased in recent years to the level of the 1990s with the difference that rather than the implicated drug being heroin, "Prescription painkillers such as oxycodone, morphine and codeine . . . were present in over 30% of deaths in 2016." (ABS 2016). The following illustrates the extent to which this phenomenon is already impacting on country towns:

> "Issues relating to heart and blood pressure are big health problems in the town, in line with the rest of the country. But racing up the charts is the use of pain medications, such as the opioids – a subject that has received a lot of publicity in the United States and the Trump administration. In the pharmacy Doug starts talking to me about Australia's impending ban on over-the-counter codeine products that also contain opioids. He says regional communities will suffer because lower-dose codeine products are used to treat short-term pain, like a football injury or falling off a horse, especially when you can't easily get to see a doctor, as is so often the case in small towns.
>
> "I have heard about the rising use of opioids and tracked the debate in the United States. I question his resistance to the ban. So he invites me behind the counter to see the physical manifestation of his biggest concern. The pharmaceutical dispensing station, Dougo shows me his 'Drugs of Addiction', or DD, safe. It's large 1.5 m, and it's full of boxes, neatly stacked according to brand. 'It will last a week,' he says" (Chan 2018).

146. Australia is following the United States where the dependence on prescription opioids is having economy-wide effects. Princeton University research published just this year revealed that 40% of prime age men who are out of the labour force report that pain prevents them working full-time and that nearly 2/3 of them take prescription medication to relieve the pain (Krueger 2017). Here in the past year well over 1 million Australians (4.8%) misused prescription pharmaceuticals (AHS 2016).

Eliminate their legitimate supply by cutting down on doctor shopping and they will quickly turn to the illicit black market.

147. The United States began experiencing serious problems of dependency on pain medications well before Australia. There it has been shown that: “on-the-job injuries can give rise to chronically painful conditions, potentially resulting in a downward spiral of disability and poverty” (Dasgupta, Beletsky & Ciccarone 2017).

148. So widespread is the problem in America that depressed labour force participation has become intertwined with the opioid crisis:

> “Nearly half of prime age [not in the labor force] men take pain medication on a daily basis, and in nearly two-thirds of these cases they take prescription pain medication. Labor force participation has fallen more in areas where relatively more opioid pain medication is prescribed. . . . Prime age men who are out of the labor force report that they experience notably low levels of emotional well-being throughout their days and that they derive relatively little meaning from their daily activities” (Krueger (2017)).

149. In essence this study shows how drug policy concerning the mass use of prescription medications is having serious economy wide and societal impacts in the United States. The same can be expected to occur in Australia. It would be remissful in the extreme for the drug strategy to say nothing of this emerging threat.

Incarceration

150. If reoffending is to be addressed, the two most prominent characteristics of those sentenced to prison must be addressed. These are dependence on illicit substances as are more than two thirds of prisoners and a range of other serious mental health conditions that afflict about the same proportion. The predicament of women is even worse. So crowded are prisons with people suffering from mental health conditions that they have become modern day mental health institutions. In a large measure the drug laws are drivers of this situation, not in terms of imprisonment for minor use and possession charges, but in terms of young people becoming mixed up with a criminal peer group, being enticed by the easy money of drug dealing and property crime to fund their dependency – possibilities enhanced by common pre-existing factors like anxiety and youthful risk taking.

151. The Institute of Public Affairs has called out the very high cost of incarceration in Australia:

> “Australian prisons are among the most expensive in the world. Among countries for which 2014 data is available, Australia had the fifth highest per prisoner annual prison cost. The cost of putting one person in prison for a year was $109,500. Only Sweden, Norway, the Netherlands and Luxembourg had higher costs” (Bushnell 2017, p.4)

152. It does not make sense to invest heavily in compulsory treatment when there is a crying shortage of treatment slots for those who seek it voluntarily. A Sydney treatment service has described the situation in the following terms:

> “Prolonged meth[amphetamine] use is known to contribute to drug-induced psychosis. As meth addiction ravages the nation, many people may need a stay in a psychiatric hospital to stabilise before they can begin addiction treatment.

> "However, psychiatric beds are also being reduced across the country, which means that hospital space is available only as a last resort. Because of this shortage of available resources, people are only being offered help after a serious incident, rather than early on — in an effort to prevent further danger for the addict and the people around them.
>
> "Psychiatric bed space is dwindling, and addiction treatment centres are overloaded. Treatment providers at Sydney's Odyssey House say that they are now seeing more people present with meth as their primary addiction than alcohol. With a high demand for space, once people enter treatment they are not receiving it for as long as necessary to successfully achieve long-term addiction recovery. People are waiting months to enter treatment and meanwhile delving further into the addictive cycle and court systems´ (Cabin 2015).

153. In all likelihood, plugging gaps in voluntary services is cheaper and more effective, not to mention cheaper, in reducing offending than compulsory services embedded in the criminal justice system (White 2016). The ACT Tobacco and Other Drug Association (ATODA) reports that "Reduced involvement in crime was the number one self-reported outcome of specialist AOD treatment in the ACT, with 91% of service users reporting a reduced involvement in crime since accessing the service" (ATODA budget sub).

154. Even a conviction, much less a prison sentence, in the government's proposed "reintegration centre" can destroy a young Australian's life chances.

155. Similar considerations operate in the case of older Australians. There is absolutely no community interest or benefit in disrupting the well established life of a latter day tax paying family man reliving his hippie days for whom a drug charge would mean a loss of livelihood, family and disgrace.

Mental institutions

156. A new approach would have a much greater role for the range of mostly non-government organisations which, over many decades, have built skills in the provision of psycho-social support – living skills, housing and employment support, increasingly mixed with specialist and even clinical skills. These organisations receive only around 7% of Australia's mental health budget.

EXPERIENCES OF COUNTRIES THAT HAVE ABANDONED PROCESSING DRUG USERS AS CRIMINALS

157. The burden of mental illness in Australia is in a large measure increased by the coincidence of illicit drug abuse and other mental illness. This paper has suggested that the reliance on the criminal law works to create and foster the social and economic conditions that drive mental illness. In this final section we briefly consider the experience of other countries that, at least to some extent, have ceased to rely upon the coercive processes of the criminal law to control drugs. Increasingly countries are claiming a large margin of appreciation in the interpretation of the multilateral drug treaties, thereby giving themselves the discretion to adapt their domestic drug policy to meet their own particular needs. European countries, in particular, have taken advantage of the recognised exclusion from the rigours of the convention of the use of classified substances for scientific and medical purposes and, in place of prosecution and conviction, to implement "measures for the

treatment, education, aftercare, rehabilitation or social reintegration of the offender" (1988 Convention, art. 3(4)). In the words of a British think tank: "Drug policy around the world is a patchwork of approaches shaped by different cultural, political and social landscapes" (Transform Drug Policy Foundation 2018).

158. The impact of many of the recent reforms such as regulated availability of cannabis in Uruguay, the United States and Canada have yet to be fully assessed but more and more countries such as Ireland and Norway are considering implementation of a Portuguese style drug policy.

159. In the 1980s, Australia led the world in ameliorating the rigours of the criminal law on drug users by applying principles of harm minimisation. This took the form of making sterile syringes available to minimise the risk of transmission of HIV and other blood borne viruses; providing for the dispensation of the artificial opiate, methadone; substituting expiation notice systems for standard prosecution in the case of minor cannabis offences and diversion schemes that have seen drug users referred to education and treatment rather than being subjected to the usual processes of the criminal law. These successful steps were taken with the express intention of minimising the disruption to the life of drug users, it being realised that a conviction for a criminal offence and imprisonment disrupted the family, social life and work of people. With a conviction it is extremely difficult for anyone to secure employment and impossible to travel to some countries. Studies have documented the beneficial outcome of many of these measures (Lenton *et al.* 1998, x) but in virtually all cases the criminal law has remained the gatekeeper for processing drug users and criminal sanctions serve as the ultimate enforcer in the event of failure to comply with the ameliorating measure. In other words, the life of the drug user and particularly the dependent drug user is perpetually threatened by the Damocles sword of criminal sanctions.

160. Australia has long since lost its pre-eminence and world leadership in drug policy innovation. Other countries, particularly in Europe, Canada and, at least in the case of cannabis, the United States, have stolen a march on Australia and it is to the experience of these countries that we now briefly turn.

THE UNITED KINGDOM:

161. The United Kingdom is unique in always having permitted heroin to be prescribed to addicted patients as recommended by the Rolleston Committee in 1926. Moreover, the drug continues to be widely used as an analgesic for intractable pain. The right of doctors to continue prescribing it as a pharmacotherapy to treat opiate addiction was substantially curtailed in 1956. Since then only a small number of specialist doctors have been permitted to continue to prescribe heroin for this purpose. Only some 300 receive that treatment (Metrebian *et al*. 2006). From 1982 until 1995, Dr John Marks in Liverpool expanded a heroin prescription program from a dozen people to more than 400 for opiate dependent drug users. The situation of patients treated at this clinic improved markedly (Hari 2015, pp.207-14).

THE NETHERLANDS:

162. Decriminalisation of the use of drugs and introduction in 1976 of a policy not to prosecute them for possession. Thenceforth, in application of an expediency principle under Dutch law, those who use the drug are not prosecuted for possession of small quantities for personal use. Cannabis is openly tolerated in coffee shops where it may be consumed.

163. In 1998 the Netherlands followed Switzerland in conducting a heroin trial. The Swiss study had not precisely compared the efficacy of diacetylmorphine (i.e. heroin) with the gold standard opiate substitution treatment of methadone. This was done in The Netherlands where a group of treatment-resistant heroin addicts who had already been treated with methadone was prescribed heroin in combination with methadone. These were compared with another group on methadone alone (Van Den Brink, 2003). The trial "validated indicators of physical health, mental status, and social functioning".

GERMANY:

164. Substitution therapy is possible in seven locations, namely Bonn, Frankfurt am Main, Hamburg, Hannover, Karlsruhe, Cologne and Münich where a trial had taken place. Further localities have yet to be established. According to the government, at the end of the year in 2010, 360 patients were receiving artificial heroin at public expense (Deutsches Ärzteblatt 2011).

PORTUGAL:

165. Portugal decriminalised the personal possession of all drugs in 2001. This means that, while it is no longer a criminal offence to possess drugs for personal use, it is still an administrative violation, punishable by penalties such as fines or community service. The specific penalty to be applied is decided by 'Commissions for the Dissuasion of Drug Addiction', which are regional panels made up of legal, health and social work professionals.

> "In reality, the vast majority of those referred to the commissions by the police have their cases 'suspended', effectively meaning they receive no penalty. People who are dependent on drugs are encouraged to seek treatment, but are rarely sanctioned if they choose not to – the commissions' aim is for people to enter treatment voluntarily; they do not attempt to force them to do so" (Murkin 2014)

SWITZERLAND:

166. In the years leading up to the announcement in 1992 by the Swiss Federal Council to undertake an intervention research program on the diversified prescription of narcotic substances, Switzerland was experiencing a severe heroin problem. Realising that years of repressive drug law enforcement was not reducing the problem, the authorities in Zurich decided to set aside a park outside the railway station as an area in which drug users could, without intervention by the police, use their drugs. This became the notorious needle park and a scandal of the city. This led to the 1992 announcement of a heroin trial undertaken in accordance with a general study plan of November 1993. The plan required that those admitted be at least 20 years of age, have a heroin dependency of at least two years and have repeatedly failed previous treatments. The Swiss had to guide them only the small-scale trial undertaken by Doctor Marks in Liverpool. The trailblazing Swiss initiative attracted worldwide attention including much criticism. The data collected over three years between January between 1994 and 1996 was carefully evaluated (Uchtenhagen *et al.* (1999) p. 1 & Rihs-Middel and Hämig 2005). It showed remarkable improvement in the well-being of dependent heroin users on the program. So positive were the findings that Switzerland thereupon incorporated heroin prescription into its national drug policy. This was challenged by those championing a drug free approach and made the subject of two national referenda both of which endorsed the program. Meanwhile the World Health Organization

reviewed the results of the trial. It confirmed the achievement of the spectacular results but criticised the study's design on the ground that it was not possible to determine whether the improvements derived from the prescription of heroin or the significant psychosocial support provided to the drug users (WHO 1999). This qualification was used by the Australian Government of the time as a further ground for rejecting a heroin trial in Australia. It also influenced the design of a trial by The Netherlands which ensured that its trial compared opiate dependent drug users receiving heroin (diamorphine) with standard methadone.

IMPROVEMENTS IN HEALTH AND SOCIAL INTEGRATION

Fall in involvement in crime

167. *Liverpool* Police reported "that in the 18 months before getting a prescription from Dr. Marks, [the 142 heroin and cocaine addicts studied in the area] received, on average, 6.88 criminal convictions, mostly for theft and robbery. In the 18 months afterwards, that figure fell to an average of 0.44 criminal convictions. In other words: there was a 93 percent drop in theft and burglary. "'You could see them transform in front of your own eyes,'" an amazed [Inspector] Lofts told a newspaper: "'They came in in outrageous condition, stealing daily to pay for illegal drugs; and became, most of them, very amiable, reasonable law-abiding people.'" (Hari p. 211).

The drop in shoplifting was so massive that Marks & Spencer publicly praised the intervention and sponsored the first world conference on harm reduction and drug taking in Liverpool in 1990" (Hari p. 214).

168. *Switzerland* On the basis of self reporting there was a reduction of 94 per cent or more in the "prevalence and incidence rates of self-reported criminality after one year of treatment in the programme, compared to the time before admission." These reductions were confirmed from police records and self reported victimisation which drug users themselves often experience. Overall " . . . street robberies (a crime typically committed by drug addicts) have dropped in Zurich (City and Canton) by about 70 per cent between 1993 and 1996" (Killias, Aebi & Ribeaud 2005, p. 197).

169. So spectacular has been the reduction in crime of those receiving prescribed heroin that a noted Swiss criminologist has concluded: "In all, heroin treatment constitutes without doubt one of the most efficacious crime prevention measures ever trialled." (Killias *et al* 2002 p. 80).

A cost benefit analysis of the analysis found that it was "that for every franc invested in the program there is a benefit of CHF1.75." The authors added:

> "Knowing, however, that the largest part of costs were accounted for whereas benefits were estimated only very partially, one could argue that the cost-benefit ratio of the program is even higher. Basing ourselves on data found in the literature, we believe that a cost-benefit ratio between 3 and 5 would be more realistic. Thus, society would recover, in the shape of benefits, between three and five times the amount invested in the program" (Gutzwiller & Steffen 1999 p. 7).

170. *Portugal* "The proportion of drug-related offenders (defined as those who committed offences under the influence of drugs and/or to fund drug consumption) in the Portuguese prison population also declined, from 44% in 1999, to just under 21% in 2012 . . . During the same period, there was a reduction in recorded cases of other, more complex crimes typically committed by people who are dependent on

drugs, such as thefts from homes and businesses" (Murkin 2014). It is a mark of the effectiveness of program that it was maintained by a succession of governments of different political persuasions and in spite of severe economic troubles in the country.

Decline in drug use

171. *Liverpool*: "[Drug use] actually fell – including among the people who weren't being given a prescription. Research published in the proceedings of the *Royal College of Physicians of Edinburgh* compared Widnes, which had a heroin clinic, to the very similar Liverpool borough of Bootle, which didn't. In Bootle, there were 207.54 drug users per h undred thousand people; in Widnes it was just 15.83 – a twelvefold decrease." (Hari p. 213).

172. *Netherlands:* No country exceeds the Netherland's permissive reputation for cannabis with its so-called "coffee shops". In spite of those using the drug not being prosecuted for possession of small quantities, the usage of cannabis (and indeed) of other drugs is substantially lower there than in Australia and the United States (Netherlands 2008).

> "Countries with more stringent policies towards illegal drug use did not have lower levels of such drug use than countries with more liberal policies. In the Netherlands, for example, which has more liberal policies than the US, 1.9% of people reported cocaine use and 19.8% reported cannabis use. (Greenwald 2009, p. 25).

173. *Switzerland*: Participants on the heroin trial reported a dramatic reduction in use of heroin in the first six months of treatment and in the following six-month period a further, albeit less pronounced, progression was found. Cocaine consumption as reported by the patients and corrected for urine samples also showed a marked progressive tendency to reduction (Uchtenhagen *et al.* (1999) 55). Decrease in consumption of illicit heroin and cocaine "reduces the risk of continued contacts with the drug market" (Uchtenhagen *et al.* (1999) p. 58)

174. A study of the canton of Zurich, reported in *The Lancet,* has shown a large decline in the number of new heroin users. This study was carried out after the trial ended and while heroin prescription had become a standard treatment:

> "The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%" (Nordt & Stohler 2006, p. 1,833).

175. *Portugal*:

> "• Levels of drug use are below the European average
> • Drug use has declined among those aged 15-24, the population most at risk of initiating drug use
> • Lifetime drug use among the general population has increased slightly, in line with trends
> • lifetime use is widely considered to be the least accurate measure of a country's current drug use situation
> • Rates of past-year and past-month drug use among the general population – which are seen as the best indicators of evolving drug use trends – have decreased
> • Between 2000 and 2005 (the most recent years for which data are available) rates of problematic drug use and injecting drug use decreased

• Drug use among adolescents decreased for several years following decriminalisation, but has since risen to around 2003 levels
• Rates of continuation of drug use (i.e. the proportion of the population that have ever used an illicit drug and continue to do so) have decreased.

176. Overall, this suggests that removing criminal penalties for personal drug possession did not cause an increase in levels of drug use" (Murkin 2014).

Decline in drug trade

177. *Liverpool*: "On the streets of the neighbourhood, the drug gangs started to recede. [Dr Marks] overstated it at the time when he said drug dealing had been totally wiped out – the writer Will Self, reporting on the ground, asked around and learned there was still dealers to be found. But the police said there were far fewer than before – Inspector Lofts explained at the time: "Since the clinics opened, the street heroin dealer has slowly but surely abandoned the streets of Warrington and Widnes."" (Hari p. 211).

Improvement in general well-being

178. *The Netherlands:* The group of treatment-resistant heroin addicts who had already been treated with methadone and who were prescribed heroin in combination with methadone were compared with another group on methadone alone. The study concluded that:

> ". . . the treatment with heroin in combination with methadone is more effective than the continuation of methadone alone. With this additional heroin therapy, the patients can benefit from the treatment with respect to their health and their social functioning. This applies to both intravenous and inhalation administrations of heroin. In a number of patients there is an indication for continuation of treatment."

179. On its completion, the study had to face a problem of what to do with patients whose condition had markedly improved from the combination of methadone and heroin therapy. It was found that:

> " . . . discontinuation of the heroin prescription in most patients who benefited from the treatment resulted in a serious deterioration of the health status within two months of stopping."

180. In summary for those receiving combination therapy,

> "Undesirable effects with regard to the health of the patients and problems associated with control and management during the treatment were relatively scarce leading to the overall conclusion " . . . that treatment with heroin is practicable, at least under the conditions described in the protocols of the [study]. The costs of the treatment are presented in the report. . . . [Thus] supervised medical co-prescription of heroin may be a useful supplement to the existing treatment options for chronic heroin addicts" (van den Brink *et al.* 2002 p. i)

181. The Dutch results are all the more spectacular in that the interventions brought improvements to those who had been using for an average of 16 years, had been on methadone for 12 years and had high levels of physical, mental and social dysfunction.

182. *Germany*: In the estimation of the city authorities, the success of the project is unambiguously positive. Up to now every controlled heroin prescription has been based on an exceptional authorization of the Federal Institute of Medicine and Medical Products. The project has been extended three times, each for half a year, up to the end of June this year (*Deutsches Ärzteblatt* 2007).

183. The health department of the city of Frankfurt stressed that for a particular group the controlled prescription of heroin is the only promising entrance to therapy and has long since proved itself. The city began the pilot scheme in 2003 with just under 100 drug addicts. The city wants the group expanded up to 150 clients.

184. According to information of the health department nearly all the Frankfurt study participants have found an apartment, even though many had previously been homeless. Some had even gained employment. The study has also shown in other cities that a stabilised social situation of drug addicts reduces the corresponding level of criminality. (*Deutsches Ärzteblatt* 2007)

Improvement in physical health

185. Switzerland: "There was a marked regression in particular in the area of injection related skin diseases. Underweight conditions after 18 months of treatment primarily involved patients with HIV infection. The need for medical treatment was considered to be about the same level as after 12 months of treatment" (Uchtenhagen *et al.* (1999) p. 48).

186. *Portugal*: "Although the number of newly diagnosed HIV cases among people who inject drugs in Portugal is well above the European average, it has declined dramatically over the past decade, falling from 1,016 to 56 between 2001 and 2012. Over the same period, the number of new cases of AIDS among people who inject drugs also decreased, from 568 to 38. A similar, downward trend has been observed for cases of Hepatitis C and B among clients of drug treatment centres, despite an increase in the number of people seeking treatment" (Murkin 2014 and similarly Goulão 2015).

Improvement in mental health

187. *Switzerland:* In the Swiss trial of heroin maintenance, the proportion of patients with good mental status increased from 64% on admission to 82% after 18 months & those with poor status halved from 36% to 18% (Uchtenhagen *et al.* (1999) 51). "The decrease in aggressive behaviour also showed further improvement after the 12th month of treatment" (p. 53)

Pregnancies

188. *Switzerland:* the physical state of health of women on the trial was impaired. All had suffered hepatitis B and 10 women also had hepatitis C. Two were HIV positive. Psychological features included depression, eating disorders and personality disorders. The course of pregnancies and births, with the exception of one spontaneous abortion during withdrawal, went without complications. No malformations occurred in the children and there were no sudden infant deaths (Uchtenhagen *et al.* (1999) 54).

Poverty

189. *Switzerland:* Pharmacotherapies have helped dependent users to reintegrate into the community in other ways. "Financial debts constitute a serious impediment to social integration; they represent a major obstacle and have a demoralising effect. . . . Debts decreased continuously during the [pharmacotherapy] treatment period.

After 18 months of treatment, one third of patients were debt free and a further quarter were only moderately indebted" (Uchtenhagen *et al.* (1999) p. 60).

Welfare dependency

190. *Switzerland*: The number of patients receiving welfare increased slightly before dropping below that of the initial value in the third six-month treatment period. The group progression is significant. It is noteworthy that not always the same patients were involved. More than a third of those initially requiring welfare no longer needed this type of support, and more than a third of those who were originally independent of welfare later received it, as this income was reduced (Uchtenhagen *et al.* (1999) p. 61).

Housing

191. *Switzerland:* "homelessness decreased and patients no longer had to live in institutions. Even the non-dependent form of accommodation in lodgings decreased, whereas independent accommodation became more common . . . Unstable living conditions dropped below half the initial value, stable living conditions increased accordingly. These changes were continuous over the entire treatment period and are highly significant" (Uchtenhagen et al. (1999) pp. 58-59).

Employment

192. *Switzerland:* "The result is impressive: despite a difficult labour market situation, there was nearly a twofold increase in permanent employment whereas unemployment dropped to less than half. The differences are highly significant. It also became evident that 28% of those unemployed on admission found regular employment and 24% of those originally working temporary had found a permanent job. The changes occurred predominantly during the first year of treatment" (Uchtenhagen et al. (1999) pp. 59-60).

Social contacts

193. *Switzerland:* the circle of friends and contacts of dependent drug users is typically other drug users. There were " . . . clear changes in contact with drug users. The proportion of those who had contact with drug users several times weekly fell to less than half during the first year of treatment. Accordingly, the number of those increased who rarely or never had such contact. It [was] unclear to what extent new contacts with drug users relate to other patients participating in the programme" (Uchtenhagen et al. (1999) pp. 61-62).

194. One can do no better than end with a quote by Johann Hari summing up the triumph of Swiss drug policy: " "The number of addicts dying every year fell dramatically, the proportion with permanent jobs tripled, and every single one had a home. A third of all addicts who had been on welfare came off it altogether. And just as in Liverpool, the pyramid selling by addicts crumbled to sand" (Hari, p. 222).

CONCLUSION

195. It is manifest from this short summary that countries that have ceased to process drug use as a crime have reaped a large benefit and have shown the hollowness of the fear that removing the threat of criminal sanction would promote an increase in usage of dangerous drugs. The benefits range beyond the particular focus of the Productivity Commission's present reference, namely mental health. In a large measure this is because mental health status was not specifically measured though it was in the case of the Swiss trial of heroin assisted treatment. As is shown by the measured improvements in other domains, the overall well-being of drug

users is improved. Such improvements are known to have a bearing upon mental health of drug users. Reducing contact with a criminal peer group, less involvement in crime and less time spent in prison all constitute reduction in potent risk factors for mental illness. What is abundantly clear is that removing the Damocles sword of criminal sanctions facilitates engagement of drug users with services providing treatment and social support.

196. And, one must emphasise in the context of the terms that the Treasurer framed his reference to the Productivity Commission, the changes to drug policy have produced large cost savings with potential economy wide benefits. If co-occurring substance dependency and other mental health issues are the expectation rather than the exception, then the Commission has no choice but to advise how drug policy may be better framed so as to improve mental health. Dividends will be greater economic participation and enhancement of productivity and economic growth, not to mention the general well-being of society.

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committed to preventing tragedy that arises from illicit drug policy

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Inquiry into
Youth Mental Health in the ACT
by the
Standing Committee on
Education, Employment and Use Affairs

Submission of
Families and Friends for Drug Law Reform

Annexure B Post draft submission dated 16 January 2020 to the inquiry of the Australian Productivity Commission into the Social and Economic Benefits of Improving Mental Health

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21 January 2020

Prof Stephen King,
Commissioner,
Inquiry into Mental Health
Locked Bag 2, Collins St East
MELBOURNE Vic 8003, Australia

Dear Prof King,

Post draft submission on Mental Health

1. We take it from the reaction to our submission at the hearing you kindly gave us in Canberra on 25th November that the Commission does not consider that the review of drug policy falls within your remit. Even so, the nub of my halting presentation urged no more than what you simply and succinctly expressed in your draft report, namely that "for effective treatment there should be an alignment between mental health and alcohol and drug policies" (Draft report, vol. 1, p. 26). Indeed, on the basis of what you, the Commission, have so carefully assembled in your draft report, that conclusion is unavoidable.

2. We therefore propose that you reinforce your position with a specific recommendation to that effect in your final report and that the National Mental Health Commission specifically monitor the degree to which progress is being made in integrating mental health and alcohol and drug policies and programs as part of its routine monitoring of the Fifth National Mental Health and Suicide Prevention Plan:

> In the light of the heavy burden on the mental health system of co-occurring substance dependency which is the expectation rather than the exception recognised by successive National Mental Health Plans and Drug Strategies, the government should examine how to better align and integrate mental health and alcohol and drug policies and programs.
>
> This examination should draw upon available evidence about the successful integration of services to people's suffering.from those co-occurring conditions and set out the elements of a national approach which will yield

measurable improvements for these individuals, families, the community and the economy.

That the National Mental Health Commission include monitoring the degree to which progress is being made in integrating mental health and alcohol and drug policies and programs in its monitoring of the Fifth National Mental Health and Suicide Prevention Plan.

3. As the rest of the letter summarises, it is only by the integration and alignment of mental health and alcohol and drug policies that the needs of people suffering from complex mental health conditions and stigma and alienation can be effectively addressed.

4. The Foundation for Alcohol Research and Education in its submission no. 269 has drawn your attention to the pertinent acknowledgement of the New Zealand Inquiry into mental health and addiction that addiction should be treated as a health rather than a criminal justice issue. According to that New Zealand government inquiry:

> "The criminalisation of drug use has failed to reduce harm around the world. A shift towards treating personal drug use as a health and social issue is required to minimise the harms of drug use. Demand for addiction services is increasing and investment in more services is needed, from brief interventions in general practice and primary care settings to social and detox options and follow-up community-based services. Alcohol and other drug policy leadership and coordination also needs a clear home within government"[1]

5. As we endeavoured to make clear in our submission and presentation, our interest focused particularly on the cohort of "consumers with the most complex mental health needs" (draft report vol. 1, p. 27) who in large measure suffer from a co-occurring substance issue. Indeed you acknowledge that: "The rate of substance use comorbidity among people who seek treatment is so high that it is considered 'the expectation, not the exception'" (vol. 1 p. 324).

6. At the core of your draft recommendations you have identified the need to assist "clinicians and other providers in the health system . . .to better deliver mental health services" (overview, p 25). You propose navigation platforms to facilitate entry of consumers to the mental health system via non-health pathways; care plans for those requiring intensive clinical treatment (p. 26) and care coordinators to oversee the implementation of care plans for the estimated 460,000 people with "the most complex mental health needs." (p. 27) - overwhelmingly those with co-occurring substance dependency and other mental health issues. To bring about these admirable changes you have recognised the need for **"**A health workforce that can

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New Zealand, *He Ara Oranga – Report of the Government Inquiry into Mental Health and Addiction* (2018). Retrieved from https://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf, p. 14.

deliver the changes needed" (p. 27) by augmenting the knowledge and skills of GPs in mental health (p. 28) and, of course, by increasing the availability of mental health specialists (p. 29).

7. Essentially, these recommendations repeat a call for collaboration and capacity enhancement of services that are found in earlier national mental health plans. You are following their lead in looking to clinicians and other providers to resolve the current considerable problems and challenges of the mental health system – problems that are particularly burdened by people with complex needs.

8. Your draft report acknowledges this similarity of response:

> "Nationally, substance use comorbidity has been a focus area for about 20 years. The National Comorbidity Project, launched in 2000, brought together the National Drug Strategic Framework and the Second National Mental Health Plan (DoH 2009b). This Project identified several areas for action, including greater collaboration between services and building the capacity for services to improve their response to comorbid mental health and substance use problems. This was followed by the National Comorbidity Initiative in 2003-04, which funded several research projects (Australian Government 2003, p. 175)" (Draft report, vol 1 p. 325).

9. Echoing the *Fourth National Mental Health Plan* at p.44, the current fifth National Mental Health and suicide prevention Plan of 2017 draws attention to the fact that:

> 'The combination of substance misuse and mental illness makes diagnostic and treatment decision-making difficult and successful interventions are often dependent on concurrent responses to both disorders. It is therefore essential that the linkage and management of these comorbidities are considered in system and service planning. Implementation of the Fifth Plan will be progressed with reference to work committed to under the National Drug Strategy 2017-2026, which provides a framework to guide the work of governments, communities and service providers in minimising alcohol and other drug-related harms" (*The Fifth National Mental Health and Suicide Prevention Plan*, p. 8).

In its 2019 review of the Fifth Mental Health Plan, the National Mental Health Commission makes makes a similar point about the struggle of the existing mental health system to address the complexity of mental health needs and that progress requires " . . . real commitment to integrate services and increase accessibility integration of services across government" (p. 8):

> " . . . The relationship between social determinants and mental health is dynamic and complex. As a result, the effects of social determinants on mental health and wellbeing should not, and cannot, be addressed by mental health interventions alone." (p. 11).

10. Repeating in your draft a call for clinicians and other service providers to better coordinate their services is, thus, not innovative and unlikely to produce better, much less “the best possible mental health and wellbeing outcomes” sought by the Treasurer in his reference to you.

11. You correctly identify the need to reduce stigma (draft report vol. 1, p. 93) that the Submission of the Australian Drug Foundation points out is intimately associated with illicit drug dependence (a recognised mental health condition):

> "The evident lack of treatment for people with substance use disorders is attributable partly to stigmatisation because drug dependency is regarded normatively as a consequence of “personal choice or moral failure” [27]. The World Health Organisation rates illegal drug dependence as the most stigmatised health condition and lists alcohol dependence as the fourth most stigmatised. Reducing the stigma around alcohol and other drug dependency is important if those in need are to gain help as early as possible." (submission 288).

12. We also applaud your recognition of the need to address a range of psychosocial factors if the burden of mental ill-health is to be reduced:

> “the importance of non-health services and organisations in both preventing mental illness from developing and in facilitating a person’s recovery are magnified, with key roles evident for — and a need for coordination between — psychosocial supports, housing services, the justice system, workplaces and social security” (p. 2).

13. For all that, your draft recommendations do little more than repeat elements of existing mental health plans with the stress they place on destigmatisation of mental illness. The Fifth Plan regards “Reducing stigma and discrimination [as] critical to improving the wellbeing of people living with mental illness” (39) and places the reduction of stigmatisation and discrimination among the eight priority areas of the Fifth Plan (p. 15-16). Moreover, your draft report like these plans considers destigmatisation in the context of social inclusion:

> Reducing stigma and discrimination is critical to . . .promoting better mental health within society. While there have been some improvements in knowledge about mental illness, there is still widespread misunderstanding, and people living with mental health illness still experience significant stigma. It will take a sustained and collective effort to dispel the myths associated with mental illness, change ingrained negative attitudes and behaviours and, ultimately, support social inclusion and recovery.(Fifth Plan p.39 and, similarly, 2009 – 2014 Plan p. 13)

14. Your draft also follows the fifth and the fourth plans in calling for an integrated approach to address psychosocial impediments to good mental health:

> "An integrated, culturally competent and sustainable service system provides the right amount of tailored clinical and community supports, at the right time, for people with severe and complex mental illness" (Fifth Plan p.29).

In the words of the 2009 – 2014 Plan:

> Recognition of the importance of social, cultural and economic factors to mental health and wellbeing means that both health and social issues should be included in the development of mental health policy and service development. The principle includes support to live and participate in the community, and
>
> Effort to remove barriers which lead to social exclusion such as stigma, negative public attitudes and discrimination in health and community settings. The National Social Inclusion Principles should underpin reform in mental health. (p. 13)

15. Given your failure to identify any new credible strategy to reduce the very large burden of disease and personal suffering that flows from situations of comorbidity involving substance use, we are at loss to understand how you can realistically expect that the stepped care model that you favour will improve the situation. After all, you acknowledge that "Stepped care has been adopted nationally in Australia, and while its use is widely accepted, its implementation has proved challenging" (vol. 1, p.17). Why? Our submission and halting presentation offered an answer. The characterisation of this cohort as criminals creates and intensifies stigmatisation and alienation, colours the response of clinicians and other service providers, fractures family support, leads to the warehousing of people in prisons thereby intensifying their mental health problems and compounds their complex knot of social problems like homelessness, unemployment and poverty that are recognised risk factors for mental ill-health (and substance abuse).

16. Benefits from the elimination of the tensions created between the law's characterisation of drug users as criminals and a caring and supportive therapeutic environment regarded as a *sine qua non* of good health care are obvious.

17. In our view it would be to kick the can down the road for the Productivity Commission to leave unaddressed the interaction between drug policy and the mental health system. Indeed, as I pointed out at the beginning of this letter, you have acknowledged that effective treatment requires "an alignment between mental health and alcohol and drug policies" (Draft report, vol. 1, p. 26). If you do not consider that your terms of reference authorise you to explore drug policy we urge you to at least point out in your conclusions the apparent potent interaction of drug policy and mental health. To reiterate, there is a need for a specific recommendation to address this:

> In the light of the heavy burden on the mental health system of co-occurring substance dependency which is the expectation rather than the exception

recognised by successive National mental health plans and drug strategies, the government should examine how to better align and integrate mental health and alcohol and drug policies and programs.

This examination should draw upon available evidence about the successful integration of services to people experiencing those co-occurring conditions and set out the elements of a national approach which will yield measurable improvements for these individuals, their families, the community and the economy.

That the National Mental Health Commission include monitoring the degree to which progress is being made in integrating mental health and alcohol and drug policies and programs in its monitoring of the Fifth National Mental Health and Suicide Prevention Plan.

Yours sincerely,

(Bill Bush)
President,
Families and Friends
for Drug Law Reform

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committed to preventing tragedy that arises from illicit drug policy

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Inquiry into
Youth Mental Health in the ACT
by the
Standing Committee on
Education, Employment and Use Affairs

Submission of
Families and Friends for Drug Law Reform

Annexure C Submission dated 11 April 2016 of Families and Friends for Drug Law Reform inquiry into youth suicide and self harm in the ACT by the Health, Ageing, Community and Social Services Standing Committee.

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INQUIRY INTO YOUTH SUICIDE AND SELF HARM IN THE ACT BY THE HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES STANDING COMMITTEE

SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM

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Inquiry into Youth Suicide and Self Harm in the ACT by the Health, Ageing, Community and Social Services Standing Committee

Submission of
Families and Friends for Drug Law Reform

Introduction

1. Families and Friends for Drug Law Reform commends the Assembly and this committee for commissioning the current enquiry into youth mental health and suicide prevention. We are most grateful for the opportunity to make a submission. That there has been, as the media release reports, a 650% increase in deaths from self harm of young children in the ACT between 2007 and 2012 is cause alone for great concern.

2. In this submission Families and Friends will explore the link between alcohol and illicit drugs and suicide. We will show that poor mental health is a driver for drug abuse and suicide. However, we will also demonstrate that illicit drug consumption leads to a higher chance of suicide than alcohol consumption due to the different ways Australians view alcohol and illicit drugs. The criminality surrounding consumption of drugs automatically brings discriminates against and alienates users increasing their marginalisation and reducing their chance of receiving appropriate health care.

About Families and Friends for Drug Law Reform

3. Families and Friends for Drug Law Reform was formed 21 years ago as a result of the public meeting in April 1995 of a group of people in the Australian Capital Territory who had a child, relative or friend who had died from a drug overdose. Its membership now extends across Australia. The grief that all shared turned to frustration and anger that those lives should have been lost: many would be alive today if drug use and addiction had been treated as a social and medical problem and not a law and order one. The criminal law, and how it was enforced, contributed significantly to the death of these young Australians.

4. Families and Friends for Drug Law Reform does not promote the view that all drugs should be freely available. Indeed it believes that they are too available

now in spite of and probably because of their illegality. As this submission will demonstrate, the fact that personal drug use is deemed a criminal activity helps to alienates drug users from their family, employment is and non-drug using peer group. High prevalence of depression and other mental health problems among dependent drug users is a a consequence. Mental health conditions such as this are notoriously influential drivers of suicide and self harm.

5. Since its establishment FFDLR has been intent on reducing the tragedy arising from illicit drugs, reducing marginalisation and shame, raising awareness of the issues surrounding illicit drugs and encouraging the search for, and adoption of, less damaging drug policies. Accordingly, the criterion that we apply in assessing the measures bearing upon drug use is whether they will promote the following objectives:

(a) make currently illicit drugs less available; and

(b) ensure that those who happen to consume such drugs that are available do not die or are harmed, thus reducing in society the suffering that has been experienced by so many FFDLR families and members.

Approach adopted in this submission

6. Families and Friends has made an extensive review of the literature available in regards to the effective management of illicit drugs over its 21 years. We have also investigated jurisdictions that take a very different approach to current Australian drug policy. The scientific and practical evidence clearly supports our position that decriminalisation of all illicit drugs for personal use supported by a well funded and extensive health support system is the only way that the scourge of drugs can be abated. We will demonstrate why such an approach is required in the rest of this report and show how its adoption would result in far fewer suicides of young Australians.

Association between substance abuse and suicide.

7. If the committee is to make any serious investigation into youth suicide examination of the role of drugs and drug policy is unavoidable. There is widespread evidence that illicit drug dependence is a powerful driver of suicide. In the words of Suicide Prevention Australia: “Alcohol and other drug (AOD) abuse confers a high risk of suicide” (SPA 2011, p. 3). The 2010 Senate report into Suicide in Australia noted that:

> "The role of alcohol and drug abuse in completed suicides was frequently mentioned during the inquiry. Alcohol or substance abuse disorders are often comorbid with other conditions which have an increased risk of suicide" (Senate 2010, para. 620, p. 86).

8. The suicide/drug policy link is shown by a meta analysis of 64 papers. The analysis was published in 2004 in the reputable peer reviewed journal, *Drug and*

Alcohol Dependence utilising the statistical concept of standardized mortality ratios that reveal the extent to which death in a study population exceeds the rate of the population at large:

> " . . . standardized mortality ratio (SMR) is a relative index of mortality, expressing the mortality experience of a given study population relative to that of a comparison ("standard") population. In this study, the SMRs were used to estimate whether risk for suicide among those with specific alcohol or drug use disorders were at greater risk than expected in the general population. SMRs were calculated by dividing the observed number of suicides by the expected number of suicides and multiplying by 100, in order to yield results without decimals as . . . " (Wilcox *et al.* p. S13).

9. The meta-analysis showed that while Alcohol use disorder was a high risk factor for suicide, it was far exceeded by risk factors associated with the consumption of illicit drugs. Someone with an alcohol use disorder was almost 10 times more likely to attempt suicide than a member of the community at large (being just a heavy drinker raises one's risk of suicide by a mere 3.5 times), the risk factor for those with an opioid use disorder were 13 more times more likely, intravenous drug users were between 13 and 14 times more likely and mixed drug users (those we would refer to as polydrug users) an astounding 16 to 17 times more likely (Wilcox *et al.*).

10. The studies relied upon in this meta-analysis were undertaken in the United States, Sweden, Norway, the Netherlands and parts of the United Kingdom. As far as Families and Friends is aware no similar study has been undertaken in Australia and while we can be confident that the situation here will be similar, it would be well for the committee to recommend that a study of Australian standardized mortality ratios be undertaken by a drug research agency. Given that overseas research shows the variation of association between mortality and different addictive substances, SMRs would be developed for users of each such substance.

Recommendation 1:

> A drug research agency should be commissioned to develop standardized mortality ratios of users of different addictive substances in Australia.

11. The Bureau of Statistics has pointed out about its latest release on causes of death in Australia that accidental poisonings including drug overdoses are among the leading causes of death for the youngest cohort:

> "Among those aged 15 to 44, the leading causes of death were Intentional self-harm (suicide) (X60-X84), Accidental poisonings (including drug overdoses) (X40-X49) and Land transport accidents (V01-V89)." (ABS 2016a).

Road accidents are, of course, also among the leading causes. That is particularly significant in the Australian Capital Territory where in 2013 and 2014 “the number of ACT opioid-related deaths . . . (32) was almost twice the number of people who died in motor vehicle crashes in the ACT over the same period (17—seven in 2013 and 10 in 2014)” (Olsen *et al*. 2015 p. 19). These data are surprising because fatal overdoses are particularly associated with heroin suggesting that, contrary to the media and political pre-occupation with the stimulant crystal methamphetamine, this depressive drug is making a come back.

12. Of course, not every drug overdose death is a suicide but most likely many are. This is even more likely now that the availability of naloxone will hopefully reduce the number of unintended overdose deaths.

13. The ABS seem to include overdoses among "Accidental poisoning by and exposure to noxious substances (X40-X49)" (ABS 2016b). Within the categories X40-X49 opiate overdoses seem listed under category X42 (Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified). In the provisional figures released for 2014, 11 deaths are listed (8 male and 3 female). The breakdown of ACT deaths in 2014 by age reveals that there were no deaths classified in the range X40-X49 of anyone less than 45 (ABS 2016c). This suggests the conclusion that none of the 45 deaths recorded for intentional self harm of those aged between 15 and 44 years was effected by overdose (ABS 2016c).

Suicide by drug users can be effected by means other than drug overdoses

14. The causes of death as published by the Bureau of Statistics hide the extent of suicide by drug users. Many dependent drug users despairing of ever getting on top of their addiction end their life by means other than drug overdose. Thus Neri, whose story is related below, took her own life at the age of 21 by asphyxiating herself in a friend’s car. A writer of this submission has spent many hours communicating with another drug user who, also despairing of getting “the gorilla” of addiction off, as his back as he puts it, has talked at various times of his determination to end his life by means such as jumping off the top of a tall public housing block or of driving his car over the side of Scrivener dam. That he has not yet implemented these schemes has been thanks to a handful of us in whom he has confidence enough to talk with, his fear of his attempt being unsuccessful and his own realisation of the distress that suicide brings to others.

15. There is a disconnect between the trend of suicides and overdoses. What still seems to be the most comprehensive analysis of opiate overdoses and suicide mortality was published by the National Drug and Alcohol Research Centre in 1999 (Hall, Degenhardt & Lynskey 1999). That showed that between 1964 and 1996 "the age of death among suicides *decreased* marginally while

that among opioid overdose deaths *increased* steadily." (*ibid.* p. 18). "The average age of deaths among persons whose death was attributable to suicide declined from approximately 35 years in 1964 to approximately 30 years in 1997" (*ibid.* p. 15). In contrast, from the late 1960s "the average age at death [from opiate overdoses] steadily increased" (*ibid.* p. 11).

16. Such information makes it of the first importance to secure accurate information about the psychological motivations for suicide and the extent to which those who have intentionally killed themselves were dependent drug users. The public health challenge is to ensure that information about the causes of heroin overdose and motives of suicide are gathered so that measures can be put in place to address them.

Recommendation 2:

Statistics should be assembled by coroners and published:

(a) on whether the consumption of drugs causing death was taken with the intention of ending the victim's own life; and

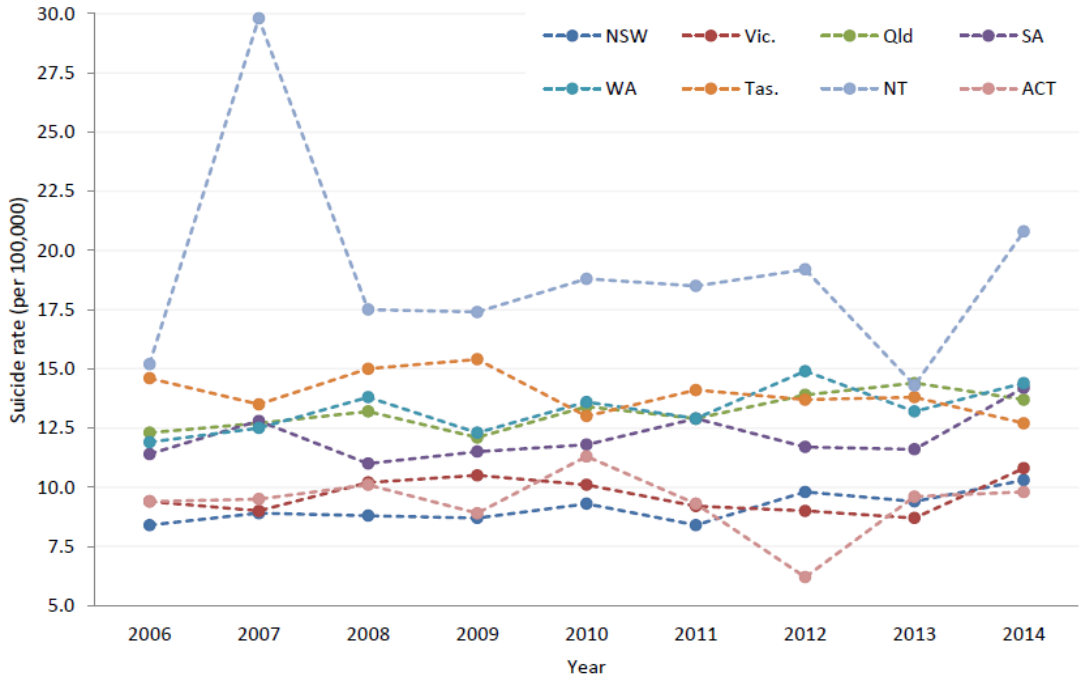
(b) whether those who intentionally take their own life by means other than the consumption of drugs were themselves drug users.

Rate of suicide generally in the Australian Capital Territory

17. The recent alarming spike in child suicide needs to be put into the context of the overall trends in suicide in the territory. The rate of suicide in the territory measured in terms of deaths per 100,000 of the population is 9.8 (at HIMH 2016 Table 1. Suicide count and rate by State/Territory and Sex, 2014). This rate was in 2014 the lowest in the country, slightly lower than that of New South Wales (10.3) within which the ACT lies. Furthermore, the overall suicide rate here has remained fairly stable at least since 2006 (*ibid*).

18. By comparison then, the ACT is doing reasonably well but 38 self-inflicted deaths in a year is 38 too many. What the ACT is doing may be better than other jurisdictions but it is still not good enough, particularly in the light of the surge in suicides of children.

Figure 21. Age standardised death rates, by State and territory, 2006 – 2014



SOURCE: HIMH 2016 table 21.

Shared risk factors of suicide and drug dependence

19. Most, if not all, of the risk factors that are associated with suicide are also risk factors for drug dependence. What is more the responses to drug use dictated by current drug policies intensify the risk factors for suicide. “Both suicide and AOD abuse share some common risk factors that can be targeted at a social level, often by instilling protective factors during early childhood and adolescence” (SPA 2011, p. 3).

Mental illness as a driver of suicide

20. Suicide Prevention Australia points out that “mental disorders are present in the majority of suicides” to the extent that “Mental illness is one of the most common and significant contributing factors to suicide in Australia” (SPA 2009 p. 2).

People who commit suicide are commonly overwhelmed with problems in their life. This is typically associated with depression and anxiety.

Social exclusion and isolation as drivers of suicide

21. According to Suicide Prevention Australia the two most salient explanations for drug users becoming suicidal are:

> • Long-term substance abuse can lead to social issues such as financial stress, criminality, physical ill health or family breakdown, resulting in distress and social exclusion and thus suicide risk.
>
> • Social disadvantage, childhood adversities, personal traumas and mental illness contribute to a risk for both substance abuse and suicide concurrently. (SPA 2011 p. 9).

The ground breaking Not for Service report of 2005 included the following testimony of a consumer advocate:

> "Social isolation & loneliness are guaranteed triggers of episodes of mental illness, substance abuse, self harm & suicide. This happens, and it happens all the time. And in rural and isolated communities, where resources are even more scarce, the problems are much worse" (MHC 2005: pp. 134 & 249).

22. Loneliness that comes from social disconnection also occurs in the case of alcohol abuse (*ibid.* p.7). That the standardized mortality ratios for most illicit drugs is between a third and a half higher than for alcohol indicates that the factors of social exclusion at work in the case of illicit drugs are significantly more intense and potent than for alcohol (above para. 8). 23. The obvious difference is the impact of the different policy environments applicable to alcohol on the one hand, and illicit drugs on the other. The exclusionary impacts of processes of the criminal law that apply directly to drug possession and use but not to the possession and use of alcohol.

Recommendation 3:

> That the committee carefully consider the effect of criminalisation of drugs on the marginalisation of drug takers and how changes to drug policy would have a direct bearing on the suicide rate.

24. In purchasing, possessing and using illicit drugs drug users are exposed to the stigmatising procedures of arrest, search, and prosecution. As a result they are far more likely to become disconnected from their family, employment and non-drug using friends than those who misuse alcohol.

25. These considerations were apparent at a community forum in Queanbeyan last Tuesday evening (5th April) entitled *Breaking the Ice in our Community*. Speakers from the Australian Drug Foundation, the Southern New South Wales Local Health District, Winnunga Nimitijah and Family Drug Support all stressed the importance of connection. A flavour of this approach is given by the following transcript of a videoed talk by a drug user in recovery that was

shown at the gathering. This gives an insight into the profound isolation and remorseless despair that is often associated with the life of dependent drug users.

Jay Morris's Story

Jay Morris, ex-user of massive methylamphetamine: It is really important, I feel, that we look beyond the person that you see who is affected by drugs and realize that I am a person, that the person that you have in your life who is using is a person. They have emotions, they have feelings, they need help. I started using ice when I was 20 years old. I used it recreationally and formed a habit over a period of a couple of months and it ended up spiralling into something that I couldn't control and then I went through a very long and painful recovery period. The triggers for me that made me realise crystal meth was a problem was that I felt like by my addiction I had done everything wrong by hurting my family. Not in a violent way. But you can hurt people in other ways, emotionally, mentally like lying to my family, stealing from my family. All of that stuff bottled up inside me to make me feel that what I was doing just wasn't right. That feeling of loneliness, complete and utter loneliness was not worth it at all. From recognising what the issues were and those being triggers, a few things came together to make me realise that I needed help. I was going out regularly to night clubs and there was a security guard said to me that I needed to get a rehab which was amazing. Really, to this day, the fact that somebody - I get emotional with it - somebody put their hands out and said you need help. It was a kick in the arse. It really pushed me along and that was the moment that I realised that yes I need help; yes I need to move forward. So as soon as I got into a rehab facility, I had a huge impact with stigma and then going out into the community it was like a waterfall of stigma. But it is important to be strong enough to know that recovery is possible and that recovery is a better life than using. So my message for anybody out there using the drug would be that the first step is just call someone and talk; admit you have a problem. My life has changed dramatically since recovering from crystal meth. I am going to be studying in social work giving back to everyone who has given to me. My hope for the future is to see that the stigma around drug addiction ceases and that as a community and as an individual we look at the people in addiction as human beings. So it's really important to recognise that and give them support as people and to look beyond the drugs. My name is Jay Morris. I am a recovering addict. I'd like you to see the person and not just the drug.26. Families and Friends urges the committee to view the complete video from which this transcript is taken. It is available on the website of the Australian Drug Foundation at http://adf.org.au/cdat-breaking-the-ice-resources.

27. What beneficial role could be played by the police in promoting recovery was an obvious question that was expressly put to the Queanbeyan meeting. It

was apparent that ready availability of illicit drugs shows that police are not effective in eliminating or even reducing supply. There was a marked difference in the role of the police depending upon whether the issue was characterised as a welfare one involving assistance in the case of mental health problems, as can happen with psychoses of drug users often associated with crystal methamphetamine. In such cases police are often called upon as the first line of assistance and must serve as a *de facto* mental health service to secure medical help for the psychotic person. If, on the other hand, the same person is discovered with drugs in his possession, or in selling drugs to friends as a means of financing his or her own habit, then the police will be likely to process him or her as a criminal. It can be arbitrary which path the police will follow.

28. A policy problem facing the committee is how to recommend less alienating and isolating processing of drug users without exposing the government to the charge of "sending the wrong message" or being "soft on drugs." But, if risk of suicide is to be ameliorated then an isolating tough on drugs approach is very much the wrong approach.

29. The dynamics associated with drug use and how dependent drug users can take a perfectly rational decision to end their own lives as the only way out of their predicament is revealed in the following story of a young woman who died not far from here at 21. The isolating factors illustrated by this story that the committee can and should do something about, include the absence of holistic mental health and drug treatment, absence of adequate opiate pharmacotherapies; the widespread stigma found even among the caring professions against drug users.

Neri's story

Neri was a richly endowed young woman. She had spirit, beauty, athleticism and words the last of which would by now have made her a household name in Australian literary circles if not those of the world had she not at 21 ended her own life in a friend’s car filled with exhaust fumes. The autopsy showed no trace of drugs in her body.

She was a brilliant student with a commitment to perfection always convinced she was fated to disappoint and a heart so big that it was bound to shatter. She wrote in her diary:

. . . it sounds like I expect a lot of myself, but I don’t. I expect very little from me and the one thing I can proudly say is that I never disappoint myself. There are a lot of people out there who expect more and I’m constantly disappointing them. I don’t mean to disappoint people and I don’t like to disappoint people either, I just do. . . .
I’m afraid Neri just doesn’t perform.

As a brilliant school student and debater she met smack. The two embraced just as so many sensitive young talented children have done. Her mother who witnessed this commented:

Neri turned to drugs first out of a sense of dare-devilment and a wish to experiment and live a bit on the edge. She didn't climb mountains, she didn't drive fast cars, she didn't sail the Southern Ocean. She used drugs to get her thrills, to make herself a more exciting person, to speak with confidence and to act with a sense of power. Then she needed them to give her back the confidence that drug usage had sapped. . . . The shame of drug use stopped her from seeking my help, the one person close to her who might have been able to give it.

Her struggle to free herself from her lifestyle as a drug user and her brilliance and sensitivity only served to enmesh her more deeply in it.

Neri finally fell in love. Her mother believes that this would have helped had it happened earlier, but it was too late. Her mind was tattered from using all sorts of drugs in her attempts to escape the grip of heroin. She feared for her sanity and she hated her past. "I think she felt she could not offer anyone a future. She held no hope for her own future."

Recommendation **4:**

The Government should develop effective:

- holistic mental health and drug treatment services;
- opiate pharmacotherapies successfully implemented overseas; and
- to combat widespread stigma found even among the caring professions against drug users.

11/04/2016

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Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug policy

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Inquiry into
Youth Mental Health in the ACT
by the
Standing Committee on
Education, Employment and Use Affairs

Submission of
Families and Friends for Drug Law Reform

Annexure D Paper dated 1 June 2020 calling for the initiation in the Australian Capital Territory of heroin assisted treatment to underpin the release of vulnerable prisoners, improve mental health and protect The ACT population from COVID-19

CALL FOR THE INITIATION IN THE AUSTRALIAN CAPITAL TERRITORY OF HEROIN ASSISTED TREATMENT TO UNDERPIN THE RELEASE OF VULNERABLE PRISONERS, IMPROVE MENTAL HEALTH AND PROTECT THE ACT POPULATION FROM COVID-19

By Bill Bush

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CALL FOR THE INITIATION IN THE AUSTRALIAN CAPITAL TERRITORY OF HEROIN ASSISTED TREATMENT TO UNDERPIN THE RELEASE OF VULNERABLE PRISONERS, IMPROVE MENTAL HEALTH AND PROTECT THE ACT POPULATION FROM SARS-CoV-2

By Bill Bush

> I think every government needs to look in every corner, every nook and cranny of the country and say where is vulnerable because if you don't find it first the virus will find it for you.
> (*Dr Dale Fisher ABC 7:30 report Monday 27 April. Dr Fisher is an Australian infectious disease physician who is professor of medicine at the National University of Singapore. He is working for the World Health Organization in leading Singapore's response to the coronavirus including its sudden resurgence attributed to migrant workers*.)

I. ABSTRACT

The ACT's overcrowded prison along with other prisons across the country are particularly vulnerable to an outbreak of SARS-CoV-2 virus. The health status of the prison population is poor with physical and mental health problems. As elsewhere, the ACT prison population is characterised by co-occurring substance dependency and other mental health issues. It is acknowledged that people with mental health problems are warehoused in prisons as de facto modern day mental health institutions. People with mental health conditions are at high risk of becoming drug users, a small proportion of whom will become dependent and at risk of resorting to property crime to support their habit. Sourcing their drug supply will also bring them under the influence of a criminal peer group and otherwise intensify risk factors for crime like unemployment, poverty, homelessness and alienation from their families. Their processing as criminals leads them into prison where the harsh, untherapeutic prison environment will further intensify their mental health problems and the very risk factors that led them into prison.

Adjusting drug policy to remove the threat of criminal sanctions over drug users is the surest way of reducing the flow of people into prison and the accelerated release of those from prison. The quickest and most effective way of doing this is by introducing enhanced treatment options superior to methadone and other pharmacotherapies that are currently available in Australia. Heroin assisted treatment (HAT) provides that option. Eight trials of it have taken place demonstrating its superiority to methadone in retaining in treatment patients who had consistently failed to be benefited by methadone. Patients were stabilised and reintegrated into society. It is

also shown to be one of the the most effective crime reduction measures ever tried.

A Cochrane review of the trials of HAT has confirmed the benefits of the intervention and promotion of a heroin trial by the Carnell government of the ACT in the 1990s as a response to then epidemics of heroin addiction, blood-borne diseases, property crime and drug overdose deaths. In the last three months of 2019 clinics for the treatment have been opened in Middlesbrough in the north of England and Glasgow in response to outbreaks of HIV among injecting drug users.

While most attention is on the impact of crystal, the stimulant, it is opiates, whether illicit or from misuse of powerful prescription analgesics, that remain the main factor in overdose deaths. Justice Health encourages ACT prisoners to become inducted onto existing pharmacotherapies but there is a high attrition rate with those who are released not continuing on the program.

HAT is shown to increase the general well-being and mental health of drug users and combat the stigma and isolation which intensifies much mental illness.

The article includes remarks on the possible benefits of hybrid hydromorphone comparable to HAT and on the likely benefit of HAT on reducing the grossly disproportionate incarceration of indigenous Canberrans and ends with remarks on the ineffectiveness and indeed crime enhancing influence of imprisonment and comparison of the ACT incarceration rate with overseas jurisdictions which to some extent have rolled out HAT.

II. Introduction

1. In the words of the British-based world Prison Brief, "The coronavirus pandemic presents formidable challenges for prisons worldwide – challenges they will struggle to meet, with potentially grave consequences for the health of prisoners, prison staff, their families, and all of us." It is only a matter of time before the SARS-CoV-219 virus epidemic infects overcrowded Australian prisons wreaking death on those with compromised health detained inside them and serving as a hotbed of infection into the broader community. In the words of the World Health Organization: "the risk of rapidly increasing transmission of the disease within prisons or other places of detention is likely to have an amplifying effect on the epidemic, swiftly multiplying the number of people affected." Deaths from the virus have already occurred in prisons in the United Kingdom, United States and Brazil. *The Guardian* reports that it is suspected that five recent suicides in six days in prisons in England and Wales are linked to the pausing of programs and confinement in cells of prisoners for 23 hours in the day.

2. A Second Open Letter of 20 March calls for the early release of vulnerable populations including women, Aboriginal and Torres Strait Islanders, the elderly and people detained for "non-violent drug offences". The letter also refers to the disproportionate effect of the virus "on vulnerable populations over-represented in

prisons" including "people from low socio-economic backgrounds; people experiencing homelessness; and people with disabilities". The last includes the majority in prison suffering from mental health conditions. Fear of infection has produced unrest and even riots.

3. Such vulnerable people should be released. This step should be complemented by measures to reduce the flow of people into prisons. This paper describes how these objectives can be achieved without compromising, and indeed by enhancing, community safety This can be done while respecting the need for community safety by changing laws to address the reason why so many find themselves in prison. The paper argues that these results can be achieved by changing our drug laws in ways that numerous other countries have already done in response to epidemics.

4. The criminal law and policies have been changed in the past in response to earlier epidemics like HIV and hepatitis C when Australian drug policies moved from one that relied upon the sanctioning by the criminal law of users as the first line of defence to the policy of harm minimisation which sought a balance between its three arms of supply reduction (principally law-enforcement), demand reduction such as education and harm reduction involving actions that reduced the harm to those who, in spite of all, continued to use drugs. It was in this third limb that Australia led the world at that time in permitting sterile syringes (previously outlawed).

III. Heroin assisted treatment as a response to a SARS-CoV-2-like situation faced by the Carnell government

5. It was in the context of this flux that the then Chief Minister of the ACT, Formerly a pharmacist put the weight of her government behind the development of a trial of heroin assisted treatment. Her advocacy and that of her health Minister, independent Michael Moore, succeeded bringing on board the federal government the health Minister of which, happily, was a medical doctor, Dr Wooldridge. The state governments were persuaded to approve it. A number had interests that needed to be accommodated: Tasmania grew opium poppies and, under the trial developed by the National Centre for Epidemiology and Population Health of the ANU, Victoria and New South Wales would be required to participate in later phases of the trial.

6. The Federal Cabinet approved the proposal (the Commonwealth would have to permit the importation of heroin) but all was undone on 19 August 1997 when on the insistence of the Prime Minister, Mr Howard, the Cabinet approval was countermanded. The Prime Minister, Mr Howard, countermanded that trial[1] on the ground that "heroin prescription might be linked with more permissive attitudes to illegal drug use, encouraging use especially among young people."[2]

1. Alex Wodak, The heroin trial 10 years on: how politics killed hope, *Crikey*: Wednesday, 22 August 2007 at http://www.ffdlr.org.au/commentary/docs/Herointrial10yearson.htm.

2. Gabriele Bammer, Anja Dobler-Mikola, Philip M. Fleming, John Strang, Ambros Uchtenhagen, The Heroin Prescribing Debate: Integrating Science and Politics, *Science* vol. 284, issue 5418, pp. 1277-1278, 21 May 1999

A. Health and social crises facing the Carnell government

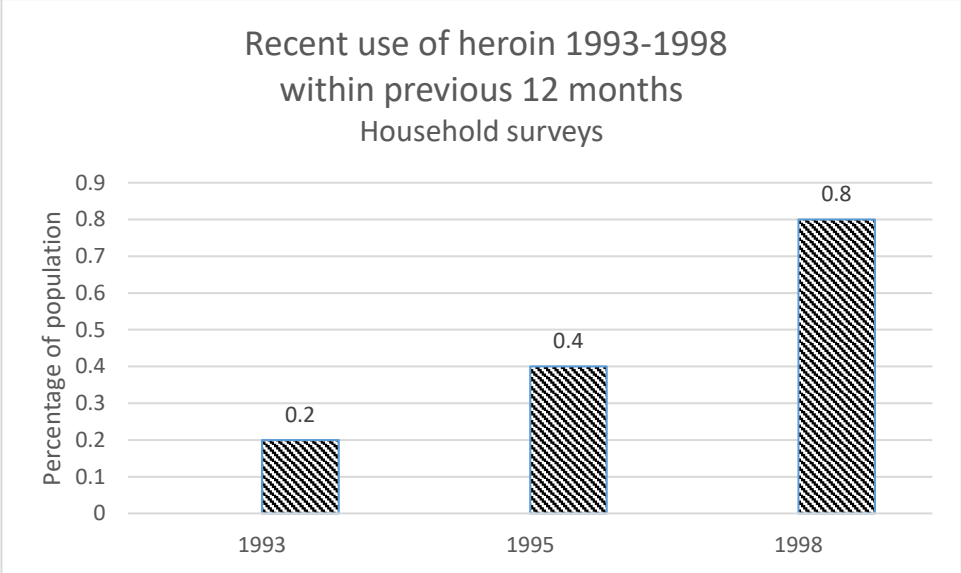
7. The predicament that Kate Carnell faced up to was a fourfold epidemic:

- an epidemic of heroin use;
- an epidemic of blood-borne diseases in particular of HIV (AIDS) and the recently isolated hepatitis C virus both of which are easily spread by injecting drug use, which was the main form of administration of heroin and for which, like SARS-CoV-2 at the moment, there existed no cure or vaccination;
- an epidemic of opioid overdose deaths from heroin use; and finally
- an epidemic of crime associated with the increasing heroin use.

8. There were reasons to think that heroin assisted treatment would help control these four.

B. Growth in heroin use

9. The household survey showed that heroin use quadrupled between 1993 and 1998.



C. HIV/Aids

10. By the end of 1996 it was "estimated that there were 11,080 people living with HIV infection in Australia . . . ."

> "HIV prevalence has been very low (less than 0.6%) in both men and women seen at metropolitan sexual health centres in 1992-1996 who identified themselves as injecting drug users (Figure 15). HIV prevalence in people attending needle and syringe exchanges has also remained low (less than 3%) except among men who identified themselves as either bisexual (4%) or homosexual (26%) (Figure 16)."[3]

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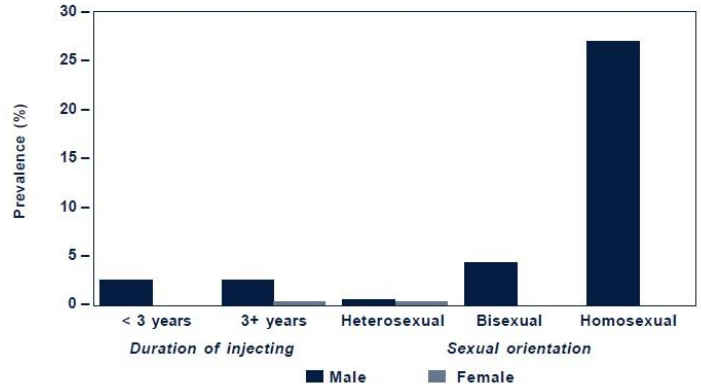
3. National Centre in HIV Epidemiology and Clinical Research, *HIV / AIDS and related diseases; annual surveillance report 1997* (National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, NSW. 1997) pp.17-18 at

Figure 16 HIV prevalence in people seen at needle and syringe exchanges, 1996, by duration of injecting drugs and sexual orientation



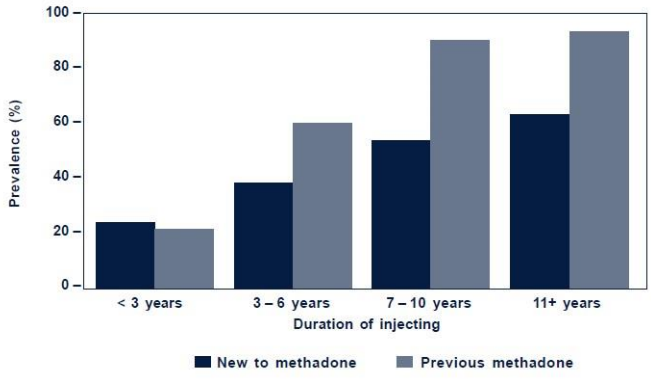
11. While the prevalence of HIV was low among injecting drug users, it was feared that injecting drug use, particularly in prisons where sterile syringes were not available, would be a vector by which the disease could spread into the community as was happening in some countries.

1. Hepatitis C virus

12. The number of hepatitis C diagnoses increased from 4116 in 1991 to 9060 in 1996. The first national report in 1997 on these diseases noted that:

> "HCV prevalence in people attending needle and syringe exchanges was very high, with an overall level of 65%. HCV prevalence was strongly related to duration of injecting in both males and females with levels of over 70%in people who have injected for three years or longer, though HCV prevalence was already high (around 30%) in men and women who had been injecting for less than three years. "The strong relationship between HCV prevalence and increasing duration of injecting was also seen in people tested on entry to methadone treatment (Figure 18)."[4]

Figure 18 HCV prevalence in people seen at methadone clinics, 1996, by duration of injecting and history of methadone treatment



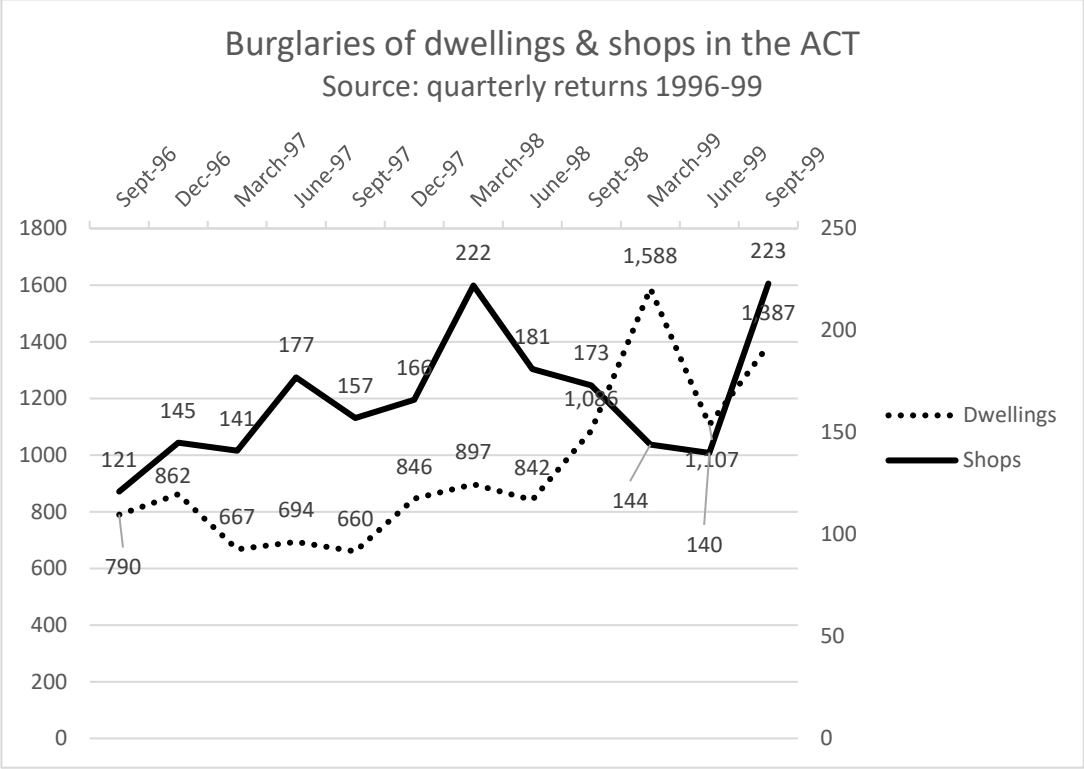
https://kirby.unsw.edu.au/sites/default/files/kirby/report/SERP_1997-Annual-Surveillance-Report.pdf

4. The same.

> "Reuse of equipment for injecting illicit drugs has been an infrequent mode of HIV transmission in Australia, but transmission of hepatitis C infection is occurring at very high rates in people who inject drugs."

2. Property crime

13. "Dependent opioid users are . . . more likely to be criminally active"[5] ACT criminal justice quarterly statistics for burglary of dwellings doubled between 1996 and 2000 (790 in September 1996; 1422 in June 2000). Burglary from shops also doubled in that period. In the 13 years up to that time "property crime, of which stealing accounts for half, increased by 89%"[6] "those charged with the property offence are more likely to report they are dependent on heroin (37%) and either cocaine (2.7% or amphetamine (10.3%)."[7]



14. The then Labor leader of the Opposition, Rosemary Follett, spoke in support of the proposed heroin trial in terms of the crime that it might ameliorate:

> " . . . the use of heroin has led to an increase of crime in our community - crime against the person, crimes of violence, and crime against property. Our entire community is at greater risk because there are people in our

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5. Karen Toohey, Gabrielle McKinnon, & Ingrid Osmond, *Review of the opioid replacement treatment program at the Alexander Maconochie Centre: Report of the ACT Health Services Commissioner*, (ACT Human Rights Commission, March 2018) p.9 at https://www.parliament.act.gov.au/__data/assets/pdf_file/0009/1185057/Alexander-Maconochie-Centre-Review-of-the-Opioid-Replacement-Treatment-Program.pdf visited 22/06/2020.

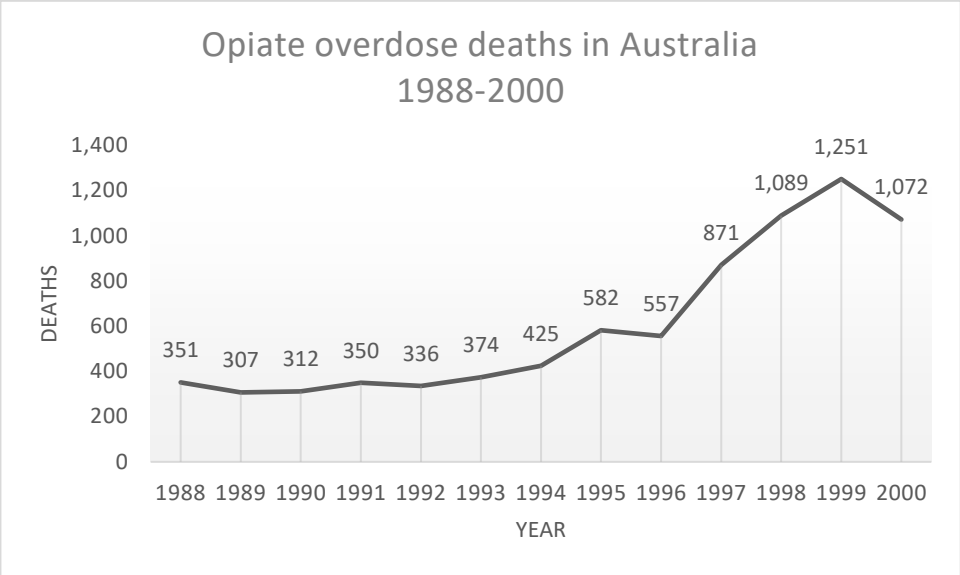
6. Satyanshu Mukherjee, Debbie Neuhaus & John Walker, *Crime and justice in Australia* (Australian Institute of Criminology, Canberra, 1990) p. 7.

7. Toni Makkai, *Illicit drugs and crime,* Adam Graycar & Peter Grabosky (eds), *The Cambridge handbook of Australian criminology* (Cambridge University Press, 2002) chapt. 6, pp. 110-125 at p. 120.

community who choose to use this substance illegally. Our whole community is at greater risk of burglary, greater risk of mugging, greater risk of theft, and so on. So the cost in terms of crime in our community ought not to be discounted."[8]

3. Explosion of opiate overdose deaths

15. Overdose deaths more than tripled from 350 in 1991 to 1,251 in 1999.



D. The nightmare of worst-case scenarios:

16. The prevalence of HIV/AIDS in Australia including prisons may have been low in the early 1990s but it was feared that unless more effective measures of harm reduction were taken that then fatal infection could spread from intravenous drug users into the community. Intravenous users of heroin were congregated in prisons. On public health grounds there was therefore an imperative to reduce the concentration of this vulnerable population in a prison environment where injecting drug use was rife but without access to sterile syringes. In other countries and as with HCV in Australia, blood-borne diseases are "pervasive among IV drug users, who are dramatically over-represented in correctional institutions."[9] The United States National Commission on AIDS commented in 1991 that "by choosing mass imprisonment as the federal and state governments' response to the use of drugs, we have created a *de facto* policy of incarcerating more and more individuals with HIV infection."[10] The actuality of the foregoing health and social crises was ground enough for the Carnell government to promote radical measures but the nightmare was that worse was on the cards if the government did nothing to counter the growth in heroin use.

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8. *Hansard,* 27 February 1996.

9. TM Hammett. *AIDS in Correctional Facilities: Issues and Options*. 3rd ed.Washington, DC: US Department of Justice, 1988, at 26 quoted in Rick Lines, Ralf Jürgens, Glenn Betteridge, Heino Stöver, Dumitru Laticevschi, Joachim Nelles, Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience (2004 Canadian HIV/AIDS Legal Network)

10. Quoted in Lines et al., cited above, p. 10.

1. HIV/Aids

17. Lithuania

"In Latvia it is estimated that prisoners comprise a third of the country's HIV-positive population, and that a fourth of all HIV-positive persons in Latvia were infected while in prison.14 In Lithuania, in May 2002 the number of new HIV-positive test results among prisoners found in a two-week period equalled all the cases of HIV identified in the entire country during all of the previous years combined."[11]

18. Canada

"During the mid-1990s, the Canadian city of Vancouver experienced an HIV outbreak on an unprecedented scale among people who inject drugs. "At its peak, the rate of new infections reached 18 per 1,000 person-years, comparable to incidence rates seen in parts of sub-Saharan Africa. Up to 25% of the city's population of people who inject drugs became infected." [12]

19. Scotland

During 2015, a total of 47 cases of HIV were diagnosed among people who inject drugs in Glasgow, of whom 43 share the same strain (subtype C). This represents an almost fivefold increase on the previous annual average of 10 new infections, with laboratory testing indicating recent transmission in the majority of cases. There have been 13 further cases of HIV among people who inject drugs diagnosed during 2016 to date. Transmission appears to be predominantly via injecting drug use, though a degree of sexual transmission cannot be ruled out. Such an outbreak is unusual in an area such as Glasgow which provides a range of prevention services, including low-threshold access to sterile injecting equipment, opioid substitution therapy, sexual health services, and HIV treatment. Most of those affected are male, with relatively long histories of injecting drug use."[13]

20. Russia

260 prisoners contracted HIV in a Russian correctional colony in 2001

2. Tuberculosis

21. In an article entitled *Prisons in Post-Soviet Russia Incubate a Plague Scientific American* reported that *"*Between 1991 and 2001 the incidence of TB in Russia's prisons reached a staggering 7,000 cases per 100,000 inmates. According to one estimate, prisoners made up 25 percent of all new cases in the nation. In this oil-rich province [, Western Siberia] with just over a million

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11. Quoted in Lines et al., cited above, p. 6.
12. NHS Greater Glasgow & Clyde, "Taking away the chaos": the health needs of people who inject drugs in public places in Glasgow city centre (NHS Greater Glasgow and Clyde, 2016) p. 15 at https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf visited 25/04/2020.
13. The same, p. 12.

inhabitants, the prison TB rate reached the equivalent of 4,000 cases per 100,000 inmates, with nearly one of every 11 cases proving fatal."[14]

22. According to the World Health Organisation "The prison environment is often conducive to tuberculosis transmission and rates may be higher than in the general population. Furthermore, tuberculosis is increasingly associated with HIV/AIDS, so that the presence of HIV-infected prisoners may increase the risk of tuberculosis transmission. Vigorous application of WHO guidelines on HIV infection and AIDS in prisons efforts are therefore needed "to reduce the risks related to the environment (e.g., by improving ventilation, reducing overcrowding, and providing adequate nutrition); to detect cases of tuberculosis as early as possible through screening for tuberculosis on entry and at regular intervals during imprisonment, and through contact tracing; and to provide effective treatment."[15]

3. Botulism

23. Scotland

December 2014 – December 2015

• 26 cases resident in NHSGGC [NHS Greater Glasgow & Clyde), of whom 2 died

• 44 cases and 4 deaths across Scotland as a whole among public injecting drug users in 2014 – 15[16]

4. Anthrax

24. Scotland

December 2009 – December 2017

• 35 cases resident in NHSGGC, of whom 9 died – a serious infectious disease among people who inject drugs in Glasgow

• 119 cases and 14 deaths across Scotland as a whole [17]

1. Clostridium novyi

25. Scotland

April – August 2003

• 55 cases resident in Glasgow or surrounding areas, of whom 19 died

• 60 cases and 23 deaths across Scotland as a whole

Many of the cases "were identified to be part of a core group of particularly chaotic drug users with close links to the city centre and its drug scene." [18]

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14. Merrill Goozner, Prisons in Post-Soviet Russia Incubate a Plague (*Cook*, August 25, 2008) at https://www.scientificamerican.com/article/prison-plague-post-soviet-russia/.

15. WHO guidelines on HIV infection and AIDS in prisons (WHO Global Programme on AIDS, First printed 1993) pp. 7-8.

16 NHS Greater Glasgow & Clyde, (2016) p. 46

17 The same.

18 The same.

2. Soft tissue and Staphylococcus aureus bloodstream infections

Scotland

26. "Serious bacterial and fungal infections remain a significant hazard among people who inject drugs. Among clients accessing injecting equipment provision services in Scotland during 2013-2014, 28% had experienced an abscess, sore or open wound during the past year33. A large outbreak of soft tissue infections occurred among people who inject drugs in Edinburgh during 2014 and 2015, with many of those affected requiring prolonged hospitalisation and surgical intervention. NHSGGC [NHS Greater Glasgow & Clyde] are also currently investigating an apparent increase in Staphylococcus aureus bloodstream infections among people who inject drugs in Glasgow during the last year." [19]

27. The government's response to the current SARS-CoV-2 emergency should be informed by reflection on what might have been had the ACT in Australia proceeded with the trial of heroin assisted treatment. Switzerland, facing a public health emergency and scandal from heroin use in cities like Zürich, embarked on the heroin trial that the ACT was prevented from having. In doing so it was guided by the careful designed work that went into the design of the ACT trial.

E. Methadone

28. Methadone is an artificial opiate which, as a pharmacotherapy can address a number of the critical issues that faced the ACT government in the 1990s. It " . . .was introduced into Australia [as a treatment for heroin dependence] in 1969.

1. Australian endorsement of methadone

29. Methadone Maintenance Treatment (MMT) was endorsed by State, Territory and Commonwealth Governments as an appropriate and useful treatment for heroin dependence at the launch of the National Campaign against Drug Abuse in 1985." (Commonwealth Department of Health).
Pharmacotherapies like methadone are known to:

- retain "patients in treatment;
- decrease heroin use better than treatments that do not utilise opioid replacement therapy"[20]; and
- reduce offending among opiate dependent drug users.[21]

2. Methadone and crime reduction

30. Opiate Replacement Therapies like methadone aim ". . . to provide stability for the client, to reduce risks of overdose and other health and social

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19 The same.

20. R.P. Mattick, C. Breen, J. Kimber, M. Davoli, "Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence", Cochrane Database of Systematic Reviews 2003, Issue 2. Art. No.: CD002209. DOI: 10.1002/14651858.CD002209 at http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002209/pdf_fs.html

21 John C. Ball & Alan Ross, The effectiveness of methadone maintenance treatment: patients, programs, services, and outcomes (Springer-Verlag, New York, Berlin &c, 1991) table 10.4, p. 202 and Maree Teesson et. al., (2003) *Twelve month outcomes from the treatment of heroin dependence: findings from the Australian Treatment Outcome Study (ATOS), New South Wales* (Technical report no. 191, National Drug and Alcohol Research Centre, University of New South Wales, Sydney) p. 21.

harms, and encourage positive lifestyle changes which may eventually allow a client to successfully achieve abstinence from opioid use."[22]

31. Crime reductions accompanying methadone maintenance treatment have been carefully assessed in a lot of studies. Even so, offending behaviour of patients is shown to decline while in opiate maintenance treatments. For example, a large-scale outcome study of methadone maintenance treatment involving six methadone maintenance programs, two in each of Baltimore, Philadelphia and New York, over a three-year period between 1985 and 1987 found that methadone maintenance had "a dramatic impact" on crime among the 388 patients who remained in treatment:

> "The reduction of crime associated with retention in methadone maintenance . . . appeared impressive. The study sample had an extensive criminal history prior to entering methadone: a total of 4,723 arrests, with a mean of nine arrests for the 86% of the sample who had been arrested. Sixty-six per cent of the group had spent some time in gaol, 36% having been incarcerated for two years or more. Although these figures indicate extensive criminal involvement, they seriously underestimate criminal activity which is better estimated by self-reported crime.
>
> "The sample admitted to 293,308 offences per year during their last period of addiction. Among those who admitted committing criminal acts, each person committed an average of 601 crimes per year (range 1 to 3,588), and had committed criminal offences on an average of 304 days per year during their last addiction period. After entry to methadone, the number of self-reported offences declined to 50,103 crimes per year and the mean number of 'crime days' per year decreased from 238 in the year prior to entry to 69 crime days during the early months of methadone maintenance. The number of crime days continued to decline with the number of years spent in treatment. In terms of the number of crimes committed, the reduction during methadone maintenance was 192,000 offences per year. As [the authors of the study] remark, such a substantial reduction in criminal activity among heroin users is usually only achieved by incarceration".[23]

32. More recently according to a large Australian evaluation of pharmacotherapies for opioid dependence:

> "Property crime was reported at baseline by a significantly greater proportion of Heroin Users (20%) than Methadone Patients (5%), as was drug dealing (23% vs. 8% respectively); fraud (8% vs. 2% respectively); and violence (3% vs. 1% respectively).

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22. *Review of the opioid replacement* (2018) cited above p. 10 at https://www.parliament.act.gov.au/__data/assets/pdf_file/0009/1185057/Alexander-Maconochie-Centre-Review-of-the-Opioid-Replacement-Treatment-Program.pdf.

23. Jeff Ward, Richard P. Mattick and Wayne Hall, *Key issues in methadone maintenance treatment* (National Drug and Alcohol Research Centre, University of New South Wales Press Ltd, 1992) p.35.

33. Criminal behaviour among Heroin Users was halved at the three month follow-up. Their average monthly expenditure on heroin decreased from $2,611 at baseline to $572 at three-month follow-up, consistent with the decreases in heroin use"[24]

3. Buprenorphine /Suboxone

34. Buprenorphine was introduced in Australia in the 1990s to supplement methadone as an opioid agonist or opioid substitution treatment. It is taken as a regular dose to remove the need for illicit opioids such as heroin, or in the treatment of pharmaceutical opioid dependence and is also commonly prescribed to treat chronic pain.[25]

35. Suboxone is a fixed combination of buprenorphine (a partial μ-opioid receptor agonist) with naloxone (an opioid antagonist) in a 4:1 ratio. The addition of naloxone to buprenorphine is expected to decrease the intravenous abuse of buprenorphine, because when taken sublingually, absorption of naloxone is minimal, however it can rapidly precipitate opioid withdrawal when injected.[26]

36. In the ACT prison: "Methadone (in the form of biodone) is the preferred medication for Opiate Replacement Therapy (ORT). Buprenorphine (in the form of Suboxone) is only available for limited periods to manage withdrawal on entry and shortly before release to reduce risk of overdose in the community. A short trial of Suboxone maintenance was conducted at the AMC but was ceased due to allegations of widespread diversion."

4. Inadequacy of methadone and buprenorphine

37. There was thus strong evidence of the efficacy of methadone as a pharmacotherapy that stabilised heroin dependent drug users to the extent that it was regarded as "the gold standard" for opiate treatment. But it clearly was insufficient to allay the serious health and social challenges facing the ACT government in the 1990s and which moved it to propose a trial of heroin assisted treatment for the many opiate dependent drug users for whom methadone did not help. Methadone has a bad name among many opiate dependent drug users. To be effective patients are required to take a "holding dose" which effectively means that they are required to add a dependency on methadone to their dependency on heroin. This was something that many did not want to do given that for many it is harder to overcome a methadone dependency than a heroin one.

38. Methadone may have unpleasant side effects. As stated above, it is addictive. Like other opiates it is a 'drying' drug and can cause constipation and

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24. Mattick RP, Digiusto E, Doran CM, O'Brien S, Shanahan M, Kimber J, Henderson N, Breen C, Shearer J, Gates J, Shakeshaft A and NEPOD Trial Investigators, *National Evaluation of Pharmacotherapies for Opioid Dependence: Report of Results and Recommendations*. (National Drug and Alcohol Research Centre, Sydney, 2001 pp. 4 & 41.

25 National Drug and Alcohol Research Centre, *What is buprenorphine?* (UNSW, Sydney) at https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Buprenorphine.pdf.

26. Canadian Agency for Drugs and Technologies in Health, Suboxone Versus Methadone for the Treatment of Opioid Dependence: A Review of the Clinical and Cost-effectiveness at https://pubmed.ncbi.nlm.nih.gov/24716256/.

reduced saliva production. Long term effects can include tooth decay from reduced saliva and loss of libido. Methadone can be harmful for people with kidney and liver diseases.[27] Further drawbacks associated with methadone arise from the restrictive, demeaning and alienating regime often prescribed for its dispensation. Moreover, it is not effective for some heroin dependents and can itself produce a fatal overdose unless administered carefully under medical supervision. No wonder that methadone is sometimes referred to as "liquid manacles".

39. The bad reputation of methadone among many drug users is reflected in the large fall rate from the Opiate Replacement Therapy (ORT) program of the ACT prison as reported by the ACT Health Services Commissioner:

> " . . . it appears that there is a high attrition rate for participation in ORT on release into the community. Figures provided by Justice Health indicate that in 2016-17, 74% of detainees referred to building 7 on release took up that referral but that three months post release only 33% of this 74% were still receiving their opioid maintenance at Building 7. This is only a slight improvement from 2015-16 where 78% of released detainees commenced initially but only 21% of this group had continued in treatment at Building 7 after three months. It was not possible to obtain reliable data beyond three months post release."[28]

40. For many methadone therefore fails a crucial test of any drug treatment, namely its capacity to retain in treatment dependent drug users thus enabling them to stabilise their life and reintegrate into society.

41. The risks of buprenorphine appear similar but slightly less than those of methadone:

> "As with other prescription drugs, buprenorphine can suppress respiration resulting in fatal overdoses; however, buprenorphine is known to have less effect on respiration compared with other opioids. Buprenorphine can also cause sedation, though this is thought to be less than with methadone . . . Withdrawal from long-term use of buprenorphine may produce some symptoms similar to those experienced through withdrawal from other opioids, such as heroin or morphine. However, symptoms tend to be milder than for heroin or other opioids, such as methadone withdrawal."[29]

IV. Heroin assisted treatment shown to address the failings of methadone

42. The shortcomings of methadone inspired search for treatments that would engage the substantial number of dependent heroin users who were unable to engage with that or any other treatment. It seemed counter intuitive to consider

27. Australia, Department of Human Services and Health, *Handbook for medical practitioners and other health care workers on alcohol and other drug problems* (Australian Government Publishing Service, Canberra, 1994) p. 46

28. *Review of the opioid replacement* (2018) cited above p. 44.

29. National Drug and Alcohol Research Centre, *What is buprenorphine?* Cited above.

heroin as a treatment for the addiction that it caused. The European Monitoring Centre for Drugs and Drug Addiction explained why that approach commended itself:

> "Why do we need to utilise such a potentially controversial treatment approach, if other treatments already exist and are approved, and have the same therapeutic objectives? The answer is that there remains a substantial minority of patients who fail to benefit from these treatments and for whom we may need to consider more intensive and alternative forms of treatment. For those patients who repeatedly fail with existing orthodox treatments, are they just 'untreatable' or might we be able to devise alternative and/or more intensive treatments which enable them to achieve the gains that have, thus far, been unattainable?"[30]

43. " . . .[T]he proportion of the opiate dependent population reached through this modality [methadone] rarely approaches 50%. . . . It cannot be assumed that all or even the majority of opiate users want methadone."[31] A substantial number of those not reached through methadone have a long history of failure to engage with methadone and other and other treatments. These people have typically lost faith in their capacity to break out of their long-term addiction, demoralised with little expectation of experiencing conventional rewards in life. It is thus postulated that for these people, heroin assisted treatment is "much more reinforcing than oral methadone or buprenorphine"[32] and so has a far greater capacity to attract and retain this hard to reach population.

44. Stymied, after the Howard government's veto of its trial of heroin assisted treatment, the ACT handed the baton to Switzerland which drew heavily upon the preparatory work in designing its own trial. The admission criteria for the Swiss trial selected precisely those for whom methadone did not work. Participants needed to be of:

- of a minimum age of 20,
- have had a minimum duration of daily heroin consumption of two years,
- have had negative outcome of at least two previous treatments; and
- have documented social and/or health deficits as a consequence of their heroin dependence.[33]

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30. John Strang, Teodora Groshkova and Nicola Metrebian, EMCDDA insights: New heroin-assisted treatment: recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond (EMCDDA, 2012) at http://www.emcdda.europa.eu/system/files/publications/690/Heroin_Insight_335259.pdf visited 18/04/2020.

31. Richard Hartnoll, Epidemiological problems, in *Heroin-assisted treatment: work in progress* edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 347-64 at p. 358.

32. James Bell, Vendula Belackova, Nicholas Lintzeris, Supervised Injectable Opioid Treatment for the Management of Opioid Dependence, *Drugs* (2018) 78:1339–1352; *Drugs*. 2018 Sep;78(13):1339-1352 at p. 1,341. doi: 10.1007/s40265-018-0962-y.at https://pubmed.ncbi.nlm.nih.gov/30132259/ visited 17/05/2020..

33. Martin Killias, Marcelo Aebi and Denis Ribeaud, "Key findings concerning the effects of heroin prescription on crime" p. 112 in *Heroin-assisted treatment: work in progress* edited

45. The trial was undertaken in the context of the AIDS and hepatitis epidemics for which injecting drug use was a principal pathway.

- in 1989 45% of all new transmissions among men of IV infection were caused by drug injections and 53% among women;
- more than 40% of registered HPV infections in Switzerland were accounted for by IV drug users; and
- about 60% of registered hepatitis C infection were detected among IV drug consumers.[34]

46. In 1980 there had been an evaluation of heroin maintenance in a controlled trial in the United Kingdom.[35] The Swiss trial inspired a series of studies that took place in six other countries within the next decade (namely: Belgium, Canada, Germany, The Netherlands, Spain, and a second one in the United Kingdom).

> "In response to the need for providing treatment options for illicit opioid users resistant to available therapeutic opioid maintenance interventions with generally established effectiveness (e.g., oral methadone maintenance treatment [MMT] and oral buprenorphine maintenance treatment [BMT]) and an increasing focus on the public order challenges related to un- or ineffectively treated heroin addiction, half a dozen countries (Canada, Germany, The Netherlands, Spain, Switzerland, and United Kingdom) have embarked on the experimental implementation of medical "heroin-assisted treatment" (HAT) initiatives over the past decades."[36]

47. A Cochrane review of trials in six countries (including Belgium) concluded:

> "Five studies compared supervised injected heroin plus flexible dosages of methadone treatment to oral methadone only and showed that heroin helps patients to remain in treatment, and to reduce use of illicit drugs".[37]

48. An overview published in 2006 of the "largely positive" outcome of five trials concluded to that point noted that:

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by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 193-98

34. Thomas Steffen, Reduction of infectious diseases in a medically controlled heroin prescription programme (PROVE) p. 110 at in *Heroin-assisted treatment: work in progress* edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 109-16.

35. Hartnoll RL. Evaluation of heroin maintenance in controlled trial. *Archives of General Psychiatry* 1980;37:877-84

36 Benedikt Fischer, Eugenia Oviedo-Joekes, Peter Blanken, Christian Haasen, Jürgen Rehm, Martin T. Schechter, John Strang, and Wim van den Brink, Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics, *J Urban Health.* 2007 Jul; 84(4): pp. 552–562 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/

37. Ferri M, Davoli M, Perucci CA, Heroin maintenance for chronic heroin-dependent individuals (Review), *Cochrane Database of Systematic Reviews* 2011, Issue 12. Art. No.: CD003410.

> "there is a mounting onus on the realm of politics to translate the—largely positive—data from completed HAT science into corresponding policy and programming in order to expand effective treatment options for the high-risk population of illicit opioid users."

49. In the light of these positive results Denmark in 2010 initiated heroin assisted treatment and in October and November 2019 clinics providing for that treatment were opened in Middlesbrough and Glasgow respectively.

1. Drop in Heroin use.

50. Addicted heroin users commonly engage in drug dealing to their drug using peers. This practice is seen as a more honourable course to raise money to support their habit than scamming family and friends and engaging in property crime. The Swiss trial brought about a large reduction in drug trafficking offences which disrupted the retail pyramid drug market. The rate of self-reported reduction by those on the Swiss trial in selling of "hard" drugs was 92% and there was a 76% reduction in selling "soft" drug (principally cannabis). This self-report was confirmed by reports of reduced police contact. There was a 78% reduction in use and possession of heroin, a 57% reduction in use or possession of cannabis and a 57% reduction in trafficking offences. These changes occurred within the first six months of the trial and extended to 24 months.[39]

51. It is fair to conclude that Australia would have substantially reduced the explosion of heroin use that it experienced throughout the 1990s.

2. Reduced transmission of blood-borne viruses.

52. An account of the impact of the heroin assisted program on infectious diseases summarises the results in the following terms:

> " . . . the cohort [of 1035 participants in the program] showed an incidence rate of 0.9% for HIV during the first six months. There are only 11 new cases. Therefore, no clear trend could be found. For hepatitis we found an incidence rate of 10% for both hepatitis B and C during the first half year of treatment. Progress and analysis over 30 months showed that in patients remaining in treatment the relative risk of new viral hepatitis infections was cut in half the first check on progress after six months was compared with later checks. New infections occurred more often among young patients and those consuming cocaine."

53. Lithuania and Russia provide examples of HIV infection exploding from prisons into the community. In Lithuania in 2002, almost 300 new cases of HIV were identified in a correctional facility through sharing of drug injection equipment. 260 prisoners contracted HIV in a Russian correctional colony in 2001 (Lines et. al. 2004, p. 6). The same could happen here unless the biggest incubator of blood borne viruses in the ACT is not closed down by deploying the full range of proven preventative measures.

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38. The same.

39. Killias, Aebi and Ribeaud (2005) cited above, pp. 196-97.

3. Far fewer Deaths

54. The Swiss trial of heroin assisted treatment came close to eliminating the risk of overdose deaths among the 1,146 patients on the program. Only two of these died of an overdose though not as result of the prescribed narcotics. One death occurred during treatment and one after dropping out. In all 36 deaths occurred, the majority after the patient left the program producing a mortality rate for the cohort per treatment year of 1% which was within the range of the mortality rate within the community at large. A higher mortality rate had been expected in view of the considerable impairment of health of the participants on admission.[40]

4. Crime reduction

55. "This reduction in crime was verified in three ways: from self-report, reduction in police contacts and reduction in victimisation of those on the trial (victimisation being a recognised proxy for criminal activity).

56. A consistent finding from this series of randomised trials is of the substantial improvement in health and well-being of the patients receiving SIH compared with those provided with oral methadone treatment. This improvement includes, in particular, a major reduction in the extent of continued injecting of 'street' heroin, improvements in general health, psychological well-being and social functioning, as well as major disengagement from criminal activities (such as acquisitive crime to fund continued use of 'street' heroin and other street drugs).

57. Table 1: Prevalence and incidence rates of self-reported criminality after one year of treatment compared to the time before admission (reference. Six months, N=305[41]

Table 1: Prevalence and incidence rates of self-reported criminality, after one year of treatment in the programme, compared to the time before admission (reference period of 6 months, N=305).

offence type	*prevalence rates*				*incidence rates*			
	before	*after*	*p*	**drop**	*before*	*after*	*p*	**drop**
serious property offences[1]	11.2	0.7	<.001	94%	0.388	0.007	<.001	98%
other property offences[2]	39.9	17.4	<.001	56%	7.238	0.954	<.001	87%
selling «soft« drugs	26.3	12.5	<.001	52%	8.960	2.162	0.001	76%
selling «hard« drugs	46.9	8.2	<.001	83%	25.297	2.030	<.001	92%
assault[3]	1.0	1.0	ns	ns	0.017	0.016	ns	ns

[1] burglary, muggings, robbery, pick-pocketing
[2] thefts, shoplifting, receiving or selling stolen property
[3] with or without weapon

40. Uchtenhagen, A. et al. (1999) cited above. pp.73-74.

.41. Martin Killias, Marcelo Aebi and Denis Ribeaud, "Key findings concerning the effects of heroin prescription on crime" p. 195 in *Heroin-assisted treatment: work in progress* edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 193-98.

58. Table 2: Prevalence and incidence of rates of self-reported victimisations after one year of treatment compared to the time before admission to the program (N=604)[42]

offence type	*prevalence rates*				*incidence rates*			
	before	*after*	*p*	drop	*before*	*after*	*p*	drop
robbery	11.5	4.7	<.001	59%	0.273	0.084	<.001	69%
assault	3.6	2.7	ns	–	0.036	0.043	ns	–
sexual offences	1.7	1.4	ns	–	0.092	0.013	ns	–
fraud with drugs	55.3	16.0	<.001	71%	4.465	0.572	<.001	87%
thefts	23.0	13.0	<.001	43%	0.792	0.180	<.001	77%
theft of bicycle	14.1	9.7	.096	31%	0.201	0.128	.063	36%

59. Table 3: Incidence raised of police contact, by offence type, period of six months before and after admission to the program (N equal 604)[43]

offence type	*before*	*after*	drop	*p**
violent and sex offences	0.023	0.022	4%	ns
shoplifting	0.164	0.078	52%	<.01
burglary	0.041	0.013	68%	<.02
robbery / mugging	0.012	0.002	83%	.06
trespassing	0.028	0.007	75%	<.02
theft of vehicles	0.048	0.020	58%	<.03
other theft and property offences[1]	0.139	0.033	76%	<.01
other criminal code offences[2]	0.023	0.007	70%	<.01
traffic offences	0.040	0.013	68%	ns
use or possession of cannabis	0.131	0.056	57%	<.01
use or possession of heroin	0.689	0.149	78%	<.01
use or possession of cocaine or ecstasy	0.285	0.132	54%	<.01
use or possession of other or several substances	0.166	0.025	85%	<.02
drug trafficking	0.119	0.051	57%	<.01
offences to other laws[3]	0.017	0.005	71%	.07
overall incidence rate	*1.924*	*0.613*	68%	*<.01*

* t test for paired samples, two-tailed significance
1 including receiving stolen property and forgery
2 including fare dodging
3 including searches

60. Swiss researchers observed that " . . . The decrease has been particularly strong for serious property crime and drug trafficking."[44] Contrary to expectations,

42. The same.
43. Killias, Aebi & Ribeaud (2005) cited above p. 196.
44 Martin Killias, Marcelo Aebi and Denis Ribeaud, "Key findings concerning the effects of heroin prescription on crime" in *Heroin-assisted treatment: work in progress edited by*

heroin prescription tended to decline as did the use of other (i.e. not prescribed drugs).

61. The foregoing tables record large reduction in drug trafficking offences. This reduction appears to have disrupted the retail drug distribution system. As mentioned above, a follow up study published a decade later suggests this disruption contributed to a decline in recruitment of new drug users.

62. While beyond the scope of the trial of heroin assisted treatment, on a population wide basis, street robberies, a crime typically committed by dependent drug users dropped in both the city and Canton of Zürich by about 70%.[45]

The German trial of heroin assisted treatment recorded comparable reductions in crime by participants in the program:

> "Illegal activities, according to EuropASI formulation of involvement in illegal activities in the last 30 days, decreased [by 2/3] in the first year of treatment, without a further decline in the second year."[46]

Delinquency which "decreased decreased rapidly ". . . was associated closely with the decline of illicit drug use and vanished procuring pressure."[47]

5. Reduction in illicit drug use

63. Contradicting the fear that motivated refusal in 1997 of the Howard government of the Carnell government's proposal for a heroin trial, the treatment produced a reduction in drug use. This was evident doing during the three-year trial in the large reduction noted above in drug dealing offences. There was understandably a quick and big reduction in use of illicit heroin. Participants on the heroin trial reported a dramatic reduction in use of heroin in the first six months of treatment and in the following six-month period a further, albeit less pronounced, progression was found. This reduction extended to other drugs too. Cocaine consumption as reported by the patients and corrected for urine samples also showed a marked progressive tendency to reduction.[48] Decrease in consumption of illicit heroin and cocaine "reduces the risk of continued contacts with the drug market".[49] While "illicit heroin and cocaine use regressed rapidly and markedly, benzodiazepine use decreased only slowly alcohol and cannabis consumption hardly declined at all. In a minority of patients, the continued regular use of cocaine (5%) and benzodiazepines (9%) even after 18 months of treatment

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Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) p. 194.

45. The same, p. 197.

46. At baseline at baseline 69.9% of the participants had been involved in illegal activities in the previous 30 days. At the end of 12 months this had sunk to 23.4%. Verthein, U., Bonorden-Kleij, K., Degkwitz, P Christoph Dilg , Wilfried K. Köhler , Torsten Passie , Michael Soyka , Sabine Tanger , Mario Vogel & Christian Haasen (2008), 'Long-term effects of heroin-assisted treatment in Germany', *Addiction* 103, pp. 960–966.

47. The same.

48. Uchtenhagen, A. Dobler-Mikola, T. Steffen, F. Gutzwiller, R. Blättler & S. Pfeifer, *Prescription of narcotics for heroin addicts* vol. 1 *main results of the Swiss national Cohort Study* p. 6 (Karger, Basel, Freiburg, Paris &c, 1999) p. 55.

49. The same, p. 58.

remains a difficult therapeutic problem to manage."[50] The study went on to note that "reduction in trafficking of hard drugs is particularly important as hard drug users play an important role in the recruitment of new consumers."[51] This impact was confirmed by a later study of the canton of Zurich carried out a decade after the trial ended and while heroin prescription had become a standard treatment:

> "The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%"[52]

6. Superiority to methadone alone

64. The assessment of heroin assisted treatment in The Netherlands and elsewhere considered combined treatment with heroin and methadone of people with chronic, therapy-resistant opiate dependency. It found that the treatment was safe:

> "The treatment is more effective than in the case of methadone alone. The physical and mental health, as well as social functioning improve, including a reduction of crime."[53]

65. The German trial reported a 73% reduction in illegal drug use for those receiving heroin assisted treatment compared to just 51.5% for those on methadone.[54]

66. According to a survey by the European Monitoring Centre for Drugs and Drug Addiction there was "A consistent finding from this series of randomised trials is of the substantial improvement in health and well-being of the patients receiving [supervised injectable heroin treatment] SIH compared with those provided with oral methadone treatment."[55]

B. Hydromorphone

67. Hydromorphone is an opioid used as a potent painkiller. Trials in Canada have shown that injectable hydromorphone produces results comparable to heroin assisted treatment among so-called "treatment refractory opioid dependent individuals". A 2010 pilot study compared the "treatment response with injectable hydromorphone [with] diacetylmorphine [pharmaceutical-grade heroin]." The result pointed to "Hydromorphone [being] similarly safe and effective as

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50. The same, p. 5.

51. The same, p. 67.

52. Carlos Nordt & Rudolf Stohler, "Incidence of heroin use in Zurich, Switzerland: a treatment case register analysis" in *The Lancet*, vol. 367, pp. 1,830-34 (3 June 2006).

53. J.E.E. Verdurmen, A.P.M. Ketelaars, M.W. van Laar, *The Netherlands National Drug Monitor: Fact Sheet Drug Policy* (Trimbos Institute, Utrecht, [2005]) p. 20 http://www.trimbos.nl/Downloads/Programmaas/NDM/Factsheetdrugsbeleid-2005DEF%20Engels.pdf.

54. Christian Haasen, Uwe Verthein, Peter Degkwitz, Juergen Berger, Michael Krausz and Dieter Naber, Heroin-assisted treatment for opioid dependence; Randomised controlled trial, *British Journal of Psychiatry*, Heroin-assisted treatment for opioid dependence: Randomised controlled trial, *British journal of Psychiatry* (2007), vol. 191, no. 55 pp. 55-62, table 2.

55. Strang, Groshkova and Metrebian (2012), cited above pp. 160-61.

diacetylmorphine as opioid-agonist substitution treatment."[56] A further double-blind controlled trial in Vancouver comparing hydromorphone and heroin found "no statistically significant differences in treatment retention between the double-blind and open-label treatment periods, suggesting that patients can be successfully attracted and retained in treatment with open-label hydromorphone."[57] More serious adverse effects have been reported for heroin assisted treatment than for hydromorphone. These have mostly concerned respiratory depression associated with the heroin. All such events were treated successfully. It is advised that

> "Due to the risk of respiratory depression or epileptic seizures, patients should be observed for at least 15 minutes after heroin injections in a facility with first-aid resources (qualified staff, including a physician, and first-aid equipment)."[58]

68. A subsequent trial comparing adverse events associated with the same two treatments concluded that "When injectable hydromorphone and diacetylmorphine are individually dosed and monitored, their opioid-related side effects, including potential fatal overdoses, are safely mitigated and treated by health care providers."[59] A 2016 report of a trial in British Columbia that confirmed that hydromorphone was comparable in efficacy to heroin treatment observed that some variation in adverse effects in favour of hydromorphone between those pharmacotherapies reinforces the need for " . . . a patient-centered approach that offers a choice of opioids, as is the standard of practice in other clinical areas, such as palliative care."[60] In the midst of an opioid overdose epidemic, injectable options are timely to reach a very important minority of people who inject street opioids and are not attracted to other treatments.

69. Inexplicably the current ACT drug strategy did not retain a commitment found in the earlier ones to "support researchers to seek funding to participate in a

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56. Oviedo-Joekes E, Guh D, Brissette S, Oviedo-Joekes E, Guh D, Brissette S, et al. Double-blind injectable hydromorphone versus diacetylmorphine for the treatment of opioid dependence: a pilot study. *J Subst Abuse Treat* 2010*;* 38*:* 408–11.

57. Eugenia Oviedo-Joekesa, Heather Palisa, Daphne Guh, Kirsten Marchanda, Suzanne Brissettec, Scott Harrisond, Scott MacDonald, Kurt Lock , Aslam H. Anis , David C. Marsh, Martin T. Schechter, Treatment with injectable hydromorphone: Comparing retention in double blind and open label treatment periods, *Journal of Substance Abuse Treatment,* vol 101, pp.50-54, June 1, 2019.

58. Reimer, J., Verthein, U., Karow, A., Schäfer, I., Naber, D. and Haasen, C. (2011), 'Physical and mental health in severe opioid-dependent patients within a randomised controlled maintenance treatment trial', *Addiction* 106, pp. 1647–1655.

59. Eugenia Oviedo-Joekes, Suzanne Brissette, Scott MacDonald, Daphne Guha, Kirsten Marchand, Salima Jutha, Scott Harrison, Amin,Janmohamed, Derek Z.Zhang, Aslam H. Anis, Michael Krausz, David C.Marsh, Martin T.Schechter, Safety profile of injectable hydromorphone and diacetylmorphine for longterm severe opioid use disorder in Drug and Alcohol Dependence 176 (2017) 55–62.

60 Oviedo-Joekes E, Guh D, Brissette S, Marchand K1, MacDonald S, Lock K, Harrison S, Janmohamed A, Anis AH, Krausz M, Marsh DC, Schechter MT, Hydromorphone Compared with Diacetylmorphine for Long-term Opioid Dependence: A Randomized Clinical Trial. *JAMA Psychiatry*. 2016 May 1;73(5):447-55.

clinical research trial of hydromorphone in the ACT."[61] In spite of the apparent equivalence efficacy of hydromorphone and diacetylmorphine [heroin], this paper urges the clinical adoption of the latter for the reason that it is more studied and implemented than hydromorphone. Undoubtedly hydromorphone should be considered though if heroin impracticable.

70. The failure to retain reference in the current ACT drug strategy to heroin assisted treatment and hydromorphone is all the more inappropriate in the light of the approval of a National Health and Medical Research Council grant signed off by the Commonwealth Health Minister Greg Hunt of a trial of hydromorphone under the direction of Professors James Bell, Alison Ritter and Carla Treloar and others of the University of New South Wales.

> "Implementation of time-limited parenteral[62] hydromorphone in people with treatment-resistant injecting opioid use disorder: Feasibility, acceptability, and cost."[63]

This trial was approved in 2019, after the release in December 2018 of the current ACT drug strategy.[64]

71. In the light of the many practical difficulties in the way of the initiation of heroin assisted treatment in Australia, not least the approval of the Commonwealth government and New South Wales and Victorian governments if it is to be imported through those states, hydromorphone may be the more practicable option even though the weight of evidence attested by numerous trials and a Cochrane review favours heroin assisted treatment.

V. Secondary beneficial outcomes of heroin assisted treatment

72. The National Health Service paper that formed the basis for the decision to institute late last year Heroin Assisted Treatment in Glasgow summarises the benefits in the following terms: "Randomised controlled trials from a number of countries have demonstrated that, for this group, heroin-assisted treatment can have both individual and social benefits in terms of retention in treatment, decreased illicit drug use, reduced criminal activity and incarceration and, potentially, reduced mortality. There is also evidence – including from the UK – that heroin-assisted treatment is cost-effective from a societal perspective.

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61. ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 at http://www.atoda.org.au/wp-content/uploads/2017/09/ACT-Alcohol-Tobacco-and-Other-Drug-Strategy-2010-2014.pdf visited 6/22/2020.

62. Administered or occurring elsewhere in the body than the mouth and alimentary canal. In other words, injectable hydromorphone.

63. National Health and Medical Research Council, 2018 Partnership Projects Third Call for Funding Commencing in 2019 at https://www.nhmrc.gov.au/sites/default/files/documents/attachments/grant%20documents/Partnership-third-call-2019.pdf visited 01/06/2020.

64. ACT Health Directorate, *ACT Drug Strategy Action Plan 2018-2021: A Plan to Minimise Harms from Alcohol, Tobacco and Other Drug Use* (ACT Health Directorate, Canberra, 2018) at https://health.act.gov.au/about-our-health-systempopulation-health/act-drug-strategy-action-plan

Although relatively small numbers of people are eligible for heroin-assisted treatment, the health and social harms they experience, the costs they incur, and their lack of benefit from other treatments, provide strong clinical and economic arguments for its provision."[65]

1. Reductions in risk factors for crime and illicit drug use

73. Regarded by the law as criminals, dependent illicit drug users are quintessentially stigmatised and marginalised from society. These are injecting drug users with a bundle of adverse health and social factors that have " . . . come to be known as severe and multiple disadvantage: homelessness, offending, chronic poverty, and previous trauma. Such factors are inextricably linked to health, and must be directly addressed if any response to public injecting is to succeed."[66]

74. "The ultimate goal of treatment is thus not just . . ." to help those affected overcome dependence" but also to "be fully reintegrated into society."[67] Re-integration is also the acknowledged objective of opiate replacement therapy within the ACT prison:" The overarching aim of treatment is to provide stability for clients on release, to allow them to participate in employment and other activities and to minimise the legal, health and social harms associated with the use of illicit drugs."[68] The "marked improvements in social functioning" attributed to heroin assisted treatment[69] 'improved in all the intervention groups with heroin groups having slightly better results."[70]

75. The Swiss trial recorded that:

> "The patient's housing situation rapidly improved and stabilised (there was in particular no longer any homelessness).
>
> "Fitness for work improved considerably; permanent employment more than doubled (from 14 to 32%), unemployment fell by more than half (from 44 to 20%); the remainder lived on allowances or any regular employment or engaged in housework.
>
> "Debts during the treatment period were constantly and substantially reduced.
>
> "A third of the patients who depended on welfare on admission required no further support; on the one hand, others now required welfare (as result of the loss of illicit income).

65. NHS Greater Glasgow & Clyde, p. 66, (2016) cited above.

66. The same, p. 72.

67. Bammer *et al*., (1999) cited above.

68. Review of the opioid replacement treatment (2018) cited above, p.43

69. Transform Drug Policy, Foundation, Heroin-assisted treatment in Switzerland (ND) at https://transformdrugs.org/heroin-assisted-treatment-in-switzerland-successfully-regulating-the-supply-and-use-of-a-high-risk-injectable-drug/ visited 17/04/2020.

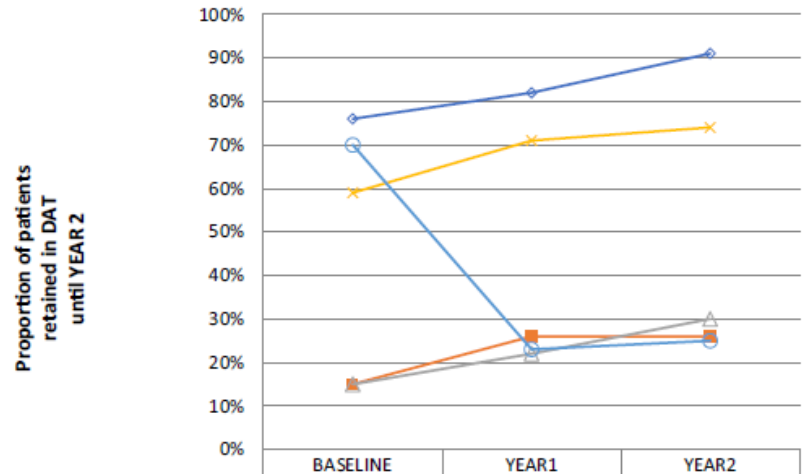
70. Ferri, Davoli & Perucci (2011) cited above

> "Contact with drug addicts and the drug scene decline massively but was not adequately replaced by new social contacts during the observation period." [71]

The improvement social integration and reduction of risk factors for crime ascertained German trial of Heroin Assisted Treatment showed comparable improvements:

> "The social situation improved markedly during the 2-year treatment (Table 3). The housing situation stabilized and the proportion of subjects in employment increased. Drug-free contacts, i.e. leisure activities in the company of people without drug or alcohol problems, increased and leisure behaviour generally improved."[72]

These improvements are summarised following graph:[73]



	BASELINE	YEAR1	YEAR2
Stable housing	76%	82%	91%
Employment	15%	26%	26%
Drug-free social contacts	15%	22%	30%
Leisure activities	59%	71%	74%
Illegal activities	70%	23%	25%

Fig. 2 Significant impact of DAT on participants' social outcomes over 2 years (German study—Verthein et al. [49])

76. These improvements in social deficits characteristically shared by people who end up in prison are translatable into reductions in acknowledged risk factors for crime.[74] To the social deficits can be other added other risk factors like chronic illness and psychiatric disorders that the trials of heroin assisted treatment were

71. Uchtenhagen, A. *et al.* (1999) cited above. p. 6.

72. Verthein, Bonorden-Kleij, & Degkwitz, et al. (2008), cited above.

73 Bell, Belackova, & Lintzeris (2018) cited above p. 1,347

74. National Anti-crime Strategy, *Pathways to prevention: developmental and early intervention approaches to crime in Australia; Full report* (Attorney-General's Dept, Canberra, 1999) p. 136 at http://www.ag.gov.au/agd/www/rwpattach.nsf/viewasattachmentPersonal/%28E24C1D4325451B61DE7F4F2B1E155715%29~no6_fullreport.pdf/$file/no6_fullreport.pdf visited 24/11/2011

also shown to ameliorate. This means that more effective drug treatment that heroin assisted treatment offers reinforces the crime reduction influence of that treatment. With improved social integration there is less incentive to engage in property crime to finance drug habits.

2. Mental health

77. The Swiss trial saw substantial improvements in the mental condition of participants in the trial conducted over three years of heroin assisted treatment more than 40% of whom " . . . were in a poor mental condition on admission. Need for psychiatric treatment reported by the attending physicians was greater than the need for physical treatment."[75]

> "The general state of mental health improved on average, and the need for treatment was estimated to be slightly lower compared to the status on admission.
>
> "In particular, depression and other affective disorders became less frequent, which is not the case for schizophrenic conditions. Of the schizophrenic psychoses, diagnosed at the outset (N = eight), five stayed on the program for at least 18 months. This matched the mean retention rate in the program, in contrast to high dropout rates of dual diagnosis patients in general.
>
> "Affective disorders required psychiatric treatment considerably less often after the second month in the program. The same applies to personality disorders and other behavioural disturbances. The corresponding data for schizophrenia showed no reduced need for treatment."[76]

78. Comparable improvements in mental health were measured in the first year of the trial in Germany comparing oral methadone with of heroin assisted treatment. The mental health of those recruited was very poor:

> "Almost 70 points (T value) on the Global Severity Index of SCL-90-R [Symptom Checklist] (inclusion criterion was a minimum of 60 points) indicate a high average degree of mental strain. 30% even reach the highest score of 80 points. In external assessment by the Global Assessment of Functioning Scale (GAFS), axis V of the DSM-IV, patients reached only an average score of 53 to 54 points. Accordingly, the clinical global assessment concerning the existence of a mental disease ranges from "moderate," to "distinctly ill". To fit to the study patients had attempted suicide at least once."[77]

79. Improvements in mental health were assessed utilising Symptom Checklist 90 (SCL-90) which is a widely applied self-assessment instrument for a broad

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75. Uchtenhagen *et al.* (1999) cited above, p. 44.

76. The same p.51

77. Dieter Naber, The German model project for heroin assisted treatment of opioid-dependent patients – multi-centre, randomised, controlled treatment study; clinical study report of the first study phase (Centre for Interdisciplinary Addiction Research of Hamburg University, January 2006) p. 23 at http://www.heroinstudie.de/H-Report_P1_engl.pdf visited 20/05/2020

range of mental disorders that assesses the subjective symptom burden in patients with mental disorders:

> "The development of mental symptoms took a parallel course: the SCL-90 score of heroin patients dropped from 76.3 at baseline to 55.1, methadone patients, the SCL score "only" dropped from 72.7 to 62.1 points." [78]

80. There was a "marked deterioration" in mental health during a trial of two-months when trial treatments were withdrawn.[79] A further research report specifically focusing on the outcomes of the German trial that compared heroin assisted treatment with oral methadone in seven treatment centres noted that:

> "The course of mental distress, as measured by the SCL-90-R, . . . decreased in both groups; the decrease was greater in the heroin group, and, again, within this group it was greater in completers compared to dropouts. Similarly, psychosocial functioning, as measured by the GAF [Global Assessment of Functioning], improved. The initial score improved in both groups, but it was better in the heroin group; in this case, completers of both the heroin and methadone groups benefited more than their respective dropouts."[80]

3. Physical health

81. Physical afflictions are also common among people experiencing mental health problems not to mention among the large co-occurrence of substance dependency and other mental health issues. In the first month of treatment of the Swiss trial "30 abscesses were diagnosed in a subsample of 147 patients. After one year, only one absence per month was diagnosed." After 18 months the Swiss trial found that 18 6% of patients had good health compared to 79% on admission that those with poor physical health declined from 21% on admission to 14% after 18 months.[81] The German trial of heroin assisted treatment used the Opiate Treatment Index [OTI] health scale to measure the improvement in physical health of participants as well as the Symptom Checklist 90 to measure the improvement in mental health. The outcomes are reflected in the following charts:[82]

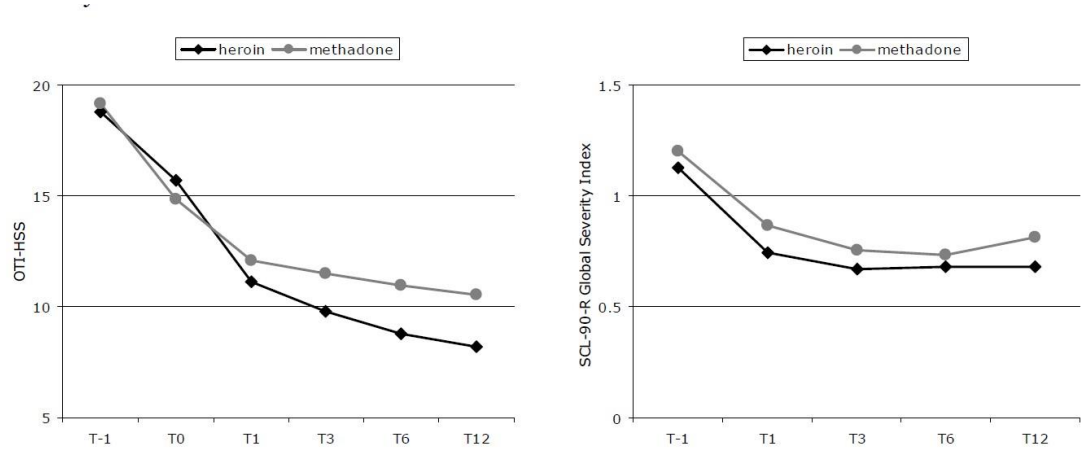
78. The same, p.22 & also table. 7.2, p. 70 at http://www.heroinstudie.de/H-Report_P1_engl.pdf visited 20/05/2020

79. The same, p. 23.

80. Reimer et al. (2011), cited at p. 1651.

81. Uchtenhagen, A. et al. (1999) cited above. pp. 48 & 49.

82. Naber, The German model project for heroin assisted treatment (2006), figure 7.2, p. 80.



82. In another report on the German trial the improvement in physical health was summarised the following terms:

> Physical health, as measured by the OTI–HSS, improved in both treatment groups, although the improvement was more pronounced in the heroin group, and within the heroin group it was more pronounced in completers compared to dropouts. Development of the nutritional status (BMI) and the KPS[83] resembled OTI–HSS data; BMI and KPS improved in both treatment groups and the improvement was again more pronounced in the heroin group, and within the heroin group more pronounced in completers compared to dropouts (Table 3). A pathological electrocardiogram (total n = 582) was present in 20.4% of patients at baseline; this decreased to 17.7% (of n = 339) at follow-up in the heroin group and increased to 21.8% (of n = 243) in the methadone group (the group difference was not statistically significant). The frequencies of pathological echocardiograms decreased in the heroin group and increased in the methadone group.[84]

83. The situation regarding blood-borne viruses to which injecting drug users are particularly exposed discussed below at VI.2 (p. 31).

84. A review of multiple trials concluded that "Patients receiving SIH [supervised injectable heroin treatment] treatment achieved gains in physical and mental health . . ." What is more "available evidence suggests added value of SIH alongside supplementary doses of methadone for long-term treatment-refractory opioid users".[85]

VI. Where would the ACT be now if the Australian heroin trial had gone ahead?

85. It is fair to conclude that had the Australia heroin trial gone ahead and, in the light of positive results on a par with those from Switzerland and other

83. KPS stands for Karnofsky Performance Status which is a standard way used to determine a patient's prognosis and changes in a patient's ability to function.

84. Reimer et al. (2011), cited above at p. 1,651.

85. Strang, Groshkova and Metrebian (2012), cited above p. 12.

countries, been implemented, the landscape of illicit drug use, health, crime and corrections in Australia would be very different from what it has turned out to be.

86. This part will consider the likely impact on the preoccupations facing the ACT government when it moved to establish a heroin trial in the mid-1990s when, to recapitulate, it was facing four epidemics: One of heroin use; a second of blood-borne diseases; a third of opioid overdose deaths and finally an epidemic of crime associated with the increasing heroin use.

87. Let us speculate on the situation that the ACT (and in some cases Australia as a whole could) could reasonably have found itself in had it proceeded with the trial and implemented it.

88. Heroin assisted treatment has produced bountiful dividends that, transposed to an Australian context, will be outlined – benefits like reduced homelessness, poverty and less mental illness bolster social cohesion and reinforce community well-being.

> "The chaos and instability of addiction is a major barrier to better health among [the] population [of injecting heroin users who have failed to benefit from opiate replacement therapies like methadone], . . . Prescribed injectable heroin would be a welcome addition to existing opioid substitution therapies."[86]

89. In the context of the current pandemic, the ACT community would not be as at high risk as it is now from Covid19 virus spreading within and beyond the vulnerable prison population and would have reaped other health and social benefits.

1. Heroin use

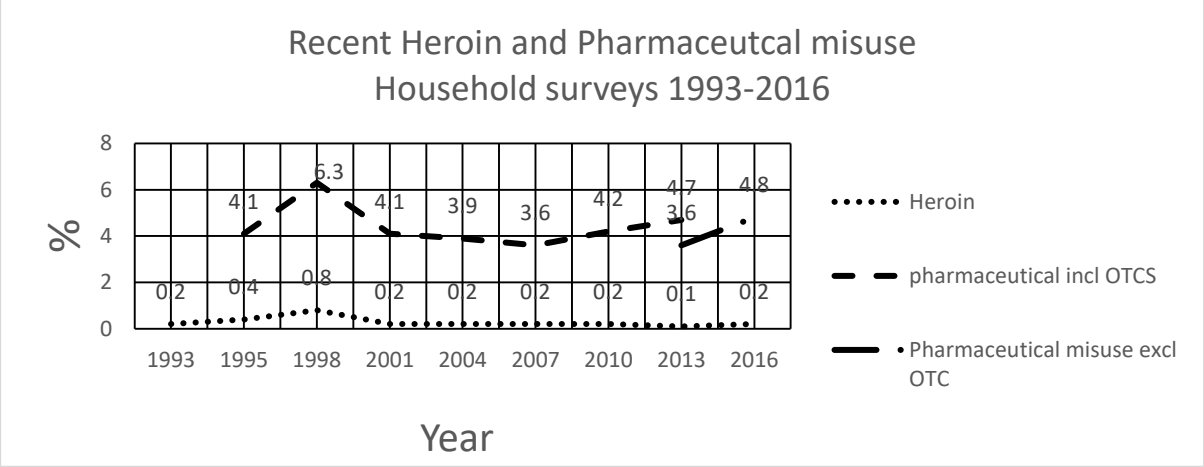
90. Heroin use reach its apex in 1998 when the household survey recorded that 0.8% of the population had used it within the previous 12 months. It was probably higher in the following year but had sunk back to merely 0.2% when the next household survey was conducted in 2001 after the onset of the heroin drought at the end of 2000. Subsequent household surveys have reported that its use has remained fairly stable but opiate misuse has not declined and has indeed expanded. Rather than heroin a lot of the population is turning to pharmaceuticals opiates, often in search of pain relief.

91. In 2018 the ACT Health Services Commissioner described this trend in the following terms:

> "While there has been a decline in the use of heroin in the Australian community since 2010, in favour of drugs such as methamphetamine (ice), this has been counterbalanced by increasing rates of addiction to prescription opioids such as oxycontin, tramadol and endone, reflecting significant shifts in practice in the use of opioids for pain relief. Australian opioid dispensing episodes increased from 500,000 prescriptions in 1992 to 7.5 million prescriptions in 2012 and it is now apparent that the ongoing use of these medications can lead to dependency and misuse. There is a higher

86. NHS Greater Glasgow & Clyde, (2016) cited above p.74

prevalence of misuse of prescription medication amongst female prisoners, with just over one quarter of women in prison reporting misuse of analgesics/painkillers (27% of women compared with 11% of men)."[87]



92. The 2016 household survey noted that: "The majority of people misusing pharmaceutical analgesics and opioids bought them from a pharmacy (52%) and about 1 in 5 obtained it with a prescription or by doctor shopping." Measures to tighten up on these practices are known to drive people seeking pain relief to access the black market for those medications and also for heroin. The resurgence in opiate overdose deaths discussed below is tragic evidence of this trend. The ACT would clearly be in a far better position to ameliorate this situation were the medical profession to have a greater range of treatments options including the capacity to prescribe heroin or hydromorphone. Heroin used to be widely prescribed in Australia until stocks ran out after the Commonwealth prohibited its import in 1953. It is still a widely prescribed analgesic in the United Kingdom for severe pain.

93. The profile of non-medical opiate use and new drugs like the stimulant methamphetamines may have come into fashion but heroin misuse remains a principal drug used by people sentenced to prison: "Lifetime heroin use is up to 10 times higher in the prison population and prisoners are 20 times more likely to inject drugs than the general population."[88]

2. Blood-borne diseases

94. Viral hepatitis remains a major public health concern. 182,144 people in Australia are living with chronic hepatitis C and 226,612 with chronic hepatitis B. There were 10,537 notifications of hepatitis C in Australia and 66 liver transplants due to chronic hepatitis C or hepatitis C related hepatocellular carcinoma (liver cancer). An estimated 584 deaths were attributed to hepatitis C. An estimated 584 death were attributed to hepatitis C and 428 deaths attributable to hepatitis B during 2016-2017.[89]

87. Review of the opioid replacement (2018) cited above p. 11.

88. Review of the opioid replacement (2018) cited above p. 10

89. Hepatitis Australia, *Hepatitis Statistics* (2019) at https://www.hepatitisaustralia.com/hepatitis-statistics visited 16/04/2020.

95. ‘No cases of HIV have been detected in prison entrants in the NPEBBV&RBS [National Prison Entrants’ Bloodborne Virus and Risk Behaviour Survey] since 2007.”[90]

> “The prison population is especially at risk of hepatitis C infection, due to the high proportion of people in custody with a history of injecting drug use (IDU), the at-risk behaviours associated with illicit and injecting drug use, including needle-sharing, and other at-risk behaviours, such as amateur tattooing and violence that can lead to blood-to-blood contact. People in prison often come from marginalised groups, where medical care in the community is unavailable or not accessed, so are at risk of having undiagnosed hepatitis C before prison.” [91]
>
> “Prison clinics are an ideal place to detect and treat people with undiagnosed hepatitis C. In recent years, new medications for hepatitis C have led to an enormous increase in the treatment rate of people in prison with hepatitis C.”[92]

96. 22% of prison entrants are hepatitis C positive but the availability of new direct-acting antiviral treatment mean it is much less of a problem than it was in the 1990s. A 2018 review by the ACT Health Commissioner reported a striking improvement in the prevalence of hepatitis C among inmates:

> “ACT Health have informed us that in 2010 approximately 30% of detainees at the AMC were Hepatitis C positive. In July 2017, with the support of Hepatitis C treatment made available through the Pharmaceutical Benefits Scheme (PBS) in 2016, those figures have reduced to less than 2 percent.”[93]

97. While acknowledging that, prisons remain a fertile ground for the contraction and spread of blood-borne diseases. This is because of the extent of injecting drug use, the reuse of syringes that goes on within prisons and the refusal of most governments, prison administrations and corrections officers to countenance the provision of sterile syringes that have helped control the spread of these infections in the community.

98. The Burnett Institute 2010 evaluation of the ACT prison described the extent of injecting drug use in the following terms:

> “Nearly one third reported ever injecting drugs at the AMC and approximately one quarter reported injecting drugs in the past four weeks and that the last time they injected drugs was in prison. Of those that

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90. Australian Institute of Health and Welfare, *The health of Australia’s prisoners 2018* (30 May 2019, Cat. no. PHE 246. Canberra: AIHW) p. 56 at https://www.aihw.gov.au/getmedia/2e92f007-453d-48a1-9c6b-4c9531cf0371/aihw-phe-246.pdf.aspx?inline=true.

91. The same, p. 49.

92. The same, pp. 51-52.

93. *Review of the opioid replacement* (2018) cited above p. 49 at http://hrc.act.gov.au/wp-content/uploads/2018/03/ORT-Report-Final-Ready-to-Print.pdf visited 27/04/2020.

reported injecting in the past four weeks, approximately equal proportions reported injecting less than weekly or weekly or more often."[94]

99. The 2016 health and well-being survey recorded that "Among all respondents, over one-quarter of respondents reported ever injecting heroin (27%) and meth/amphetamines (28%) in prison."[95] The boredom of prison life fosters drug seeking behaviours[96] that is reflected in the prison adage: "a day off your mind is a day off your time."[97]

100. The confronting reality of injecting drug use in prison is described in an AIVL working paper:

> "Syringes are rented out from person to person and reused many times. It is common place for needles to be sharpened on match boxes and other suitable surfaces and if one is lucky enough to have clean injecting equipment then it is heavily guarded and is often the focus of stand over tactics."

101. The health and financial benefits of the needle/syringe programs were assessed in the Commonwealth Government report *Return on Investment in Needle and Syringe Programs in Australia*. That showed clearly that "NSPs are effective in reducing the incidence of both HIV and Hepatitis C and that they represent an effective financial investment by Government."

102. The retreatment of people who have become reinfected with hepatitis C comes at a huge cost to the Pharmaceutical Benefits scheme. "The direct acting antiviral medications are among of the most expensive oral medications in history, with wholesale acquisition prices ranging from $417 (Glecaprevir-pibrentasvir) to $1,125 per day (Ledipasvir-sofosbuvir). . . . For example, the wholesale acquisition cost of a 12-week course of Sofosbuvir is $84,000 and the estimated production cost is $68 to $136.[98]

3. Opiate overdose deaths

103. The Swiss trial of heroin assisted treatment came close to eliminating the risk of overdose deaths among the 1146 patients on the program. Only two of these died of an overdose though not as result of the prescribed narcotics. One death occurred during treatment and one after dropping out. In all 36 deaths

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94. Stoové, M., Kirwan, A. (2010). External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre. (Burnet Institute: Melbourne) April 2011 p. 125

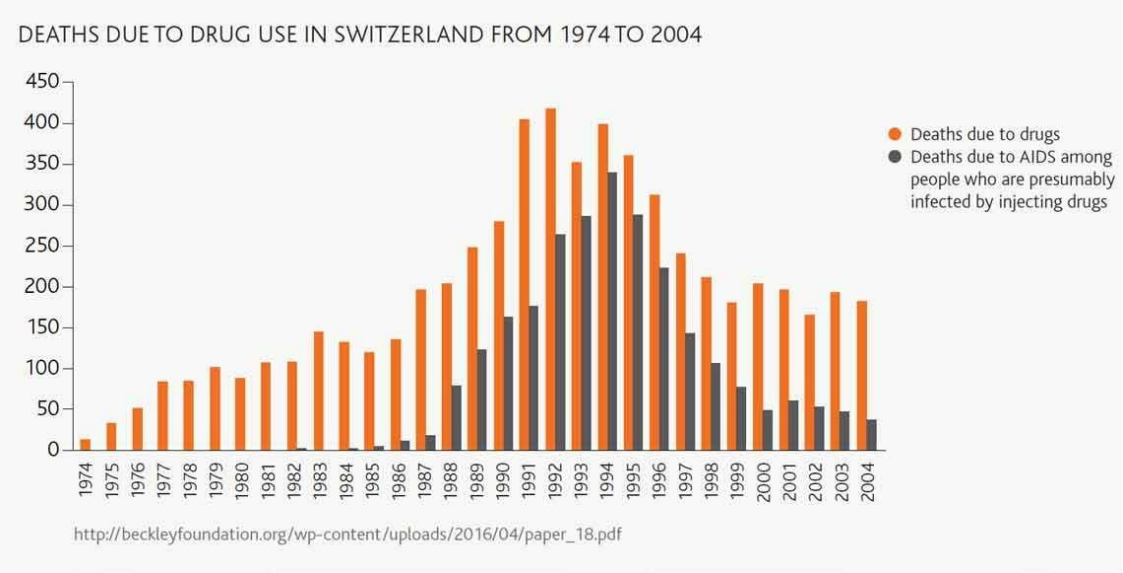
95. Young J.T., van Dooren, K., Borschmann R., & Kinner S.A. (2017), *ACT Detainee Health and Wellbeing Survey 2016: Summary results.* ACT Government, Canberra, ACT. p. 42 & p. 43 at https://stats.health.act.gov.au/sites/default/files//2016%20ACT%20Detainee%20Health%20and%20Wellbeing%20Survey%20Report.pdf.

96. The same, p.3 & 12.

97. The same, pp. 24, 25 & 47.

98. Sophie L. Woolston, H. Nina Kim, Cost and Access to Direct-Acting Antiviral Agents (Hepatitis C Online, last Updated: May 31st, 2018) at https://www.hepatitisc.uw.edu/go/evaluation-treatment/cost-access-medications/core-concept/all visited 27/04/2020

occurred, a majority of which did so after the patient left the program producing a mortality rate for the cohort per treatment year of 1% which was within the range of the mortality rate within the community at large. A higher mortality rate had been expected in view of the considerable impaired health of the participants on admission.[99]



104. Since Switzerland introduced its program in the mid 1990's deaths due to drug use and deaths due to AIDs among drugs addicts have declined steadily.[100]

105. It is reasonable to deduce that had the proposal of the ACT government prevailed and heroin assisted treatment introduced in Australia that there would not have been anything like the number of opiate overdose deaths. In 2016 there were 1,225 such deaths which was higher than the previous peak in 2000 when 1,072 died. Even applying the same 1% death rate experienced in Switzerland to the sum of Australian opiate deaths since 1998, it is fair to say that 17,327 lives might well have been saved had the Howard government not vetoed the heroin trial in 1997.

106. The increase of opiate overdose deaths in recent years owes much to prescription opioids "opiate-based analgesics including codeine, oxycodone and morphine, and synthetic opioid prescriptions including tramadol, fentanyl and methadone."

107. Many of the people now dying have become addicted while seeking relief from chronic pain. The response of our political leaders to this complex challenge will, if anything compound the problem. Without large expansion of pain treatment, the response of our political leaders to this complex challenge will, if anything compound the problem. Without large expansion of pain treatment tightening up procedures to clamp down on doctor shopping tends to drive desperate people

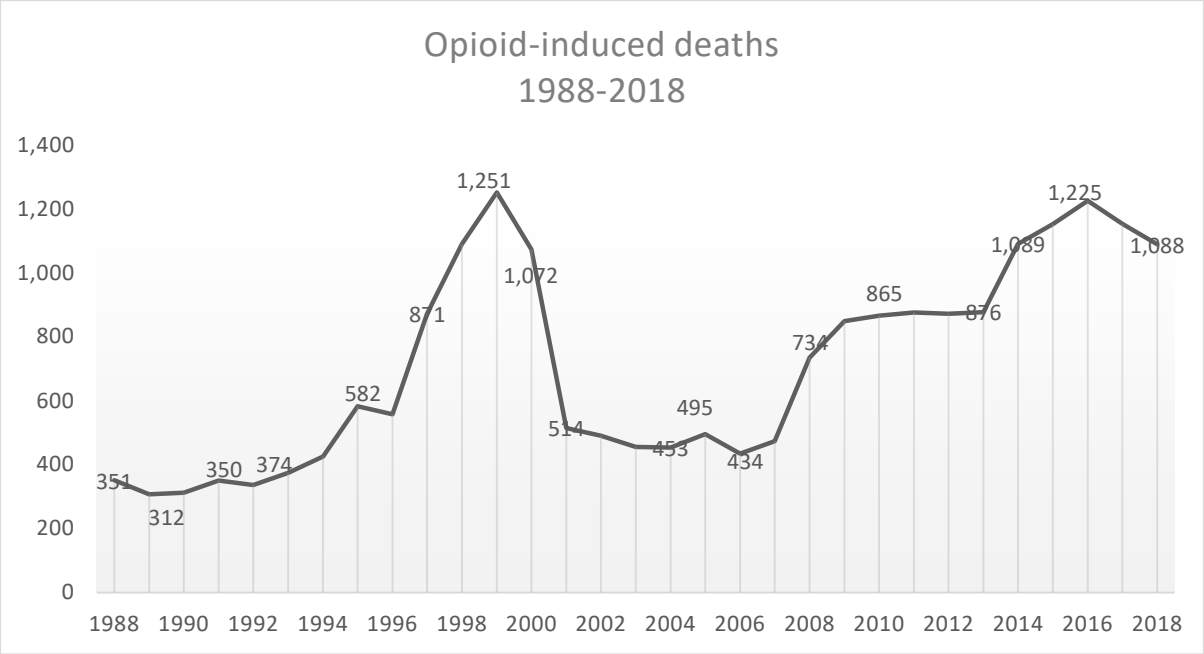
99. Uchtenhagen *et al.* (1999) cited above, pp. 73-75.

100. Transform Drug Policy Foundation, (ND) cited above.

who have become addicted to pain medications to source their continuing supply from the criminal black market.

108. Moreover, the profile people dying from opiates has changed. The Australian Bureau of statistics noted that “In 2016, an individual dying from a drug induced death in Australia was most likely to be a middle aged male, living outside of a capital city who is misusing prescription drugs such as benzodiazepines or oxycodone in a polypharmacy (the use of multiple drugs) setting. The death was most likely to be an accident.

109. “This profile,” the Bureau continued, “is quite different from that in 1999, where a person who died from a drug induced death was most likely to be younger (early 30s) with morphine, heroin or benzodiazepines detected on toxicology at death.”



110. In these respects Australia is following on the heels of the epidemic of addiction and deaths in the United States from prescription medication where it is assessed as a phenomenon with economy wide ramifications:

> “Participation in the labor force has been declining for prime age men for decades, and about half of prime age men who are not in the labor force (NLF) may have a serious health condition that is a barrier to work. Nearly half of prime age NLF men take pain medication on a daily basis, and in nearly two-thirds of these cases they take prescription pain medication. Labor force participation has fallen more in areas where relatively more opioid pain medication is prescribed, causing the problem of depressed labor force participation and the opioid crisis to become intertwined.”[101]

101. Alan B. Krueger, "Where Have All the Workers Gone? An Inquiry into the Decline of the U.S. Labor Force Participation Rate" (Brookings Papers on economic activity, BPEA Conference draft, September 7-8, 2017) at https://www.brookings.edu/wp-content/uploads/2017/09/1_krueger.pdf visited 10/9/17

111. A concomitant of this opioid crisis has been a rash of "'deaths of despair' [alcohol, suicide, and accidental poisonings]" among prime-age males the highest rates being in counties which "had an average prime-age male participation rate of 73 percent in 2014, compared to 88 percent for the prime-age male population across the country."[102]"

4. Crime reduction

112. The reduction in property crime reviewed above by participants in the Swiss trial of heroin assisted treatment was in the region of 90%. A leading criminologist concluded that "heroin treatment constitutes without doubt one of the most effective measures ever tried in the area of crime prevention."[103]

113. The Cochrane review of eight studies of heroin trials was a little less forthright but still positive: "Results on criminal activity and incarceration were not possible to be pooled but where the outcome were measured results of single studies do provide evidence that heroin provision can reduce criminal activity . . ."104 The review of the European Monitoring Centre for Drugs and Drug Addiction included among the "consistent findings" of the Swiss and other trials a " . . . major disengagement from criminal activities (such as acquisitive crime to fund continued use of 'street' heroin and other street drugs) . . ."[105]

114. One can add to these enhancement of other crime reduction factors brought about by assisted treatment: big reductions in drug dealing by those on the program – and hefty reduction in dealing hard drugs.

5. Imprisonment

115. In 1965 which was when drug law enforcement began to be ramped up, the Australian incarceration rate as a whole was 71.64 per 100,000.[106] The Productivity Commission now report it to be 171.5. Unlike the United States which is seeing a distinct downturn since a peak of 755 in 2008, the Australian rate continues to rise.[107] The situation in the United States is attributable in part to a perception that the rate of incarceration is financially unsustainable.[108] The decline

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102. The same.

103. Translation from Martin Killias, Marcelo F. Aebi, Denis Ribeaud & Juan Rabasa, Rapport final sur les effets de *la prescription de stupéfiants sur la délinquance des toxicomanes*, 3rd ed. (Institut de police scientifique et de criminologie, Lausanne, September 2002) p.80.

104. Ferri, Davoli & Perucci (2011), cited above.

105. Strang, Groshkova & Metrebian (2012), cited above, p. 161.

106. Adam Graycar & Peter Grobosky eds, *The Cambridge handbook of Australian criminology* (Cambridge UP, 2002) table 1.3, p. 16.

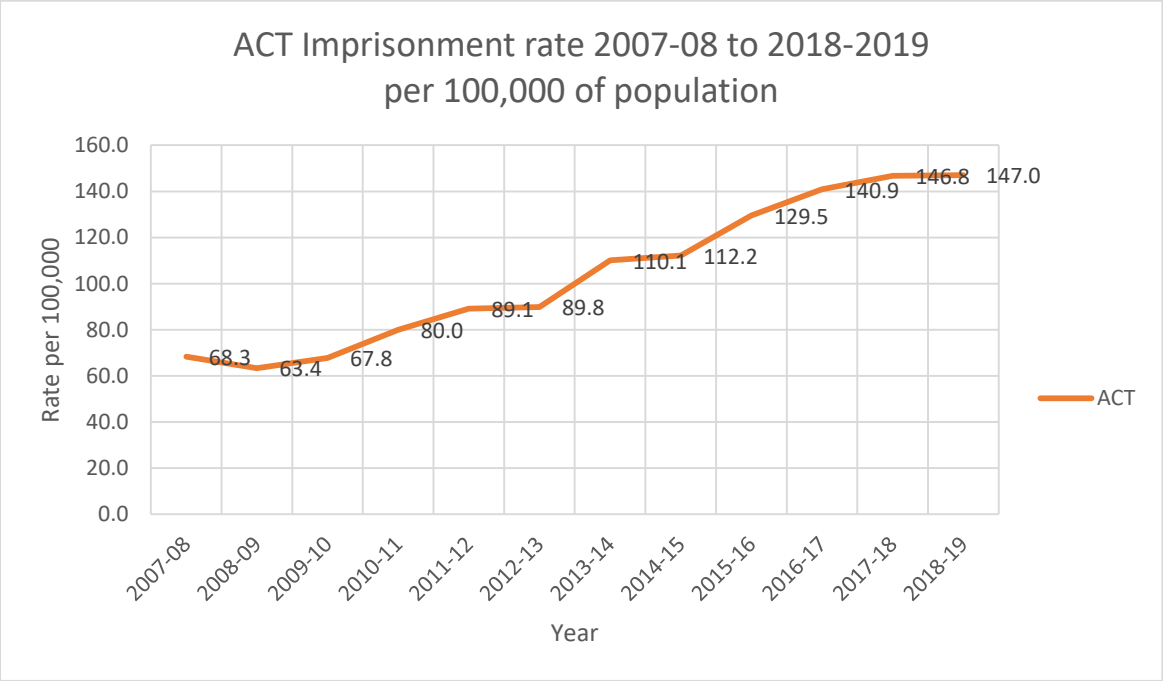
107. https://books.google.com.au/books?id=2xFYQLiLlSUC&pg=PA105&lpg=PA105&dq-=Prison+population+rate+and+composition,+and+occupancy+level,&source=bl&ots=nq8mW9DrMn&sig=ACfU3U2DJfLTnSM_-lLHiWkhZmPqyh8Fgg&hl=en&sa=X&ved=2ahUKEwiNsYPz1L7oAhWIILcAHQdjBg0Q6AEwAHoECAkQAQ#v=onepage&q=Prison%20population%20rate%20and%20composition%2C%20and%20occupancy%20level%2C&f=false

108. Jacobson *et al., op.cit*. p. 12.

which followed the Global Financial Crisis and a 2011 order of the Supreme Court to reduce overcrowding.[109]

116. While the imprisonment rate in the ACT is substantially less than for Australia as a whole, its increase represents a shattering of the vision for a human rights compliant, rehabilitative correctional institution that guided the decision for the territory to establish in 2008 its own prison rather than continuing to transport prisoners to New South Wales. This vision was reflected in according it the name of the great 19th-century penal reformer, Alexander McConachie.

117. Measured by the number of people per 100,000 in the population, the incarceration rate in the ACT has shot up in the decade from 2009–10 when a mere 67.8 Canberrans found themselves behind bars. This had grown to 147 in 2018–19, an increase of 117%. Since the ACT prison was officially opened on 11 September 2008 the ACT rate of incarceration has increased by 132%. In terms of numbers: "the prison commenced operations in 2009. Since that time the prison population at AMC has expanded rapidly, from 158 detainees in July 2009 to 441 in 2016 and the prison has increased its capacity from approximately 270 to 539 through the addition of new accommodation units."[110]



SOURCE: Productivity Commission (2020): 8A Corrective services — Data tables contents table 8A.5 at https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/justice/corrective-services/rogs-2020-partc-section8-data-tables.xlsx & : Productivity Commission, Report on government services 2018, corrective services, Table 8A.5.

118. It is not easy to draw comparisons between the ACT and the imprisonment rate in overseas jurisdictions. This is because of the multitude of societal factors that bear upon the level of crime and the administration of the justice system.

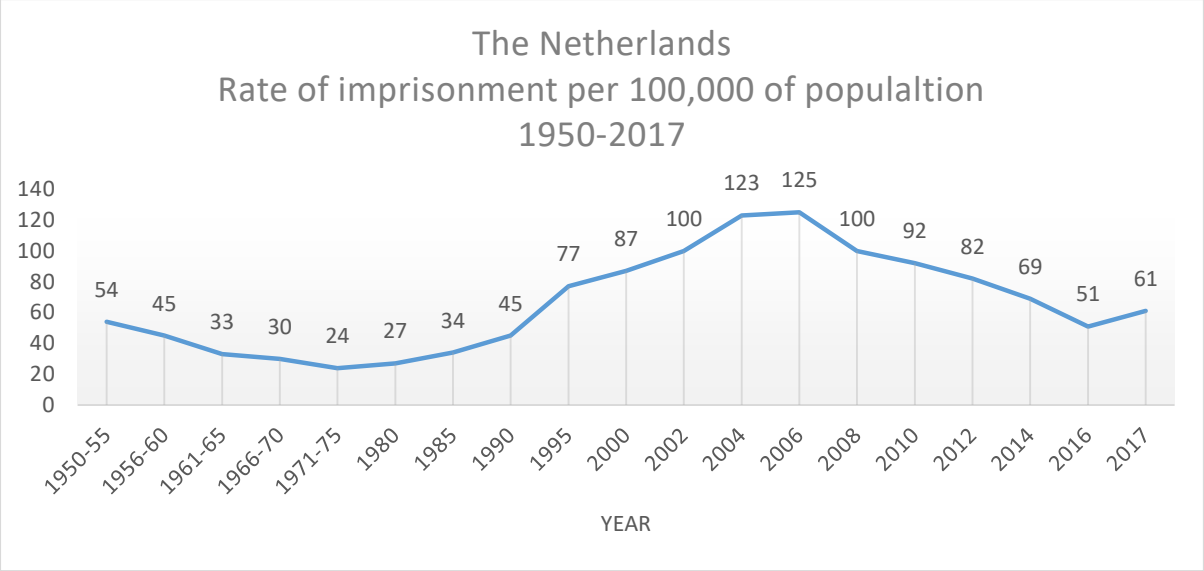
109. David Biles, No Excuse for complacency: bar problems with jail systems in Australia pale by comparison, the US reminds us of the mistakes to avoid, *The Canberra Times,* Monday,May 7, 2012 p 9

110. *Review of the opioid replacement treatment* (2018) cited above, p.13

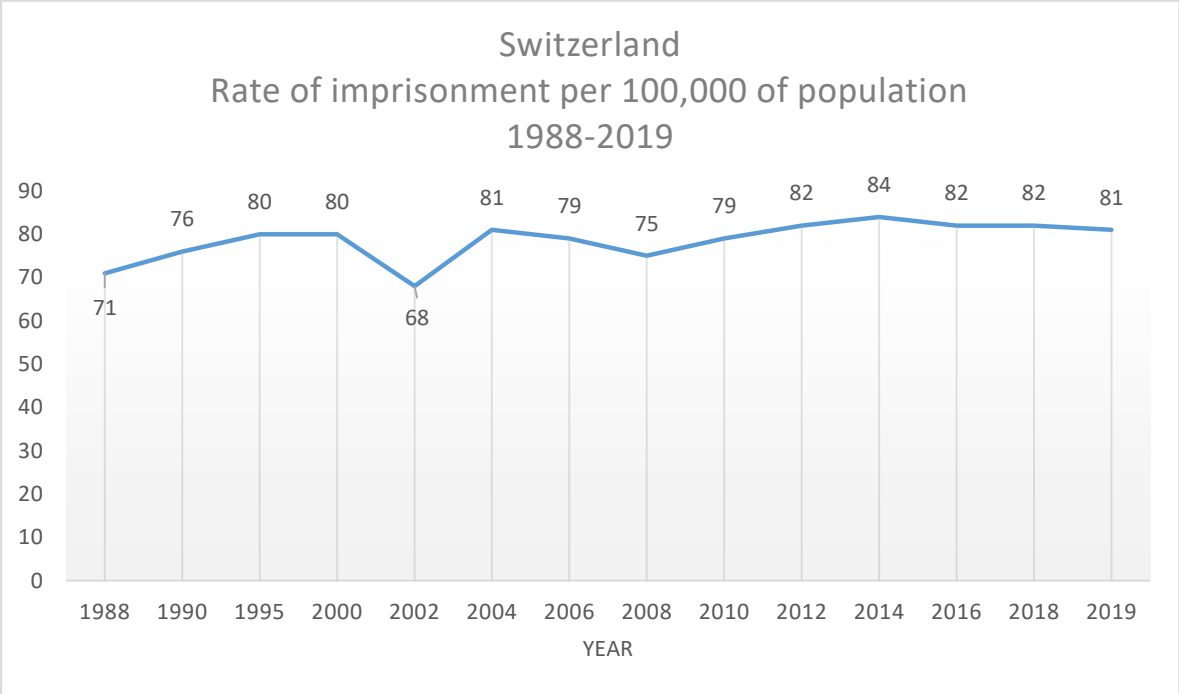
These factors include the demography, the extent that drug treatment services are rolled out across the community and attitude of the media and the community towards crime and punishment. Subject to the foregoing caveats it is still instructive to compare the ACT with other jurisdictions which have taken a somewhat less punitive attitude to drug use. Set out below is, therefore, information on the rate of imprisonment in The Netherlands, Switzerland, Germany, Denmark, Canada, British Columbia and the United Kingdom all of which have adopted to some extent heroin assisted treatment. A significant British development occurred in Scotland in November 2019, when a clinic providing the treatment was opened in Glasgow in Scotland with the aim of treating "20 patients with the most severe, long-standing and complex opioid problems in its first year, and 40 in the second year." This followed hot on the heels of a similar clinic in Middlesbrough.

119. Noted are the percentage difference in the rate of these jurisdictions compared to that of the ACT as well is the number of detainees that that difference represents. The following data are taken from the World Prison Brief at https://www.prisonstudies.org/highest-to-lowest/prison-population-total:

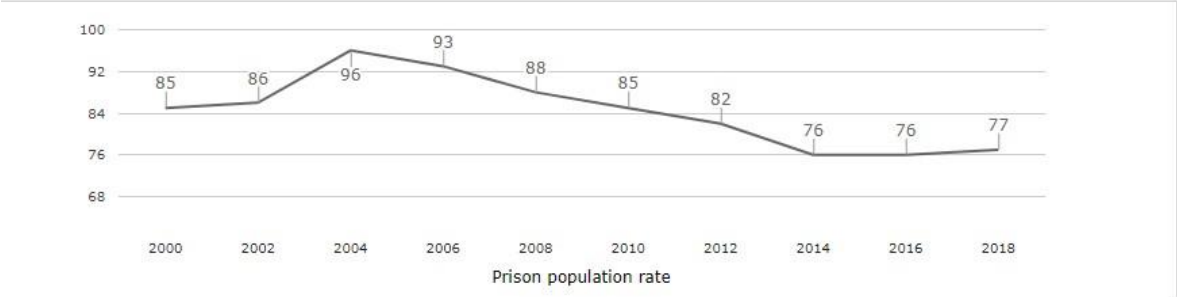
120. Netherlands: 61 per 100,000 = 41% of the ACT imprisonment rate translating to 277 fewer detainees



121. Switzerland: 81 = 55% of the ACT imprisonment rate translating to 212 fewer detainees



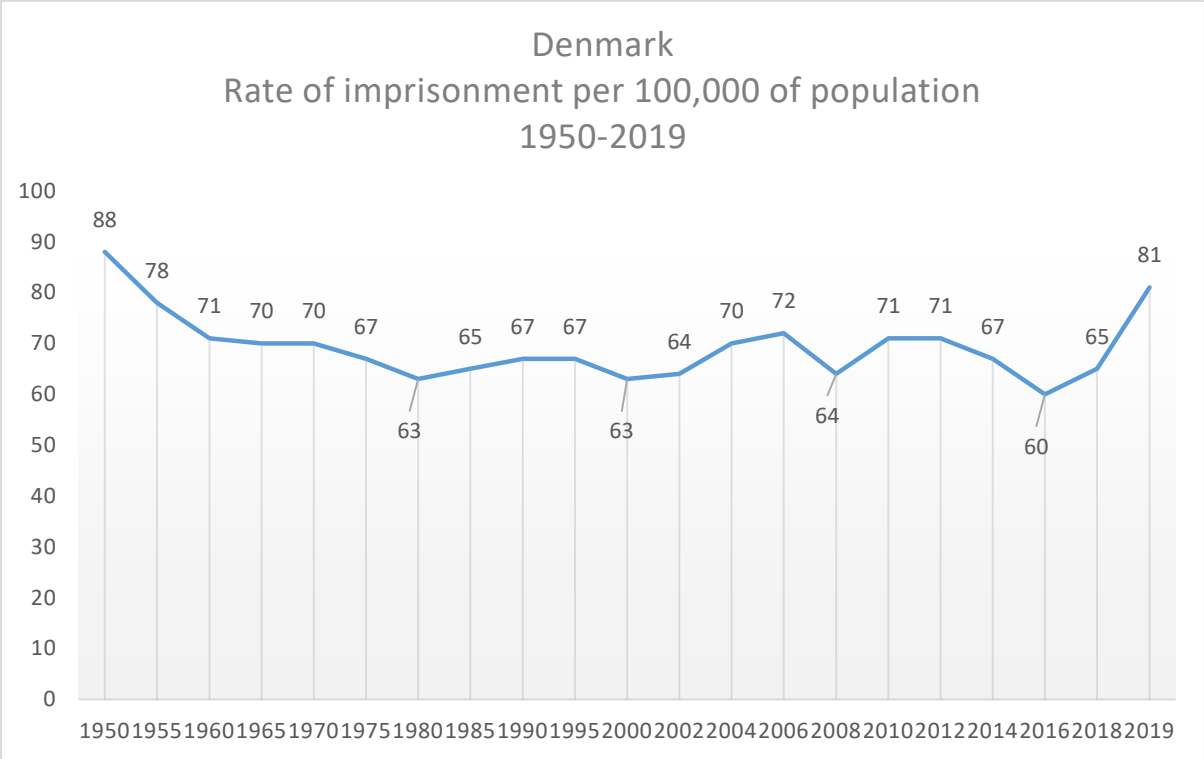
122. Germany: 77 = 52% of the ACT imprisonment rate translating to 225 fewer detainees



111

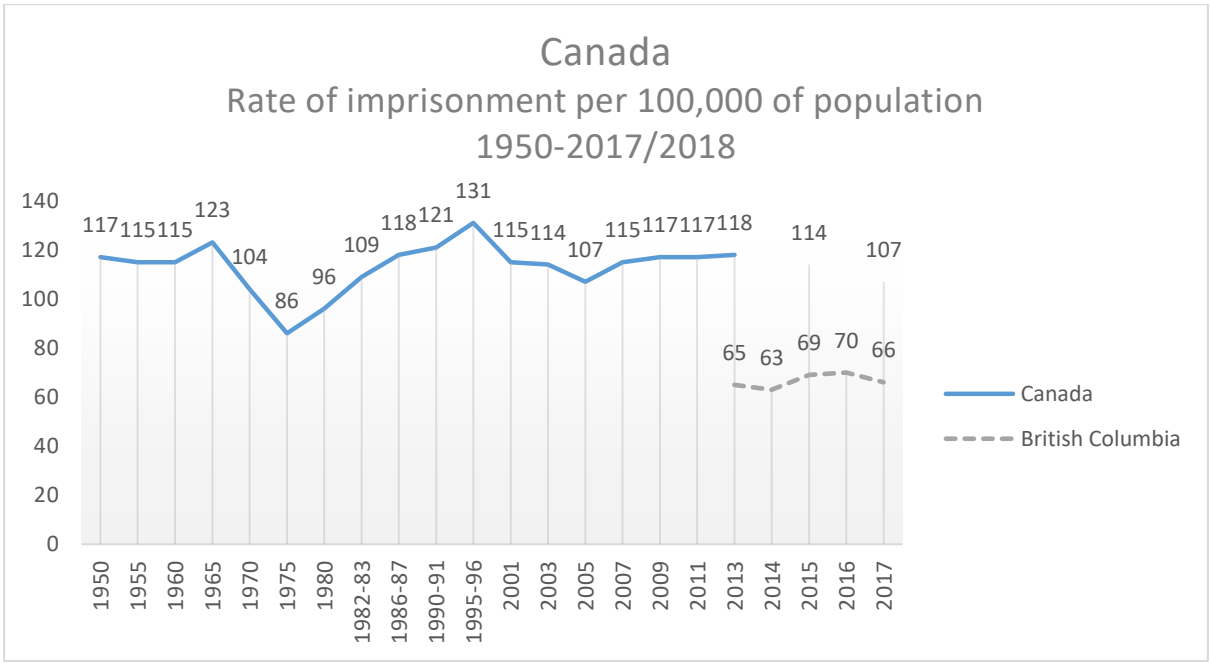
111. *World Prison Brief* data at https://www.prisonstudies.org/country/germany

123. Denmark: 81= 55% of the ACT imprisonment rate translating to 212 fewer detainees



124. Canada: 107 = 76% of the ACT imprisonment rate translating to 113 fewer detainees

British Columbia: 66 = 44.9% of the ACT imprisonment rate translating to 261 fewer detainees



SOURCE: *World Prison Brief* data for Canada as a whole; British Colombia imprisonment rates are taken from *Adult correctional statistics in Canada*, a series beginning with that of 2013/2014 to 2017/2018.

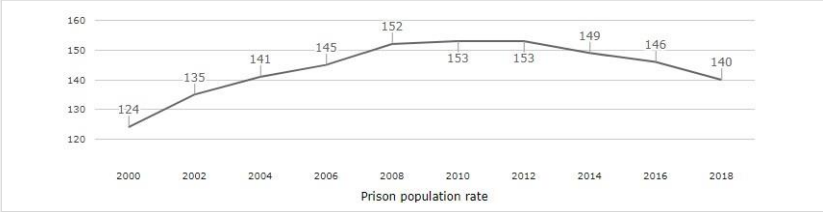
125. The imprisonment rates reported in the *Adult correctional statistics in Canada series do not appear to correspond with those in the World Prison Brief.* The 2015/2016 issue commented that:

> *"*In 2015/2016, there were on average 120,568 adult offenders on a given day, in either custody or in a community program1 (Table 1) among the 11 reporting provinces and territories for which both custody and community data were available. This represents a rate of 438 offenders per 100,000 adult population, a decrease of 3% from the previous year and a decline of 16% compared to 2011/2012."

126. Participants in a Canadian ministerial review in 2016[112] of the criminal justice system highlighted the decline in imprisonment in the youth justice system over the past twenty years.

> "Many participants felt the successful approaches in the youth justice system could also apply to the adult criminal justice system.
>
> . . .The drop was steepest in British Columbia. Its government began funding better community-based alternatives to custody. The number of youth in custody fell, so custody centres closed. That freed up money for better programming, which led to lower caseloads for community staff."

127. United Kingdom: England & Wales: 140 = 95% of the ACT imprisonment rate



128. The imprisonment rate in Scotland (140) is the same as in England and Wales.

129. In November 2019, a clinic providing the treatment was opened in Glasgow in Scotland with the aim of treating "20 patients with the most severe, long-standing and complex opioid problems in its first year, and 40 in the second year."

130. The United Kingdom has long permitted the prescription of heroin for the treatment of opiate addiction though the numbers who have been able to access it had been very small. As of about 15 years ago around 450 patients are prescribed heroin in Britain.[113] Just as used to be the case in Australia, heroin is a widely prescribed analgesic in the United Kingdom for severe pain. In October 2019 a clinic permitting the medically supervised supervision of heroin injection was

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112 Jody Wilson-Raybould, What we heard - Transforming Canada's criminal justice system: Message from the Minister, circa2016, at https://www.justice.gc.ca/eng/rp-pr/other-autre/tcjs-tsjp/p1.html.

113. Nicola Metrebian, a research fellow at Imperial College London, quoted in "Handouts fix drug crime" in http://www2.swissinfo.org/sen/swissinfo.html?-siteSect=2251&sid=6001767&cKey=1123755067000 visited 22/3/2007.

opened in Middlesbrough. The numbers receiving heroin assisted treatment in England and Wales and Scotland are too small to have any detectable impact on the rate of crime and imprisonment.

B. Secondary beneficial outcomes of heroin assisted treatment

131. What, might, one asks, is the purpose of providing heroin to treat those addicted to the same substance? The answer is clear when one looks for benefits well beyond the narrow confines of medical treatment for an addiction:

> "In fact, the answer to this question is remarkably similar to the answer for other medication-based treatments — it is the quitting of use of 'street' heroin, alongside other improvements in physical and psychological well-being, as well as the disengagement from any criminal activity and broader social integration."114

1. Reductions in risk factors for crime and illicit drug use

2. Social integration

132. The Cochrane review of trials comparing the extent that heroin assisted treatment promoted social integration came out firmly in favour of treatments involving heroin:

> "Social functioning improved in all the intervention groups with heroin groups having slightly better results. If all the studies comparing heroin provision in any conditions vs any other treatment are pooled the direction of effect remain in favour of heroin."115

133. A similar intervention in Canberra has the ability to reduce the social deficits of both the existing crowd of prisoners and the population likely to take their place who in the words of the Public Health Association of Australia " . . . have poorer health than the general community, with particularly high levels of mental health issues, alcohol and other drug misuse, and chronic conditions. They are a vulnerable population with histories of unemployment, homelessness, low levels of education and trauma."116

134. The 2010 inmate survey confirmed the applicability to the ACT of this description:

> "A majority of the participants came from a socially disadvantaged background. Thirty-eight per cent of participants were placed in care before 16 years of age; 19% of participants had either parent incarcerated when he/she was a child (Table 3); 42% of participants had spent some time in juvenile justice when they grew up; 68% of participants were excluded from

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114. P. 160.

115. Ferri, Davoli & Perucci (2011) cited above p.1

116. Public Health Association of Australia, *Prisoner health background paper (*Deakin ACT, October 2017) at https://www.phaa.net.au/documents/item/2579 visited 21/04/2020.

school; only 47% of participants were employed six months prior to imprisonment: and 6% had never been employed."[117]

135. The 2016 survey[118] confirmed and expanded upon this picture of disadvantage:

In care: 23% of a smaller sample of participants had been "in care before 16 years of age";

Removal from family: "Twenty-three respondents (24%) reported that they had been removed from their family for one month or more. Sixty percent of these respondents reported that they had been placed in institutions; and few reported placements with other family members."

Parent incarcerated: 21% of them had a parent who was incarcerated when participant was a child

Juvenile detention: "One-quarter (25%) of non-Indigenous respondents indicated that had ever experienced custody in Bimberi or Quamby, compared with 61% of Indigenous respondents." Quamby operated until 2006 when Bimberi replaced it. The survey added that "Respondents with a history of juvenile detention reported being in juvenile detention on a median of 4 occasions (range 1 to 50). Non-Indigenous respondents reported slightly more episodes of juvenile detention compared with Indigenous respondents (median of 4.5 vs. 4.0 occasions, respectively)."

Education: "Respondents indicated that they had spent fewer than 10 years (mean ±standard deviation (SD)) 9.6 years (±1.7) (range 5 to 12 years) at school. Indigenous respondents left school at a mean age of 14.3 years (±1.4); non-Indigenous respondents left school at a mean age of 15.7 years (±1.8).

Exclusion from school: "Nearly two-thirds of respondents (64%) reported that they had never been expelled from school. Of those who reported being expelled, the first expulsion occurred at a mean age of 12.3 years (±3.3)."

Employment: "44% reported employment in the six months prior to prison."

Victimhood of crime: "Nearly three-quarters of respondents (73%) reported that they had ever been a victim of crime; over half (56%) were a victim of person-based crimes and 37% of property-based crimes (Table 2.1.2)."

Housing: "Approximately one in five of respondents (21%) reported unstable accommodation in the four weeks prior to their current incarceration (Table 2.2.1)."

136. More effective drug treatment as exemplified by trials of heroin assisted treatment facilitates social reintegration of troubled young people who typically fill the ACT prison. The adoption of such treatment here can be reasonably expected to reduce the flow of people into the prison and to facilitate the release of many

117. ACT Health*, 2010 ACT Inmate Health Survey: Summary results* (Canberra 2011) p.71

118. Young *et al.* (2017) cited above.

already inside it. In blunt terms better drug treatment can turn off the tap and drain away much of the problem.

3. The quick return of heroin assisted treatment

137. The benefits of heroin assisted treatment manifest themselves quickly. In the Swiss heroin trial there was a marked decrease in those on the program committing offences "in the first six months of treatment . . . And in the second six months there was a further reduction."[119] A recent review of different studies noted that "Most improvement occurs within the first 6–12 months of SIOT, improvements plateau at 2 years, and at follow-up a degree of improvement is sustained."[120] The report of the Swiss trial records improvements within a matter of months in a large range of metrics: in accommodation, employment social contact and mental health. Of mental health the study tracked depression, anxiety/delusion and aggressive acting-out: "follow-up analysis over 18 months showed a reduction in depressive syndrome is. Anxiety and delusional syndrome is also diminished markedly as did aggressive acting-out. The decrease in depressive symptoms occurred primarily in the first 12 months of treatment and then remained stable. The decrease in anxiety and delusional symptoms was continuous and extended beyond the first 12 months of treatment. The decrease in aggressive behaviour also showed further improvement after 12 months of treatment."[121]

VII. Mental health problems

138. "Mental health problems are " . . . a strong risk factor for future offending in adults. There is emerging evidence that adult onset offending may be directly associated with adult-onset mental health problems, particularly schizophrenia and bipolar disorders."[122]

139. People with mental health conditions are aggregated in prisons. The 2016 health and well-being survey of ACT detainees found that over half of respondents (54%) reported that they had received one or more mental health diagnoses in their lifetime. Twenty-one respondents (21%) indicated that they had ever been admitted to a psychiatric unit or ward in a hospital, including 14% of Indigenous and 24% of non-Indigenous respondents.

140. The majority of participants had other mental health issues. About 70% of them had a formal psychiatric assessment at some time in their lives. Among those being assessed, 27% were told that they had Attention Deficit Hyperactive Disorder. Further, a notable portion of the participants (40%) had suicidal thoughts. Among those who had suicidal thoughts, 69% of them had attempted

119 Uchtenhagen, A. et al. (1999) cited above. p. 67.

120. James Bell, Vendula Belackova, Nicholas Lintzeris, Supervised Injectable Opioid Treatment for the Management of Opioid Dependence, *Drugs* (2018) 78:1339–1352; Drugs. 2018 Sep;78(13):1339-1352 at p. 1349.

121. The same pp. 52-53.

122. Queensland Productivity Commission, *Imprisonment and recidivism, final report*, vol. 1 (2019) cited above,p. 61 and p. 62.

suicide. About 62% of the participants had experienced a head injury where they became unconscious

141. The draft report this of the Commonwealth Productivity Commission in the course of its current investigation into mental health records that:

> "People with mental illness are overrepresented in every part of the justice system. Among police detainees, around 43% of males and 55% of females were reported to have a previously diagnosed mental disorder; while around 40% of prison entrants have been told they have a mental health disorder at some stage in their life (including substance use disorder) — double the rate of the non-prison population. Mental illness is particularly common among female prisoners, and at a much higher level among those Aboriginal and Torres Strait Islander people who are in prison."

142. The Australian Institute of Health and Welfare stresses the much higher prevalence of mental illness in prisons than in the community at large:

> "Mental health conditions, particularly severe conditions, are over-represented in the prison population. For example, the prevalence of psychosis in a London prison population was found to be more than 20 times that of the general community, and almost 70% of people in prison had more than one mental health disorder".

143. This is confirmed in the ACT context by the 2016 health and well-being survey of ACT detainees which found that over half of respondents (54%) reported that they had received one or more mental health diagnoses in their lifetime. Twenty-one respondents (21%) indicated that they had ever been admitted to a psychiatric unit or ward in a hospital, including 14% of Indigenous and 24% of non-Indigenous respondents.

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1. Co-occurrence of substance dependency and other mental health issues

146. The crossover between substance dependency and other mental health conditions is so common that the ground-breaking Senate Select Committee on Mental Health in 2006 termed it "the expectation not the exception".[123] That Committee lamented that:

> "Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system."[124] (Senate Mental Health (2006)).
>
> "Population estimates indicate that more than one-third of individuals with an AOD use disorder have at least one comorbid mental health disorder; however, the rate is even higher among those in AOD treatment programs. Additionally, there are a large number of people who present to AOD treatment who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder"[125].

147. The Queensland Productivity Commission inquiry into imprisonment and recidivism heard that mental illness is among a cluster of risk factors that "increases chances of offending and imprisonment. Risk factors arise from many sources, including birth related events, mental health, personal relationships and substance use. Queensland research shows that both offenders and prisoners are likely to have had mental health issues and/or a history of child neglect story of child neglect."[126]

148. "A systematic literature review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia found rates ranging from 47% to 100%. In addition, a large number of people who present for substance use treatment display symptoms of mental disorders, while not meeting the full criteria for a diagnosis of a disorder."[127]

149. "For young people aged 10-24 years, alcohol and other drug (AOD) use are the leading causes of the total burden of disease in males (8.2% and 2.0%,

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123. Senate 2006: Senate, Select Committee on Mental Health, *A national approach to mental health: from crisis to community,* First report (March 2006) chapt. 14.

124. The same §2.29.

125. Marel C, Mills KL, Kingston R, Gournay K, Deady M, Kay-Lambkin F, Baker A, Teesson M (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* (2nd edition). (Commonwealth Department of Health, Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales) p. xi.)

126. Queensland Productivity Commission, Imprisonment and recidivism, final report, vol. 1 (August 2019) p. 58 at https://qpc.blob.core.windows.net/wordpress/2020/01/FINAL-REPORT-Imprisonment-Volume-I-.pdf visited 02/05/2020.

127. Productivity Commission, Mental Health*, Draft Report (Productivity Commission, October 2019*, volume 1) p. 324 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf visited 22/06/2020.

respectively), and alcohol and iron deficiency in females (3.4% and 1.0%, respectively)."[128]

150. "As a whole, mental and substance use disorders make up 12% of the total health loss in Australia, behind cancer, cardiovascular diseases, and musculoskeletal conditions (AIHW 2019c). However, they represent the second highest proportion of years lived with disability in Australia (figure 2.9)."[129])

2. Those with the most complex needs end up in prison

151. Those with a high co-occurrence of substance dependency and other mental health issues often become enmeshed in the criminal justice system. This is the cohort of "consumers with the most complex mental health needs" (draft report vol. 1, p. 27) whose difficulties the Productivity Commission notes "can be more profound . . ., due to additional stigma and discrimination" (p. 625). It is the co-occurrence that elevates the risk of offending, reoffending and return to prison. A 2010 American study found that:

> "those with a co-occurring psychiatric and substance use disorder presented with a substantially higher risk of multiple incarcerations over a 6-year period compared to prisoners with psychiatric disorders alone or substance use disorders alone."[130]

Relying upon an extensive survey of the prison population in New South Wales the NSW Law Reform Commission mentions that "it would appear that the rate of mental health impairment in prisoners is more than triple the rate in the general population, with the rate of over-representation varying, in some cases significantly, depending on the actual mental health impairment concerned. For example, the rate of psychosis in sentenced and reception prisoners is much greater than the apparent rate in the general population – possibly as much as 21 times the rate in the general population."[131] "Research comparing community and prison samples in the UK found that the weighted prevalence of psychosis in prisons is 10 times greater than that of the general population."[132]

152. Drug prohibition underpinned by the criminal law has criminalised mental ill health producing an epidemic of imprisonment of people with co-occurring substance dependency and other mental health conditions.

> Forensic hospitals receive an ever-increasing share of the mental health budget. Even so, most mentally ill offenders do not get the benefit of such

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128. Orygen, The National Centre of Excellence in Youth Mental Health,and headspace, *Submission to the Productivity Commission's Inquiry into Mental Health*, April 2019, p.3.

129. PC, Mental Health Draft Report, (2019) vol. 1, cited above, p.153.

130. As summaried in Artemis Igoumenou, Constantinos Kallis, Nick Huband, Quazi Haque, Jeremy W. Coid & Conor Duggan, Prison vs. hospital for offenders with psychosis; effects on reoffending, *The Journal of Forensic Psychiatry & Psychology*, v. 30 no.6, pp. 939-958, (7 Aug 2019) p. 940.

131. NSW Reform Commission, People with cognitive and mental health impairments in the criminal justice system: Diversion, Report 135 (June 2012) p.90 at https://www.lawreform.justice.nsw.gov.au/Documents/Publications/Reports/Report-135.pdf.visited 25/04/2020.

132. Igoumenou *et al,*cited above, p.939.

> sustained and comprehensive rehabilitation, and are instead crowded into our new asylums, the prisons, where the prevalence of schizophrenia is at least 10 times that of the wider community.[133]

153. It has been evident to forensic psychiatrists for many years that " . . . the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing. In one of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995".[134] Substance abuse problems among persons with schizophrenia increased from 8.3% in 1975 to 26.1% in 1995.[135]

154. The large-scale co-occurrence of substance dependency and other mental health conditions complicates the treatment of both conditions and life of the people experiencing both. This complication is intensified by the fact that the same mutually reinforcing correlates constitute risk factors for mental illness,[136] drug dependency,[137] crime and imprisonment[138] creating a knot of complexity and dysfunction dauntingly hard to disentangle. The Productivity Commission's 2019 draft report reflects upon this interplay:

> People with dual diagnosis commonly experience poorer physical health, greater levels of disability and increased risk of suicidal behaviours than those with substance use disorders only (Prior et al. 2017). In addition, clients presenting with comorbid mental health conditions often have a

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133. Olav Nielssen, Patrick McGorry, David Castle and Cherrie Galletly, The RANZCP guidelines for Schizophrenia: Why is our practice so far short of our recommendations, and what can we do about it? at *Australian & New Zealand Journal of Psychiatry* 2017, Vol. 51(7) 670–674 at https://www.pc.gov.au/__data/assets/pdf_file/0003/238260/sub037-mental-health-attachment2.pdf visited 26/04/2020.

134. Paul E Mullen, Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services (2001) p.17 at http://crg.aic.gov.au/reports/mullen.pdf visited 22/06/2020.

135. Cameron Wallace, Paul E. Mullen & Philip Burgess, "Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders" in *American Journal of Psychiatry*, vol. 161, pp. 716-727 (2004).

136. Commonwealth Department of Health and Aged Care, *Promotion, prevention and early intervention for mental health-a monograph* (Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, 2000) at https://familyconcernpublishing.com.au/wp-content/uploads/2013/12/PPEiMentalHealth2000.pdf visited 13/11/2018.

137. Penny Mitchell, Catherine Spooner, Jan Copeland, Graham Vimpani, John Toumbourou, John Howard and Ann Sanson, *The role of families in the development, identification, prevention and treatment of illicit drug problems: commissioned by the NHMRC for the Strategic Research Development Committee's National Illicit Drug Strategy Research Program* (National Health and Medical research Council, 2001) at https://test1.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds8.pdf visited 21/04/2020.

138. National Anti-crime Strategy, *Pathways to prevention: developmental and early intervention approaches to crime in Australia; Full report* (Attorney-General's Dept, Canberra, 1999) at researchgate.net/publication/43493789_Pathways_to_Prevention_Development_and_Early_Intervention_Approaches_to_Crime_in_Australia.

variety of other family and social problems, such as housing, employment, welfare and legal problems (Marel et al. 2016, p. xi). This can lead to social isolation and higher levels of distress for their families and carers (VIC DHHS nd).[139]

3. Overcrowded condition of Australian prison

155. The annual Reports by the Commonwealth Productivity Commission on Government Services charts the extent to which Australian prisons are overcrowded. Its Report on Government Services Table 8A. has it that the ACT prison utilisation is 110.5% thus exceeding its design capacity. This is better than New South Wales that incarcerate's the largest number of prisoners in the country (the latest reported figure of 122.9% is for 2016-17) but more crowded than Queensland (105.5%).

156. The impacts of the crowded conditions in the ACT are reflected in reports of the ACT Inspector of Correctional Services.[140] He writes that overcrowding compounds the difficulty of managing the complexity of the sole ACT prison population that must accommodate males and females and prisoners of all classifications: "overcrowding at the AMC is placing pressure on the ability of ACTCS to make accommodation placements that address individual needs." (p. 39). For example," significant overcrowding limits the ability of AMC management to ensure older detainees can access an appropriate physical space" (p. 97). The situation is worse for women than for men. Women are now accommodated " . . .in a former male high security unit while male protection detainees occupy the Women's Community Centre cottages." This, the inspector commented, "is unsatisfactory". The women are disadvantaged with regard to access to green space, recreation opportunities, employment, and reintegration programs and their proximity to men's units exposes them to verbal harassment and abuse. The ACT government needs to find a quick and effective solution to this problem (p.21).

4. The unhealthiness of prison environment for people with mental illness and other disabilities.

157. Jail populations are made up of many suffering from different disabilities – far more than the 18% estimate for the community at large. They include people with acquired brain injury, and those suffering from a substance dependency as well as other mental health conditions. The 30% of the ACT prison population who have a disability[141] have a hard time there.

158. A detainee survey found that:

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139. PC, Mental Health Draft Report, (2019) vol. 1, cited above p. 324 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf visited 22/06/2020.

140. ACT Inspector of Correctional Services, Report of a review of a correctional centre, *Healthy prison review of the Alexander Maconochie Centre 2019 (*ACT Inspector of Correctional Services, Canberra 2019) at https://www.ics.act.gov.au/__data/assets/pdf_file/0007/1429495/191120-OCIS-AR-Final-Web-Version.pdf visited 28/03/2020

141. "Nationally there are estimates that as much as 50%[76] of detainees have a disability compared with around 18% in the general population" The same, p. 95

44% (n=71) reported that their needs arising from a disability are 'rarely' or 'never' met
28% (n=71) reported being discriminated against by other detainees and that
39% (n=72) reported being discriminated against by staff

159. The Inspector commented:

> "The experience of having a disability in detention can vary widely and be very significant. For example, there may be physical accessibility issues; limitations around understanding prison routine and instructions; barriers to fully participating in programs, education and work; a risk of increased social isolation; increased vulnerability to bullying, harassment and physical or sexual violence; difficulty coping with prison conditions resulting in co-morbidity with mental health disorders and other physical conditions; and behavioural responses or actions resulting from not understanding rules and expectations that are punished as discipline breaches."[142]

160. "Prison culture can be scary and threatening. The rules by which we live in the community often mean nothing in the prison environment."[143] Scary and threatening the ACT prison certainly is with highest rate of prisoner on prisoner violence in any prison system in the country at 3.51 "serious assaults" per 100 prisoners (defined as requiring overnight hospitalisation or ongoing medical treatment) and 9.09 other assaults (defined as causing physical injury not requiring overnight hospitalisation et cetera)[144] this renders derisory the professed commitment of Corrective Services to rehabilitation. The ACT prison is not a safe place. All too often it re-traumatises people for whom traumatisation earlier in their life contributed mightily to their incarceration.[145] There were no reports of assaults by prisons on staff.

161. Forensic Psychiatrists like Prof. Dr Paul Mullen, Clinical Director, Victorian Institute of Forensic Mental Health, writes that the experience of prison compounds mental health problems:

> "Mental disorders and intellectual limitations are frequently constructed by staff and prisoners alike as a sign of vulnerability and vulnerable is not a safe label to wear in prison. Those who do seek mental health treatment

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142. The same, p. 96.

143. Australian Injecting & Illicit Drug Users League (AIVL), Discussion paper: Prison-Based Syringe Exchange Programs (PSE Programs), Canberra, revised May 2008 p.6 at http://www.aivl.org.au/wp-content/uploads/2018/05/prison-based-syringe-exchange-programs-aivl-position-paper-2008.pdf visited 17/04/2020.

144. Productivity Commission (2020), Report on Government Services 2020: 8A Corrective services — Data tables contents, table 8A.17 at https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/justice/corrective-services/rogs-2020-partc-section8-data-tables.xlsx visited 28/03/2020..

145. See, for example the high level of domestic violence experienced within 12 months prior to incarceration, Table 2.6.27, 56% had been the victim of "person-based" crime, table 2.1.2 and 1/4 had been removed from their family (*ACT Detainee Health and Wellbeing Survey 2016* cited above).

are at risk of being seen by staff as attempting to evade the rigours of prison, and by fellow prisoners as weak and unacceptably alien. Prisons and jails are intended to be punishing and they provide hard and unforgiving environments which often amplify distress and disorder."[146]

5. Imprisonment compounds mental health and other harms of inmates

162. The processes of the criminal justice system are singularly inappropriate, ineffective and harming of people with schizophrenia who, because of drug laws, are increasingly incarcerated:

> "Prisons are our new asylums. There are about 1600 psychiatric hospital beds in NSW and between 900 and 1000 people with schizophrenia in prison at any one time. Prisons are cheaper, but the length of stay is greater, and they are very inefficient places to provide care. Moreover, the imprisonment of people with schizophrenia is often due to the failure of community care, and the interface between prison and the community does little to stop the door from revolving."[147]

163. Indeed, prisons are just about the worst place for people with mental health problems to be. In the words of a review by the University of London Institute for Criminal Policy Research:

> "'It has long been recognised that psychological harm can result from the loss of liberty, separation from family and community, deprivation of autonomy and material deprivation – all factors that characterise imprisonment. The often traumatic experience of being taken into custody (for the first time, in particular) can exacerbate pre-existing mental illness and can propel people with mental health vulnerability into violence, substance abuse, self-harm and even suicide. People with existing mental health conditions have been found to be more likely to be involved in violence, victimisation and prison rule infractions (Fazel et al, 2016)."[148]

164. Heroin assisted treatment holds out the real prospect of stopping or at least slowing that revolving door.

165. Prisons inflict not just the intended harm of deprivation of liberty, but also aggravate many of the problems that were a factor in people being sent to prison

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146. Paul E Mullen, Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services (2001) p.36 at http://crg.aic.gov.au/reports/mullen.pdf visited 26/04/2020.

147. Olav Nielssen, Submission to Productivity Commission mental health enquiry, submission 37 of 17 March 2019 at https://www.pc.gov.au/__data/assets/pdf_file/0009/238257/sub037-mental-health.pdf visited 22/04/2020.

148 Catherine Heard, Towards a health-informed approach to penal reform? Evidence from ten countries (Institute for Criminal Policy Research, University of London, London, June 2019) at https://www.prisonstudies.org/sites/default/files/resources/downloads/icpr_prison_health_report.pdf visited 6/22/2020.

in the first place. Not least among these is the presence of illicit drugs. These are present in prison to such an extent that non-drug users are known to commence drug use while in prison: "prison environments have been identified as sites of injection initiation".[149]

6. Prison undermines the capacity of people to flourish in the community

166. The fracturing of community links to family, friends, employment and other protective factors follows from arrest and incarceration. This disruption bears particularly keenly on people with mental illness making it all the more difficult for them to reintegrate into the community. While noting that prisons amplify distress and disorder, Dr Mullens notes that some thrive under a prison regime:

> "Equally however they provide remarkably predictable environments with clear rules and limited but well delineated roles. Some mentally disordered individuals thrive in this world stripped of the contradictions and complexities of the outside world. Sadly thriving in total institutions is rarely conducive to coping in the community."[150]

167. The views about predictability gel with evidence before the Victorian Ombudsman:

> "Upon release, [prisoners] return to homelessness and re-entry to prison is a pretty good option when you have a clean bed, three meals, a job and your mates! The difficulty of reassimilation into an unwelcoming community is overwhelming for [people] who are suffering severe anxiety with depression, from years of trauma and incarceration."

7. Stigma and social exclusion

168. The harm reduction element of Australia's and the ACT's professed policy of harm minimisation seeks to improve the health and social exclusion of people who continue to use illicit drugs. Critics of harm reduction measures like NSP programs, peer support and opiate replacement therapies see them as normalising and thus encouraging drug use. At the root of drug policy is thus a tension: there is a tendency in some quarters to view the intended stigma and isolation that is fostered by the criminal nature of drug use as therapeutically desirable in so far as it deters people from becoming drug users. The truth is rather the reverse. Stigma forms and often insurmountable barrier between healthcare providers and people with co-occurring mental health conditions that include substance dependency.

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149. Dan Werb, R. N. Bluthenthal, G. Kolla, C. Strike, A. H. Kral, A. Uusküla & D. Des Jarlais, "Preventing Injection Drug use Initiation: State of the Evidence and Opportunities for the Future" *Journal of Urban Health,* vol. 95, issue no.1, pp 91–98, February 2018, at https://link.springer.com/article/10.1007/s11524-017-0192-8 visited 4/5/2019 and Gore SM, Bird AG, Ross AJ. "Prison rites: starting to inject inside", *BMJ*.;311(7013):1135–6, 1995.

150. The same. Paul E Mullen, Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services (2001) at http://crg.aic.gov.au/reports/mullen.pdf visited 22/06/2020

169. People suffering from a substance dependency and another mental health issue tend to be snared by this dynamic. A qualitative study of patients at the Crosstown clinic in Vancouver that administers heroin assisted treatment illustrates how that pharmacotherapy helped break down on the part of both provider and patient the obstacle in the way of understanding and respectful care without which effective medical care is likely to be ineffective. It comes down to a question of trust:

> "Trust issues [are] rooted in participants' prior experiences of discrimination in the healthcare system related to their use of street opioids.
>
> > "[My iOAT (Injectable opioid agonist treatment) doctor] treats people with respect and dignity, which is huge. [For] many years in my life, I've been 'the junkie'… Looked down on by people in that [healthcare] field, no matter where or what their position was. I don't get that there [at Crosstown Clinic]… The staff is amazing... I really feel like each and every one of them cares." (N10)
>
> "As participants' trust in healthcare providers grew, they discovered that staff also had "a lot of understanding….A lot more understanding than the average person" (N24)."[151]

Such judgemental and marginalising attitudes were also evident in some community reactions to the AIDS epidemic. At its outset, HIV disease settled among socially devalued groups, and as the epidemic has progressed, AIDS has increasingly been an affliction of people who have little economic, political, and social power."[152] Most of the public injecting drug users in Glasgow who contracted HIV around 2015 were ". . . male, with relatively long histories of injecting drug use . . . Most report[ed] multiple social vulnerabilities, including unemployment, homelessness, and offending. The combination of these factors is often referred to as severe and multiple disadvantage (SMD) and is increasingly recognised as a powerful marker for ill health and social exclusion."[153]

170. The intensification of the marginalisation of people with mental illnesses unrelated to substance misuse is thus fostered by the community perception of co-occurrence:

> "Stigma around AOD use remains considerably higher than for mental health issues, and lack of understanding about what treatment entails or fear of judgement result in many young people not seeking help or

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151. Kirsten Marchand, Julie Foreman, Scott MacDonald, Scott Harrison, Martin T. Schechter, and Eugenia Oviedo-Joekes, Building healthcare provider relationships for patient-centered care: A qualitative study of the experiences of people receiving injectable opioid agonist treatment, *Subst Abuse Treat Prev Policy*. 2020.

152. Albert R. Jonsen and Jeff Stryker, *The social impact of AIDS in the United States*, (National Academy Press, Washington, D.C. 1993) p. 9.

153. NHS Greater Glasgow & Clyde, "Taking away the chaos": the health needs of people who inject drugs in public places in Glasgow city centre (NHS Greater Glasgow and Clyde, 2016) p.12 at https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf visited 25/04/2020.

disclosing an AOD issue to a clinician to ensure a timely and effective treatment approach is taken to respond to the comorbidity."[154]

171. The law's labelling of drug users as criminals intensifies the disempowering and marginalising stigma that impedes their recovery including access to services: family and peer group engagement that is vital for reintegration. The stigma around drug use makes the work of both the AOD and mental health sector so much more difficult. "Service users and providers alike spoke of stigma as a powerful barrier to accessing much needed services among this population. Many people with active or former injecting drug use described a need for more person-centred care, and wanting more input into decisions about their care. We were struck by the strength and value of the existing peer network for people in recovery, and by the opportunities for empowerment, engagement, and harm reduction that a similar network could offer for people who inject drugs."[155]

172. In its submission to the Productivity Commission, Anglicare stressed the vital importance for health and well-being of social connection: "

173. Disengagement and isolation from families, society flow from the stigma and marginalisation of drug users: "clients presenting with comorbid mental health conditions often have a variety of other family and social problems, such as housing, employment, welfare and legal problems. This can lead to social isolation and higher levels of distress for their families and carers (VIC DHHS nd).

174. Anglicare Australia recommends that the Commission acknowledge the importance of social connection and attention to the social determinants of health and well-being:

> "Social connection and networks go beyond the family, and are also important pillars of our wellbeing. Here, the design of our lived environment and policy settings can have a direct impact on social connection, and there is a role for government at a population level. . . . (sub. 376 Anglicare Australia)
>
> • Reflects on population level government policy settings that impact the social determinants of health in its draft report;
>
> • Acknowledges the role of these settings in creating risks such as chronic stress, which significantly increases peoples' vulnerability to developing widespread mental illnesses such as anxiety and depression; and
>
> • Make recommendations that capture well-documented changes to government policy settings such as increases to government income

154. PC, Mental Health Draft Report, (2019) vol. 1, cited above, p.331

155. Anglicare, Care dignity respect change hope: submission to the Productivity Commission Inquiry into "The Social and economic benefits of improving mental health". April 2019, Submission 376, p. 11.

payments, and the provision of social housing, which would significantly reduce this negative impact to many people's mental health. [156]

175. There are qualitative reports of heroin assisted treatment reducing stigma and alienation. The major theme reported by respondents in a qualitative study was carried out during the final months of the trial of supervised injectable opioid treatment (SIOT) in Spain:

> "was that patients and family members saw SIOT as "medicalization" of heroin use. Instead of a drug which controlled their lives, it became a medication. Respondents apparently saw this as positive, as reducing stigma. Family members commented that they looked on their affected member as 'chronically ill' and not as 'addicts' once they were in SIOT."[157]

176. There is an ambivalence by some dependent heroin users towards the medicalisation implicit in heroin assisted treatment:

> "Some perceive medicalization as helpful, but resent being in treatment. For some, medicalization takes the fun out of using heroin."[158]

Attitudes like this help explain why many drug users receiving the treatment move to other treatments and abstinence. In other words, heroin assisted treatment is not the sticky flytrap that it often made out to be by opponents. Rather, treatment helps participants stabilise their life and facilitate social reintegration.

8. Inadequacy of prison health services

177. Even the best intended and well-resourced prison health services is handicapped providing health services to a prison populations whose health needs are very high. Reviews of the ACT Inspector of Correctional Services and the Health Services Commissioner[159] give a sense of the obstacles in the way of adequate health treatment. The delivery of healthcare in prisons is a demanding and time-consuming exercise given the congregation within the stressful environment of prisons of people with manifold mental and physical health conditions.

178. Qualitative research associated with the Crosstown clinic in Vancouver[160] that allows heroin assisted treatment described as iOAT [Injectable opioid agonist treatment] illustrates the transformative environment facilitated by that intervention that empowers and facilitates opiate dependent people with a history of failed

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156. Anglicare, Care dignity respect change hope: submission to the Productivity Commission Inquiry into "The Social and economic benefits of improving mental health". April 2019, Submission 376, pp. 11-12

157. James Bell, Vendula Belackova, Nicholas Lintzeris, Supervised Injectable Opioid Treatment for the Management of Opioid Dependence, Drugs (2018) 78:1339–1352; Drugs. 2018 Sep;78(13):1339-1352 at p. 1348.

158. The same.

159. *Review of the opioid replacement* (2018) cited above.

160. Kirsten Marchand, Julie Foreman, Scott MacDonald, Scott Harrison, Martin T. Schechter, and Eugenia Oviedo-Joekes, Building healthcare provider relationships for patient-centered care: A qualitative study of the experiences of people receiving injectable opioid agonist treatment, *Subst Abuse Treat Prev Policy*. 2020.

engagement on an adversarial basis with health services to address multiple health and social problems in their lives.

> Reduced street opioid use was the most consistent initial iOAT goal and outcome described. . . . Some participants credited this outcome to how well the medication suppressed cravings and withdrawal (e.g., "*I actually feel it and it gets me better*" (N28)). Others reflected that the accompanying financial or social costs of street acquired opioid use were no longer worth the "risk", because "*I risk my freedom every time I do it* [use street heroin]" (N25). Narratives about "freedom" were also rooted in participants' goals to disconnect from the "*constant struggle*" (N23) of daily street opioid use that was "*extremely anxiety inducing*" (N11). Participants attributed this struggle and anxiety to: "*living a day ahead because you don't want to wake up sick*" (N30); "*spend[*ing*] our lives chasing the drug, or the money...there's no time for anything else, but your addiction*" (N07); and "*having to steal sometimes in order to support that habit*" (N11). Being able to disconnect from this struggle and anxiety brought an increasing sense of "*stability*", "*having a life*", *normalcy*" and "cook". These outcomes carried subjective meanings, including regular sleep, food in the cupboard, money left at the end of the month, being able to attend a movie or a concert, and reconnecting with family.
>
> Within narratives of "stability", participants defined positive changes to health functioning (e.g., "*weight gain*", "*eating and sleeping better*"). Generally, participants felt they were taking better care of their health by prioritizing treatment for chronic conditions that had been neglected over the years (e.g., Hepatitis C treatment, dental and vision, medications and counseling for depression and anxiety). Such health outcomes were primarily discussed in relation to the delivery of holistic care that was part of this iOAT setting. Examples of how these outcomes arose further emphasized that building relationships (especially feeling supported, accepted, and understood) was fundamental to these outcomes. For instance, when the nurse practitioner took the extra time to go over a participant's health history, this "*got me thinking more in terms of what do I need to just feel good for today, what can I do to make my future better, you know? Yeah, taking care of my pap tests, my breast exams and both my mom and grandma had breast cancer*" (N04).

179. The stigma associated with criminality flowing from illicit drug use compounding stigma associated with mental illness (see part VII.7 p.52) in the harsh demeaning prison environment renders it immensely difficult if not impossible to delivery person centred care known to be necessary for the healing of these vulnerable people. Research identifies the following ingredients of effective care of this vulnerable and troubled populations:

- trust between participants and healthcare providers in contrast to the participants' history of discrimination in the healthcare system as users of illicit drugs;
- an understanding and respectful attitude of healthcare providers towards participants;
  - "a positive therapeutic relationship was fundamental to experiencing care was *meeting me where I am*."

- an open-minded and respectful communication style of healthcare workers with participants;
- a sense of safety of participants to speak up about their needs and preferences and willingness of healthcare providers to heed those preferences;
  - this approach is in contrast to the common experience of drug users that their views are dismissed: ""[My doctor] doesn't listen, and [she/he] just does what [she/he] wants to do… [she/he] still tries to push methadone on me…I tried to go up on my dose a couple of times in the past and [my doctor] wouldn't let me, like [she/he] said 'you gotta do this first."
- the discovery by participants of their own self-reported outcomes
- the aggregation in one place health and other support services
  - "centralized care was closely aligned with participants' needs. As one participant explained, '*when you are trying to get some order in their life…you can't have [us] going all over the place and that, to have it all in one hub, it's right there man*'"
- receipt of tailored comprehensive care
- encouragement of participants to take responsibility
- encouragement of a sense of agency in participants to invest in their own care
  - encouragement of participants to take responsibility for their own lives. Participants emphasized that holistic care be delivered in a manner that encouraged clients to '*have the responsibility to invest in [our] own lives'* (N10).'
  - When healthcare providers took time to understand the evolving needs of their patients and were presented with information in an unbiased manner, they gained an increased sense of empowerment.

180. All these elements go towards the goal of person centred care. As the following paragraphs shows that it is nigh on impossible to realise that objective in either the prison environment or in the mandatory directive context of the ACT is drug court and its so-called "therapeutic jurisprudence". Government thinking must go further than the slogan that drug policy is a health rather than a criminal issue.

181. All told, the obstacles in the way of the provision of health services within prisons commensurate with the needs of inmates renders it extremely hard if not practically impossible to honour the human rights principle of equivalence under which prisoners "should have access to the same standard of care available to people outside prisons."[161] The counterpoint to this view is put forward by the Australian Medical Association ". . . that prison offers an opportunity to access disadvantaged groups who are normally hard to reach in the community. This access provides an opportunity to address health inequalities including drug, alcohol and tobacco use, primary health care access and mental health care

161. ACT Human Rights Commission, Human Rights Audit on the Conditions of Detention of Women at the Alexander Maconochie Centre A Report by the ACT Human Rights and Discrimination Commissioner April 2014 pp. 130-31 at https://hrc.act.gov.au/wp-content/uploads/2015/02/HRC-Womens-Audit-2014.pdf visited 24/04/2020.

treatment."[162] A strong case can be made that these advantages are neutralised and undermined by prison environments. The New South Wales coroner observed that the "poorly coordinated and planned mental health care of Jonathan Hogan, a young Wiradjuri man at the Junee Correctional Centre contributed to him taking his own life. "He had a history of substance abuse and [earlier] a psychiatrist had "formed the opinion that he had paranoid schizophrenia . . . and on his intake the jail staff knew that he had previously been on medication for depression and schizophrenia and had a history of self-harming."[163]

The Inspector of Correctional Services in his 2019 Healthy Prison Review[164] did, for example mention some of the obstacles at the ACT prison:

- only one psychologist position at the AMC to provide general (as opposed to forensic) psychological service to some 500 detainees. This staffing level is grossly inadequate and must be addressed as a matter of urgency.
- A prevailing atmosphere of "lethargy and boredom" in part contributed to by the absence of meaningful work.

182. Challenges adverted to by the Health Services Commissioner included:

reconciling the tension between the health needs of detainees to which the prison health services accord priority with the security priorities of corrective services. This manifests itself in:

i. although by the Health Services Commissioner did not compare the ACT prisons to the Adult Mental Health Unit at the Canberra Hospital or to Dhulwa Mental Health Unit, there is clearly not available to Justice Health a level of specialist mental health staff sufficient to treat the high concentration of people detained in the prison with mental health conditions;
ii. rejection at the instance of corrections of Suboxone on the ground that it can be more easily diverted methadone. "A short trial of Suboxone maintenance was conducted at the AMC but was ceased due to allegations of widespread diversion";[165]
iii. rejection by corrections officers and prison administration of the introduction of a needle and syringe program to guard against the spread of blood-borne diseases.[166]
iv. Impediments in the sharing of information relevant to the health needs of inmates;[167]

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162 The same, p. 108 and similar wishful thinking of PC, Mental Health Draft Report, (2019) vol. 1, cited above p. 601 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf visited 22/06/2020.

163 *The Canberra Times,* 13 May 2020, p. 8.

164. ACT Inspector of Correctional Services, Report of a review of a correctional centre, Healthy prison review of the Alexander Maconochie Centre 2019 (ACT Inspector of Correctional Services, Canberra 2019) at https://www.ics.act.gov.au/__data/assets/pdf_file/0007/1429495/191120-OCIS-AR-Final-Web-Version.pdf visited 28/03/2020.

165. Review of the opioid replacement (2018) cited above p.13

166. The same, pp. 48-49.

v. The prisoner/warder mindset inculcates distrust and impedes corrective services staff fulfilling their fiduciary responsibilities for the well-being of prisoners in matters like supporting medication rounds and observing detainees in the course of their induction onto the methadone this[168]

vi. inadequacy of premises for the health service to meet the needs of a much larger number of prisoners: “the Hume Health Centre facility has not been expanded since commencement, placing strain on health services and facilities which were not designed for the current number of detainees.”[169]

vii. constraints imposed by prison routines on the ready access of health service staff to detainees and of detainees to health service staff.[170] These constraints can lead to irregular dosing times, failure to note and react to overdoses, inadequate observation and monitoring of detainees being inducted onto pharmacotherapies like methadone,[171] inadequate support for detainees wishing to cease opioid pharmacotherapy and the ready flow of health information.

viii. The unavailability and absence of capacity to administer Naloxone to reverse overdoses. “Naloxone (a medication which blocks the effects of opioids to reverse overdose and is available for peer use in the community) is not available to be administered in the event of an overdose. We understand that currently, if an overdose occurs after-hours, when health staff are not onsite, naloxone could not be administered until paramedics arrive at the AMC to treat a detainee who has overdosed.”[172]

ix. the risk of detainees receiving pharmacotherapies being stood over to divert those pharmacotherapies to fellow prisoners.[173] “In the prison environment diverted methadone is a tradeable commodity and the illicit supply of diverted methadone can place other detainees at real risk of harm and overdose.”

x. Constraints on a prison based health service securing the cooperation of Corrections and other services in putting in place *after care services for discharged detainees*. As well is drug treatment after care services should include social support services. “In addition to drug dependence treatment needs, many ex-prisoners have housing and financial difficulties and in some instances psychiatric problems. They may be released to either poor family support or deeply dysfunctional families and friends. For this reason, aftercare cannot be limited to drug treatment but needs to include social support services.”[174] In England

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167. The same, p.23.

168. The same, pp.12 & 29.

169. The same, p. 13.

170. The same, pp.13,15 & 30.

171. The same, p. 30.

172. The same, p. 31.

173. The same, p. 36

174. The same, p. 43.

and Wales “patients discharged from hospitals but not subjected to the Care Programme Approach (CPA). The CPA mandates that the patients are subject to a package of care including regular reviews by their clinical team (including Care Coordinator, Social Worker and Consultant Psychiatrist) focusing not only on their mental state but also on risk prediction and management.” In comparison it is not the norm for prisoners with mental health diagnoses, to be followed up by community mental health services.[175]

VIII. Indigenous incarceration in the ACT

183. The Productivity Commission makes the point that “Many Aboriginal and Torres Strait Islander people experience high levels of distress — for example, one in three adults report having experienced high or very high distress in a recent four week period.”[176] It then traces a pathway that leads a hugely disproportionate number of indigenous Australians to prison:

> “Disadvantage and psychosocial stress often go hand in hand, and pose a concurrent risk to people’s health. Among other things, inadequate housing, a lack of employment, high rates of incarceration or insufficient education opportunities are sources of disadvantage for Aboriginal and Torres Strait Islander people that may lead to psychological distress. Entrenched poverty amongst Aboriginal and Torres Strait Islander people is recognised as a ‘significant underlying factor’ that contributes to self-destructive behaviour, intentional self-harm and suicide.”

184. Social exclusion follows from these experiences. Incarceration further marginalises all those struggling with the chaotic experience of co-occurring substance dependency and other mental health issues whether they be indigenous or non-indigenous Australians. In other words, incarceration intensifies and compounds the very problems that led to imprisonment. It is a bond of suffering with non-indigenous people battling substance dependency and other mental health problems but is that much keener for indigenous Australians because they are marginalised in the land of their ancestors. Stan Grant writes:

> “I interviewed one Australian criminologist who said that the rates of imprisonment are ‘unbelievable’. But we believe it. To us it is all too real. The same criminologist told me that we are locked up for crimes that would see other Australians walk free. He said it isn’t because there is rampant crime in black communities. Indigenous people murder and rape at half the rate of the general population, and commit drug crime about eight times less. But once locked up indigenous people begin a spiral of reoffending in jail. Over and over people are trapped in a cycle of violence, drugs and alcohol, mental illness, sexual abuse, unemployment and abject poverty.”[177]

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175. Igoumenou *et al,*cited above, p.951.
176. Productivity Commission, Mental Health*, Draft Report (Productivity Commission, October 2019*, volume 2) p. 831 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume2.pdf visited 24/04/2020
177. Stan Grant, *talking to my country* (HarperCollins, Sydney, 2017) p.106.

185. “The NSW Health Aboriginal Mental Health and Wellbeing Policy cites the high prevalence of grief, trauma and loss in Aboriginal communities, as well as a rate of suicide and self harm that is at least twice the national rate. It has been reported that the rate of mental illness in these communities is affected by “socio-cultural, socio-economic and socio-historical factors”[178]

186. The Queensland Productivity Commission heard that “The overlap between offending, child protection and prisoners . . . larger for Aboriginal and Torres strait islander people [around 60 per cent] than non-Indigenous people and larger for women than men. It is most severe for Indigenous women—three-quarters of Indigenous female prisoners have had a mental health episode, been in child protection, or both."[179] “This research emphasises that offending is strongly connected to a history of child maltreatment and mental health admissions. This connection is even stronger for prisoners, who on average exhibit more harmful or more frequent offending than offenders generally.”[180]

187. In his address to the Legislative Assembly on 24 August 2004 on the ACT prison then being planned, The Chief Minister said that indigenous prisoners then constituted approximately 9 per cent of the ACT prison population which at that the time were all transported to New South Wales to serve their sentence. He termed this level to be unacceptable. How much less acceptable is the situation 14 years on when, according to the Productivity Commission, indigenous Canberrans now constitute 23% of the ACTs own prison?

188. In 2018-19 in the ACT the crude imprisonment rate for the Aboriginal and Torres Strait Islander population was 3,398.6 offenders per 100,000 relevant adult population, compared with 112.2 for the non-Indigenous population. After adjusting for differences in population age structures, the rate per 100 000 Aboriginal and Torres Strait Islander population in 2018-19 was 1,602.5, compared with a rate of 107.6 for the non-Indigenous population. Therefore, after taking into account the effect of differences in the age profiles between the two populations, the ACT indigenous corrections rate is 14.9 times greater than for the non-Indigenous population. Rates that do not take age profile differences into account are almost 18.9 times greater (only Western Australia, at 19 times, is worse). In 2004 the Chief Minister could claim indigenous imprisonment rate was lower than the national average.

178. NSW Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: Diversion*, Report 135 (June 2012) p.17 at https://www.lawreform.justice.nsw.gov.au/Documents/Publications/Reports/Report-135.pdf visited 25/04/2020.

179. Queensland Productivity Commission, Imprisonment and recidivism, final report, vol. 1 (2019) cited above, p. 62 and p. xliii

180.. The same.

189. The gross overrepresentation of indigenous people in the ACT prison make all the more pointed comments of the Productivity Commission in its draft report on Mental Health[181]:

> "The incarceration of Aboriginal and Torres Strait Islander people, its causes and devastating effects have been the subject of a number of inquiries and Royal Commissions, the most recent being the ALRC inquiry in 2017. . . . A large proportion of those incarcerated are diagnosed with mental illness and cognitive disabilities (section 16.2).
>
> > 'The issues pertaining to the needs of prisoners with mental illnesses and/or cognitive impairment are amplified for Aboriginal and Torres Strait Islander offenders given their significant overrepresentation in the criminal justice system.'"

190. The ACT Health Services Commissioner has pointed out that to address this disturbing inequality "it is vital that all aspects of treatment of Aboriginal and Torres Strait Islander detainees meet their cultural needs and support their rehabilitation."[182])

191. In the context of SARS-CoV-2 virus, the large number of indigenous Australians in prison evokes the historical memory of widespread death of aborigines from diseases introduced by the European invaders.

> " . . . Aborigines had had no opportunity to acquire immunity or to evolve genetic resistance [to European-introduced germs.] Within a year of the first European settlers arrival at Sydney, in 1788, corpses of aborigines who have died in epidemics became a common sight. The principal recorded killers were smallpox, influenza, measles, typhoid, typhus, chickenpox, whooping cough, tuberculosis and syphilis."[183]

192. Australia as a whole has replicated albeit to a more modest degree the stratospheric levels of imprisonment in the United States with more than 2 million Americans incarcerated at a rate of 655 per 100,000. This has been attributed to zealous drug law enforcement of that country's prohibitionist policies.

> "Harsher sentencing of drug offences was a key development, in the context of the US government's 'war on drugs' as declared by President Nixon in 1971 – with the consequence that admissions for drug offences accounted for almost one-third of all admissions to state and federal prisons over the period 1993 to 2009."[184]

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181. PC, Mental Health Draft Report, (2019) vol. 1, cited above p. 628 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf

182. Review of the opioid replacement (2018) cited above p.27.

183. Jared Diamond, *Guns, germs and steel: a short history of everybody for the last 13,000 years* (Vintage, London, 1998) P 320.

184. Jessica Jacobson, Catherine Heard and Helen Fair, *Prison evidence of its use and over-use from around the world* (Institute for Criminal Policy Research, London 2017) p. 11 at

193. “Indigenous people entering prison were more than twice as likely as Indigenous people in the community.”[185]

194. “Indigenous prison entrants (56%) were more likely than non-Indigenous prison entrants (38%) to report they had been in prison in the previous year.” (p.112).

195. “In 2018, Indigenous prison entrants (56%) were 1.5 times as likely as non-Indigenous prison entrants (38%) to report they had been incarcerated in the previous 12 months. This gap had increased between 2015 and 2018. In 2015, less than half (45%) of Indigenous prison entrants said they had been in prison in the previous year, compared with 38% of non-Indigenous entrants (Figure 14.2).

196. “This means that, in 2018, two of the most vulnerable groups in the prison population—women and Indigenous people—were more likely to report a history of incarceration in the last 12 months than they had in previous years. These groups also showed poorer health outcomes than men and non- Indigenous people in the prison system.” (ibid).

IX. The ineffectiveness of Prisons

197. The NSW Law Reform Commission quoted with approval an important British study to the effect that “prison is a high-cost intervention which is ineffective in reducing subsequent offending.”[186] Mentioned in the section above on mental health is another British study that compared “matched pairs of adult males with psychosis (schizophrenia or delusional disorder)” released from prison with those released from mental health hospitals. This study found that” males with psychosis released from prisons had a hazard of reoffending nearly 3 times the one of their matched” controls with psychosis discharged from hospitals. [187]

A. There is a high churn of people in and out of prison

198. People spend on average only 5.9 months in the ACT prison[188] and there is continual contact between prison staff and inmates which means, from a public health point of view, detainees are not isolated from the community not protected from infections circulating in the community.

B. Recidivism

199. The Sentencing Advisory Council of Victoria reports in 2015–16 44.2% of prisoners returned to prison within two years and 69.9% returned to corrective services. This is consistent with the 2019 Report on Government Services of the Productivity commission that includes the following chart of rates of return of

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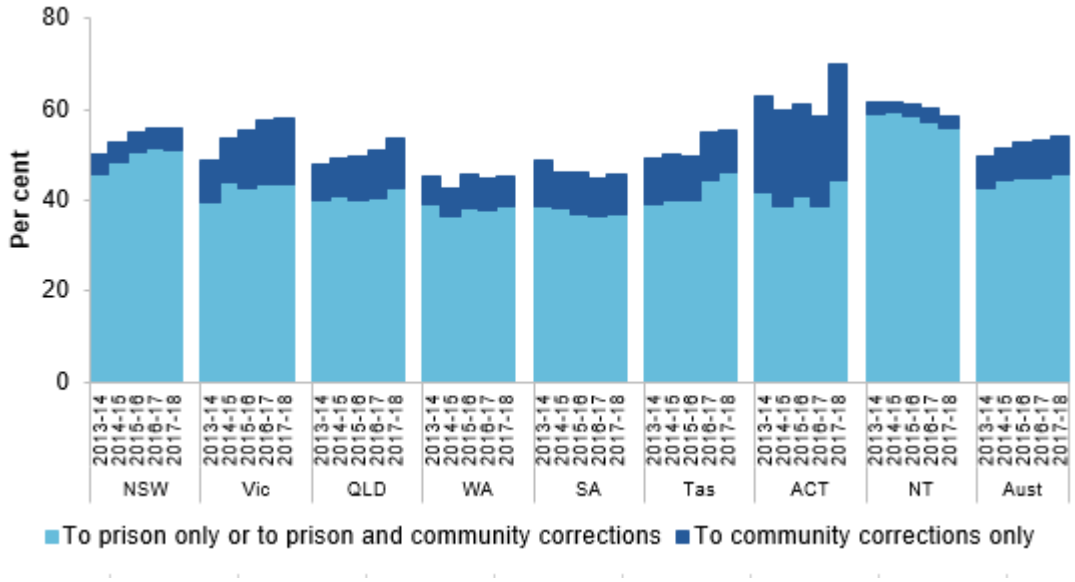
https://www.prisonstudies.org/sites/default/files/resources/downloads/global_imprisonment_web2c.pdf

185. AIHW, The health of Australia’s prisoners (2019), cited above p. 97
186. NSW Law Reform Commission (2012), cited above, p.39.
187. Igoumenou *et al,*cited above,p.946.
188. Michael Moore & Melanie Walker, *Balancing access and safety Meeting the Challenge of Blood Borne Viruses in Prison: report for the ACT Government into implementation of a Needle and Syringe Program at the ACT’s prison, the Alexander Maconochie Centre* (Public Health Association of Australia, Canberra, 19 July 2011) p. 11.

released prisoners to corrective services. It shows rates of return to prison on a par with other jurisdictions but reflects an effort to reduce the rate of incarceration in the ACT, in the form of a relatively large rate of return to community corrections.

Figure C.3 Prisoners returned to corrective services with a new correctional sanction within two years of release (per cent)[a, b]



a See table CA.4 for detailed footnotes and caveats. **b** Rates for a financial year relate to prisoners released two years prior to that reporting period who returned within two years of their release date.

200. Most people who find themselves in prison sentenced for a relatively short period so that they will soon re-enter the community. For example "although the average sentence length in Victoria is three years, more than a quarter of Victoria's prisoner population, or 26.2 per cent are serving a sentence of less than one year."

201. In its draft report on mental health the Productivity Commission has noted that:

> "the majority of prisoners with mental illness spend relatively short periods of time in custody before returning to the community, inadequate healthcare in prisons and poor transition support services are likely to raise the burden on the community healthcare system and increase recidivism."

The inquiry into recidivism of the Queensland Productivity commission made a similar point about imprisonment increasing the burden on the mental health system in the community:

"These indirect costs [of imprisonment] can include forgone employment, as well as higher rates of unemployment, social exclusion, homelessness and poor mental health following release."[189]

202. According to the Bureau of Statistics the median sentence length for defendants sentenced to custody in a correctional institution in 2015–16 remained unchanged compared with 2014–15 at:

- 30 months for the Higher Courts; and
- 6 months for the Magistrates' Courts and Children's Courts

C. Imprisonment increases crime

203. There is a persuasive string of evidence that imprisonment actually increases rather than reduces crime. Dr Don Weatherburn director of the NSW Bureau of Crime Statistic and Research reported in a 2010 study that "There is no evidence that prison deters offenders convicted of burglary or non-aggravated assault. There is some evidence that prison increases the risk of offending amongst offenders convicted of non-aggravated assault." He added as a caveat that "further research with larger samples is needed to confirm the results."

204. In that same paper Dr Weatherburn reviewed the research literature on the deterrent effect of imprisonment. The results were mostly equivocal. He went on to consider Australian studies. These did point to imprisonment increasing the risk of reoffending:

- A 1974 study of seven categories of offence from the probation register of the NSW Department of Child Welfare found recidivism "to be higher after detention for all but two offences: 'behaviour problems' and 'take and use motor vehicle."
- A 1996 study of a large group of convicted juveniles in New South Wales. The results of his study suggested that those subject to a custodial penalty "were more likely to reoffend".
- A 2009 study of juveniles comparing two groups of juveniles, one subject to a custodial penalty and the other not, "found no significant effect of detention on risk of re-offending."
- Another 2009 study in which also Weatherburn was involved looked at adult offenders and concluded that "Prison was found to exert no effect on time to re-offend amongst those who had not previously served time in custody. Offenders who had previously served time in custody, however, actually re-offended more quickly if they received a prison sentence than if they received a suspended sentence."

205. In the light of the insights from this research, why on earth should we, without fundamental reform to it, persevere with an institution that fails so cruelly and miserably and at such cost to achieve its objectives? That we do persevere with our prison invites one to reflect on the part that sadism and masochism play

189. Queensland Productivity Commission, *Imprisonment and recidivism, final report*, vol. 1 (2019) cited above, p.xxi.

in shaping public policy. Justice Reinvestment initiatives stand as some recognition of the irrationality in the present course.[190]

X. Conclusion

206. Heroin assisted treatment would have substantially ameliorated the explosion of heroin use that Australia experienced throughout the 1990s.

207. There would have been a far reduced burden of disease from hepatitis C than was able to be achieved merely by measures such as needle/syringe programs in the community and harm reduction measures like provision of condoms and bleach in prisons.

208. Property crime and other crime particularly associated with addiction to illicit drugs would have been much less that it is now.

209. Above all there would not have been anything like the thousands of heroin overdose deaths that occurred in Australia in the latter years of the 1990s and subsequently up to the present with the renewed availability of that drug and the growth of opiate dependence from prescription painkillers.

210. There would not have been an epidemic of so-called “deaths of despair” like suicide that are fostered by the stigmatisation and marginalisation of dependent drug users.

211. There would not be as much overcrowding of ACT prisons as there is and it may even have been unnecessary for the ACT to establish its own prison.

190. Matthew Willis and Madeleine Kapira, Justice reinvestment in Australia: A review of the literature AIC reports Research Report 09 (Australian Institute of Criminology, Canberra,2018) at file:///C:/Users/Bill/Downloads/rr09_justice_reinvestment_in_australia_160518_0.pdf visited 22/06/2020.