ATODA response to questions on notice

Parliamentary Inquiry into Drugs of Dependence (Personal Use) Amendment Bill 2021

Question taken on notice

(Jonathan Davis): I am interested in talking about those drugs that we have, for a range of reasons, already deemed socially acceptable—alcohol and tobacco in particular. I am interested in the efficacy that you can speak to of treating someone's problematic relationship with either alcohol or tobacco at the same time as treating their problematic relationship with drugs that are currently illicit. Anecdotally, it has been put to me that complementary supports would not be very useful, but I would be interested in your take. Further to that, do you think that, as a government, we are currently doing enough to limit the health impacts of tobacco and alcohol?

Response

The *ACT Drug Strategy Action Plan, 2018-2021* provides the basis for drug policy in the ACT[1]. It draws on various Australian Institute of Health and Welfare data sources to summarise the several leading risk factors contributing to the total burden of disease.

Table 1. Leading risk factors contributing to the total burden of disease, 2011[1]

Risk Factor	ACT (%)	Australia (%)
Tobacco use	5.4	9.0
Combined dietary risks	5.1	7.0
High body mass index	4.5	5.5
Alcohol use	4.2	5.1
High blood pressure	4.2	4.9
Physical inactivity	4.0	5.0

Illicit drug use (including opioids, amphetamines, cocaine and cannabis and other illicit drugs) has been calculated to account for 2.2% of disease burden in the ACT compared to 2.3% Australia wide.[1] In other words, **alcohol causes almost twice as much harm as all illicit drugs combined, and tobacco use is the leading risk factor** contributing to the burden of disease.

The most recent relevant AIHW burden of disease report, which does not provide a breakdown by state and territory, shows an increase in the burden of disease from all illicit drugs to 2.7% nationally.[2] It remains well below the burden of disease from alcohol (4.5%) and tobacco (9.3%).[2]

Alcohol also accounts for a higher proportion of people seeking specialist treatment than any form of illicit drug. In 2019–20, for clients in the Australian Capital Territory receiving treatment episodes for alcohol or drug use, alcohol was the most common principal drug of concern for clients (42% of episodes).[3] Amphetamines were also common as a principal drug of concern, accounting for just under one-quarter (23%), followed by cannabis (11%), and heroin (10%).[3]

People seeking treatment for alcohol and other drug (AOD) issues are often disadvantaged in multiple ways, and this is reflected in higher additional health risks. For example, the 2018 Service Users Satisfaction Outcomes Survey (SUSOS), which surveys all recipients of AOD services in the ACT on a single day,[4] indicated that 76.9% are smokers, compared to an average (aged 15 and over) rate of 8.2% in the wider ACT population.[5]

In the latest survey, service users were asked about their change in smoking behaviour since entering or starting to use the specialist AOD service. Of those who responded to the question, 12.2% responded 'I have quit smoking completely', and 36.2% responded that they 'smoke less now'. Integrating nicotine dependence treatment into AOD treatment and support has been found to increase smoking cessation,[6] and improve AOD treatment outcomes for service users.[7,8]

Limiting health impacts of tobacco

The overall daily smoking rate in the ACT is 8.3% (aged 15 and over).[9] Using the latest available Australian Bureau of Statistics population figures[10] this equates to an estimated 28,900 people who still smoke in the ACT, as shown in Table 3.

*Table 3. Prevalence of smoking in ACT**

Entity	Daily smoking prevalence* (%)	Population (million)*	Estimated number of smokers (000)
Australia	11.2	20.92	2,343
ACT	8.3	0.35	28.9

*Daily smoking prevalence of people aged 15 and over, 2019 figures (AIHW)[9]; Population data for people aged 15 and over, 30 September 2020[10]

The annual health and social cost of tobacco in 2015-16 in Australia was estimated at $136.9 billion dollars. Given that at that time there were about 2,433,000 smokers in Australia,[9] this equates to **$56,268 dollars per annum** per smoker annually.

Multiple levels of government have implemented legislation and regulation programs for tobacco cessation targeting the general population. The *ACT Drug Strategy Action Plan 2018-2021* and the *Healthy Canberra ACT Preventive Health Plan 2020-2025* both include the commitment to 'Further develop approaches to reduce smoking rates among high-risk population groups in the ACT'. However, the plan to achieve this has not been articulated. People in lower socio-economic groups, people dependant on alcohol and other drugs, Aboriginal and Torres Strait Islander people, and people with mental illness are harmed in especially high numbers.[11-14]

About 13% of ACT's smokers attend an AOD service each year. Most want to quit, presenting a tremendous opportunity to reduce the ACT's overall smoking rate. Best practice in nicotine dependence treatment is for the provision of combined nicotine replace therapy (NRT)—or other prescription medications—complemented by advice and support, including more intensive psychosocial supports where appropriate. Specialist AOD services are providing best practice smoking cessation supports to service users where they can. However, they are often constrained by lack of funding for free NRT, which most service users cannot afford.

ATODA's 2021-2022 Budget submission[15] presents evaluation data on a small but successful program to help AOD service users quit smoking. Conservative modelling projects an additional 4.05 per 100 motivated smokers are likely to quit if supported by an expanded program, with a return on investment of over $2.6 for every $1 invested in the first year. The return on investment increases massively when people remain smoke free for multiple years, as many will.

Limiting health impacts of alcohol

Alcohol is one of the most heavily marketed products in the world,[16] and causes significant harm in the ACT. Forty-four per cent of presentations to treatment services in the ACT are for alcohol related problems.[4]

The 2018 SUSOS indicated that the overall level of client satisfaction with alcohol and other drug services was high, with 92.4% of survey respondents stating that they were overall 'mostly satisfied' or 'very satisfied' with the service that they had received. Similarly, 93% indicated that they would come back to this service if they needed help again. However, many people who need treatment cannot access it in a timely manner. The latest SUSOS[4] shows that for people who were accessing residential programs, 73.9% indicated that they had to wait to access the service. Of these, 45.4% waited between three weeks and two months, and 40.7% waited more than two months. The underlying challenge is under-funding for services as elaborated in our testimony and original written submission.

A further key factor reducing seeking of treatment is the stigma and discrimination that many people experience from the health services sector. The average national waiting time from the onset of drinking at problematic levels to seeking treatment for alcohol dependence is 18 years[17].

The National Alliance for Action on Alcohol (NAAA) has highlighted nine policy areas for state and territory governments to reduce a population's risk from alcohol harm: regulating physical availability, modifying the drinking environment, drink driving countermeasures, education and persuasion, treatment and early intervention, data management and research, transparent and independent policy, and restrictions on marketing.[18] The NAAA's 2018 Scorecard noted that the ACT has a Drug Strategy Action Plan 2018-2021 (the Plan), and a Drug and Alcohol Court, but its overall finding was that "(the Plan) ... does not address ways to reduce harm associated with the way alcohol is made available in the ACT", and the ACT ranked sixth out of eight jurisdictions.[18] There is real opportunity to reduce alcohol related harm in the ACT.

Other impacts of illicit drug use

As illicit drug use is not currently treated solely as a health issue, individuals are also often exposed to contact with the criminal justice system. Several submissions to the Inquiry have suggested that people caught in possession of small amounts of drugs are not charged or imprisoned in the ACT. A 2019 study provides the most up-to-date summary of the evidence on this matter of which we are aware.[19] Key facts included:

- '268 people were detected in the ACT with the principal offence of use or possess illicit drugs, in 2014-15' (the latest year included in the study). Principal offence means the most serious offence for which they were charged.
- For 79% of the ACT offenders this was their first (detected) offence.
- An average of 6 people per year were sentenced to imprisonment at the AMC for drug possession over the period 2010-11 to 2014-15.[19]

These figures suggest that the numbers of people sentenced to imprisonment for drug possession in the ACT are low, but it does happen. Each sentence has significant impacts on health, well-being and social status of the individuals concerned, and their families and friends.

Overall advice

ATODA strongly advocates for the Government to set clear and ambitious targets for alcohol, tobacco and other drugs (for instance, a smoking rate of 5% in five years) in its health services planning. This should include the Territory-wide Health Services Plan and Alcohol and Other Drug Services Plan. The targets should be accompanied by financial

investment at an appropriate level. As noted in ATODA's written submission to the Inquiry (pp. 22-24), the best estimate is that alcohol and other drug services need to at least double to meet current demand. At the same time greater investment in reducing harm from tobacco would deliver substantial financial returns, and there is scope to develop a coherent strategy to reduce harm from alcohol.

References for testimony given

In addition to ATODA's submission to the Inquiry and references contained therein, ATODA also referred to the following evidence in our oral testimony. The evidence is listed against the relevant question from the Panel and is attached separately.

Jonathan Davis: There seems to be agreement from most individuals and most organisations that have made written submissions to the committee that decriminalisation of small amounts of drugs for personal use would be a good thing. That seems to be the majority view. However, the submission presented from Drug Free Australia seems to be the clear outlier. Like your submission and like many others, it cites a whole range of facts. It puts me, and I am sure other members of the community, in a bit of a compromised position to try and deduce which are the authoritative facts. Can you explain the difference?

Our detailed testimony is recorded in the Hansard. We referred to a 2012 paper giving a balanced review of the evidence surrounding the Portuguese decriminalisation of illicit drugs. This is:

- (I) Hughes, CE & Stevens, A 2012, *'A resounding success or a disastrous failure: re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs'*, Drug Alcohol Rev, vol. 31, no. 1, pp. 101-13.

We also referred to reports by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) which provide data on illicit drug use rates in Portugal and in other European countries. The most recent of these is:

- (II) European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2021, *European Drug Report 2020: trends and developments*, Publications Office of the European Union, Luxembourg, https://www.emcdda.europa.eu/publications/edr/trends-developments/2021_en.

Chair: 'At yesterday's hearing in particular we heard from families who had very unfortunate personal stories. I would suggest—and I am happy to be corrected— that their view was not that, but that there just was not enough there to help them deal with their unfortunate situation'

Our testimony noted that the way AOD and mental health services are coordinated in delivery to people is really important. Some past attempts have been unhelpful. The best approach is to coordinate effective, autonomous AOD and mental health services rather than integrating them. This means that both areas should maintain their specialisations and enhance their capacities. Crucially, they should improve their coordination with each other. Crucially, this means treating the whole client, not just one aspect of them (AOD or mental health issues). We referred to an important study on the mental health and AOD systems by Professor Nicole Lee and Professor Steve Allsop, leading national experts on this topic, which reviews the latest evidence on treatment efficacy. This is:

- (III) Lee, N & Allsop, S 2020, *Exploring the place of alcohol and other drug services in a successful mental health system*, 360Edge, Melbourne, https://360edge.com.au/assets/uploads/2020/12/360Edge-NMHC-AOD-in-the-mental-health-sector-FINAL-REPORT-November-2020.pdf.

The option of mandatory treatment was also discussed by many of those who testified in relation to people experiencing significant AOD and mental health issues. The following publication is probably the most up-to-date and accessible source reviewing mandatory treatment options and their efficacy. It summarises the (limited) experience of mandatory treatment in Australia, as well as international experience.

- (IV) Vuong, T, Ritter, A, Hughes, C, Shanahan, M & Barrett, L 2019, *Mandatory alcohol and drug treatment: what is it and does it work?*, DPMP Bulletin Series no. 27, Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney, Sydney, https://ndarc.med.unsw.edu.au/resource/bulletin-no-27-mandatory-alcohol-and-drug-treatment-what-it-and-does-it-work.

The publication provides useful definitions of the key terms (p.2):

"Mandatory treatment compels someone to treatment through one of two mechanisms:

1. Involuntary treatment: where the individual has no choice or say in the matter
2. Coerced treatment (sometimes referred to as forced choice): where individuals can choose between a criminal justice sanction and a treatment program"

The ACT's Drug and Alcohol Sentencing List of the ACT Supreme Court is an example of a coerced treatment program.

Overall, the publication concludes (p. 6, fourth research finding) that "Coerced treatment models were found to be cost effective, involuntary treatment programs were not." It also notes (p. 3) that mandatory treatment programs raise "a number of ethical and motivational concerns including how much the state should impose on civil liberties and whether individuals need to both recognise their problem and want treatment for the treatment to be successful."

This reference is also relevant and useful:

- (V) Coleman, M, Ridley, K & Christmass, M 2021, 'Mandatory treatment for methamphetamine use in Australia', *Subst Abuse Treat Prev Policy*, vol. 16, no. 1, pp. 33, open access https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8033652/

Dr Paterson: One of the submitters this afternoon, I think, is going to talk about MDMA and potentially focus on that. I think it is the AFP Association. Even the submission before from the Law Society was talking about singling out methamphetamine. They would consider it an appropriate bill for all the other drugs, just not methamphetamine. You are alcohol, tobacco and other drugs. Yesterday afternoon one of the family members really highlighted how alcohol is as much a drug and alcohol is the main problem in emergency rooms. I am interested in why it is important that this bill captures all drugs, or drugs that we know and general street drugs, rather than singling out particular drugs.

Our response referred to advice from the relevant United Nations bodies to decriminalise all drugs and avoid punitive sanctions for personal drug use. Key references are:

- (VI) World Health Organization, 2017, *Joint United Nations statement on ending discrimination in health care e settings*, <https://www.who.int/news/item/27-06-2017-joint-united-nations-statement-on-ending-discrimination-in-health-care-settings

- (VII) International Narcotics Control Board. Report of the International Narcotics Control Board for 2019 (United Nations, Vienna, 2020).

References

Referred to during testimony:

I) Hughes, CE & Stevens, A 2012, *'A resounding success or a disastrous failure: re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs'*, Drug Alcohol Rev, vol. 31, no. 1, pp. 101-13.

II) European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2021, *European Drug Report 2020: trends and developments*, Publications Office of the European Union.

III) Lee, N & Allsop, S 2020, *Exploring the place of alcohol and other drug services in a successful mental health system*, 360Edge, Melbourne, https://360edge.com.au/assets/uploads/2020/12/360Edge-NMHC-AOD-in-the-mental-health-sector-FINAL-REPORT-November-2020.pdf

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VI) World Health Organization, 2017, *Joint United Nations statement on ending discrimination in health care e settings*, <https://www.who.int/news/item/27-06-2017-joint-united-nations-statement-on-ending-discrimination-in-health-care-settings

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In response to question taken on notice:

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2 Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. (AIHW, Canberra, 2019).

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5 Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2019. (AIHW, Canberra, 2020).

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13 Thurber, K. A. *et al.* Tobacco smoking and mortality among Aboriginal and Torres Strait Islander adults in Australia. *International Journal of Epidemiology* **dyaa274**, doi:10.1093/ije/dyaa274 (2021).
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16 Jernigan D. The extent of global alcohol marketing and its impact on youth. *Contemporary Drug Problems* **37**, 57–89 (2010).
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19 Hughes, C., Seear, K, Ritter, A & Mazerolle, L Criminal justice responses relating to personal use and possession of illicit drugs: the reach of Australian drug diversion programs and barriers and facilitators to expansion. *DPMP Monograph Series* **no. 27** (2019). < https://ndarc.med.unsw.edu.au/resource/27-criminal-justice-responses-relating-personal-use-and-possession-illicit-drugs-reach>.