LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE DRUGS OF DEPENDENCE (PERSONAL USE) AMENDMENT BILL 2021
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Submission Cover Sheet

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

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

committed to preventing tragedy that arises from illicit drug use

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SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY OF THE SELECT COMMITTEE ON THE DRUGS OF DEPENDENCE (PERSONAL USE) AMENDMENT BILL 2021 INTO THE DRUGS OF DEPENDENCE (PERSONAL USE) AMENDMENT BILL 2021

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1. Public health principles should apply

Families and Friends for Drug Law Reform urges the committee to base drug policy on public health principles and to withdraw the criminal law from interacting with people who use drugs. Public health based interventions are supported by the strongest evidence of effectiveness and are applied as best practice policy to some extent here and elsewhere in Australia and more extensively in a number of other countries.

1.1 CURRENT DRUG POLICIES HAVE FAILED IN THEIR OWN TERMS.

Perceived benefits of drug policy are illusory (§1.1 p.14). The aim was to reduce the supply of drugs and to deter people from using them. Years of data have shown that the opposite has occurred: drugs are readily available and there has been a steady increase in the number of people using them. (See paras. 25 -30 at pp.22-25; Terms of Reference: sub-para. b)).

If reduction in the supply of drugs is the main goal then treatment brings that about far more effectively than drug law enforcement (pp. 25–27; para. 31, p. 25).

In contrast, the consumption of alcohol and tobacco has declined under regulatory settings that fall well short of criminal law enforced prohibition. (See para. 160 at p. 76; Terms of Reference: sub-para. e)).

1.2 HARMS ARE THE FOCUS OF THIS SUBMISSION.

Illicit drug use is notoriously associated with many harms. Harms are therefore the focus of this submission. It suggests that a public health approach can reduce both those harms and the supply of illicit drugs. A public health policy approach therefore allows us to have all of the gains and none of the pain!

1.3 THE HARMFUL IMPACT OF DRUG USE IS OVERSTATED

For all the harms associated with drug use the vast majority of people try illicit drugs come to no harm. They may have taken a drug to experiment or push a boundary, didn't particularly like it and aren't going to do it again. In contrast their life chances could well be derailed if they were arrested and prosecuted. Moreover, people with a sufficient income stream are able to support their habit on a long-term basis while leading a stabilised and responsible life. So can people stabilised on addictive pharmacotherapies like methadone.

1.4 CURRENT POLICIES CAUSE HARM

Public policy should be calibrated to produce the least possible harm between extremes of unfettered commercialisation and the maximum restriction of prohibition

secured by the criminal law. The goal is to fashion public policy to achieve the "sweet spot" between the two extremes that produce maximum harm. Gambling and illicit drugs exemplify these extremes. (See Figure 1: Finding the sweet spot of minimum harm, p 18 & paras. 2ff at pp. 14ff; Terms of Reference: sub-para. a)).

2. Policies to reduce many harms of drug use have been shown to work.

Lots of measures like the needle, syringe program are known to reduce the harm associated with use of illicit drugs. In response to the HIV epidemic of blood borne disease, Australia led the world in introducing harm reduction measures like these (4.1, p.34). There is a strong evidence base underpinning these measures. In contrast there is little evidence that drug law enforcement that commands the lion's share of funding is effective. Indeed there is a lot of evidence that drug law enforcement actually stimulates illicit supply (§2.5 p.25).

2.1 BEST PRACTICE POLICY APPROACHES AND RESPONSES IN OTHER JURISDICTIONS

The substitution of an expiation notice system for arrest and prosecution would bring the ACT closer to the Portuguese system particularly if the ACT substitutes a system of referral of drug users to some form of help appropriate to them (§4.3, p.36). That would include treatment only if the person apprehended using was judged to have a substance dependency or some other health condition that would benefit from treatment. The referral service should be able to link users up with housing and other psychosomatic social services that they may need.. The SBS program screened on Tuesday 1 June did make the point that while drug problems in Portugal had abated as a result of decriminalisation, there still remained a group of disengaged drug users. Families and Friends urge the committee to embrace heroin assisted treatment which solves the supply problem by entrusting the medical profession with the dispensation of heroin to dependent drug users who had a history of dropping out of other services (§5.3.343 & §5.6 p.48). ToR: a). Alternatively the ACT should consider running a trial of hydromorphone (§5.3.4, p. 43).

3. Current harms are reducible by a public health focused drug policy

The submission selects a few harms that can be reduced by a public health focused drug policy. Unintentional drug induced deaths (§ 3.2 p. 30), suicide (section 3.3, p.31); crime (§ 5.6, p. 48), imprisonment (§5.7 p. 49), indigenous incarceration and disadvantage (§5.8, p. 51), child abuse and neglect (§5.9, p.55) and homelessness (§5.10, p. 61). The submission pays attention to the extent that current drug policy stigmatises and marginalises both drug users (§5.11 p.63) and their families (Figure 26: Stages of change towards successful coping, p.85), and disempowers them (§5.5 p.47). Assessments of Portuguese style decriminalisation and Swiss style heroin assisted treatment demonstrate the capacity of different drug policies to reduce these harms and stabilise lives (Figure 19: Improvements in the social situation of patients in the German trial of heroin assisted treatment, §5.10, p. 63).

3.1 CURRENT HARMS ARE REDUCIBLE BY A PUBLIC HEALTH FOCUSED DRUG POLICY

The criminal law must be removed from the life of drug users if stigma and disempowerment are to be neutralised. These are drivers of disadvantage and social exclusion (§7.3, p.85). They undermine the capacity of dependent drug users to take responsibility for themselves and those dependent upon them and degrades the capacity of families and carers to respond helpfully to the needs of their loved ones. Stigma even colours the approach of clinicians to their patients (Figure 20: Where injecting drug users experienced discrimination, p. 64 & 7.4.5 p. 90).

3.2 DISEMPOWERMENT OF DEPENDENT DRUG USERS UNDERMINING THE CAPACITY OF DEPENDENT DRUG USERS TO TAKE RESPONSIBILITY FOR THEMSELVES AND THOSE WHO ARE DEPENDENT ON THEM.

Drug dependency is associated with exclusion from the basic minimums of what one expects of a society including housing and employment and the wherewithal to participate fully in it. Disempowerment is most keenly played out in attitudes towards and deprivations experienced by drug using parents who like any other parents want to do the best for their child (§5.9 p. 55).

3.3 SUPPORT FOR FAMILIES

Families typically experience loss, grief, the sense of failure and self blame and isolation (§6.1, p. 66). They need support. The 2019 Household Survey estimates that there are 50,000 recent drug users in the ACT (§69 p.69). Family Drug Support receives annually some 460 calls from here. Many more calls might be expected were such a service more publicised. Directions has capacity to support just a handful of parents. Far more family support is clearly needed (§6.4 p.69).

4. The Personal Use Amendment Bill

Families and Friends welcome the distancing of the criminal law from drug users. Even so under the law as amended the criminal law would still lurk in the background as gatekeeper and ultimate guarantor of the drug notice. The Bill thus fails to follow where public health principles lead.

Families and Friends support the inclusion in the bill of the drugs listed including crystal methamphetamine. As in Portugal people apprehended with drugs should be referred to treatment or other appropriate services rather than be landed with a fine. See para. 6.6.7, p. 77; ToR: preamble.

Discretion to issue expiation notices should not be in the hands of police. (See §6.6.9 , p. 78; ToR: preamble

The offence of drug use should be eliminated. (6.6.8, p.78 ToR: preamble.

5. Drug policy and mental health are intertwined

Drug dependency feeds off poor mental health and mental health off drug dependency (ToR b)). Both conditions share common risk factors (§7.2 p. 83), often but not always from the most disadvantaged (Figure 27 p. 86 & Figure 28 p.87). Recovery from both is impeded by stigma and requires psychosocial factors to be addressed in coordination with clinical interventions (§7.1 p.80). Little will improve until the dysfunctional attitudinal barriers between the psychosocial outlook of the drug and alcohol sector and the clinical approach of the mental health sector is sorted out in the interests of patients and their long suffering carers.

5.1 Changes required of Drug policy and mental health

ACT mental health services should be able to address the substance use needs of clients and provision should be made for drug and alcohol services to draw upon mental health services and for consumers in the drug and alcohol sector to access mental health services. There should be seamless referral from the mental health to drug and alcohol services and vice versa. A number of specific recommendations are included in the submission including the following more significant ones:

- To help fill the large gap in support services for family members at the end of their tether, the Family Drug Support should be sponsored to operate in the ACT its full suite of services (including support meetings and courses) (§6.4.2, p. 69.
- Low threshold services such as a medically supervised consumption room have the ability to engage people with co-occurring substance dependency and other mental health conditions. The experience of the Sydney Medically Supervised Injecting Centre demonstrates the attractiveness of the service there to engage this hard to reach population (§7.4.1, p.88, ToR e)i)).
- A mental health clinician should be employed at the proposed supervised drug consumption site (§7.4.2, p.90; ToR d)).
- Explore the feasibility of replicating in the ACT the NSW Involuntary Drug and Alcohol Treatment Program (IDAT) to expose treatment resistant dependent drug users to the feasibility of treatment and provide some respite for desperate, overwrought parents. Such a program would supplement but not replace civil commitment under the *Mental Health Act*. (§7.4.7, p. 91).

6. The financial burden of existing drug policy.

Existing drug policy imposes enormous financial burdens on the ACT community. If one looks to a share of the national costs of serious and organised crime in the proportion that the ACT National State product bears to the Gross Domestic Product (2.1%), then the ACT is shouldering $537.6 million (§Dimension of the drug trade and its costs8.1, p.94).

It is not too much to say that in adopting drug policy based on public health principles the ACT would be at the cutting-edge of fighting serious and organised crime.

Crime commissions have been saying for years that only by adopting a whole of government approach is it possible to tackle the drug problem.

Other countries have shown the financial advantages of public health focused response. Switzerland conducted a cost benefit analysis that came out firmly on the side of heroin assisted treatment (§5.6, p. 48) and Portugal has persevered since 2001 with its policy of decriminalisation through succession of governments of different political persuasions and surviving a very, very severe financial recession after the GFC.

A public health focused drug policy will make the social service dollar go further. Many existing clients with complex needs will be stabilised with the result that the cost to homelessness (§5.10, p..61) child protection services (§5.9, p.55) will be reduced.

The financial case for the reform of drug policy is compelling. The rapidity with which benefits materialise only adds to the reasons for following this course. Switzerland through a cost-benefit analysis (§8.2.2 p.98) has shown that the social as well as financial benefits can accrue very quickly and certainly within the course of an electoral cycle (ToR c)). Reduced involvement in crime (§5.6, p.48) by those stabilised on heroin assisted treatment accrued within six months of entering the treatment period.

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1. The beginning

1. Families and Friends embraces the opportunity to appear before you. Never have there been such broad terms of reference that authorise a Legislative Assembly committee to probe the settings and assumptions that underpin drug policy. Your mandate is to consider "Best practice policy approaches and responses undertaken in other jurisdictions" (ToR (a)); identify "current strengths and weaknesses in the sector" (ToR (e)(i)); "recommending services" (ToR (e) (iii) Families and Friends arose in 1995 like a phoenix from a crucible of loss and grief. That year 11 overdose deaths had occurred in the first few months before Easter. The group of distraught parents and siblings who gathered at a public meeting questioned the fundamentals of drug prohibition that had so cruelly failed to protect their families. Mothers, fathers and sisters had seen their child or sibling scared out of their wits by police and barred by the police from comforting them. The law that was said to shield and protect these young people was frightening them away from help and support only to die in lonely isolation. The police were only doing their duty so fault lay with the laws and policies that they were enforcing. Families and Friends perceived that there was a grave injustice at the heart of the body politic. The group has never ceased from arguing this case. The more it's members have learnt of the history of drug laws, of the insidious influence that drug laws have wreaked in every nook and cranny of society and the success of different approaches taken by other countries, the firmer has become its resolve to break down the barriers of shame and fear that have rendered drug policy immune from rational and humane questioning by legislatures. We therefore approach this enquiry with immense hope that it will lead to the end of grave injustices suffered by our members. It gives us particular hope that it takes place with the agreement of all three parties that endorsed the Assembly's motion adopted before the last election on 20 August. Let open-minded questioning begin.

1.1 Illusory foundations of current Illicit drug policy.

2. Throughout its existence Families and Friends have made innumerable representations to persuade decision-makers to free themselves from the straitjacket of wishful thinking and fear of political consequences. It has canvassed every aspect of this fraught area of public policy. This is borne witness to by the 39 submissions

on its website to enquiries at ACT, Commonwealth and State inquiries. (There were probably more.) They were all ignored but never rebutted. The quantity of this writing would fill several volumes. The one we present to you now is thus at least the 40th. We offer it in the confidence that its reception will be different. Please do not disappoint us.

3. As pointed out later, the harms directly attributable to illicit drug use can be overestimated. The vast majority of people who try an illicit drug come to no harm whatsoever (see para. 49 below). No society in the world is drug-free. The minority who do come to harm often if not generally do so through intervention of the law that throws their life out of kilter thereby compounding their drug problem. To this group Families and Friends urges the committee to take the understanding approach of 2019 Senior Australian of the Year, Dr Sue Packer, formerly the Paediatrician to the ACT Child at Risk Assessment Unit. She stated that:

> "the whole of our community [needs] to accept that drug use is an expression of human vulnerability and to recognise that we all have a responsibility towards the most vulnerable in our community. These include both drug users and their children. It is this reasoning which will enable some of these troubled people to escape from the dominance of drugs in their lives. These children must be nurtured and kept safe, but this will not be achieved if actions are determined by value judgements."[1]

4. First let us summarise the illusions that underpin existing drug policy:

1.2 IT FOSTERS THE ILLUSION THAT FAMILIES AND THE COMMUNITY ARE PROTECTED FROM ACCESS TO DRUGS.

3. On the contrary it elevates the danger of illicit drugs, will delegates their distribution to organised crime and underpins the profitability of the black-market trade.[2] Seizures have rarely if ever been big enough for a sufficiently protracted period to put traffickers out of business. The direct marketing of drugs at the retail level is very difficult for police to do anything more than displace.[3] Existing drug policy serves as a form of retail price maintenance.

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1. Footnote 65 above

2. "Serious and organised criminals are involved in a range of criminal activities and services, for example illicit drug activity, organised fraud, and crimes against the person such as human trafficking. Serious and organised criminal activity is supported and concealed through enablers such as money laundering, violence and corruption." Australian Crime Commission, *The Costs of Serious and Organised Crime in Australia 2013-14* (Australian Crime Commission, 2015) at https://crimecommission.gov.au/sites/default/files/CoSOCA%202015.pdf visited 17/12/2015.

3 FFDLR, 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 (12 April 2019) pp. 13-15 at

1.3 IT FOSTERS THE BELIEF THAT IT PROTECTS PEOPLE WHO USE DRUGS

5. The pretended beneficiaries have been typically young people but more recently older people in search of relief from chronic pain and psychosocial distress have become enmeshed in a web of deceit.

In fact it punishes and adds insupportable stress to the life of the very people it professes to protect.

1.4 IT PRETENDS TO BE FOUNDED ON A STRONG EVIDENCE BASE OF EFFECTIVENESS.

6. In fact, the efficacy of prohibition was never assessed before it was introduced. It was assumed to solve a problem that did not exist and which it created.

7. A sustained seizure rate of over 60% [and possibly as high as 80%] is required to put a successful trafficker out of business . . . Sustained successful interventions on this scale have never been achieved.[4]

8. The evidence base for drug law enforcement is weak or non-existent. In contrast the evidence base of measures of harm reduction is strong. They are founded on robust public health principles - principles that have demonstrated their worth in the response of our governments to the current Covid-19 pandemic.

1.5 IT PROFESSES PROMOTION OF THE COMMON GOOD AND COMMUNITY WELL-BEING.

9. Instead it divides and fractures families and community and intensifies inequality and disadvantage – all potent risk factors for the abuse of drugs (see below p. 87, Figure 28: Drug use is more prevalent in countries with highest levels of inequality).

10. Counter intuitively drug law enforcement promotes “the large financial profits and wealth [that enables] transnational criminal organizations to penetrate, contaminate and corrupt the structures of government, legitimate commercial and financial business, and society at all its levels.”[5]

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https://www.pc.gov.au/__data/assets/pdf_file/0014/241070/sub413-mental-health.pdf visited 03/06/2020.

4. United Kingdom, Strategy Unit, SU Drugs Project: Phase 1 Report: Understanding the Issues (13 June 2003) p.73 at http://image.guardian.co.uk/sys-files/Guardian/documents/2005/07/05/Report.pdf visited 05/07/05.

5. United Nations Convention against illicit traffic in narcotic drugs and psychotropic substances, Vienna, 20 December 1988, preamble.
‘There is every indication that the reach of organised crime is growing. No field where large sums of money can potentially be made escapes its gaze.(National Crime Authority, NCA Commentary 2001 (August 2001)) p. 13 in NCA Commentary 2001.pdf at http://www.nca.gov.au/html/index.html visited 19/12/01.

11. In fact prohibition bolsters the antisocial forces that are able to deploy the colossal wealth of the drug trade to corrupt and corrode the foundations of good government and of democracy itself.[6]

12. In fact the colossal wealth placed in criminal hands is more than sufficient to corrupt Australian democratic institutions,[7] make for failed states and threaten Australia's security interests.

1.6 ILLICIT DRUG POLICY INTENSIFIES MOST OF AUSTRALIA'S INTRACTABLE, CHRONIC AND MOST COSTLY SOCIAL PROBLEMS.

13. Illicit drugs are often blamed for a host of social problems like homelessness, domestic violence, premature death, blood-borne diseases, mental health problems, school dropout, unemployment, welfare dependency, crime and child abuse and neglect.

14. Existing Australian punitive strategies serve to accentuate risk factors for those social problems and disempower dependent drug users.

In fact these problems are far less acute in countries that adopt less punitive approaches and deploy treatments unavailable in Australia.

1.7 AIM FOR THE SWEET SPOT

15. The Holy Grail of public policy is to frame policy to promote "the sweet spot" which has two elements:

- minimisation if not elimination of the activity judged to be undesirable and which is the principal focus for its adoption; and in doing so;
- not cause other harm in achieving that objective – the do no harm principle of the medical profession.

16. At two extremes you might opt for a public policy setting that maximises the degree of restriction on an activity and, at the other, to maximise freedom of choice. In law the latter is the default. Something that is not prohibited is permitted under the law. Making an activity a crime and thus subjecting those who engage in it to the coercive powers of the state in application of the criminal law is the most extreme

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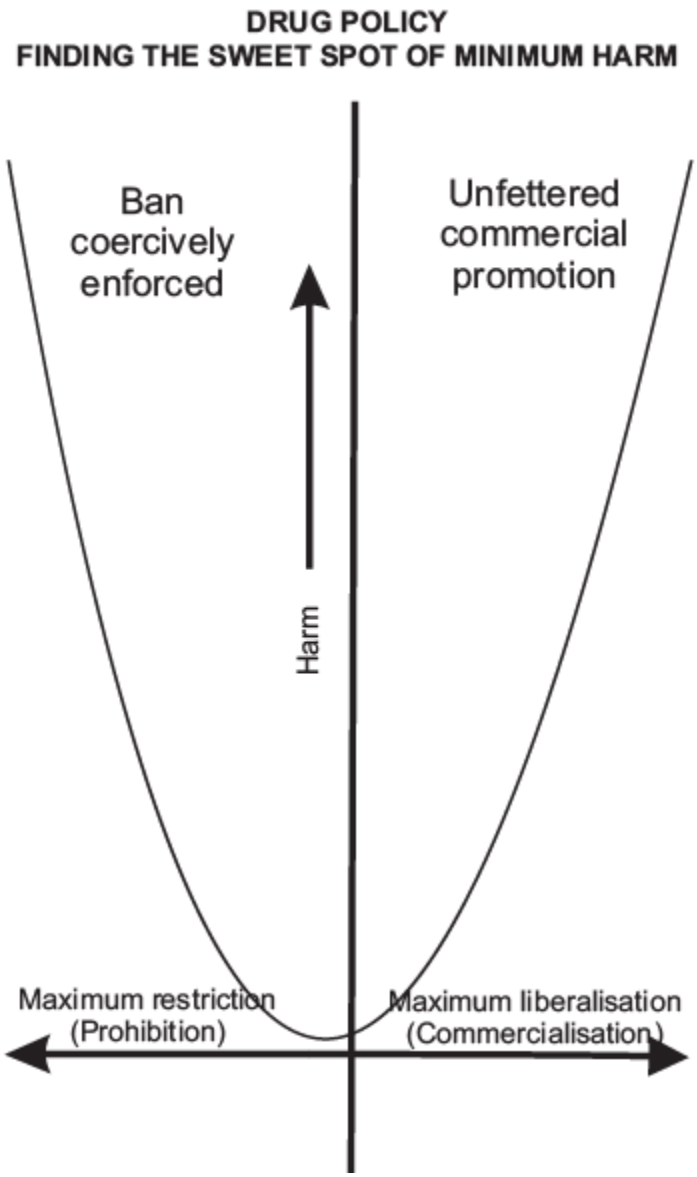
6. The reach of organised crime in Australia is pervasive, multi-faceted and carries enormous social and economic costs. Significantly, the cost is not just in direct monetary terms but in terms of lost productivity, health, violence and well being. It affects every aspect of our lives from the deaths of addicts on the streets, to the lost revenue of billions of undeclared dollars; from the overtaxing of our court and law enforcement resources, to the manipulation of markets and the creation of not merely unfair, but unlawful and unscrupulous competition; from the trauma caused by armed hold-ups and home invasions to the price we pay to insure our property (NCA Commentary 2001 fn 5 above, p. 13).

7. Australian Crime Commission, *The Costs of Serious and Organised Crime in Australia 2013-14* (Australian Crime Commission, 2015) at https://crimecommission.gov.au/sites/default/files/CoSOCA%202015.pdf visited 17/12/2015

indication of disapprobation of the targeted activity. On the other hand elimination of any restrictions at all thus leaves the citizen and corporations with complete liberty to promote the activity. If indulgence in the activity itself is judged undesirable and meriting disapprobation options short of outright prohibition are available. Your task as politicians is to recommend a sweet point where the harms of both regulatory overreach (prohibition) and of the undesirable activity are minimised. Your task is to locate a point between two extremes: namely between outright prohibition enforced by the criminal law and unfettered commercial promotion on the other.

Figure 1: Finding the sweet spot of minimum harm



2. How different Addictive activities are regulated

17. This submission urges you to identify the "sweet spot" for illicit drugs – substances that are addictive. It is well to pay passing attention to how other addictive activities are regulated.

2.1 GAMBLING

18. The foregoing graphic makes clear that if you wish to discourage an activity you do have options. Just consider the different ways other addictive activities are dealt with: gambling, tobacco, alcohol. When I studied law in Victoria, it was not an offence to enter a betting or wagering contract. The option Parliament took to discourage gambling was to render the contract void. In other words gambling was discouraged by recourse to the civil law which undermined the capacity of businesses to profit from gambling because they could never enforce gambling debts. Running a casino or poker machines could never be a viable business if gambling contracts were null and void. It was a change to the civil law that overturned all that. Were the same approach to be applied to currently illicit drugs, the operation of wholesale drug market currently in the hands of big time criminals would become legitimate business ventures promotable by all the powers of advertising that we see on billboards as we drive to Canberra and which pester us on electronic media and the Internet.

19. The commercialisation of gambling as a legitimate business has seen it grow enormously. In 2018 the total turnover from gaming machines in New South Wales amounted to $83.2 billion.[8] Governments have become co-dependent on gambling revenue." Except for slight reduction when the ex-GST was introduced, State revenue from gambling has risen rapidly.[9] Altogether this is an unhealthy situation for an addictive activity which Families and Friends do not wish to see replicated for drugs.

2.2 TOBACCO

20. Next look at tobacco. King James disapproved of it and imposed a high import tax to discourage its use. That technique in the form of ever increasing taxes have been revived to discourage a habit that research in the last half-century has shown to impose a far greater burden of disease on the community than all illicit drugs combined. A raft of government policies including increased taxes, restrictions on smoking in public or in cars, prohibition on advertising and plain packaging has seen a big reduction in the prevalence of tobacco use. This decline is evidenced by several metrics:

- the rate of current smoking comprising daily and occasional smoking has declined by 50% between 1988 – 89 and 2019;
- between 2001 and 2019 daily male smoking rate has declined by 37%;

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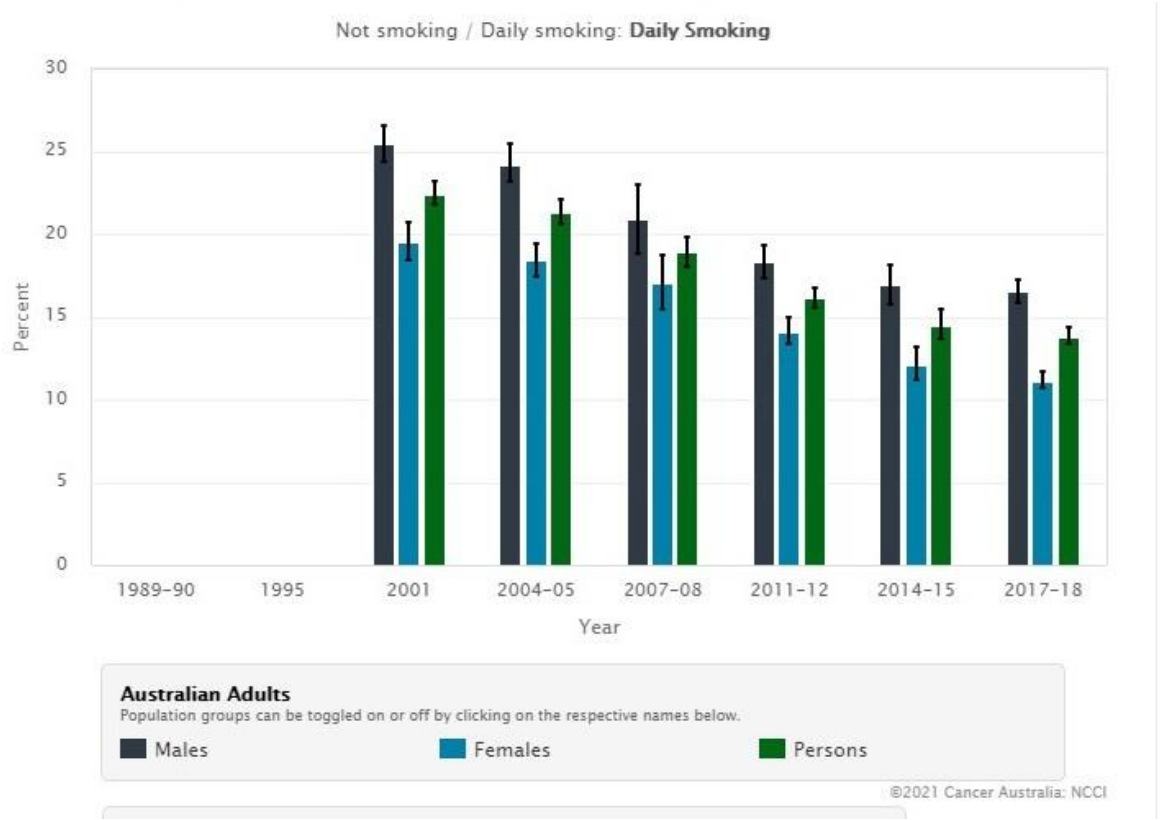
8. Total gaming turnover New South Wales, Australia FY 2018, by type Published by Thomas Hinton, Feb 8, 2021 at https://www.statista.com/statistics/940699/australia-gambling-turnover-new-south-wales-by-type/ visited 27/05/2021.

9 Productivity Commission, Gambling revenue technical paper 10 (20050 at https://www.pc.gov.au/inquiries/completed/ageing/technicalpapers/technicalpaper10.pdf visited 27/05/2021.

- The proportion of teenagers (aged 14–19) smoking has fallen by about 80% since 2001; [10] and
- The age at which people first smoked a full cigarette has been increasing over time.[11]

21. The example of regulation of tobacco shows that there are a raft of effective techniques adaptable to the discouragement of drug use. The bottom line is that it is possible to bring about big reductions in consumption of an illicit substance by measures short of prohibition. All the while tobacco has been legal even in the hands of children. (It is an offence to supply children with tobacco not for them to possess it.)

Figure 2: Proportion of Australian adults smoking daily, by year



SOURCE: Cancer Australia, National Cancer Control indicators.

2.3 ALCOHOL

22. The criminal law plays a large part in the regulation of alcohol but, only in very limited circumstances. Except in public, the possession of alcohol has never been made an offence even in the hands of people under 18. Young people are ring fenced by the criminal law with heavy penalties applicable to those who supply

10. Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2019 (July 2020) p. 9 at https://www.aihw.gov.au/getmedia/3564474e-f7ad-461c-b918-7f8de03d1294/aihw-phe-270-NDSHS-2019.pdf.aspx?inline=true

11. The same, p. 7.

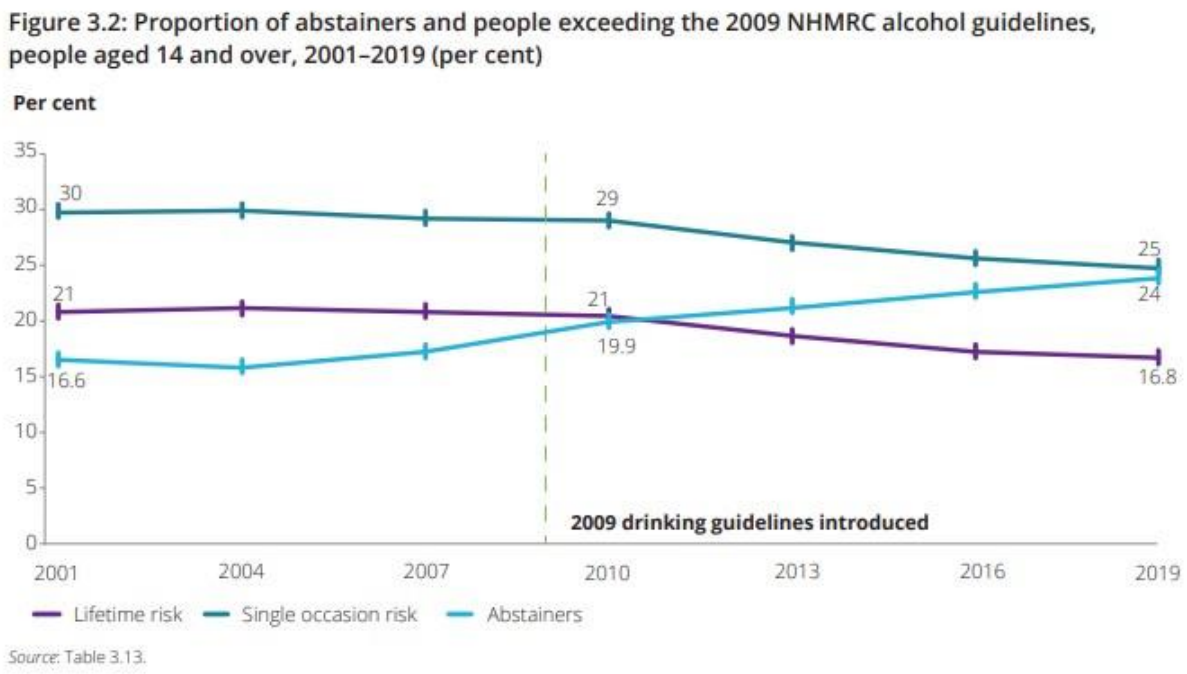
alcohol to them but, except in public places, the young person does not commit an offence by the possession of it.

23. In the words of the Alcohol and Drug Foundation:

> "There is strong international and Australian evidence linking the availability of alcohol with levels of alcohol consumption, and associated harms from alcohol. The 'availability of alcohol' refers to the density of bottle shops and drinking venues, and their trading hours, in a local area.
>
> Regulating the availability of alcohol through mechanisms like harm minimisation-focused liquor licensing can help reduce harms from alcohol."

24. By the Liquor Act 2010 the dispensing of alcohol is surrounded by a licensing buttressed by severe penalties (ss. 12 & 13). It is an offence by a child or young person to consume or possess alcohol in public places but not otherwise (ss.205 & 206). The law attempts to ring fence children and young people by imposing very severe penalties for the supply of alcohol to them (s.111). It is even an offence for a parent or guardian to supply a young person with alcohol on private premises unless the parent or guardian supervises the young person responsibly as described in the act (s. 204A(5)). "Harm minimisation and community safety principles" are embedded in the Act and its administration (s. 207). Decision-makers are bound to follow them (s. 10). The rate of risky drinking has declined 25% between 2001 and 2019 while the proportion of young people who abstain from alcohol has increased by 45%.

Figure 3: Proportion of abstainers and people exceeding the 2009 NHMRC alcohol guidelines, people aged 14 and over, 2001–2019 (per cent)



SOURCE: Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2019,* Illicit use of drugs chapter (July 2020) figure 3.2, p. 9; at https://www.aihw.gov.au/getmedia/54f66117-e846-4de0-a874-

e5f5eee57214/aihw-phe-270-4-Illicit-use-of-drugs-tables.xlsx.aspx visited 17/07/2020

2.4 ILLICIT DRUGS

25. The declining rate of consumption of tobacco and alcohol stands in contrast to the lack of success in reducing the prevalence of use of illicit drugs. As Figure 5 illustrates between 2001 and 2019 recent use nationally of any illicit drug increased by 23% percent. In the ACT the increase was smaller at 9%. Wastewater analysis that now covers 56% of the Australian population makes it possible to estimate accurately drug usage at a population level. Up to 2020, wastewater analysis confirms the rise[12] in illicit drug use (see below at Figure 6: Comparison of weight of illicit drug detections in 2017-18 and 2018-19). Unusually, the samples taken in August 2020 reveal decreases. It is speculated that these are attributed to Covid 19.[13]

26. A particularly happy concomitant of a decrease detected in the earlier 2019 household survey has been the marked decline in use of illicit drugs by young people.[14]

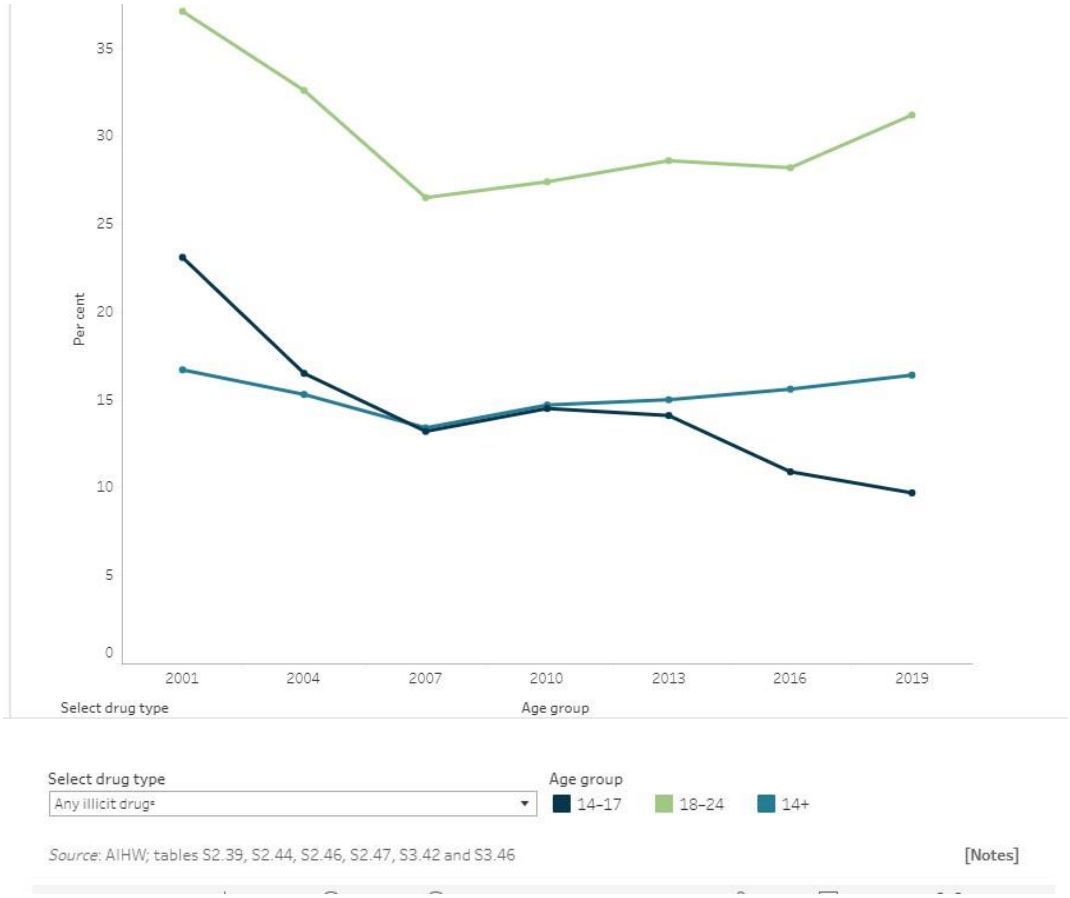
> "There has been a reduction in the proportion of young adults aged 18 – 24 who have recently used any illicit drug (from 37% in 2001 to 31% in 2019)." AIHW).

12. Australian Criminal Intelligence Commission, National Wastewater Drug Monitoring Program, report 10, 30 June 2020 https://www.acic.gov.au/sites/default/files/2020/03/nwdmp-r9-060220_ec_v8_small.pdf?v=1583758864 visited 25/05/2020.

13. Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program report 12,* 2021 p. 11 at https://www.acic.gov.au/sites/default/files/2021-02/National%20Wastewater%20Drug%20Monitoring%20Program%20Report%2012.PDF at 19/05/2021.

14. Australian Institute of Health and Welfare, Alcohol, tobacco & other drugs in Australia, Younger people, web report, last updated: 16 Apr 2021 at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/younger-people visited 19/05/2021.

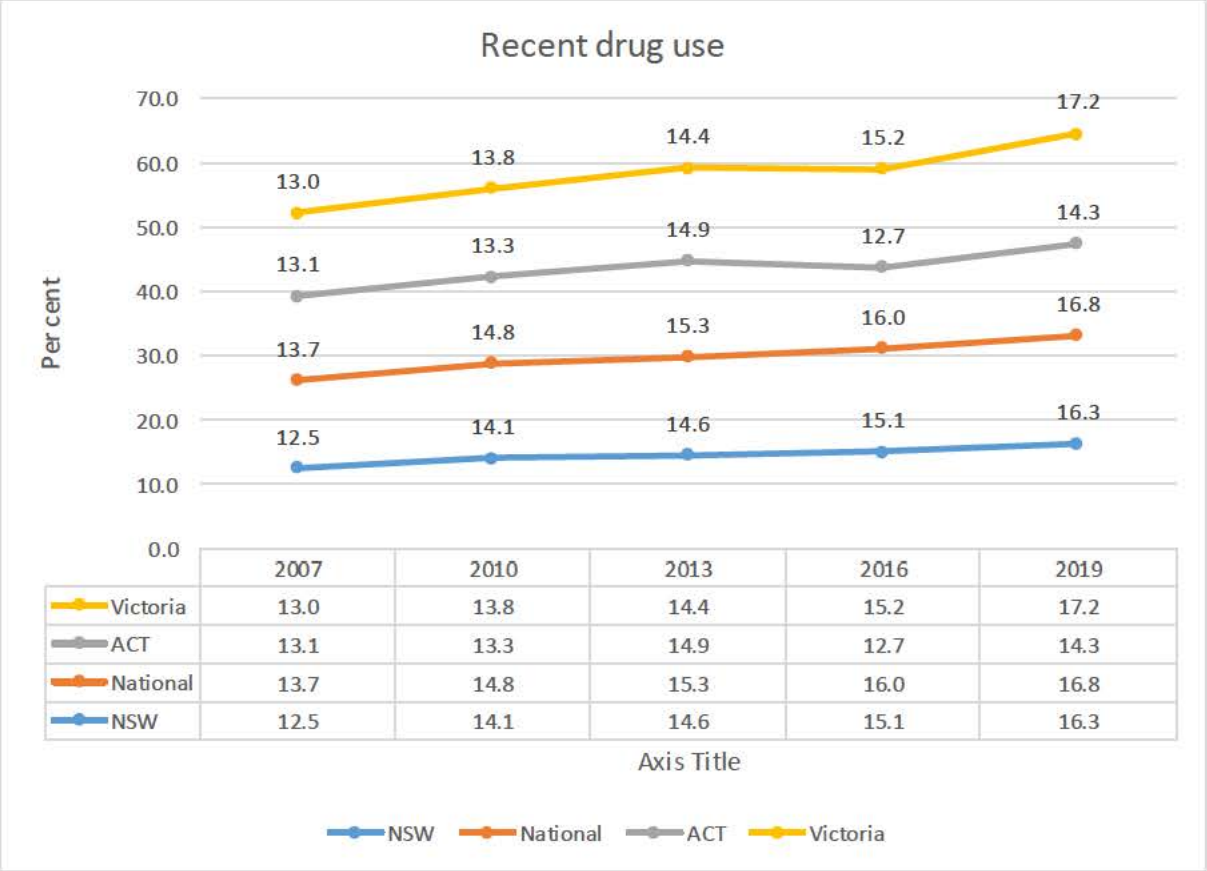
Figure 4: Proportion of people in younger age groups with recent use of any illicit drug, 2001 to 2019 (per cent)



SOURCE: Australian Institute of Health and Welfare, Alcohol, tobacco & other drugs in Australia, *Younger people, web report,* last updated: 16 Apr 2021 at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/younger-people visited 19/05/2021.

27. It would be presumptuous to attribute the declines in the rate of alcohol and tobacco use and the increase in illicit drug use entirely to the policy settings because social and cultural factors as well as the regulatory regime play a part. What one can say, though, is that reductions in engagement in undesirable activities are achievable by regimes that do not criminalise those who engage in those activities (the consumers). After reviewing the different burdens of disease associated with smoking, alcohol and illicit drug use this submission goes on to review evidence showing that the prohibitionist approach founded on the criminal law actually promotes the undesirable activity that it aims to suppress.

Figure 5: Summary of recent drug use (in the previous 12 months) of people aged 14 and over, 2007 to 2019 (age standardised per cent)



SOURCE: AIHW, Alcohol, tobacco and other drug use in Australia 2021, Interactive data Supplementary data tables (AIHW, Canberra, December 2020) tables S.7

28. The 2019 survey returned 50,000 recent drug users in the ACT[15], The latest illicit drug data for 2018 – 19 released last September illustrates the thriving state of the Australian drug market in terms of the increase in weight of drugs seized:

Figure 6: Comparison of weight of illicit drug detections in 2017-18 and 2018-19

Weight of illicit drug detections—comparison between 2017–18 and 2018–19

Amphetamine-type stimulants (ATS)		Cannabis	Heroin	Cocaine
ATS (excluding MDMA)	MDMA			
↑ 74%	↑ 50%	↑ 212%	↑ 49%	↑ 13%
2,952kg → 5,148kg	1,420kg → 2,124kg	580kg → 1,811kg	190kg → 283kg	926kg → 1,049kg

15. Table S.24: Recent illicit use of any drug(a), people aged 14 and over, by state/territory, 2001 to 2019 (persons), AIHW, National Drug Strategy Household Survey 2019, State and territory factsheets, Supplementary data tables, July 2020 at https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data?page=2 visited 22/06/2021.

SOURCE: Illicit drug data report 2018–19 (2020) p. 10.

29. The same report adds that.

> "The number of Amphetamine-type stimulants, heroin cocaine and other and unknown drug seizures increased this reporting period, with a record of 5,096 cocaine seizures in 2017-18 further increasing in 2018-19 to a record 5,378 seizures, and the 2,080 heroin seizures this reporting period was the second highest number reported in the last decade.
>
> The number of national illicit drug seizures increased 77% over the last decade, from 63,670 in 2009-10 to 112,474 in 2018–19."[16]

30. Just as a record number of fish caught shows the fish stock to be in healthy condition or hoards of mice caught shows that we are in the midst of a mouse plague, so a record number of drug seizures is an indicator of the health of the illicit drug market.

2.5 ENGAGEMENT IN TREATMENT IS THE KEY TO REDUCING SUPPLY

31. It is obvious, when one reflects on it, why the illicit drug market is so resistant to law enforcement effort.

- at all levels, the transactions are between willing participants. There is, in other words, no victim in the conventional sense of say an assault or a property crime so there is no one involved who has an interest in reporting drug offences;
- in order to raise the funds required to support their habit, users often resort to selling drugs to their peers. This is often regarded as a more honourable course of action than scamming from friends and family and engaging in petty property crime;
- this peer-to-peer pyramidal retail organisation applies the direct selling strategy that is behind the commercial success of international corporations like all;
- the wealth at the command of serious and organised crime allows them to buy influence that effectively hides their tracks (§8.1, p. 94 and enables them to engage an endless supply of footsoldiers to do the exposed risky dealings. Indeed, organised crime that controls the trade arrange their affairs to be beyond the jurisdictional reach of law enforcement agencies;
- it is the retail dealers and their customers who are the most vulnerable to law enforcement. They are the easily replaceable cannon fodder of the whole system.

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16. Australian Criminal Intelligence Commission, *Illicit drug data report 2018–19*, (Australian Criminal Intelligence Commission, Canberra City, September 2020) p. 11 at https://www.acic.gov.au/sites/default/files/2020-09/illicit_drug_data_report_2018-19_internals_v10_full.pdf visited 13/10/2020

- drugs that happen to be seized become merely a cost of doing business. Rarely if ever are seizures sufficiently large over a sufficiently long period to put organised crime groups out of business.

Figure 7: Drugs seizures as a proportion of the estimate of Australian consumption

Comparison of the weight of methylamphetamine, MDMA, heroin and cocaine seized nationally in 2018–19 and estimated consumption

Drug	Estimated consumption[a] (kilograms per annum)	2018–19 national seizures (gross kilograms)	Percentage of total estimated consumption seized (%)
Methylamphetamine	11,516	4,418[b]	38
MDMA	2,226	1,560	70
Heroin	941	197	21
Cocaine	4,636	1,638	35

a. Consumption estimates are based on data derived from Year 3 of the National Wastewater Drug Monitoring Program.
b. At this time it is not possible at a national level to provide a further breakdown of drugs within the amphetamines category. As such national seizure figures reflect the weight of amphetamines seized. Amphetamines include amphetamine, methylamphetamine, dexamphetamine and amphetamine not elsewhere classified. Based on available data, methylamphetamine accounts for the majority of amphetamines seized.

SOURCE: Illicit drug data report 2018–19 (2020) p. 12.

32. If the reduction and elimination of the illicit supply of drugs is the key objective then engaging dependent drug users in treatment is the way to go. This is borne out by the following four studies.

2.5.1 Treatment 7.3 times less costly than domestic law enforcement in reducing cocaine consumption

33. A classic 1994 Californian study on the control of cocaine undertaken by the Drug Policy Research Center of RAND 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."17

2.5.2 Methadone reduces opioid use

34. Controlled trials of comprehensive methadone maintenance and comparative observational studies have all shown that this treatment is more effective than either

17. C. Peter Rydell and Susan S. Everingham, Controlling cocaine: supply versus demand programs prepared for the Office of National Drug Control Policy, United States Army (RAND, Drug Policy Research Center, Santa Monica, 1994) pp. xv-xvi.

placebo or no treatment in retaining people in treatment and in reducing opioid use. Larger comparative observational studies have confirmed this.[18]

2.5.3 Heroin assisted treatment in Zurich brought about an 82% reduction in recruitment of new heroin users

35. 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%.[19] The flow on effect of this reduction is 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%."[20]

2.5.4 Conclusion of Cochrane review of 13 studies comparing heroin assisted treatment with methadone shows superiority of HAT in retaining users in treatment.

36. A majority of eight randomised studies involving 2007 adult patients measured the reduction in illicit drug use "Each study found a superior reduction in illicit drug use in the heroin arm [the group on the trial that received heroin] rather than in the methadone arm. This reduction is measured in different ways and the measures of effect obtained are consistently statistically significant."[21]

3. Health harms directly associated with addictive activities

37. Many of the harms associated with illicit drug use are undoubtedly attributable to their consumption. For example, the World Health Organisations ICD 11 describes opioid dependency as marked by ". . . a strong internal drive to use opioids, which

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18. 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) pp. 20-21 & 39.

19. 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 Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen* (Verlag Hans Huber, Bern etc, 2005) p. 196 and A. Uchtenhagen, A. Dobler-Mikola, T. Steffen, F. Gutzwiller, R. Blättler & S. Pfeifer, *Prescription of narcotics for heroin addicts:* main results of the Swiss national Cohort Study (Karger, Basel, Freiburg, Paris &c, 1999) pp. 64-69 being vol. 1 of A. Uchtenhagen, F. Gutzwiller, A. Dobler-Mikola, T. Steffen, M. Rihs-Middel, *Medical prescription of Narcotics for Heroin Addicts* 2 vols. (Karger, Basel, Freiburg, Paris &c, 1999).

20. 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).

21. 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. At https://pubmed.ncbi.nlm.nih.gov/20687073/ visited 06/08/2020. p. 9.

is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences" and the likely development of tolerance.[22]

38. Illness and death is directly associated with the use of drugs and legal substances but those deaths and diseases are supplemented by others mediated through risk factors of disadvantage. As discussed in section 4, pp. 34ff much of both direct and indirectly associated death and disease is avoidable by different approaches to the regulation of the substances concerned.

3.1 BURDEN OF DISEASE

39. The burden of disease associated with "tobacco, alcohol and illicit drug use were jointly responsible for 16% of the total burden of disease and injuries in 2015".[23] This burden is reason enough to adjust policy settings to do what is possible to reduce it. The Australian Institute of Health and Welfare explains that "The health impact comprises both fatal burden (dying prematurely) and non-fatal burden (living with disease)". It quantifies relative burdens attributable to different causes using a summary measure of health called disability-adjusted life years, or DALY."[24]

40. Of illicit drugs, alcohol and tobacco, tobacco comes out on top as imposing the heaviest health burden. In the words of the Australian Burden of Disease Study 2015:

> Tobacco use contributes to health burden more than any other risk factor and was responsible for 9.3% of the total burden of disease in Australia in 2015.[25]

- Most of that burden is fatal. Tobacco use contributed to 41% of all respiratory burden, 22% of all cancer burden and 12% of the cardiovascular burden.

41. The burden of disease imposed by alcohol also exceeds that of illicit drugs:

- In 2019-20, alcohol was "the number one drug for which Australians seek help".[26]
- In 2015, alcohol was the sixth highest risk factor contributing to the burden of disease in Australia (4.5% of total burden) (AIHW).

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22. World Health Organization, *International Classification of Diseases 11th Revision: ICD 11 6C43.2 Opioid dependence* at https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1120716949 visited 20/05/2021.

23. AIHW 2019. *Burden of tobacco use in Australia: Australian Burden of Disease Study 2015. Australian Burden of Disease series no. 21*. Cat. no. BOD 20 (AIHW, Canberra, 2019) p. 45 at https://www.aihw.gov.au/getmedia/953dcb20-b369-4c6b-b20f-526bdead14cb/aihw-bod-20.pdf.aspx?inline=true visited 14/05/2021

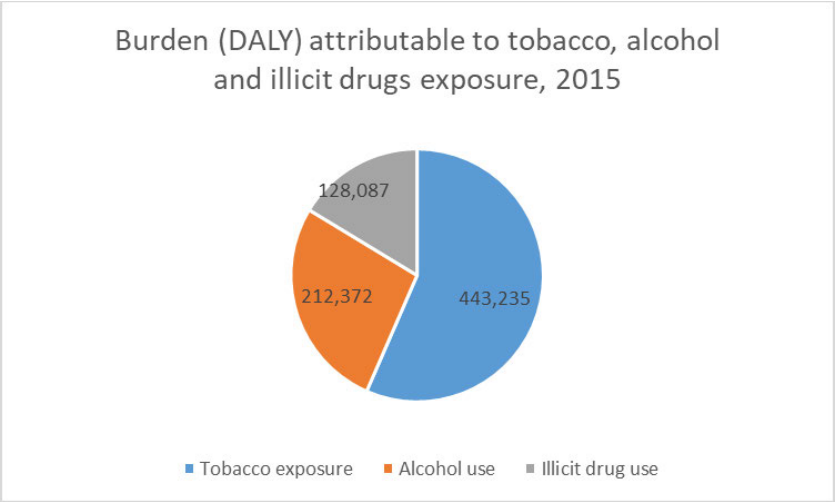
24. See fn 23 p. v

25. The same.

26. AIHW media release of 26 Jun 2020 (https://www.aihw.gov.au/news-media/media-releases/2020/june/more-australians-treated-for-alcohol-use-than-any).

The burden of disease attributable to illicit drugs is just over 6% of the total burden of the three of them at the two legal drugs.

Figure 8: Burden in disability-adjusted life years, or DALY attributable to tobacco, alcohol and illicit drugs exposure, 2015



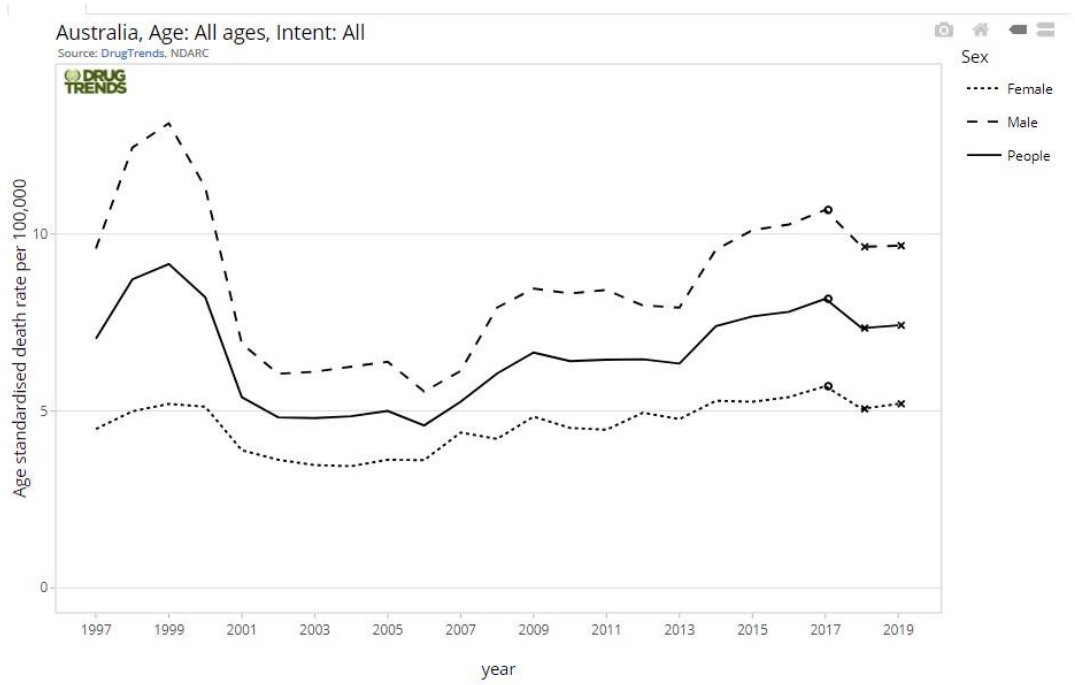
	Person DALY no.
Tobacco exposure	443,235
Alcohol use	212,372
Illicit drug use	128,087
	783,694

SOURCE: Australian Institute of Health and Welfare, Alcohol, tobacco and other drug use in Australia 2021, Impacts, Supplementary data tables (AIHW, Canberra, April 2021) tables S.1.2 and S.1.3 and for tobacco AIHW 2019. Burden of tobacco use in Australia: Australian Burden of Disease Study 2015. Australian Burden of Disease series no. 21. Cat. no. BOD 20, (AIHW, Canberra, 2019) table. 2.1 p.8.

42. Among the 15 leading causes of attributable DALYs shown, high systolic blood pressure, high fasting plasma glucose, high body-mass index (BMI), ambient particulate matter pollution, alcohol use, and drug use stand out because rates of exposure are increasing by more than 0·5% per year. (p. 1,137).

3.2 UNINTENTIONAL DRUG INDUCED DEATHS

Figure 9: Rate of Drug induced deaths of all ages and sex in Australia 1997 – 2019



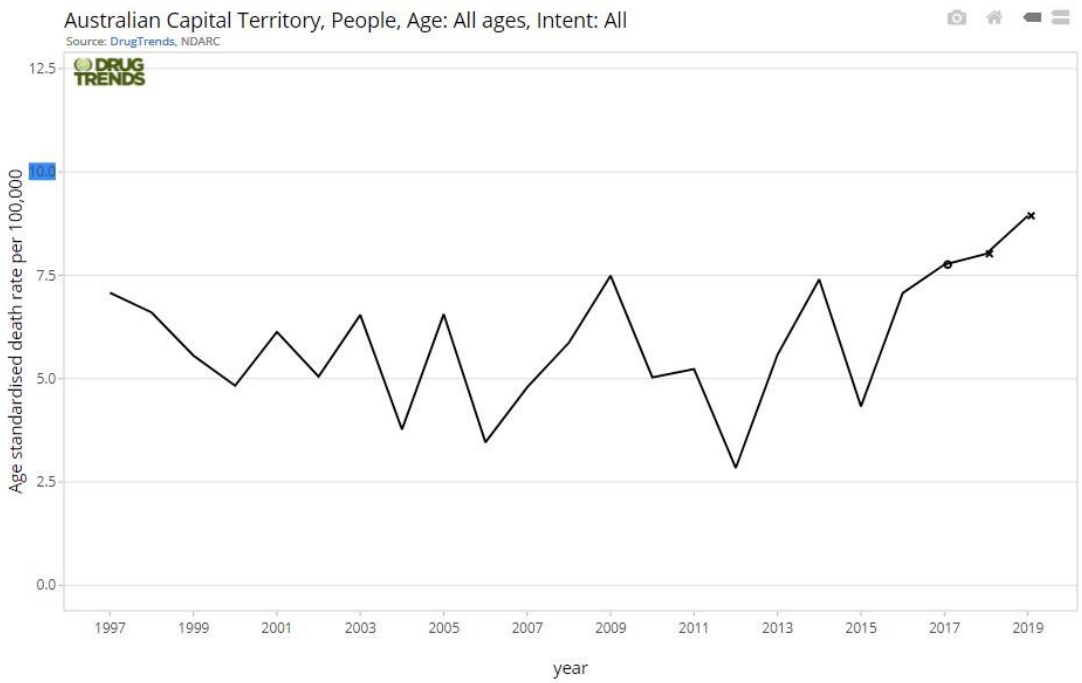
SOURCE: **NDARC, Drug induced deaths by jurisdiction, intent, age and sex (1997-2019).**

43. There is no more eloquent testimony to the utter failure of existing prohibitionist drug policy in Australia than the remorseless increase since 2006 in drug induced deaths to which the following metrics bear witness:

- Preliminary estimates indicate that there were 1,865 drug-induced deaths among Australians in 2019.
- This is equivalent to over five drug-induced deaths per day.

This is the fifth year in a row where the number of deaths is higher than the earlier peak in the late 1990s.

Figure 10: Rate of Drug induced deaths of people in the Australian Capital Territory 1997 – 2019



SOURCE: NDARC, Interactive chart at Drug induced deaths by jurisdiction, intent, age and sex (1997-2019).

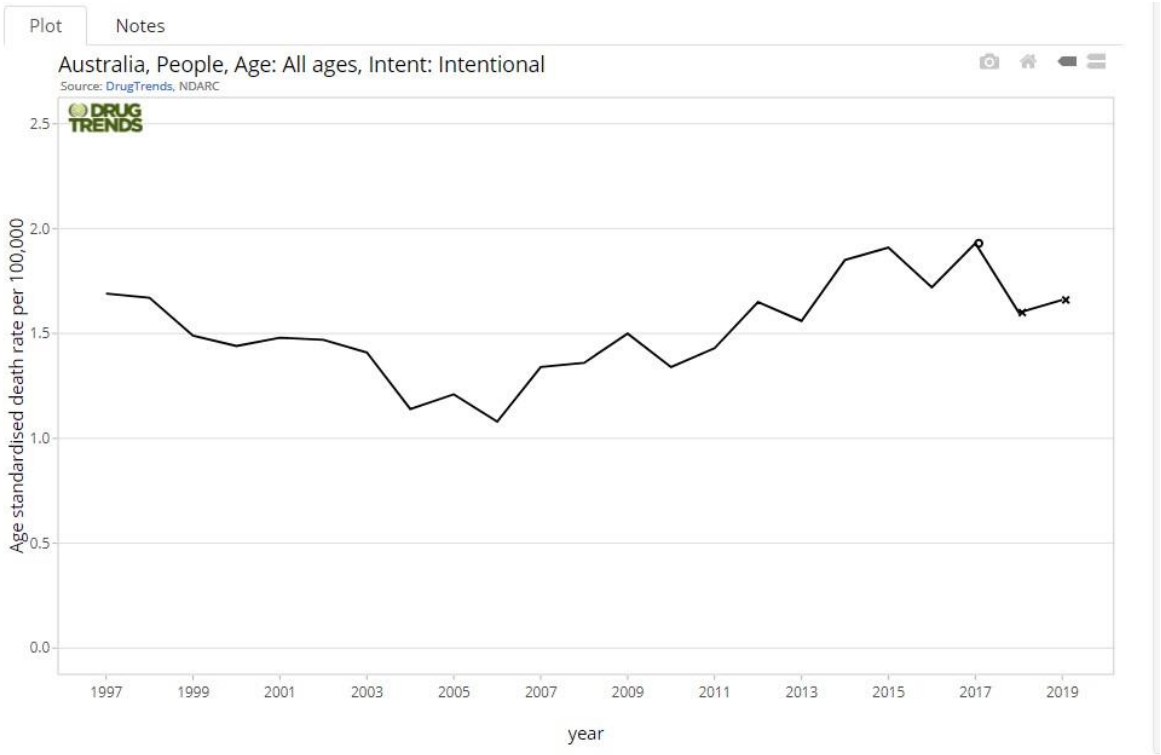
44. The foregoing chart plots the frightening rise in drug-related deaths in the ACT. In 1997 23 people died. In 2019 this had risen 65% to 38. The age adjusted rate increased 16% from 7.08 to 8.94 per 100,000.

3.3 SUICIDE

45. A death is judged intentional "where the coroner determines that the manner/intent of the injury or poisoning which led to death was purposeful"[27]

27. ABS 2016: Australian Bureau of Statistics, *3303.0, Drug Induced Deaths in Australia: A changing story,* 27/09/2017 at http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Drug%20Induced%20Deaths%20in%20Australia~6 visited 19/10/2017

Figure 11: Intentional Drug-induced deaths in Australia 1997 – 2019



SOURCE: NDARC, Interactive chart, Drug induced deaths by jurisdiction, intent, age and sex (1997-2019).

46. It is scant consolation that the rate of people who took their own life by means of a drug-induced death, has remained more or less stable in the 22 years between 1997 and 2019 (rate 1.69 per 100,000 in 1997 and 1.66 in 2019). Rate aside, the number of people who took their own life increased 43% from 309 to 442. Given the enhancement of risk factors associated with drug use the wonder is that there are not more. A meta-analysis of the number of North American studies showed that, 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 refer to as polydrug users) an astounding 16 to 17 times more likely.[28]

28. Holly C. Wilcox, Kenneth R. Connerc, & Eric D. Cainec, Association of alcohol and drug use disorders and completed suicide: an empirical review of cohort studies in *Drug and Alcohol Dependence*, vol. 76, supplement, 7 December 2004, pp. S11–S19.

PROFILE OF NATIONAL ILLICIT DRUG ARRESTS

National illicit drug arrests—comparison between 2017–18 and 2018–19

National	ATS	Cannabis	Heroin & other opioids	Cocaine	Other & unknown drugs
↑ 3%	↑ 4%	↓ -2%	↑ 3%	↑ 16%	↑ 16%
148,363 → 153,377	44,887 → 46,437	72,381 → 71,151	3,029 → 3,129	4,325 → 5,016	23,741 → 27,644

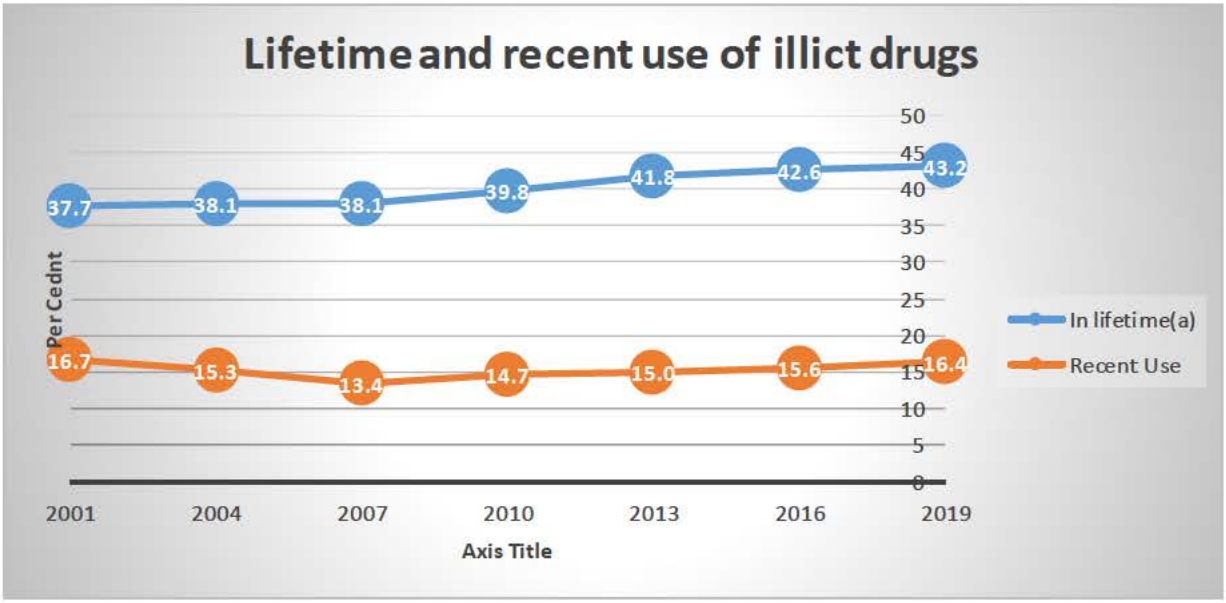
- The number of national illicit drug arrests increased this reporting period.
- In 2018–19, cannabis accounted for the greatest proportion of national illicit drug arrests (46 per cent), followed by ATS (30 per cent), other and unknown drugs (18 per cent), cocaine (3 per cent) and heroin and other opioids (2 per cent).

SOURCE: Australian Criminal Intelligence Commission, *Illicit drug data report 2018–19*, (Australian Criminal Intelligence Commission, Canberra City, September 2020) p. 12 at https://www.acic.gov.au/sites/default/files/2020-09/illicit_drug_data_report_2018-19_internals_v10_full.pdf visited 13/10/2020).

47. For retailers and in the light of the very substantial harm associated with inebriance, restrictions are placed on when and where alcohol may be dispensed. Infractions of a number of these restrictions can incur criminal penalties. The drinker does not commit an offence in consumption but can be subject to very severe criminal penalties for acts of violence and driving under the influence while inebriated.

48. While it is irrefutable that the consumption of many drugs entail grief to the people who consumed them, their families, friends and community at large, it must also be acknowledged that only a small proportion of people who ever try an illicit drug ever become dependent on it and end up fitting the stereotype of the "junkie" of popular imagination. The vast majority of people just put it down to experience and get on with the rest of their life like the rest of us. What distracts them from this course is more than likely the disaster of arrest and otherwise being caught up in the coercive processes of the criminal law.

Figure 12: Lifetime and recent use of illicit drugs



SOURCE: Table S2.31 & S2.32 of Australian Institute of Health and Welfare, *Alcohol, tobacco and other drug use in Australia 2021, Impacts, Supplementary data tables* (AIHW, Canberra, April 2021) at https://www.aihw.gov.au/getmedia/bdb49429-d179-4d94-9da1-74e2cc72eec8/aihw-phe-221-impacts_April-2021.xlsx.aspx visited 14/05/2021

49. 8.1 million people have used an illicit drug in their lifetime of which 3.4 million used in the past 12 months. An upper estimate of 700,000 are thought to be seeking treatment which is a mere 9%. But it is that 9% and those associated with them who draw the short straw.

50. Other harms including health ones, that are correlated with substance use are less directly attributable to that consumption. Thus, for example, blood-borne diseases brought about by the use of infected needles are avoidable by the supply of sterile syringes. Thus, while it is correct to say that the person would not have contracted hepatitis C if they had not injected drugs, that harm would be avoided if the consumer had had access to those sterile syringes. In those circumstances it is fair to say that the approximate cause of the harm of infection was a policy setting that prevented access to such syringes.

51. This submission next considers those avoidable harms that can fairly be attributed to drug policy rather than the drugs themselves.

4. Harms associated with illicit drug use are best addressed by the application of public health principles

4.1 AUSTRALIA LED THE WORLD IN INTRODUCING HARM REDUCTION POLICIES BASED UPON PUBLIC HEALTH PRINCIPLES.

52. Australia and indeed the ACT under the energetic and enlightened leadership of Liberal Chief Minister, Kate Carnell, led the way in promoting drug policies based

on public health principles. The territory would be in an altogether better place now if the Commonwealth government had not vetoed the trial of heroin assisted treatment for which she tirelessly advocated.

- Australia introduced the concept of harm reduction as a pillar of its national policy of harm minimisation instituted by the Hawke government in the 1980s. These pioneering steps were taken in response to the HIV epidemic. Needle and syringe programs successfully limited the spread of HIV AIDS among the particularly vulnerable injecting drug community.[29]
- The same program has had a measurable impact on limiting the spread of the hepatitis C virus.
- The medically supervised injecting centre in Sydney was the first in the English-speaking world.
    - Repeated assessments have shown its efficacy in reducing overdose deaths, engaging a hard to reach itinerant drug using community;[30]
- the ACT and then other jurisdictions making naloxone available to users and carers to resuscitate people experiencing an opiate overdose;
- Police desisting from ambulance chasing and cross-examining people experiencing an overdose for information on where they secured the drug on which they overdosed;
- Police issue public warnings about the circulation of dangerous batches of drugs;

4.2 MANY OTHER COUNTRIES HAVE ADOPTED ADDTIONAL PUBLIC HEALTH FOCUSED APPROACHES

53. Countries other than Australia have taken extra steps to distance the criminal law from drug users indecriminalisation and introducing pharmacotherapies with greater capacity than other treatments to attract, retain and stabilise dependent drug users.:

54. The Howard government Tough on Drugs Policy applied the brakes to public health inspired innovation to drug policy with the result that many other countries have surpassed us. They have done so by:

- expanding low threshold services like needle and syringe programs and medically supervised consumption rooms to facilitate engagement with drug users.
- combining a system of referral of drug users to education and treatment services if dependent or in need of other healthcare in place of arrest and criminal prosecution;

29. David Wilson et. al., Return on investment 2: *Evaluating the cost-effectiveness of needle and syringe programs in Australia 2009* (Commonwealth of Australia Department of Health and Ageing and National Centre in HIV, Epidemiology and Clinical Research, Sydney).

30. MSIC Evaluation Committee, Final report of the evaluation of the Sydney medically supervised injecting centre (Sydney, authors, 2003);

- providing heroin assisted treatment to connect with and stabilise dependent opiate users who have been unable to engage with methadone and other treatment services;
- trialling hydromorphone as an alternative to heroin assisted treatment.
- making prescribable addictive pharmacotherapies like methadone to stabilise people depend on and upon heroin;

4.3 WHAT OTHER COUNTRIES ARE DOING

55. International practice is moving away from reliance on the criminal law as the cornerstone of drug policy at the level of the drug user. Families and Friends is convinced that lifting the criminal law with all its baleful consequences, from the back of people who use drugs is vital. Unless this is done, demographics who have never fitted the stereotype of the out of control drug user, will increasingly be netted: Many sufferer of chronic pain who are unable to access the very few pain specialists or find relief in prescription opiates because of restrictions being imposed on doctor shopping. The age profile of drug users shows that it is increasingly mature age people who are accessing the black market.

56. Different approaches are possible. Countries like Uruguay and an increasing number of American States are moving to achieve this objective by decriminalising small scale supply as well as possession of small quantities. Applying its so-called expediency principle of its legal system the Netherlands has done this for years through its coffee shops with strictly policed restrictions on who can patronise them. Portugal has decided simply to refer people apprehended with small quantities to so-called commissions of dissuasion providing a referral pathway to treatment if required.

57. As the recent SBS program on Portugal showed, their decriminalisation has not eliminated the supply of drugs or. It still has a residual drug problem. The issue of supply in Portugal is akin to the so-called “back door” issue in Dutch coffee shops. Heroin assisted treatment solves the problem of supply by entrusting it to the hands of the medical profession in controlled situations like medically supervised injecting centres. This is the approach adopted in Switerland in the 1990s. This has been resounding endorsed. Heroin assisted treatment is now accepted as superior to methadone alone. 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). The worth of heroin assisted treatment has been confirmed by a Cochrane review of all randomised controlled trials. Ever since the ACT formulated its own drug strategy it had committed itself to a trial of heroin assisted treatment. This was fitting given the considerable effort that the Carnell Liberal government put into promoting an Australian heroin trial. Inexplicably the current ACT drug strategy action plan omits this commitment.

58. The evidence is now so strong in favour of heroin assisted treatment that it could be safely implemented without the need for a trial.

> “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."(fn 21 on page 27)

59. The New South Wales ice inquiry summarised this evolving patchwork of approaches in the following terms:

> "International drug policy has undergone a profound transformation in the past two decades. Evidence before the Inquiry confirms that those at the highest levels of global drug policy unanimously support the removal of criminal sanctions for simple possession. The World Health Organization, the United Nations System Chief Executives Board for Coordination and the Global Commission on Drug Policy all support decriminalisation of low-level personal drug use offences. At least 26 countries, including Switzerland, Denmark, Brazil, France, Germany, Portugal and 11 states in the United States have decriminalised simple possession of drugs in some form".[31]

5. Harms attributable to drug policy

60. While it is true that impaired autonomy from a strong internal drive to use a substance and tolerance are characteristics of addiction, dependency does not necessarily substantially disrupt a person's life. If they have sufficient income to support their habit, their drug dependency will go unnoticed. The image of the high-powered successful barrister who snorts cocaine comes to mind. Our members include parents of adult children on regular doses of methadone. That addictive pharmacotherapy has stabilised their life and enable them to who hold down demanding public service jobs. Methadone has a bad reputation amongst users as "liquid manacles" because of the demeaning procedures that restrict its dispensation. It and heroin assisted treatment require carefully supervised induction to avoid accidental overdose. But all such treatments demonstrate that it is possible for people dependent on illicit drugs to live a perfectly normal, engaged life.

61. A public health focused approach will look to engage marginalised drug users with other support services staffed by culturally sensitive and empathetic qualified clinicians.

5.1 Disengagement from health and other support services

62. The life experience of the typical dependent drug user is marked by rejection and undermined sense of self worth. Stigmatised and marginalised, dependent drug users are relegated to the most disadvantaged margins of our society.

63. Depending on the substance to which they are they are addicted, people who have a dependency can generally be stabilised while still being dependent. The characteristics of treatment should therefore:

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31. New South Wales, Report of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants (January 2020) vol 1a, para. 43, p. xxxi at https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/The-Drug-ice-1546/02-Report-Volume-1a.pdf visited 7/06/2021.

- be attractive enough to engage and retain a population of dependent drug users who have often had a long history of;
    - failed attempts to overcome their dependency;
    - low self-esteem and disempowerment.
- offer low threshold services that do not humiliate those who attend on account of those failed attempts;

5.2 BE STAFFED BY CULTURALLY AWARE, EMPATHETIC SKILLED PERSONNEL UNDERSTANDING OF THE OFTEN HIGHLY STIGMATISED AND MARGINALISED BACKGROUND OF CLIENTS.

See §5.10 p. 61 Social exclusion including homelessness

121. "Drug dependency is associated with exclusion from the basic minimums of what one expects of a society including housing and employment and the wherewithal to participate fully in it. In, for example, 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." Existing drug treatments help this process. Heroin assisted treatment does it much more efficiently. The "marked improvements in social functioning" in Switzerland attributed to heroin assisted treatment 'improved in all the intervention groups with heroin groups having slightly better results." (fn 21 above on page 27)

122. The Swiss trial recorded that:

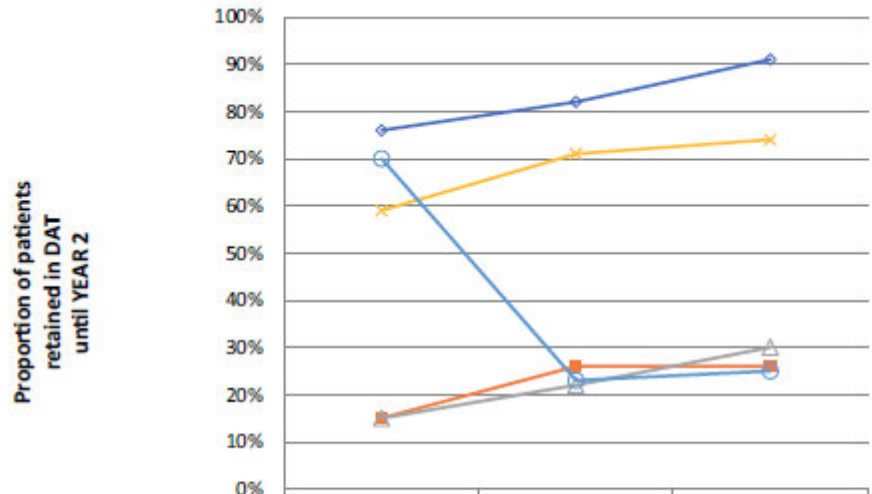
> "The patient's housing situation rapidly improved and stabilised (there was in particular no longer any homelessness).
>
> "Fitness for work improved considerably; permanent employment more than doubled (from 14 to 32%), unemployment fell by more than half (from 44 to 20%); the remainder lived on allowances 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).
>
> "Contact with drug addicts and the drug scene decline massively but was not adequately replaced by new social contacts during the observation period."

123. The improvement in social integration and reduction of risk factors for crime ascertained in the 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 reflected in the following chart.

Figure 19: Improvements in the social situation of patients in the German trial of heroin assisted treatment



	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])

SOURCE: 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. 1347. doi: 10.1007/s40265-018-0962-y.at https://pubmed.ncbi.nlm.nih.gov/30132259/ visited 17/05/2020.

Stigma towards drug users by health professionals and other service providers

5.3 PUBLIC HEALTH MEASURES TO REDUCE FATAL OVERDOSES

64. In its 2020 Annual Report, the European Monitoring Centre for Drugs and Drug Addiction identified the following suite of measures to prevent the occurrence of overdoses and to improve the survival of those who do overdose.[32] These measures accord no role for drug law enforcement:

> Enrolling and retaining problem opioid users in OST and ensuring continuity between treatment in prisons and the community and at other transition points.

32 . European Monitoring Centre for Drugs and Drug Addiction, *European Drug Report: trends and developments 2020*, (EMCDDA, Lisbon, 2020) p. 69 at https://www.emcdda.europa.eu/system/files/publications/13236/TDAT20001ENN_web.pdf visited 26/09/2020

Promoting overdose awareness, particularly around key risk periods and other risk factors, such as concurrent alcohol or benzodiazepine use.

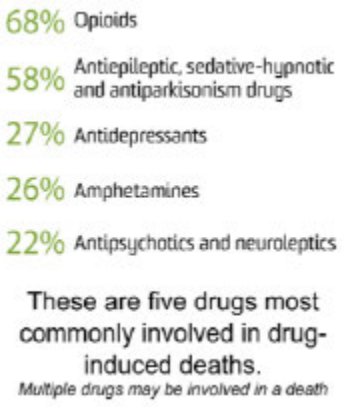
Ensuring opioid antagonist (naloxone) availability and promoting appropriate use by professionals responding to or intervening in drug overdoses.

Education and training of drug users, peers and family members to identify overdoses and intervene with take-home naloxone while waiting for the ambulance to arrive.

Provision of drug consumption rooms to support safer injecting.

65. In 2018 opioid overdoses accounted for 68% of all drug-induced deaths. From a public health point of view priority should therefore continue to be directed at reducing opioid-induced fatalities.

Figure 13: Drug-induced deaths in Australia in 2018



SOURCE: Agata Chrzanowska, Nicola Man, Rachel Sutherland, Louisa Degenhardt and Amy Peacock, Trends in drug induced-deaths in Australia, 1997-2019 funded by the Australian Government Department of Health under the Drug and Alcohol Program, (NDARC, UNSW Sydney, 2021) at https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Drug%20Induced%20Deaths%20December%202019%20Bulletin_1.pdf visited 04/06/2021

66. In Australia as in Europe and the United States where there is an epidemic of deaths from misuse of opioid analgesics, drug overdose is increasingly associated with an ageing population. "Those in the 45-54 and 35-44 age groups had the highest rate of drug-induced deaths in 2019; this contrasts with the late 1990s where the rate was highest in the 25-34 age group."[33]

67. 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

33. Nicola Man, Agata Chrzanowska, Timothy Dobbins, Louisa Degenhardt and Amy Peacock, *Trends in drug-induced deaths in Australia, 1997–2018*. Drug Trends Drug Trends Bulletin Series. (National Drug and Alcohol Research Centre, UNSW, 2019, Sydney) at https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Drug%20Induced%20Deaths%20December%202019%20Bulletin_1.pdf visited 13/10/2020.

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 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)."[34]

5.3.1 Medically Supervised Drug Consumption Rooms

68. The Committee should endorse a "clinically supervised drug consumption site in the ACT" (ToR para. d) because, as the EMCDD claims, those services save lives. The Kings Cross Medically Supervised Injecting Centre has just celebrated 20 years of operation. In that time it experienced no death and:

- Supervised **1,208,806 injections**;
- Successfully **managed 10,611 overdose**s;
- Made **19,028 referrals** connecting people to treatment and support services;
- Led to an estimated **80% reduction** in ambulance call-outs around Kings Cross;
- Caused an estimated **50% reduction** in publicly discarded needle equipment nearby; and has recorded zero drug-related deaths.[35]

69. In endorsing a consumption room to be established in Canberra city centre you, the Assembly and the government must steel yourself to face down the bullying, ignorant, media reactions such as the Victorian government is experiencing in opposition to the proposal to establish a second Victorian injecting centre in Melbourne is CBD. The Burnett Institute has points out that such a services should permit less harmful forms of self administration than injecting (hence termed a Drug Consumption Room (DCR)). It should be located where there is likely to be located where it is most accessible to the target population:

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34 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) 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.

35 Uniting media release 3 May 2021 at https://www.uniting.org/blog-newsroom/newsroom/news-releases/20th-anniversary-of-sydney-s-medically-supervised-injecting-cent visited 4/06/2021

> "A DCR needs to be situated in an area which is readily accessible by the target population. An initial DCR site should be centrally located and within walking distance of public transport."[36]

70. This points to the Canberra City. In endorsing that recommendation please reflect upon the words of Dr Marianne Jauncey, the medical director of the King's Cross centre broadcast on *Media Watch* of 24th May:

> "There are more than 250 peer-reviewed publications in the medical literature showing the benefits of such services. We now know, incontrovertibly, that they save lives, make a difference to people's lives, take public injecting off the streets, reduce needle litter in the streets, and provide a gateway into treatment and support services. Crucially, they have no negative impact on crime, and they have a positive return on investment. Put simply, they work."

5.3.2 Naloxone

71. The ACT initiated Australia's first take-home naloxone program in April 2012. The program involves comprehensive opioid overdose management training and the prescription and supply of naloxone to eligible participants who are not health professionals. Using a collaborative approach, the program is coordinated and delivered by CAHMA, with prescriptions provided by local physicians. The program has been funded by ACT Health.

72. Naloxone is an opioid antagonist used to reverse the effects of opioid overdose. It has no psychoactive effect, is not a drug of dependence and is available on prescription through the Pharmaceutical Benefits Scheme (PBS). It is often referred to as its trade name of Narcan®.The program was reviewed in 2015. The review noted that the 32 of ACT opioid-related deaths in those two years in 2013-14 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)." [37]

73. The increase in ACT overdose deaths 238 in 2019 (Figure 10: Rate of Drug induced deaths of people in the Australian Capital Territory 1997 – 2019, p. 31) shows that the existing naloxone program must be supplemented by other measures to reduce opioid overdose fatalities.

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36. Kirwan, A., Winter, R., Gunn, J., Djordjevic, F., Curtis, M. & Dietze, P. (2020). Final Report of the ACT Medically Supervised Injecting Facility Feasibility Study. (Melbourne: Burnet Institute & Canberra Alliance for Harm Minimisation and Advocacy, 2020) p. 49 at https://health.act.gov.au/sites/default/files/2021-03/ACT%20DCR%20report_February_2021_Final_18022021.pdf visited 30/05/2021.

37. Anna Olsen, David McDonald, Simon Lenton & Paul Dietze, *Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT)' Program, 2011-2014,* Final Report August 2015 (ACT Health, 2015) at http://health.act.gov.au/sites/default/files//Naloxone%20Evaluation%20Report%20FINAL_August%202015.pdf visited 25/02/2016.

5.3.3 Expansion of Opiate Substitution Therapies: Heroin Assisted Treatment

74. Opiate substitution therapies reduce overdose fatalities by their superior ability to retain patients in treatments leading to the suppression of the use of illicitly procured drugs like heroin and opiate pharmacotherapies. Patients are enabled to stabilise their life and, in treatment, reduce the risk of potentially fatal accidental overdose" (See section.2.5.2 Methadone reduces opioid use, p. 26).

75. Methadone is not, however, for everyone. It has a bad reputation among many drug users as "liquid manacles" not least because of the onorous restrictions that encompass its dispensation and the perception that it is harder to suppress addiction to it than to heroin itself. Accordingly a small percentage of opiate dependent drug users repeatedly fail to be stabilised by it. The prison population is drawn disproportionately from this group.

76. A Cochrane review has been undertaken integrating the results of the German, the British, Spanish and Canadian randomised controlled trials. The 8 studies considered involved from 50 to 1000 participants. These trials compared methadone with methadone supplemented by heroin, reported 6 deaths in the heroin groups and 10 in the methadone ones producing a statistically insignificant protective measure of effect in favour of the cohort receiving heroin (see fn 21 p. 10, at p.27 above).

77. The positive outcome in favour of heroin assisted treatment was reinforced by its superior capacity to retain patients in treatment and predict reduction of illicit drug use. Altogether these results show a superior capacity of heroin assisted treatment to engage patients in treatment and distancing themselves from the illicit drug scene.

78. According to a survey by the European Monitoring Centre for Drugs and Drug Addiction "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."[38]

5.3.4 Expansion of Opiate Substitution Therapies: Hydromorphone

79. 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 [heroin]." The result pointed to "Hydromorphone [being] similarly safe and effective as diacetylmorphine as opioid-

38. 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.

agonist substitution treatment."[39] 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."[40] 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.

80. 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 clinical research trial of hydromorphone in the ACT."[41]

5.4 SUBJECTING DRUG USERS TO ARREST AND PROSECUTION

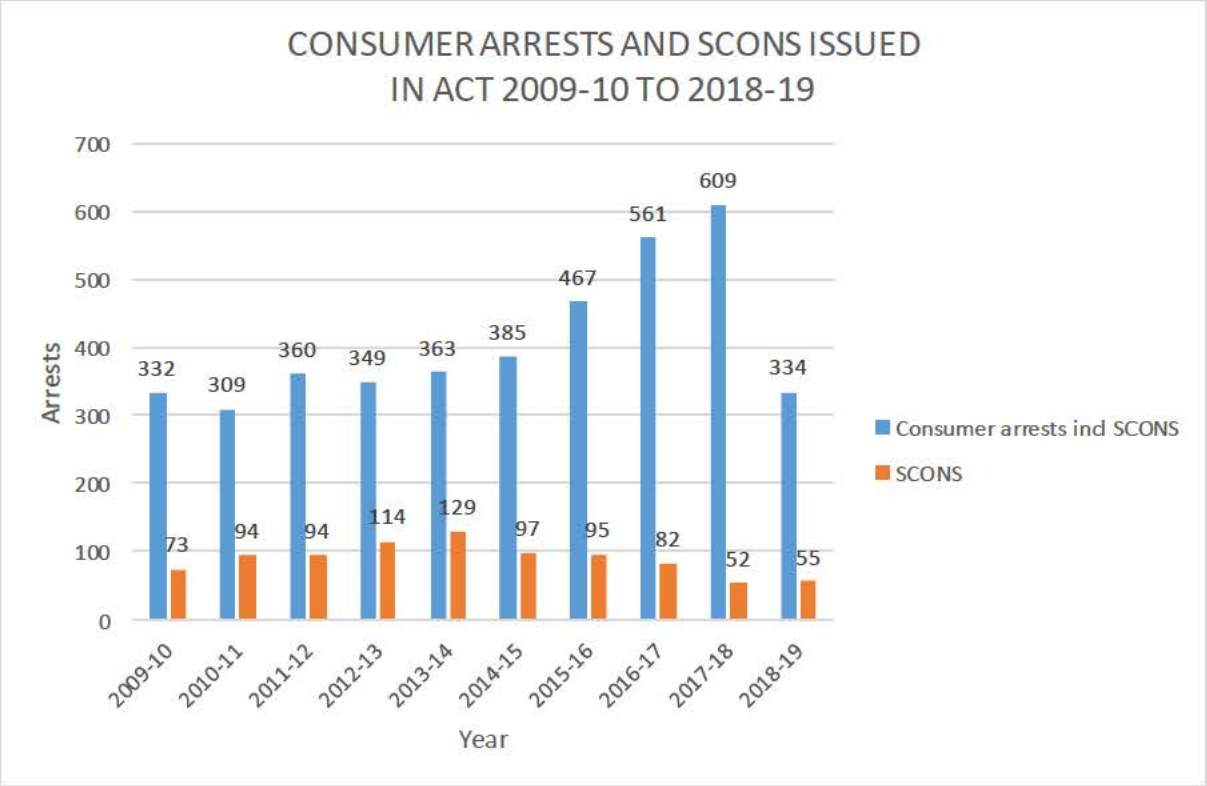
81. Police around the country assure us that they focus predominantly on arresting providers (dealers) of illicit drugs rather than consumers of them. The arrest statistics tell a different story. Even in the ACT, overwhelmingly consumers are targeted:

39. 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.

40. 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 long-term severe opioid use disorder in Drug and Alcohol Dependence 176 (2017) 55–62.

41. 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 6/22/2021.

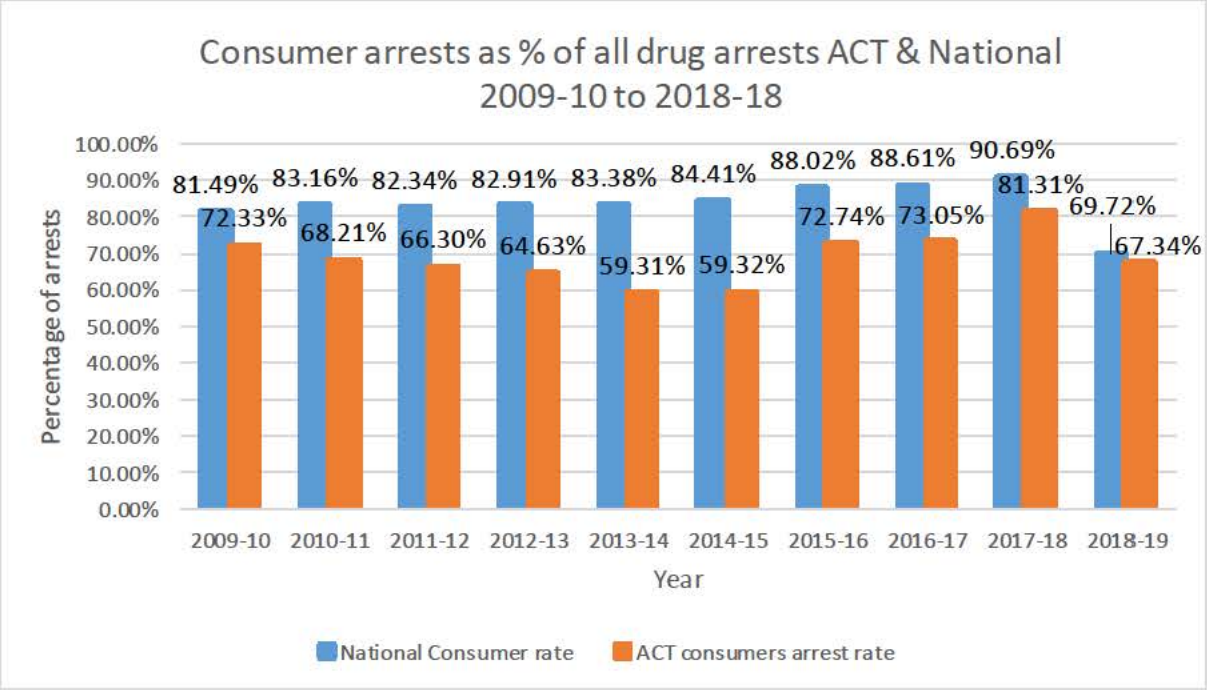
Figure 14: Consumer arrests and SCONs issued in ACT 2009-10 to 2018-19



SOURCE: Australian Criminal Intelligence Commission, *Annual Illicit Drug Data Reports,* Australia https://www.acic.gov.au/publications/illicit-drug-data-report and Australian Crime Commission, https://webarchive.nla.gov.au/awa/20160615100434/http://www.crimecommission.gov.au/publications/intelligence-products/illicit-drug-data-report.

The proportion of consumer, compared to the sum of all drug arrests reveals this sorry situation. The lower the percentage of consumer arrests the more the police are targeting "providers". The chart does not reveal the impact of the changes in the ACT from the beginning of 2020 to the regulation of cannabis.The decline in 2018 – 19 of police arrests both nationally and in the ACT hopefully results from re-prioritising police efforts but that will be revealed when further data is available.

Figure 15: Consumer arrests as a percentage of all drug arrests ACT & National 2009-10 to 2018-18



SOURCE: Australian Criminal Intelligence Commission, *Annual Illicit Drug Data Reports,* Australia https://www.acic.gov.au/publications/illicit-drug-data-report and Australian Crime Commission, https://webarchive.nla.gov.au/awa/20160615100434/http://www.crimecommission.gov.au/publications/intelligence-products/illicit-drug-data-report.

82. Mick Palmer, the former Commissioner of the Australian Federal Police and long serving officer in the Northern Territory has described the lifelong harm that can flow from arrest and prosecution of people who happen to use drugs:

> "As a young detective I found myself arresting decent young Australians who had never come to the attention of police for any other crime. Weren't ever likely to. Who were planning careers in a whole range of areas, including teaching and police 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 were never likely to for any other crime or offence?"[42]

83. Nicholas Cowdrey QC, had a complementary perspective formed as long serving, NSW Director of Public Prosecutions in deciding whether to prosecute people who had used drugs.

> "For heaven's sake it might be just an experimental thing that was done, didn't particularly like to and isn't going to do it again. Young people do experiment

42. Transcript from the film, *Half a Million Steps* (2019).

> and we have to accept that if they do then there are better ways of dealing with it than making them a full time criminal."[43]

84. "If somebody close to me," he added, "was caught up in drug use. I would want health treatment. The last place I'd want to see them is in a court of law."

> "At the same time, modelled projections of the unmet demand for AOD treatment (that is the number of people in any one year who need and would seek treatment) are conservatively estimated to be between 200,000 and 500,000 people over and above those in treatment in any one year (Chapter 8). This has significant implications for treatment planning and purchasing."[44]

5.5 DRUG POLICY DISEMPOWERS BOTH DRUG USERS AND THEIR FAMILIES.

85. Drug policy based upon the criminal law disempowers both drug users and their families. Stigma, marginalisation and fear is fostered by the illegality of drug use and possession and the ever, present if remote prospect of arrest and prosecution. This constitutes a Damocles sword that perpetually hangs over drug users and their families.

86. Disempowerment that characterises the life of so many dependent drug users, drives bad health which further undermines the capacity to take control of their lives. In the words of Sir Michael Marmot "We have strong evidence that there are two important influences on health in explaining the hierarchy in health. The first is autonomy, control, empowerment. People who are disempowered, people who don't have autonomy, people who have little control over their lives, are at increased risk of heart disease, increased risk of mental illness."[45]

The second of his two important influences was what he termed "social participation" which, courtesy of the stigma that also characterises the life of many dependent drug users. This is addressed below at Section 5.10 below, p. 61.

87. Drug policy undermines the capacity of drug users to take responsibility for their lives and those dependent upon them. In the case of families, the arrival of drug use in the their midst typically prompts a reaction of self blame. Where had their parenting fallen short? Loaded with self blame, and shame that isolates them from

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43. The same.

44. Ritter A, Berends L, Chalmers J, Hull P, Lancaster K, Gomez M. *New Horizons: the review of alcohol and other drug treatment services in Australia. Final Report.* Sydney, http://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-fund: Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW; 2014 (released Nov. 2015) July 2014, released 06 December 2015 p. 408 plus appendices 68 p. 13 at https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf visited 22/06/2021.

45. Michael Marmot, Interview with Sir Michael Marmot; Edited transcript of interview filmed for Unnatural Causes, (Public Broadcasting Service, October 2009) at https://unnaturalcauses.org/assets/uploads/file/MichaelMarmot.pdf visited 05/06/2021.

friends and wider family networks, their capacity to respond appropriately is impaired.

88. Families that had likely comforted themselves in the belief that the state was shielding their loved ones from drugs find that that is not the case (see p. 34 above Figure 12: Lifetime and recent use of illicit drugs) and when, in desperation, they reach out for help, all too often it is not there leaving them to suffer in lonely, remorseful silence.

89. Drug use striking a family will typically usher in grief for lost dreams of well-being and happiness. The whole family is left in smoking ruins. The grieving of bereavement is a consequence even before an actual death that all too often takes place (see p. 31 above, Figure 10: Rate of Drug induced deaths of people in the Australian Capital Territory 1997 – 2019).

5.6 Crime Reduction

90. 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."[46]

91. 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 outcomes were measured, results of single studies do provide evidence that heroin provision can reduce criminal activity . . ."[47] The review of the European Monitoring Centre for Drugs and Drug Addiction was more affirmative. There were, it wrote "consistent findings" of the Swiss and other trials of a " . . . major disengagement from Cook criminal activities (such as acquisitive crime to fund continued use of 'street' heroin and other street drugs) . . ."[48]

92. One can add to these enhancement of other crime reduction factors brought about by heroin assisted treatment: big reductions in drug dealing by those on the program – and hefty reduction in dealing hard drugs.

46. 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.

47. Ferri, Davoli & Perucci (2011), fn 21 p.27 above.

48. Strang, Groshkova & Metrebian (2012), p. 161, fn 38 p. 39.

5.7 IMPRISONMENT

93. 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.[49] The Productivity Commission now reports 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.[50] The situation in the United States is attributable in part to a perception that the rate of incarceration is financially unsustainable.[51] The decline followed the Global Financial Crisis and a 2011 order of the Supreme Court to reduce overcrowding.[52]

94. 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.

95. 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."[53]

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49. Adam Graycar & Peter Grobosky eds, *The Cambridge handbook of Australian criminology* (Cambridge UP, 2002) table 1.3, p. 16.

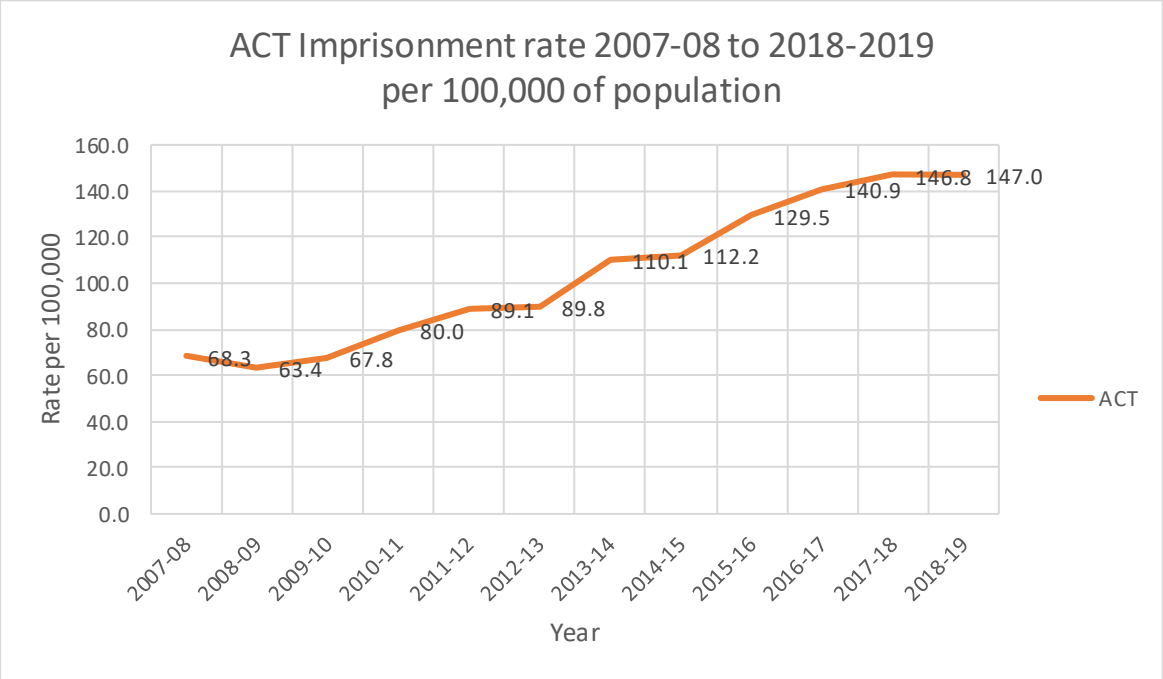
50. https://books.google.com.au/books?id=2xFYQLiLlSUC&pg=PA105&lpg=PA105&dq-=Prison+population+rate+and+composition,+and+occupancy+level,&source=bl&ots=nq8mW9DrMn&sig=ACfU3U2DJfLTnSM_-lLHiWkhZmPqyh8Fgg&hl=en&sa=X&ved=2ahUKEwiNsYPz1L7oAhWlILcAHQdjBg0Q6AEwAHoECAkQAQ#v=onepage&q=Prison%20population%20rate%20and%20composition%2C%20and%20occupancy%20level%2C&f=false

51. 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. 12 at https://www.prisonstudies.org/sites/default/files/resources/downloads/global_imprisonment_web2c.pdft.

52. 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

53. *Review of the opioid replacement treatment* (2018) cited above, p.13

Figure 16: ACT imprisonment rate 2007-08 to 2018-2019 per 1000,000 of population



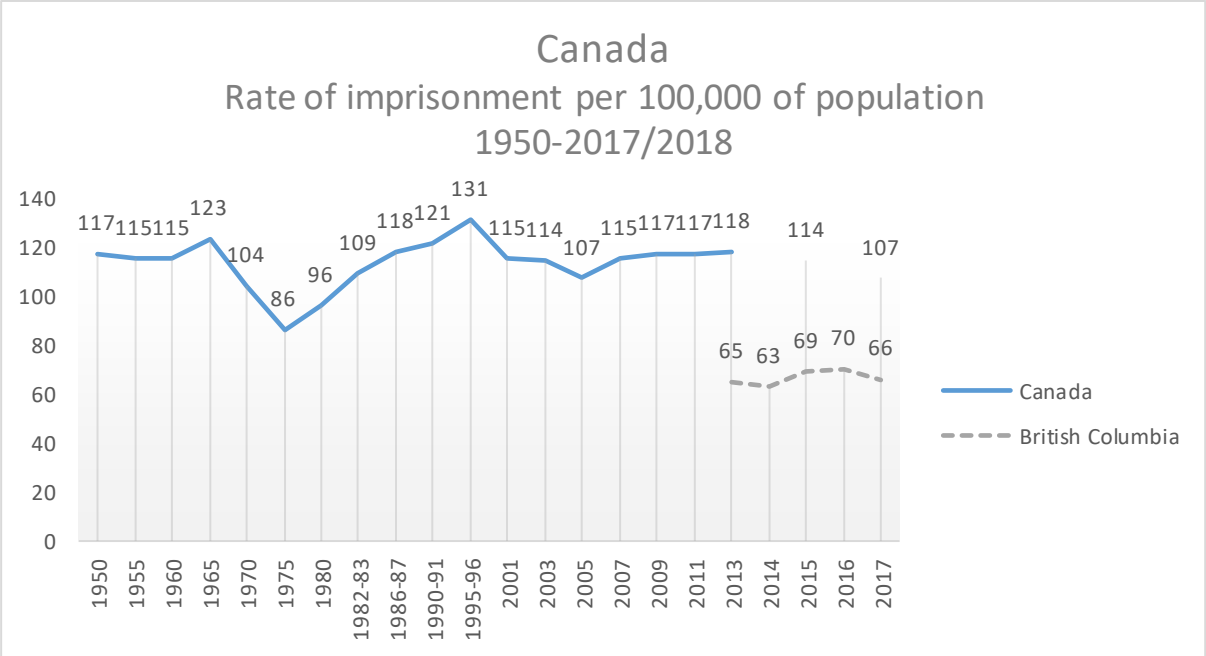
SOURCE: Productivity Commission (2020): 8A Corrective services — Data tables contents table 8A.5 at https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/justice/corrective-services/rogs-2020-partc-section8-data-tables.xlsx & : Productivity Commission, Report on government services 2018, corrective services, Table 8A.5.

96. 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. Even so it is instructive to compare the consistently lower rate of imprisonment in jurisdictions that have moved to some extent to a fifth of focused drug policy namely The Netherlands, Switzerland, Germany, Denmark, Canada and British Columbia. British Columbia as a Canadian province with a substantial indigenous (first nation) population is of particular relevance to the ACT. British Columbia followed Sydney in pioneering a medically supervised consumption room in Vancouver and subsequently moved to adopt heroin assisted treatment and a trial of hydromorphone.

97. 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

Figure 17: Rate of imprisonment per 100,000 of population 1950-2017/2018 in Canada & 2013-17 in British Columbia



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.

98. Participants in a Canadian ministerial review in 2016[54] 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."

99. Noted in §97 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.

5.8 INDIGENOUS INCARCERATION IN THE ACT

Combining a drug policy founded on public health principles with its culturally appropriate delivery by indigenous controlled agencies such as Winnunga Nimitija

54 Jody Wilson-Raybould, What we heard - Transforming Canada's criminal justice system: Message from the Minister, circa 2016???;, at https://www.justice.gc.ca/eng/rp-pr/other-autre/tcjs-tsjp/p1.html.

holds out the distinct possibility of the ACT closing rather than widening the gap of indigenous disadvantage.

The high rate of indigenous incarceration in the ACT is unforgivable.

100. 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."[55] 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."

101. 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.

102. "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 selfharm 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"[56]

103. 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. At that the time these 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

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55. 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

56. 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.

when, according to the Productivity Commission, indigenous Canberrans now constitute 23% of the ACTs own prison inmates?

104. 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 the indigenous imprisonment rate was lower than the national average.

105. 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[57]:

> "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.'"

106. 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."[58])

107. "Indigenous people entering prison were more than twice as likely as Indigenous people in the community."[59]

108. "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

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57. 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

58. Review of the opioid replacement (2018) cited above p.27.

59. Australian Institute of Health and Welfare, The health of Australia's prisoners 2018 (30 May 2019, Cat. no. PHE 246. Canberra: AIH) p. 97 at https://www.aihw.gov.au/getmedia/2e92f007-453d-48a1-9c6b-4c9531cf0371/aihw-phe-246.pdf.aspx?inline=true visited 31/05/2019 cited above

previous 12 months (Fn 59 p. 112). 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).

109. "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." (Fn 59 p. 112).

5.8.1 Imprisonment compounds mental health and other harms of inmates

110. The processes of the criminal justice system are singularly inappropriate, ineffective and harming of people with schizophrenia who, because of drug laws, are increasingly incacerated:

> "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."[60]

111. Heroin assisted treatment holds out the real prospect of stopping or at least slowing that revolving door.

112. 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 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".[61]

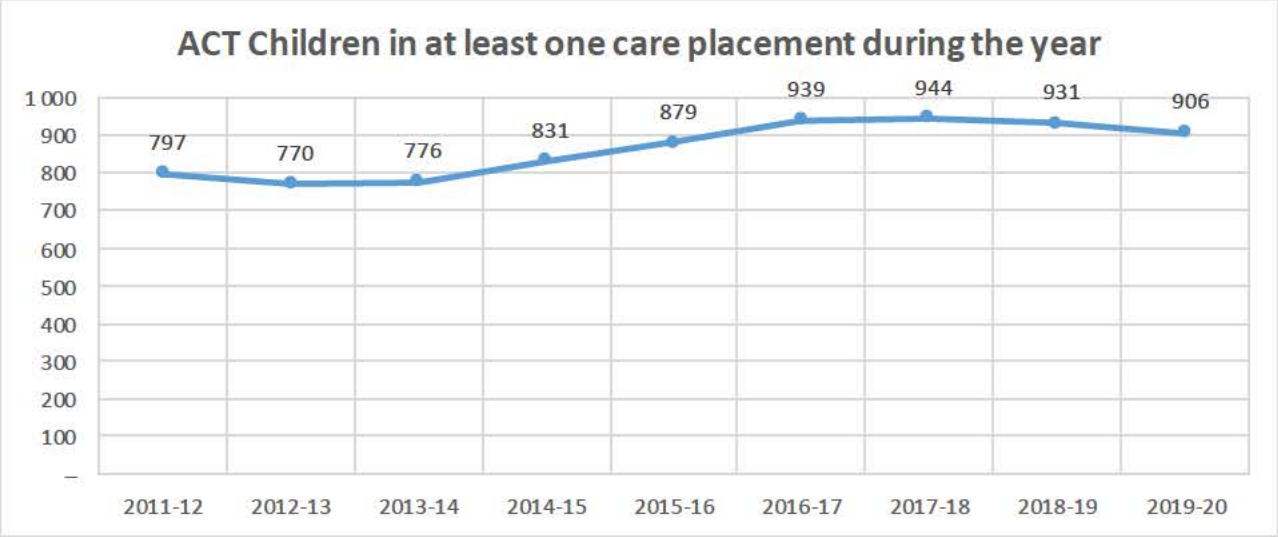
60. Olav Nielssen, Submission to Productivity Commission mental health enquiry, submission 37 of 17 March 2019 at https://www.pc.gov.au/__data/assets/pdf_file/0009/238257/sub037-mental-health.pdf visited 22/04/2020.

61. 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.

5.9 CHILD ABUSE AND NEGLECT SHOWS HOW DRUG POLICY DISEMPOWERS PARENTS WHO USE DRUGS.

113. Parental substance abuse and involvement in criminal behaviour are listed at the top of family/parental risk factors for child abuse and neglect.[62] Substance abuse is thus a factor in the high level of care placements depicted in the following chart. Drug policy characterises drug use a crime thus necessarily involves drug using parents in criminal behaviour in interacting with other drug users and those who supply them with the drugs they use.

Figure 18: ACT Children in at least one care placement during the year



SOURCE: Report on Government Services 2021, Chapt 16A Child protection services — Data tables Table 16A.13 at https://www.pc.gov.au/research/ongoing/report-on-government-services/2021/community-services/child-protection/rogs-2021-partf-section16-child-protection-data-tables.xlsx visited 24/05/2021.

114. Courtesy of years of conditioning with drug war rhetoric and fear, there is a widespread community assumption that dependent drug users, and particularly those who inject drugs, can never be fit parents. The Australian Injecting and Illicit Drug Users League (AIVL) commissioned research that confirmed the negative stereotypes:

> "The dominant personality traits of a person who injects drugs are seen to be selfishness, unreliability, dishonesty and untrustworthiness. The expectation is that as drugs are the focus of the person's life, they are

62. Australian Institute of Family Studies, *Risk and protective factors for child abuse and neglect*, CFCA (Child Family Community Australia) Resource Sheet— May 2017 (Melbourne) Table 1 at https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect visited 24/05/2021.
Common risk factors for child abuse and neglect, Laurie Glanfield, Report of the Inquiry: Review into the system level responses to family violence in the ACT (April 2016) **Table 2: at** https://www.cmtedd.act.gov.au/__data/assets/pdf_file/0010/864712/Glanfield-Inquiry-report.pdf visited 21/05/2021.

> selfish in all the actions they undertake and do not consider the impact of their actions on others. It is expected that they would do anything to get drugs, due to being addicted, so are unable to be trusted as they are not able to control themselves from acting on impulses."[63]

115. It is thus on parents who use drugs, and particularly those who inject drugs, that the stigma and marginalisation against drug users bears most heavily and disempowerment most vividly illustrated.

116. The perceived imperative that a parent who is drug dependent must become drug-free creates a tug-of-war between the love and concern that the parents may have to do the best for their child and the insistence of their habit. It is a tug-of-war that, thanks to the stigma and marginalisation of drug users is often but not always resolved at the expense of the child. Drug using parents are thus subject to a nanny state tyrant. Dr Packer nails it:

> "None of us welcome having our lives dominated and directed by others- even when we know we need help. We need to be able to be fully involved in decision-making. Working with drug abusing people is no different. Unless we look for solutions based on mutual respect, any improvements are likely to be short-lived. It is seldom straightforward, but this is not an excuse for unilateral decisions to make the process easier for us" (footnote 65 above),

117. Parents are deterred from accessing crucial ante and post natal care. Grandparents members of Families and Friends have fiercely defended the parenting capacity of their drug dependent children and earlier this year a number of us attended the funeral of a very brave woman, Jude Byrne, who spent a lifetime championing the need of support for mothers who happen to use drugs. She would listen, encourage and suggest. She would arrange for weekends at the coast for mums who had never felt the sand under their feet but only harsh judgement. Her children are fierce defenders of their mother. Always grounded in the harsh reality of the environment in which she worked, Jude was a fine person who happened to inject drugs and die of cancer. A finer, more understanding, more compassionate person, I have never known.

118. The stigma of drug dependent mothers contributes far more to child abuse and neglect than the dependency of those mothers. It is entirely possible for people who are dependent drug users to be model parents. They don't need the hammer of judgement and threat of punishment to strike their fingers as they seek to clamber out of the well into which they may have fallen.

119. Dr Sue Packer adds that a major obstacle for the Child Protection System is that its "priorities and actions are determined by legislation focused on detection of abuse, not prevention of abuse".

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63. Victoria Parr and John Bullen, AIVL National Anti-Discrimination Project; Qualitative Research Report, Prepared for: Australian Injecting and Illicit Drug Users' League (AIVL), (GfK bluemoon, February 2010) p. 19.

120. A still topical Australian survey of the impact of parental substance misuse on children is a report of the Australian National Council on Drugs (ANCD).64 Chapter 3 of that report mentions many factors associated with substance abuse and adverse outcomes for children. It is possible to distinguish between factors predominantly attributable to the substance use and those flowing from other risk factors which in most cases are traceable directly to or largely influenced by the policy response to illicit drugs. Unless otherwise indicated, references in the following section are to that ANCD report.

Women are deterred from engaging in treatment out of concern that their children will be removed

- "Of particular concern is the expressed reluctance of substance-abusing mothers to access treatment, particularly those most severely dependent upon both illicit drugs and alcohol" (§3.2.1).
- "Although drug treatment is regarded as a way of keeping children 'out of care' women are less likely to engage with drug treatment services due to anxiety that discovery of their drug problem will lead to the removal of their children" (§3.2.1).
- In the words of a nurse working in drug treatment: "because of the way the drug users themselves perceive, say, social workers that they're in the business of taking rather than supporting them to keep their kids, they don't tend to access those services because of the fear that because they're a drug user the kids are going to be lifted" (§3.2.1).
- There is evidence that women are more likely to seek treatment in England where fear of child removal is less than in the US (§3.2.1).
- "It is likely that seeking treatment is facilitated by policies that do not endorse automatic removal of children" (§3.2.1).
- Dr Sue Packer, drawing on many years experience as Paediatrician to the ACT Child at Risk Assessment Unit. has commented that for many pregnant women the approach of services " is still seen as a threat and is not trusted. Many of these women have had past dealings with a variety of government services and have come to mistrust such services because of these experiences."[65]

Stress of raising funds to support a drug habit

– Drug dependent mothers ". . . have to take care both of the business of child caring and the business of raising funds for their drug use and often that of their partners" (§3.2.1).
- "Some parents reported that their children had been exposed to periods without food, school or clean and safe home environments" (§3.3).

Significant emotional distress arising from other stresses and strains on mothers juggling substance use and parenthood

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64. Sharon Dawe, Sally Frye, David Best, Derran Moss, Judy Atkinson, Chris Evans, Mark Lynch, Paul Harnett, *Drug use in the family: impacts and implications for children* (Australian National Council on Drugs, Canberra, 2007) at https://www.researchgate.net/publication/37358668_Drug_Use_in_the_Family_Impacts_and_Implications_for_Children visited 22/06/2021

65 Sue Packer, *Parental substance abuse, parenting capacity and child protection: always a three way tug of war?* Drug Action Week Forum, 18th June, 2007 at https://www.ffdlr.org.au/forums/docs/Parental%20substance%20abuse1.pdf visited 24/05/2021.

– "The emotional distress women experience when they fail to achieve their mothering goals as the day-to-day pressures associated with the substance misuse overwhelm" (§3.2.1).

– "A vicious cycle is described where mothers use drugs to relieve the pressures of mothering, yet when 'straight' they find the damage they have committed when using so intolerable that they use again to escape the pressure of increasing worry and guilt" (§3.2.3).

Reduced capacity to attend to parenting needs

The disruptive imperative felt by drug using parents which reduces their capacity to attend to the needs of the children can be mitigated or even eliminated by pharmacotherapies and other treatments.

- "With increasing patterns of dependence, substance use becomes the central organising principle of the family. Household routines such as mealtimes, bedtimes and school attendance are said to take a secondary role to the parent's focus on the attainment of drugs. Family rituals such as bedtime reading and engagement in child play are said to rarely occur during periods of active use" (§3.4.1.1)

- "During times of active drug use, more than half of carers reported becoming irritable, intolerant, or impatient towards their children. This often resulted in parents using harsher discipline than they normally would, and being less flexible and open to children's needs . . . Other themes reported included yelling more often, being inattentive, regularly feeling guilty and overcompensation with generosity that was unaffordable, reactive and authoritarian parenting . . ." (§3.4.1.3)

Low sense of self worth of mothers arising from the marginalising perception in the community that drug using women are inadequate mothers

– "Drug-using mothers are portrayed within the media as desperate, impulsive and selfish. They are depicted as 'unfit mothers', 'victims of the frantic pull for drugs' which overrides the biological urge of motherhood, 'unable to care for others', unable to provide nurturance'" (§3.2.1)

– "Women drug users who are also mothers typically experience marginalisation and discrimination due to their parenting status" (§3.2.3)

– And to quote Dr Packer: "There is so much guilt associated with drug use. Substance using mothers often see themselves as "bad mothers" and this can be a barrier to them seeking "mainstream" help from health, mental health, housing and A&D services. I believe the way we offer these services, with so much "gate keeping", can be quite daunting" (footnote 65 above).

The low sense of self worth of many pregnant women combined with fear of the consequences of parental drug dependence becoming known, serves to isolate children of drug using parents from support networks.

- "All children interviewed expressed an intuitive awareness of the importance of keeping their parent's drug use secret outside of the family home. They reported covering up their parent's problem behaviour through the construction of stories, which normalised their home life while restricting access to the house for peers and others" (§3.3).

- "Unfortunately such behaviours served to isolate the children from available support networks both outside and within the family that might have helped foster resilience" (§3.3).

- "The fear expressed by the children about the consequences of disclosure to outsiders. Fuelled by feelings of loyalty to their parents, they are concerned that such admission might result in their separation from parents or exposure of their parent's problems and

possible imprisonment. Such fears trapped children in a position where they felt unable to ask for help" (§3.3)

- "The children of substance misusers need to be given opportunities to develop 'helping relationships' with professionals and, with that, the time and space to do so at their own pace. Children need to be encouraged to access resources and supports that might enhance the family capacity" (§3.3)

Community attitudes to drug use leads to secretiveness within families about drug use which impedes the capacity of parents to provide good parenting and causes confusion and anxiety to children.

- "The presence of the 'elephant' [of drug use], denied by the parent, obscures the child from the parent's care, and creates anxiety and confusion in the child as they question their own perceptions of the world and their place in it" (§3.3)
- There is a "need for professionals working in the field to encourage parents to break the burden of silence by speaking directly about their drug use with their children" (§3.3)
- "For many children the discovery of their parent's drug use was accompanied with heightened fears and anxiety about their parent's well-being and safety. They are aware from the media that drugs cause harm and even death, yet they are powerless to intervene." (§3.3)

Little family support for mothers who relapse

– "It has been argued that mothers who use drugs face a set of norms and standards far harsher than those confronting fathers who are also drug users. They receive less family support when they relapse than their male counterparts" (§3.2.1)

Little non-family support for drug using mothers

- "For many, the main form of assistance they receive is scrutiny of their parenting practices and subsequent removal of their children – children who often provide a key source of stability and self-worth in their otherwise chaotic lives" (§3.2.3).

Harsh penalties under criminal justice system

– Mothers often receive harsher penalties than men from the criminal justice system (§3.2.1).

Exposure of children to criminal behaviour

- "Children are also more likely to be exposed to criminal behaviour such as shoplifting, burglary or prostitution as parents attempt to finance their drug habits and this in turn may influence the child's developing attitudes towards criminal behaviour and criminal justice agencies" (§3.4.1.2).

Abandonment of children or other separation from parents

- "Abandonment or separation due to family breakdown, incarceration or raids in their homes, including times in which children had been removed in the middle of the night or when backyards/sandpits had been dug up" (§3.3).

Social deprivation

The focus on the drug dependence of parents and responses constrained by existing drug policy impede effective measures to address the underlying social deprivation that contributes to child abuse and neglect.

- "There is a strong view that social deprivation rather than drug use is the major issue in the lives of substance abusing women and their children. For many women poverty predates their drug use and is linked to the experience of adverse childhoods, the experience of violence, both past and present, lack of education, poor housing, nutrition and a general lack of support"(§3.2.1)

- "Most of the primary carers of the children were unemployed and relied on government benefits and family payments for their income" (§3.3)

The 2016 Review into the system level responses to family violence in the ACT expressed the imperative for this holistic response:

> When families experience vulnerability, they may need to access multiple services and supports spanning different service systems. These services and supports can be conceptualised as being part of the broader human services system.[66]

Yes, it comes back to a public health approach:

> "Adoption of the public health model in child protection and human services more broadly aims to shift the attention away from the statutory end of the service system to a more preventative and collaborative model by sequentially accessing the three levels for prevention usually represented as a pyramid: primary, secondary and tertiary".(the same).

Material deprivation

- "Money spent on alcohol and illicit drugs is money not available for other things. Women drug users report having to pawn their possessions in order to support their families, and some may engage in prostitution, petty crime or begging as a means of financial support" (§3.4.1.1)

Exposure of children to dangerous or inappropriate situations

- "About one-third of parents reported that their children had been negatively affected . . . from finding parents passed out or unconscious and not being able to wake them up, and from exposure to other dangerous or inappropriate situations" (§3.3).
- "Substance-abusing women are also more likely than the general population to participate in risky sexual practices and to have sex with multiple partners. This may be an important issue in many family settings. Such practices might introduce unsafe persons into the family home, which in turn may increase the child's exposure to potential situations of violence – physical, sexual or psychological – directed at the child, the parent or other occupants of the house." (§3.4.1.3)

Reluctance of women to remain in treatment out of concern for children

- "Women with two or more children [co-residing with her] in treatment are more likely to leave treatment prematurely possibly due to the competing demands between child care and program content. " (§3.2.2)
- "The risk of early departure also appears more likely when the program demands are high" (§3.2.2)

Scarcity of drug treatment services that provide for children

- "Few Australian treatment services provide facilities that welcome children, such as child-friendly waiting rooms or child care services to cater for the needs of children while their parents access treatment" (§3.2.1).

66. Laurie Glanfield, Report of the Inquiry: Review into the system level responses to family violence in the ACT (April 2016) at https://www.cmtedd.act.gov.au/__data/assets/pdf_file/0010/864712/Glanfield-Inquiry-report.pdf visited 21/05/2021.

- "Few residential treatment programs provide additional facilities and services to manage the day-to-day needs of children, while their parents are undertaking long-term treatment." (§3.2.1).
- "There is evidence that women are more likely to seek residential treatment when child care and support services are provided for their children. They tend to stay for longer periods of time and, importantly, follow-up outcomes including reduction in criminality and abstinence rates appear to be better when children reside in treatment with their mothers" (§3.2.2).
- "Co-residency with children has also been shown to significantly increase the likelihood that the family will remain intact post-treatment" (§3.2.2).

Karralika provides an excellent co-residency service here in the ACT but its capacity is severely limited and cannot meet the demand for its services.

Recommendation 1

The Government should expand the capacity of co-residency services in the ACT such as Karralika for drug dependent parents and their children.

Deterrence of co-operation of drug using mothers in research on strategies to help support them and their children

- "In contrast [to the case of alcohol], drug-using parents are reported to be reluctant to directly involve their children in research due to fears and anxieties regarding the potential of child removal" (§3.3).
- "What seems to arise in many drug-using families is 'a conspiracy of silence' – problem drug use is hidden and discussion of the topic considered taboo" (§3.3)

5.10 SOCIAL EXCLUSION INCLUDING HOMELESSNESS

121. "Drug dependency is associated with exclusion from the basic minimums of what one expects of a society including housing and employment and the wherewithal to participate fully in it. In, for example, 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."[67] Existing drug treatments help this process. Heroin assisted treatment does it much more efficiently. The "marked improvements in social functioning" in Switzerland attributed to heroin assisted treatment[68] 'improved in all the intervention groups with heroin groups having slightly better results." (fn 21 above on page 27)

122. The Swiss trial recorded that:

67. 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. 43 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.

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

> "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).
>
> "Contact with drug addicts and the drug scene decline massively but was not adequately replaced by new social contacts during the observation period."[69]

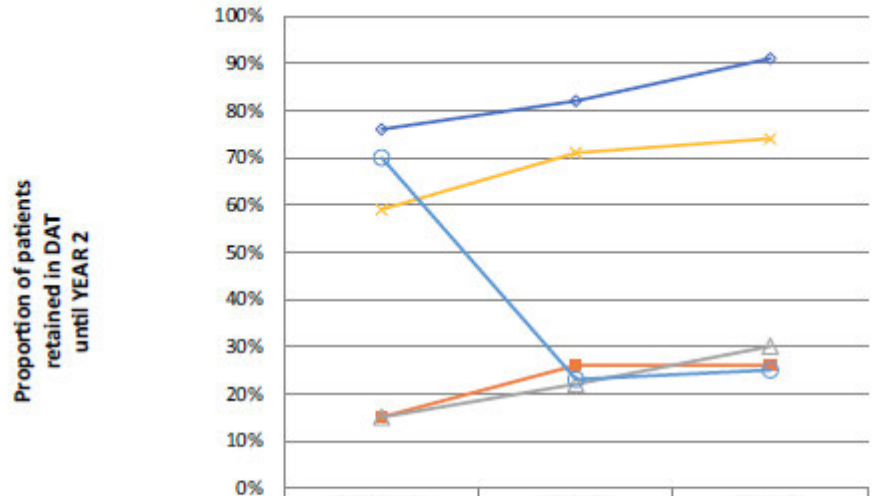
123. The improvement in social integration and reduction of risk factors for crime ascertained in the German trial of Heroin Assisted Treatment showed comparable improvements:

> "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 reflected in the following chart.

69. A. Uchtenhagen, A. Dobler-Mikola, T. Steffen, F. Gutzwiller, R. Blättler & S. Pfeifer, Prescription of narcotics for heroin addicts: main results of the Swiss national Cohort Study (Karger, Basel, Freiburg, Paris &c, 1999) being vol. 1 p .6 of A. Uchtenhagen, F. Gutzwiller, A. Dobler-Mikola, T. Steffen, M. Rihs-Middel, Medical prescription of Narcotics.

Figure 19: Improvements in the social situation of patients in the German trial of heroin assisted treatment



	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])

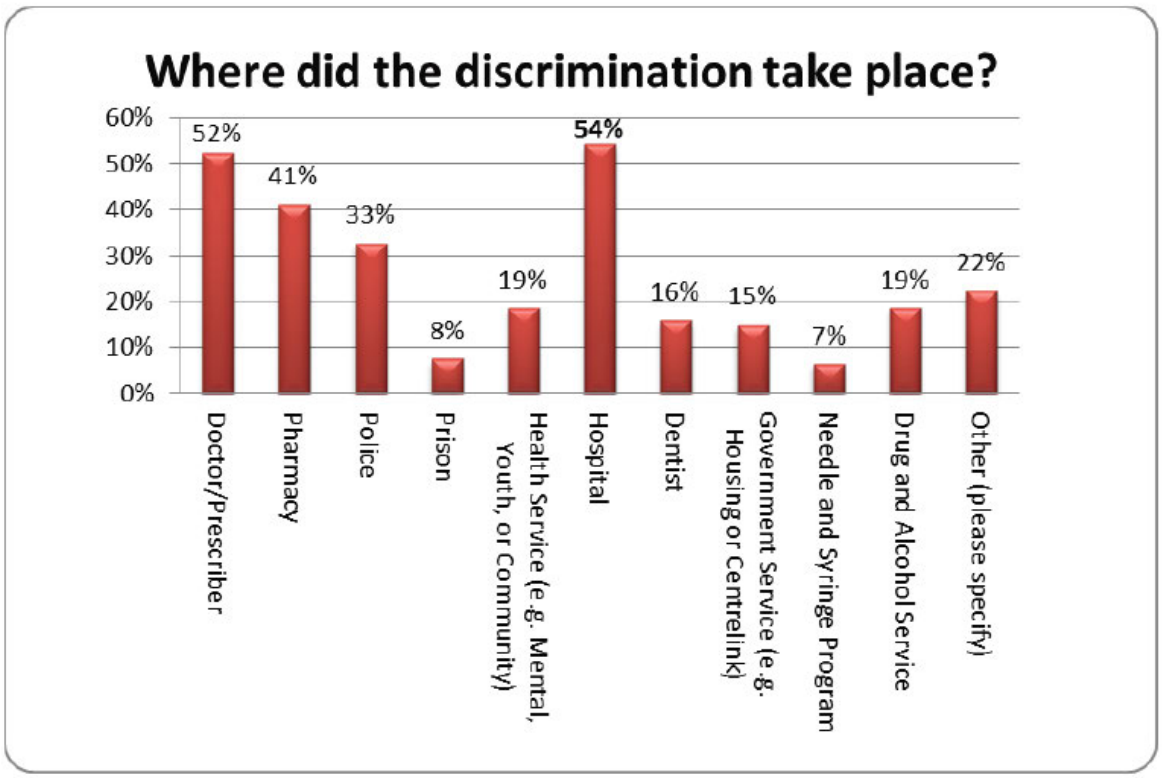
SOURCE: James Bell, Vendula Belackova, Nicholas Lintzeris, Supervised Injectable Opioid Treatment for the Management of Opioid Dependence, Drugs (2018) 78:1339–1352; Drugs. 2018 Sep;78(13):1339-1352 at p. 1347. doi: 10.1007/s40265-018-0962-y.at https://pubmed.ncbi.nlm.nih.gov/30132259/ visited 17/05/2020.

5.11 STIGMA TOWARDS DRUG USERS BY HEALTH PROFESSIONALS AND OTHER SERVICE PROVIDERS

124. It is not just community attitudes with which drug users must wrestle but also those who are there to help them. Pervasive discrimination against people who use drugs and particularly those who inject them is graphically illustrated by an online survey conducted by AIVL. The particularly frightening aspect of it is that in the eyes of injecting drug users, this discrimination is most manifested by the very people who provide the health and other services that drug users must rely upon.

125. Stigma and marginalisation of people who use drugs is very definitely a fruit of drug policy.

Figure 20: Where injecting drug users experienced discrimination

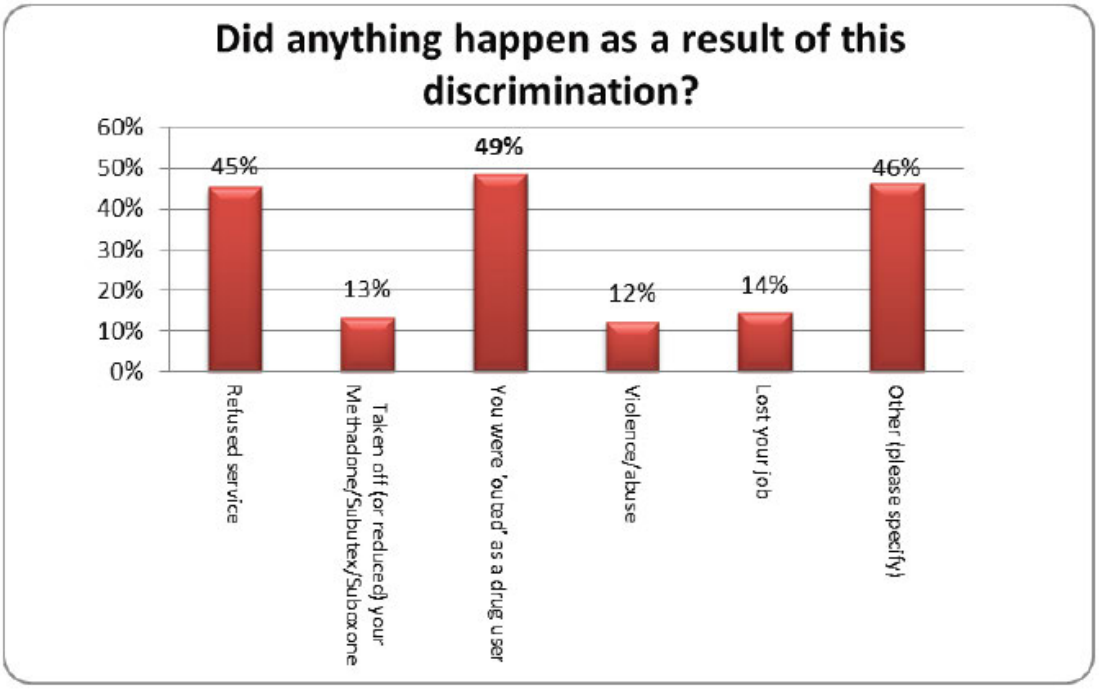


SOURCE: AIVL regular bulletin on BBV & injecting drug use related research and policy, issue 12, Apr - Jun 2012 at http://www.atoda.org.au/wp-content/uploads/AIVL-Research-Policy-Update-Issue-12_0.pdf visited 22/05/2021.

And that fruit is poisonous.

126. The discriminatory attitude of health professionals and others who drug users need to rely upon for support is translated into a barrier accessing the treatment and services they need. This stigma by health professionals towards drug users can be minimised by working closely with peer services provided by user groups; and supporting indigenous holistic health providers like Winnunga Nimitija.

Figure 21: Some consequences experienced by injecting drug users as a result of discrimination



SOURCE: AIVL regular bulletin on BBV & injecting drug use related research and policy, issue 12, Apr - Jun 2012 at http://www.atoda.org.au/wp-content/uploads/AIVL-Research-Policy-Update-Issue-12_0.pdf visited 22/05/2021.

5.11.1 Roadside drug testing for presence not impairment marginalises drug users

127. Roadside drug testing targets the mere presence of an illicit drug irrespective of whether that presence impairs the capacity of the consumer to drive. Roadside drug testing is not random. Registration plates of vehicles driven by those known or suspected of using drugs are targeted. People for whom a car is essential to support their family or hold down a job are driven by desperation to defy the law thus facing very serious consequences including imprisonment.

128. No one is arguing that road safety authorities should cut corners on road safety. Families and Friends understand that tests for impairment already exist equivalent to blood alcohol levels for driving. And we have in the past floated perfectly as feasible the idea of portable impairment testing machines that could be used in an untargeted way to detect suspected impairment arising from any drug, legal otherwise. If road safety is the overriding objective active, that is the way to go.

129. In the meantime roadside drug testing reinforces the debilitating stigma and marginalisation of drug users.

6. Support for Families

6.1 Incapacitating emotions experienced by families

130. The political attraction of prohibitionist drug policy to politicians of a certain sort is that in spite of the failure of that policy to keep drugs from their loved one, the families themselves all too often blame themselves for their awful situation. A parent, coming to the realisation that their child or other family member is into drugs is typically assailed by a range of emotions including grief for lost dreams, shame, loneliness and withdrawal from all that makes life worth living.

6.2 Grief for lost hopes and dreams

131. Grief and loss of hope that so often accompanies drug dependency of a loved one is encapsulated in why Families and Friends conducts its annual remembrance ceremony in Weston Park for those who die from our efforts to save them from drugs.

> "So this memorial and this day were chosen as a message to a nation to help break a silence of prejudice and ignorance that has left many to bear their grief in an isolation tinged with shame. Remembrance here has helped many cope with anger too: anger at the lack of help, at the pressures on us to abandon those we loved - particularly where we yielded.
>
> "The memorial is also a symbol of defiance. It affirms that the deaths of most if not all those for whom we mourn today were avoidable. They met their death along a path they chose - a path that we may not understand or agree with - but certainly a path that should not have made them an outcast or have led to their death."[70]

6.3 Isolation

132. Parents typically feel that they are completely on their own with no one to reach out to for support. Watching, powerless, a child bent on a destructive course of action is likened to a train wreck captured in slow motion.

> "loneliness is exactly what they feel. For many, the stigma and shame of having drug user the family has meant that even close friends and family – usually the sounding board for all kinds of personal troubles and secrets – not confided in. Even if they are told, the resulting reaction – often shot, followed by uncomfortable and unhelpful signs from people who just don't know how to support you – can only lead to feeling further shame, isolation and secrecy."[71]

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70 Families and Friends for Drug Law Reform, *Why Remember,* 26 October 2015 at https://www.ffdlr.org.au/memorial/docs/20th/Program15.pdf.

71. Tony Trimingham, *Not my Family; Never my Child: what do do if someone you love is a drug user* (Allen & Unwin, Crows Nest NSW, 2009) p. 47.

133. In so many ways the experience of grieving parents tracks the experience of their child implacably bent on their self-destructive course: isolation characterises the experience of both carers and consumers. The latter "commonly have limited social networks, as rejection by non-using friends often leads to social isolation"[72]. Stigma and marginalisation that so disempowers harms drug users also infiltrates the existence of fearful families and carers compounding their problems (Section 5.10 Social exclusion including homelessness

121. "Drug dependency is associated with exclusion from the basic minimums of what one expects of a society including housing and employment and the wherewithal to participate fully in it. In, for example, 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." Existing drug treatments help this process. Heroin assisted treatment does it much more efficiently. The "marked improvements in social functioning" in Switzerland attributed to heroin assisted treatment 'improved in all the intervention groups with heroin groups having slightly better results." (fn 21 above on page 27)

122. 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).
>
> "Contact with drug addicts and the drug scene decline massively but was not adequately replaced by new social contacts during the observation period."
>
> 123. The improvement in social integration and reduction of risk factors for crime ascertained in the 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]

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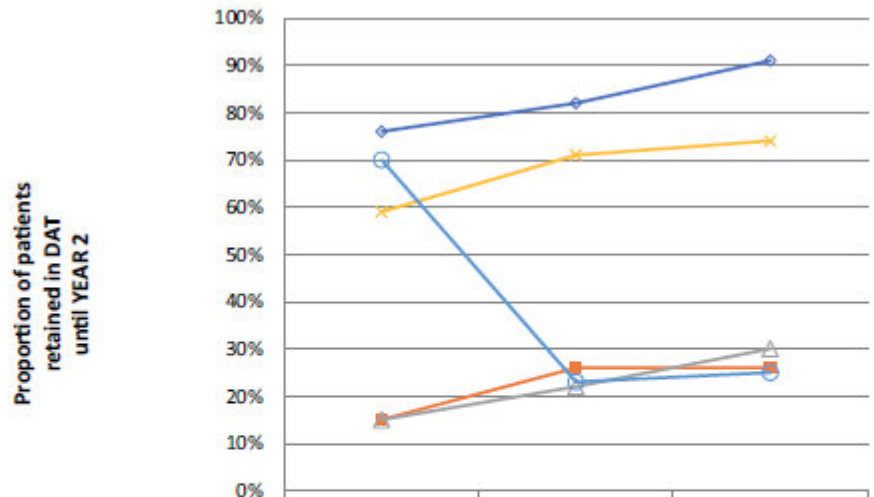
72 Goodhew M, Salmon AM, Marel C, Mills KL, Jauncey M., Mental health among clients of the Sydney medically supervised injecting Centre (MSIC). *Harm Reduct J* 2016;13:29

These improvements are reflected in the following chart.

Figure 19: Improvements in the social situation of patients in the German trial of heroin assisted treatment



	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])

SOURCE: 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. 1347. doi: 10.1007/s40265-018-0962-y.at https://pubmed.ncbi.nlm.nih.gov/30132259/ visited 17/05/2020.

Stigma towards drug users by health professionals and other service providers).

6.3.1 Sense of failure and self-blame

134. It is true that there is a greater prevalence of drug problems in disadvantaged families but drug use can afflict any family. Personality types Young people with a large swathe of personality types – risktakers and those unsure of themselves looking around for support, are at risk of dabbling with drugs.[73] Small proportion of these will become dependent. In short drug use can happen in any family. "Dismissing drug problems as afflictions of the poor, poorly educated or dysfunctional is simply not true I have seen," writes Tony Trimmingham, "people in the most exclusive suburbs battle with the same issues as people from stereotypical

73. Blue Moon Research & Planning Pty Ltd, *Illicit drugs: research to aid in the development of strategies to target youth and young people prepared for the Commonwealth Department of Health & Aged Care,* Population Health Social Marketing Unit (June 2000) at http://www.health.gov.au/pubhlth/publicat/document/reports/nidc_bluemoon1.htm visited 14/11/02

poor areas drugs do not discriminate." "It is common," he continues, "to feel shame or a sense of failure when you discover that someone you love is a drug user, however it is not your fault. It does not mean that you are a bad parent. Surrounding yourself with blame and shame will not allow you to move forward on your journey and should be dispensed with as soon as possible in order to really help yourself and the drug user."

6.4 MORE SUPPORT FOR AGENCIES THAT SUPPORT FAMILIES

135. Extrapolating from an estimated 700,000 people in Australia as the level of unmet demand for drug and alcohol treatment (para 49, p. 34 above), there would be 11,760 people in the ACT prepared to seek treatment who are unable to secure a place. If this is anywhere near correct it points to enormous pressure on families. First and foremost, families want help for their drug dependent child or other family member. The less beds there are available the greater the burden that falls upon the family.

6.4.1 Directions

136. Directions Health Services: pathways to recovery (https://www.directionshealth.com/support-self-help-groups/) provide treatment and support services for people impacted by alcohol and other drug use.

6.4.2 Family Drug Support

137. Family Drug Support operates a 24 hour, seven day a week telephone support line accessible to ACT residents. In 2018-19 it fielded 425 calls from the ACT. With a Household Survey estimate of 50,000 recent drug users[74], many more calls might be expected were such a service more publicised.

138. Family Drug Support has produced a *Guide to Coping*,[75] Its founder, Tony Trimigham, has written a book, *Not my family; never my Child: what to do if someone you love is a drug user* (see fn 71). It runs excellent Stepping Stone and other courses over two weekends that arm families with an understanding of addiction and strategies to help them cope with the situation in which they find themselves. For want of financial support from the ACT to FDS neither these courses nor support meetings for carers that the FDS runs across the country are presently available in the ACT.

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74. Table S.24: Recent illicit use of any drug(a), people aged 14 and over, by state/territory, 2001 to 2019 (persons), AIHW, National Drug Strategy Household Survey 2019, State and territory factsheets, Supplementary data tables, July 2020 at https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data?page=2 visited 22/06/2021.

75. Tony Trimingham, *A guide to coping; support for famiies faced with problematic drug use* (Family Drug Support & Queensland Injectors Health Network, Leura & Fortitude Valley, 2007).

6.5 IMPROVEMENTS TO THE PERSONAL USE AMENDMENT BILL

139. The bill will extend the old cannabis expiation notice system to a range of other drugs of concern. Families and Friends welcome this as a significant retreat from reliance on the criminal law as the principal underpinning of drug policy. We do so because this form of decriminalisation has been shown to substantially reduce the social harms associated traditional arrest and prosecution for drug use.

6.6 SOCIAL BENEFITS OF AN EXPIATION NOTICE SYSTEM

140. The social benefits of an expiation notice system were demonstrated when experience of a cannabis expiation system in South Australia was compared to the experience in neighbouring Western Australia which, at the time, retained the traditional criminal law based approach.

141. The divergent practices of those neighbouring states made it possible to compare an expiation notice process similar to on-the-spot parking tickets for minor cannabis offences with contemporaneous operation of the traditional prosecution approach; between incurring a civil rather than a criminal penalty.

142. A study[76] found that those prosecuted in Western Australia were more likely to report negative employment consequences than those who received an expiation notice in South Australia. The difference was marked. Of the Western Australia group 32% identified at least one negative employment consequence and 16% of these were sacked as a result of the offence. In South Australia only 1.7% reported such a negative consequence.

143. In personal relationships only 5% of the South Australian group reported negative consequences compared to 20% of the Western Australian group. Whereas 16% of the West Australian group reported negative consequences in their accommodation, none of the South Australian group did so.

144. In contrast to the marked negative impact of the application of the traditional criminal processes in Western Australia compared to South Australia, the Western Australian process did not serve as a stronger deterrent against actual cannabis usage. This aspect is mentioned further below (Lenton et al. 1998, x).

145. The study thus found that the different strategies used to combat cannabis usage had significantly different incidental impacts on cannabis users – impacts that heighten known risk factors for mental illness and drug use such as unemployment, poverty, homelessness, insecurity, divorce and family break-up.

146. In short the expiation notice system as provided for in the Bill would markedly reduce the harms referred to at section 5, p.37 that are attributable to drug law

76. Lenton, Simon, Paul Christie, Rachel Humeniuk, Alisen Brooks, Mike Bennett, Penny Heale (1998), *Infringement versus conviction: the social impact of a minor cannabis offence under a civil penalties system and strict prohibition in two Australian states,* National Drug Strategy monograph series no. 36 (Department of Health and Aged Care, Canberra) p. x.

enforcement. Families and Friends nevertheless believe that further adjustments should be made to the bill to maximise its benefits.

6.6.1 Drugs embraced by the Bill

The drugs which the Bill to which the expiation notice system might apply are the following:

methylenedioxymethylamphetamine (MDMA) – ecstasy
amphetamine – speed
cannabis (dried)
cannabis (harvested)
cocaine
heroin
lysergic acid (acid)
lysergide (LSD, LSD-25)
Methadone
Methylamphetamine (crystal meths)
Psilocybine (magic mushrooms)

147. The intrinsic harm of these drugs differs. A report by British experts published in The Lancet ranks 20 legal and illicit drugs according to their harm measured. It does so under three parameters: physical harm, dependence and social harm.77 The study ranked them in the following order of harmfulness with the most harmful first:

1. Heroin
2. Cocaine
3. Barbiturates
4. Street methadone
5. Alcohol
6. Ketamine
7. Benzodiazapines
8. Amphetamine
9. Tobacco
10. Buprenorphine
11. Cannabis
12. Solvents
13. 4-MTA
14. LSD
15. Methylphenidate (Ritalin)
16. Anabolic Steroids
17. GHB
18. Ecstasy
19. Alkyl nitrates
20. Khat

77. David Nutt, Leslie A King, William Saulsbury, Colin Blakemore, "Development of a rational scale to assess the harm of drugs of potential misuse" in *The Lancet,* vol 369 pp. 1,047-53 (24 March 2007) at www.thelancet.com.

148. Unfortunately the study, being based on common drugs in Britain, did not seem to rank methamphetamine.

149. You will undoubtedly need to wrestle with the argument that the more harmful illicit drugs in this list should be excluded from the expiation notice system. Families and Friends robustly rejects this argument. Those entangled with those drugs are the ones who are in most in need of help. As discussed at para. 1, p. 14criminal sanctions obstruct people who need help from getting it. This position is convincingly argued in the discussion paper of the Uniting Church on *Options for changing the law*:

> §One possible rationale for decriminalisation of some drugs but not others appears to be the assumption that substances such as cannabis are less harmful or problematic and can therefore be decriminalised with less risk. While superficially appealing, this does not survive serious scrutiny. The more serious social and health problems associated with the use of opioids and methamphetamine mean a health-and-wellbeing-oriented response is more appropriate than a criminal response for these substances than it is for cannabis. By retaining criminal sanctions for 'harder' drugs, legislative barriers preventing those who need help the most are retained.[78]

150. If drug law enforcement applied to users serves to stimulate rather than suppress drug supply, you should canvas other strategies. If decriminalisation reduces drug supply and facilitates treatment and support there should be nothing to stop its introduction.

6.6.2 Challenges posed by the inclusion of crystal methamphetamine

151. This drug is of considerable community concern. Its short term effects include nervousness, anxiety and paranoia and aggression and violence. In the longer term poor concentration and memory and psychotic symptoms such as paranoia and hallucinations.[79]

152. For all the concern about "ice" as it is commonly referred to, at 26% it ranks just fourth as involved in drug induced deaths. It is ranked well after opioids (68%), anti-epileptic sedatives- hypnotic and anti-parkinsonian drugs (58%) and antidepressants at 27% (Figure 13: Drug-induced deaths in Australia in 2018, p. 40).

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78. Uniting, Discussion paper Advocacy, and Research and Social Policy, *Possession and use of drugs. Options for changing the law* prepared collaboratively by Tom McLean, Alison Ritter, Will Tregonning, Marianne Jauncey & Emma Maiden (Advocacy, and Research and Social Policy, 25 November 2020) at https://www.uniting.org/content/dam/uniting/documents/community-impact/research-and-innovation/discussion_paper_drug_possession.pdf visited 04/02/2021.

79. Australian Institute of Health and Welfare, Alcohol, tobacco & other drugs in Australia; Meth/amphetamine and other stimulants, Web report, Last updated: 16 Apr 2021 at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/meth/amphetamine-and-other-stimulants visited 26/05/2021.

153. There is no clearer illustration of the bankruptcy of Australia's policy of drug prohibition than the advent of ice. The first mention of its import from South East Asia appeared in the *Australian illicit drug report* of 1996-97.[80] Until replaced by ice the Australian drug market was supplied with the much less potent powdered form of the stimulant amphetamine known as "speed".[81]

154. By 2001 Australian law enforcement authorities were aware of a bold business plan of South East Asian crime syndicates to introduce and aggressively market potent methamphetamine in Australia. The plan and its implementation shows the clear commercial focus and capacity of organisations of criminal groups. The then AFP Commissioner himself revealed this during the height of the heroin drought. In a press interview that he gave in June 2001 he was reported as saying that there had been: "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. . . . Mr Keelty said the Asian drug barons would continue to supply some heroin to the Australian market, but intelligence suggested they were gearing up to aim for a new and much bigger market of people prepared to use methamphetamine pills." The decision, he stressed, was "a conscious" one "to move the market away from heroin into something that is far easier to put into the marketplace".[82] He revealed that "their market research …. tells them that these days people are more prepared to pop a pill than inject themselves".[83] . 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.[84] It was a case of out of the heroin frying pan into the crystal meth fire. .

155. While initially all imported and ingested orally or inhaled, ice has come to be substantially supplied by domestic ice labs and, like heroin that it initially ousted, has come to be often administered by injection. These developments follow a familiar pattern of prohibition. Alcohol prohibition in the United States saw the replacement of

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80. Australian Bureau of Criminal Intelligence, *Australian illicit drug report 1996-97* (Australian Bureau of Criminal Intelligence, Canberra, December 1997) p. 56.

81. Families and Friends for Drug Law Reform, *Submission of Families and Friends for Drug Law Reform to the inquiry by the Parliamentary Joint Committee on the Australian Crime Commission into amphetamines and other synthetic drugs* (March 2006).

82. Keith Moor, "Drug lords push deadly new deals" in *Herald Sun* (Melbourne) Tuesday, 19 June 2001, p. 10.

83. Keith Moor, "Drug gangs' new threat" in *Herald Sun* (Melbourne) Tuesday 19 June 2001, pp. 1 & 4.

84. Ben McDevitt, general manager, Australian Federal Police National Operations, Evidence to the House of Representatives, Family and Community Affairs Committee inquiring into substance abuse in Australian communities, at *Committee Hansard*, Friday, 16 August 2002 pp. FCA 1,217-1,229 at p. 1,221.

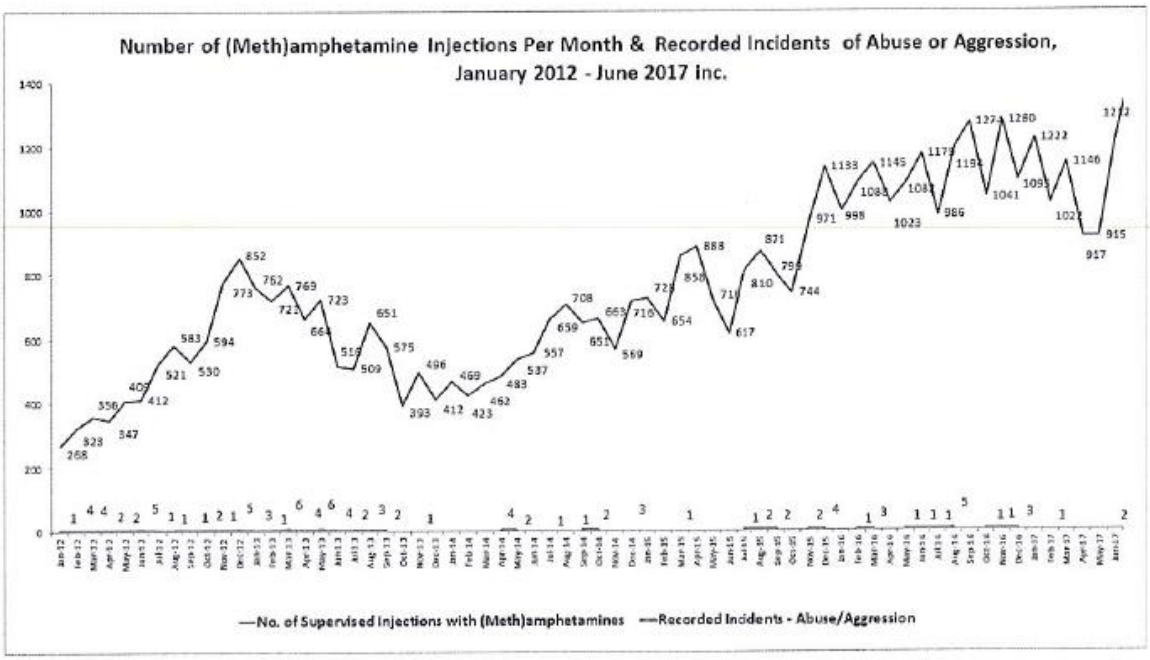
low potency beers by high potency, more harmful concentrated spirits which were more easily smuggled.

156. Tony Trimingham, the founder of Family Drug Support, has observed that for all the panic and fear associated with crystal methamphetamine, it is just a drug. The approach that FDS advocates (see Figure 26: Stages of change towards successful coping,) is illustrated in an interview of Tony Trimmingham with a mother Debbie Warner who lived with one son (Chris) who became addicted to heroin and another son (Matthew) who at the time of interview remained deeply into ice (https://www.youtube.com/watch?v=xobeOUAN9mA). The testimony of Jay Morris on the Australian Drug Foundation website (https://adf.org.au/programs/breaking-ice/) applies the same principle.

6.6.3 Aggression and violence

157. Aggression and violence which is often a concomitant can be minimised to the point of nonexistence by low threshold, skilled and understanding service. This is the experience of the Medically Supervised Injecting Centre in Sydney which has long permitted the injection of crystal meths)).

Figure 22: (Meth) amphetamine injections and recorded incidents of abuse or aggression at the medically Supervised Injecting room, Kings cross



SOURCE: Uniting. Marianne Jauncey & Robert Graham, *Uniting Medically Supervised Injecting Centre Submission*; Special Commission of Inquiry into the Drug "ice" (Sydney, 2019)

6.6.4 Search for a pharmacotherapy

Ice is such a challenging drug because there exists no pharmacotherapy with which dependent users can be stabilised. There is, in other words no equivalent of methadone, buprenorphine, hydromorphone or even heroin itself that is able to

stabilise those dependent upon opiates. "While counselling is quite effective for many people with less problematic methamphetamine use, we currently don't have a proven medication treatment for severe methamphetamine dependence." Presently treatment for ice dependency relies principally on skilled psychological counselling practising Cognitive Behavioural Therapy.

Research (termed the LiMA study) is underway into the suitability of lisdexamfetamine as a treatment to reduce methamphetamine use, cravings and withdrawal symptoms for methamphetamine dependence. Lisdexamfetamine is an existing drug used to treat Attention Deficit Hyperactivity Disorder (ADHD).

Lisdexamfetamine is showing "some initial promising results." In 2018 the LiMA study was recruiting 180 people in specialist Drug and Alcohol treatment centres in Newcastle, Sydney (St Vincent's Hospital and Western Sydney Drug Health), and Adelaide.[85]

158. A second pharmacotherapy is being trialled by the National Drug and Alcohol Research Centre of the University of New South Wales. This is N-acetyl cysteine (NAC). The drug targets "brain changes that underpin craving and addiction. It helps restore balance to those brain systems, and in doing this, it helps reduce the craving for ice." The ICE trial started in mid-2018. It is being conducted in outpatient settings in Melbourne, Geelong and Wollongong. The trial is expected to be completed this month (June 2021). The Committee needs to keep an eye out for the results.[86]

6.6.5 Decline in ice use

159. It should also should be pointed out that the Covid 19 pandemic has seen a long and substantial decline in use of crystal methamphetamine among young people. This probably indicates that the drug is going out of fashion. It reflects a far less dramatic decline in the broader population interrupted by floods of the drug:

> "The weight of ATS (including MDMA) detected this reporting period is more than double the combined weight of cannabis, heroin and cocaine detections. Methylamphetamine, which accounts for the majority of ATS, remains the most consumed illicit drug of those monitored by the National Wastewater Drug Monitoring Program based on available dose data. It is estimated that 11,516 kilograms of methylamphetamine is consumed annually in Australia, with 4,418 kilograms of amphetamines—the majority of which is methylamphetamine—seized nationally in 2018–19." (fn16 at p.2, p.25)

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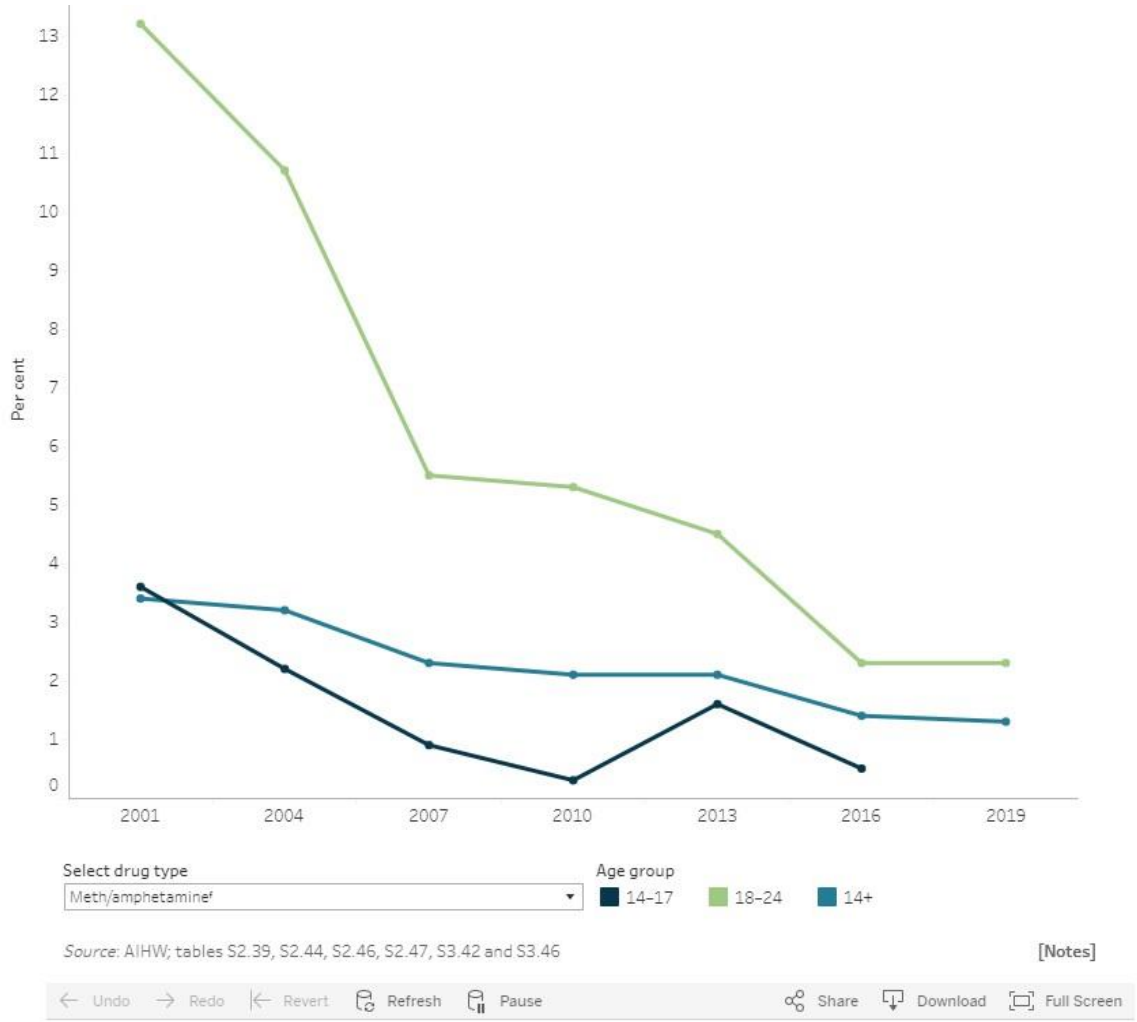
85. University of Newcastle, Study trialling ADHD drug to treat ice dependence; A world-first clinical trial to treat people with problem methamphetamine ('ice') use is now underway in the Hunter University News (University of Newcastle, 30 July 2018) at https://www.newcastle.edu.au/newsroom/featured/study-trialling-adhd-drug-to-treat-ice-dependence visited 08/06/2021.

86. The N-ICE trial: A randomised controlled trial of the safety and efficacy of N-acetyl cysteine (NAC) as a pharmacotherapy for methamphetamine ('ice') dependence https://ndarc.med.unsw.edu.au/project/n-ice-trial visited 11/06/2021

The ATS market, which in Australia is primarily comprised of methylamphetamine, is large and expanding. (fn16 at p.9, p.25).

Figure 23: Proportion of people in younger age groups with recent use of methylamphetamine, 2001 to 2019 (per cent)



SOURCE: Australian Institute of Health and Welfare, Alcohol, tobacco & other drugs in Australia; Meth/amphetamine and other stimulants, Web report, Last updated: 16 Apr 2021 at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/meth/amphetamine-and-other-stimulants visited 26/05/2021

6.6.6 The adequacy of the threshold amounts

160. Families and Friends are not in position to comment on the amounts involved beyond making the point that the amounts specified must be realistically based on the patterns of use by the people who use those drugs. Quantities that are less than that realistic level would expose users to police harassment facilitated by the much easier procedure involved in issuing an expiation notice compared to arrest and prosecution. It is important that the bill not be a device to widen the net that catches drug users.

6.6.7 The penalty envisaged still subjects drug users to the processes of the criminal law.

161. Under the bill the drug user can still be enmeshed in the harmful processes of the criminal law. Fines when incurred are enforceable on pain of imprisonment.[87] The criminal law thus remains the ultimate enforcer and guarantor of the expiation notice system. Given that drug policy invokes the coercive authority of the criminal law to achieve a therapeutic end, it stands out as a unique exception in medical practice the foremost important ethical principles of which are: "respect for autonomy, beneficence, non-maleficence and justice."[88] The infliction of a fine disrespects the autonomy of the person who uses drugs and as discussed above disrespects the principle of non-maleficence.

162. A smaller fine is obviously preferable to a larger one but even a small one can bear disproportionately on a very disadvantaged population such as many drug users are. A fine is preferable to arrest and prosecution but there are better alternatives which the committee would be advised to recommend. Families and Friends are accordingly persuaded by the position put by Uniting that taking no action is a viable option for users who are not dependent:

> "Given the fact that 43.2% of people over the age of 14 have used drugs in their lifetime (with 16.4% in the past year) (see p. 34 Figure 12: Lifetime and recent use of illicit drugs), taking no action is a credible option, at least for the vast majority of people who use drugs and are not dependent."(footnote78 above)."

163. Conceptually we would prefer to see a Portuguese model where, the focus is overwhelmingly on drawing drug users, when they can benefit from it, into treatment or other services where these are needed rather than on any punitive consequence. Essentially this was also the conclusion that the New South Wales ice inquiry came to.

> The Inquiry notes the tension between recognising that most people detected in possession of prohibited drugs do not require drug treatment services, the desirability of encouraging into treatment those whose use is harmful and concern with coercive models of treatment. The evidence supports the provision of an appropriately tailored education, health or social intervention at or close to the point of detection.' (vol 2, para. 11.17)".

87. Fine enforcement action under S.116 *Crimes (Sentence Administration) Amendment Act* 2010 (no. 21 of 2010).

88. World Medical Association, *Medical ethics manual* 3rd edition, 2015 at https://www.wma.net/wp-content/uploads/2016/11/Ethics_manual_3rd_Nov2015_en_1x1.pdf#page=18 visited 25/05/2021.

6.6.8 Elimination of the offence of drug consumption.

The Bill provides for a "simple drug notice" for the "possession" of the listed quantities of drugs. This can be interpreted as leaving unchanged the existing law that by referring to "use" in s. 174(2) of the Drugs of Dependence Act 1989, makes it an offence to consume drugs. This situation should be remedied by removing the offence of drug consumption or "use".

6.6.9 The extent to which the decision to proceed with criminal prosecution or an expiation notice is at the discretion of police

164. If all the conditions for the issue of an expiation notice are satisfied the decision whether to proceed by way of such a notice should not be in the hands of police. In other words if under the Act such a notice may be issued, the decision to do so should not be left to the discretion of the police officer.

7. Mental health

165. There is a large co-occurrence of substance dependency and other mental health conditions to the extent that this overlap is regarded as the expectation rather than the exception. In the words of the Productivity Commission

> "Substance use comorbidity is common for individuals with some types of mental illness, and a large proportion of people who present for substance use treatment display symptoms of mental illness."[89]

166. Using data from the latest household survey (that of 2019), the Australian Institute of Health and Welfare reports that "compared with people without mental health conditions, people with a mental health condition were 1.7 times as likely to have recently used any illicit drug (26% compared with 15.2%)".[90]

167. A lack of coordination between drug and alcohol policy and mental health services goes to explain much of the crisis in Australia's mental health system. Drug prohibition underpinned by the criminal law has criminalised much of 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 sustained and comprehensive rehabilitation, and are instead crowded into our

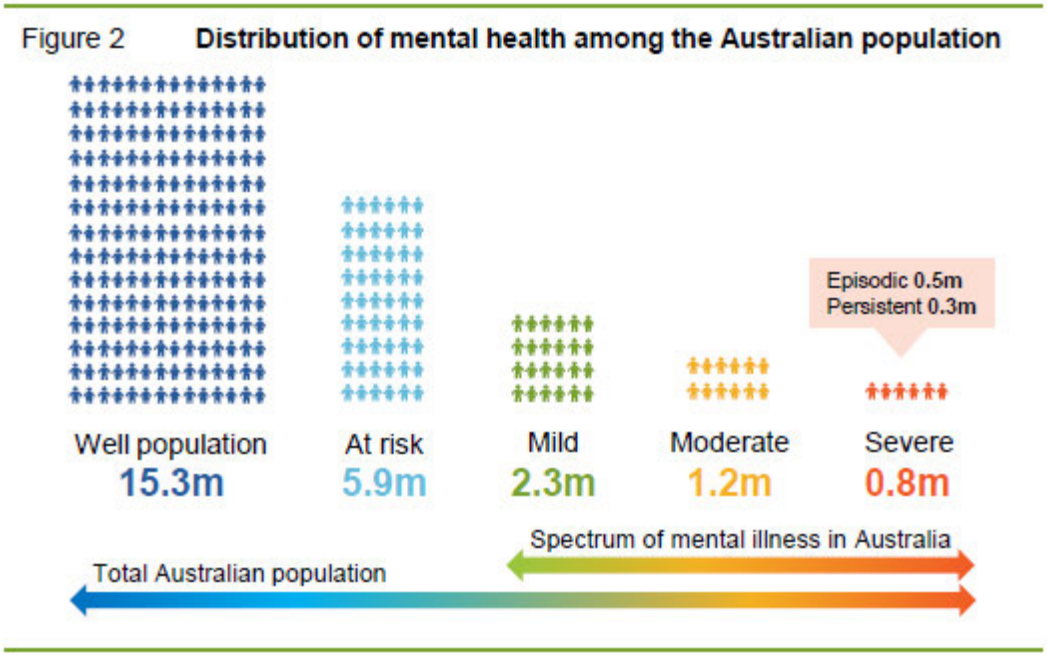
89. Productivity Commission, *Report Mental Health* vol. 1, No. 95, p.39 (30 June 2020) at https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf visited 08/12/2020.

90. Australian Institute of Health and Welfare 2021, *Alcohol, tobacco & other drugs in Australia, People with mental health conditions* (AIHW, Canberra, last updated 16/04/2021 v11.0) at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions visited 19/05/2021

new asylums, the prisons, where the prevalence of schizophrenia is at least 10 times that of the wider community.[91]

168. People experiencing co-occurring problems of mental health and substance dependency are preponderant among those with most complex needs who require high-intensity care. In the distribution of mental health needs across the population, such people make up a high proportion of those with severe conditions. It is probably no coincidence that the following figure from the Productivity Commission's report estimates that 800,000 people are in the category of those with the most severe needs. It is probably not altogether a coincidence that this number is comparable to the 700,000 people mentioned in paragraph 49 at p. 34 above who are estimated to require drug and alcohol treatment.

Figure 24: Distribution of mental health among the Australian population



169. Thus, many of the Productivity Commission's estimate of 800,000 people with severe mental health needs will have a co-occurring substance dependency. The ACT has 1.68% of the Australian population. Extrapolating from that, the ACT's share of people with severe mental health needs is 13,440, a number that would swamp the ACT's health service capacity. If the needs of those with co-occurring problems can be successfully addressed, a great burden will be lifted from the territory's mental health system.

91. 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.

170. A landmark New Zealand Inquiry into mental health saw decriminalisation as integral to the essential integration of the all too often competing silos of drug and alcohol and mental health. 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"[92]

7.1 SERVICES SHOULD ADDRESS BOTH MENTAL HEALTH AND SUBSTANCE USE NEEDS

171. No wonder that patients and carers are notoriously suffering at the hands of a dysfunctional relationship between mental health and drug and alcohol services. There are instances of people being discharged from the Adult Mental Health Unit into the care of completely overwrought parents. The parents were left with little more than intermittent support from a community mental team. This has happened in spite of pleas from parents for their child to be referred to drug treatment services for methamphetamine dependency. The New South Wales Mental Health Coordinating Council has diagnosed in the following terms the structural obstacles in that state. Albeit with a different structure, these obstacles seem applicable to the ACT.

> "Often people living with both mental health conditions and AoD issues experience difficulties accessing treatment for both issues concurrently. Many services and agencies only work with either alcohol and other drugs, or mental illness, and are unable (for a number of reasons) to treat both conditions at the same time. These reasons may be about different funding streams; difficulties in providing a 'one-shop' integrated service; and because of different skills and salary levels within the services.
>
> "The NSW Health has separate departments with responsibility for the two areas. Mental health is dealt with by the Mental Health Branch, which is responsible for developing, managing and coordinating NSW Ministry of Health policy, strategy and program funding relating to mental health. The office also supports the maintenance of the mental health legislative framework.
>
> "The Alcohol and Other Drugs Branch is responsible for developing, managing and coordinating NSW Ministry of Health policy, strategy and program funding relating to the prevention, minimisation and treatment of AoD related harm. The branch forms part of the Centre for Population Health,

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92. 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.

which oversees population and health policy, programs and initiatives in the fields of blood borne viruses, healthy lifestyles, overweight and obesity.

"People with both mental health and AoD issues often experience poor physical health. NSW Health has a policy on linking physical care and mental health care and has produced a pamphlet on this issue."93

172. In spite of the National and current ACT drug strategy designating "people with co-occurring mental health conditions" as a priority population, there has been no evident progress in developing by means of a process of co-design a plan for such people. By action 29 of the current ACT drug strategy the Government committed itself to develop and implement a "plan for responding to co-occurring mental health and AOD conditions, which could include: development of guidelines; multi-agency responses; outcome reporting, and indicators of integrated service access".[94];

173. Pressure on the ACT to lift its game in this respect also comes from the Productivity Commission which observed that "people with substance use comorbidities often do not receive adequate care for both conditions" and that, accordingly "Governments should ensure that mental health and drug and alcohol services address both mental health and substance use needs, by directly providing services, or referring the person to other services where appropriate."[95]

174. One of the many cultural differences that separate the drug and alcohol sector from the mental health sector is that the mental health sector practises a medical model of care whereas the drug and alcohol sector adopts principally a psychosocial approach. The Productivity Commission made clear that these approaches should be integrated. It usefully pointed out that addressing stigma and providing needed psychosocial support must be integrated in a holistic way if the mental health crisis in the country is to be addressed. While welcoming this, some of us are pessimistic that this most recent repetition by the Productivity Commission of a truism that has been acknowledged in drug strategies for almost to 30 years will produce the change that

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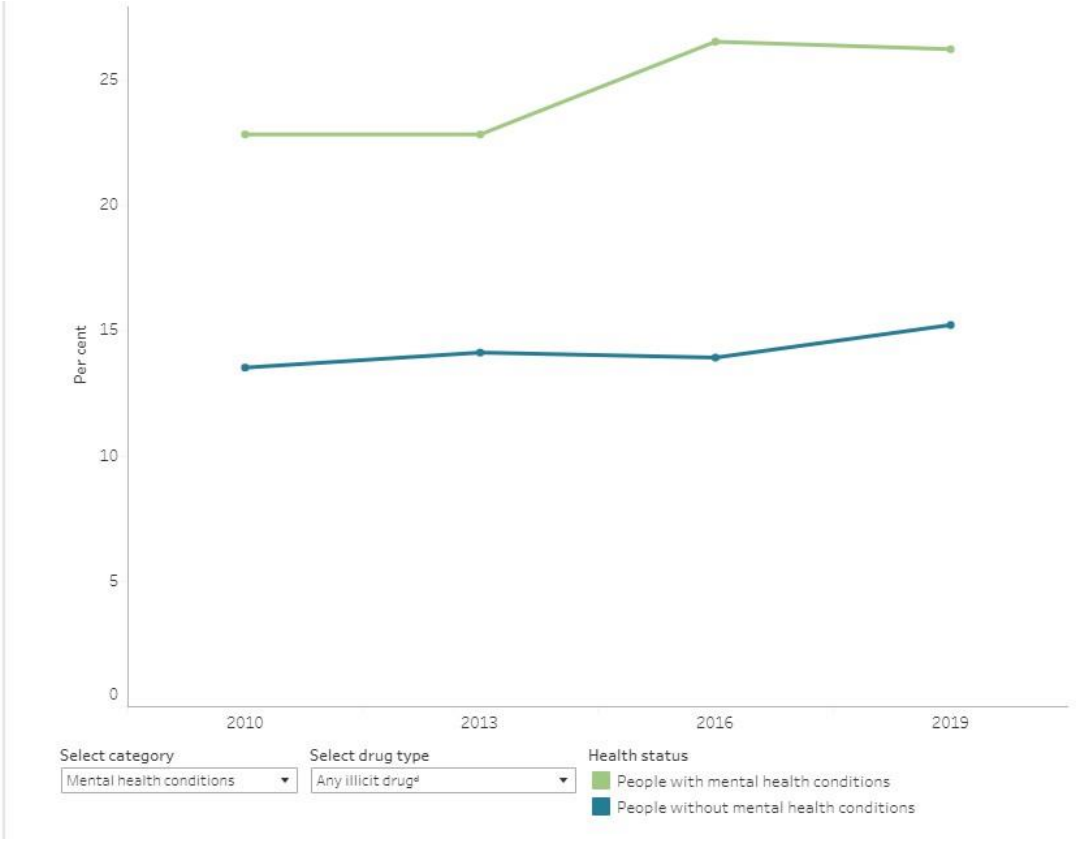
93. Mental Health Coordinating Council, The Mental Health Rights Manual: An online guide to the legal and human rights of people navigating the mental health and human service systems in NSW (4th Edition) 2015, Chapter 8 Section F_ People with mental health conditions who have alcohol and other drug issues – MHCC Mental Health Rights Manual.pdf at https://mhrm.mhcc.org.au/chapters/8-people-with-mental-health-and-co-existing-conditions/8f-people-with-mental-health-conditions-who-have-alcohol-and-other-drug-issues/ visited 6/06/2021

94. 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.

95. Productivity Commission, *Report Mental Health* vol. 1, No. 95, 30 June 2020 p. 39 at https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf visited 08/12/2020

is required.[96] It is beholden on the ACT and indeed on this committee, to show that this pessimism is ill founded.

Figure 25: Recent illicit drug use, by self-reported mental health condition and psychological distress, 2010 to 2019 (per cent)



SOURCE: Australian Institute of Health and Welfare 2021, *Alcohol, tobacco & other drugs in Australia, People with mental health conditions* (AIHW, Canberra, last updated 16/04/2021 v11.0) at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions visited 19/05/2021

175. It is no coincidence that the overlap between mental health conditions and substance dependency has long been described as the expectation rather than the exception and observed that they are both linked to disadvantage.[97]

96. Bill Bush, Tackling the mental health crisis in the time of Covid 19; prescribing the same remedy over and over again? *Pearls & irritations*, 29 Sept. 2020 at https://johnmenadue.com/tackling-the-mental-health-crisis-in-the-time-of-covid-19-prescribing-the-same-remedy-over-and-over-again/ visited 30/09/2020.

97. See, for example, Australia, Parliament, Senate, Select Committee on Mental Health, *A national approach to mental health: from crisis to community*, First report (March 2006) Chapter 14, paras. 14.1 & 14.4 at https://www.aph.gov.au/~/media/wopapub/senate/committee/mentalhealth_ctte/report/report_pdf.ashx visited 13/11/2018.

176. In the words of the Productivity Commission, inequality translates to disadvantage which the Commission recognises as a key factor in poor mental health outcomes:

> Children who are exposed to trauma (that either affects them directly or their family), those who are affected by entrenched disadvantage in their communities and children in the out-of-home care system face substantial risks to their mental health — but at the same time, they are also far less likely to have access to care and support, compared with other children in the population.[98]

7.2 MENTAL ILLNESS AND SUBSTANCE OF ABUSE DISORDERS SHARE COMMON RISK FACTORS

177. Mental illness and substance dependency share many common risk factors and each condition is a risk factor for the other. In the words of a foundational study:

> ". . . 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 are 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."[99]

178. Substance dependency is the most insidious for it is a generator as well as a multiplier of those common risk factors. Children from well-adjusted, privileged families may still be born with a personality that puts them at high risk of dabbling with illicit drugs. Both risk takers and those who are shy and inward looking are among those at risk. A proportion of those who dabble will become dependent.[100] Those that do accumulate a wardrobe of disadvantage like dropping out of school, associating with a dysfunctional peer group, unemployment and poverty which can produce disadvantage for them and their offspring that can increase in intensity from one generation to another. This dynamic and the out of print but very relevant

98. See fn no 95 at p. 21 and .

99. Louisa Degenhardt, Wayne Hall and Michael Lynskey, What is comorbidity and why does it occur? in Maree Teesson & Heather Proudfoot eds., *Comorbid mental disorders and substance use disorders: epidemiology prevention and treatment* (NDARC, Sydney 2003) pp. 18-19.

100. Blue Moon Research & Planning Pty Ltd fn 73

publication were discussed in detail in a Families and Friends submission to an Assembly inquiry into support services for families of people in custody.[101]

179. Typically the situation of families caught up with drug dependency of a family member who has underlying mental health problems is extremely challenging. Typically the family will be faced with a hugely complex and confronting situation with no quick solution. The initial response of parents faced with evidence of drug use is denial followed by one of intense feelings that:

> "include guilt and self-blame – questioning what you might have done wrong to lead to this situation occurring within your family. There is also fear – what's going to happen to him /her? '– Grief for lost hopes and dreams and then anger the choices drug user has made with anger, we often rant and rave but this only results in causing more stress".

180. Mental illness compounds the intense emotions experienced by families when they discover their loved one is using drugs (see 6.1Incapacitating emotions experienced by families, p. 66).

> The assertion of control is the typical third stage. "The masculine solution is: when we have a problem, we fix it. It is often accompanied by a determined, zero-tolerance approach – part of the desire to get back to 'normal'as quickly as possible."
>
> "The feminine solution is often based around a desire to save everyone involved – the drug user, the husband partner, the other children and other relatives. With this desire, women involved in the life of the drug using child can often try to mask some of the actions of the drug user in the hope that it will cause less confrontation and help ease the tensions
>
> Single parents often vacillate between both types of control. Any form of control – either masculine or feminine never works."
>
> When control fails, as it inevitably does "we find ourselves in chaos. We feel incompetent and powerless. When a drug-using child is involved, parents can often pin blame on each other, causing their own relationship crumble and meaning other siblings are under even more stress." [102]

181. Tony Trimmingham prophetically identifies a fifth stage, that of Coping

> "The good news is that there is another stage – coping. When families reach out to get help through support, education and awareness, they can learn skills in coping – including communication and boundary setting.

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101. FFDLR, Submission of Families and Friends for Drug Law Reform to the Inquiry into support services for families of people in custody by the Standing Committee on Community Services and Social Equity of the Legislative Assembly for the Australian Capital Territory (September 2003) at https://www.ffdlr.org.au/submissions/docs/ACTFamilyPrisSub.PDF

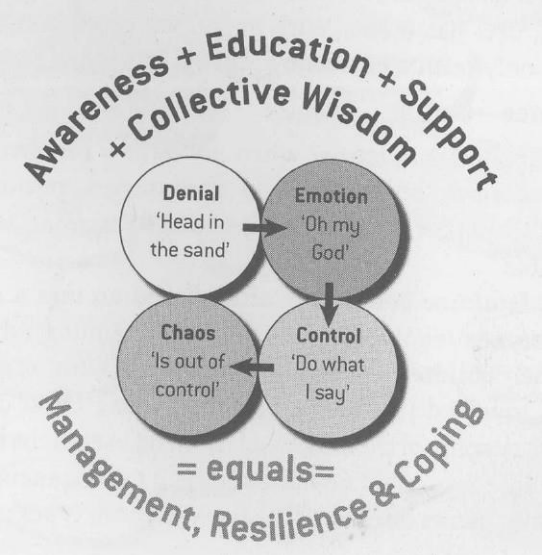
102. Trimingham, fn this71, pp. 53-55.

They can learn to "have a life and look after their own physical, emotional and spiritual well-being. The rest of the family are acknowledged and included.

While a drug user may still not be drug-free, it is a fact that, the healthier the family, the more likely the drug user will eventually respond positively" (see fn 102 above).

182. The following diagram represents these four stages:

Figure 26: Stages of change towards successful coping,



SOURCE: Tony Trimingham, Not my Family; Never my Child: what do do if someone you love is a drug user (Allen & Unwin, Crows Nest NSW, 2009) p. 54.

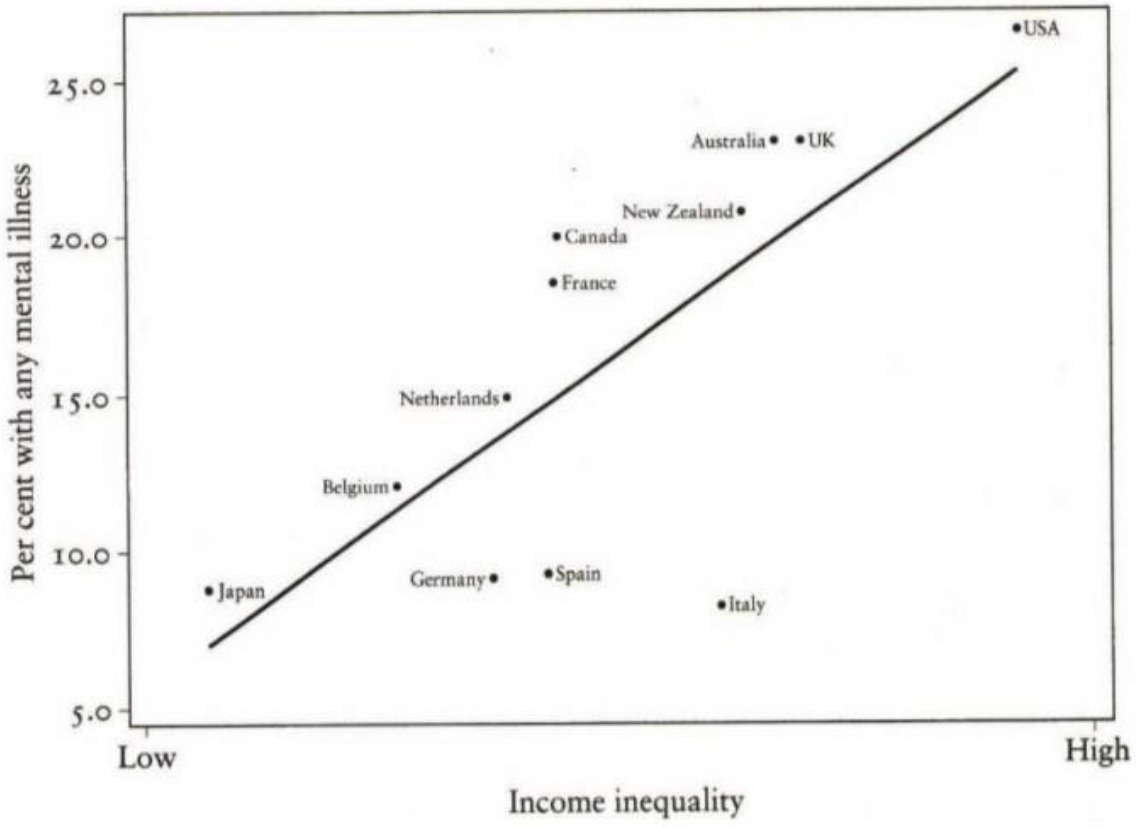
7.3 INEQUALITY AND DISADVANTAGE IS CORRELATED WITH BOTH DRUG DEPENDENCY AND MENTAL ILLNESS

183. Australia stands out as having both high inequality and prevalence of mental illness:

> "In Germany, Italy, Japan and Spain, fewer than 1 in 10 people had been mentally ill within the previous year; in Australia, Canada, New Zealand and the UK the numbers are more than one in 5 people; and in the USA . . . more than 1 in 4."[103]

103. Richard Wilkinson & Kate Pickett, *The spirit level: why greater equality makes societies stronger* (Bloomsbury Press, New York, Berlin, London & Sydney, 2010) p.67.

Figure 27: Mental illness is more prevalent in countries with highest levels of inequality



-More people suffer from mental illnesses in more unequal countries. (Wilkinson & Pickett, p. 67, 2009).

Wilkinson and Pickett go on to observe that as with mental ill health, there is "a strong tendency for drug use to be more common in more unequal countries" like Australia.[104]

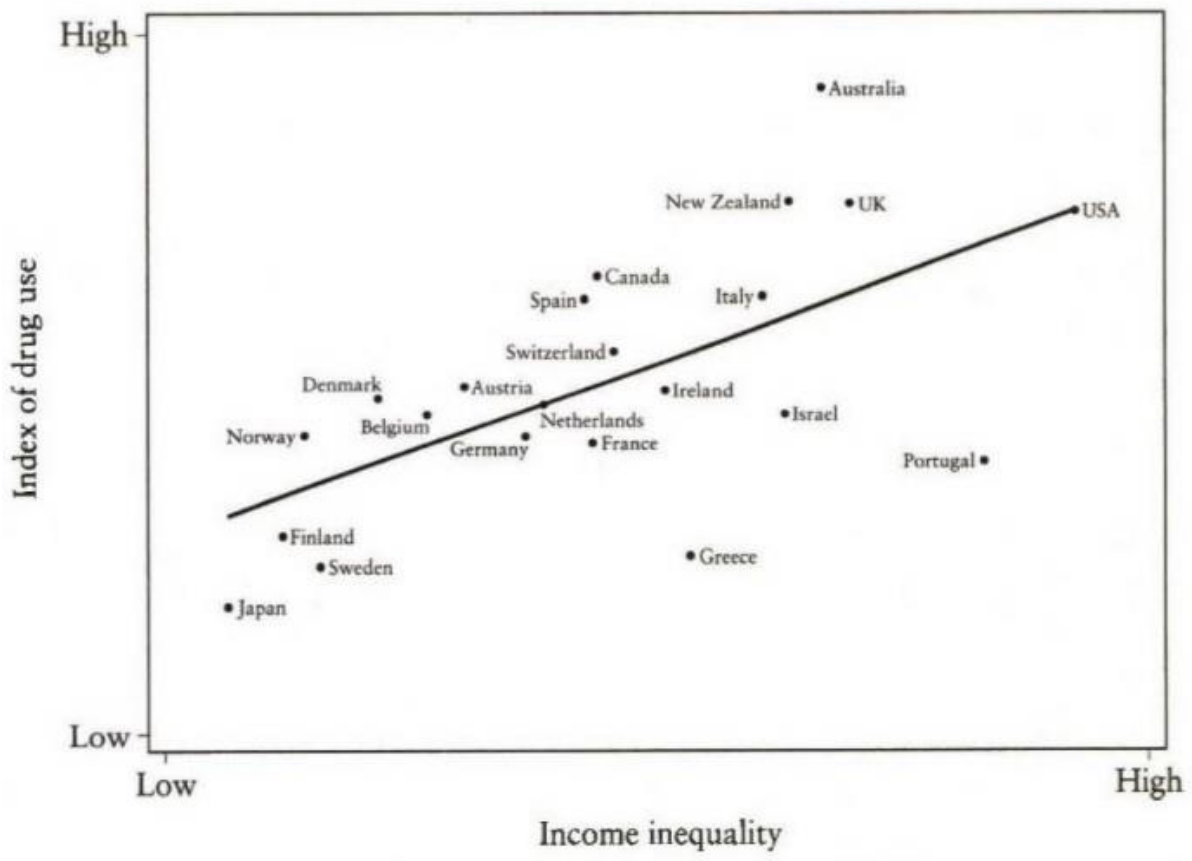
184. Sir Michael Marmot has identified "autonomy, control, empowerment" (See Section 15.9) and what he terms as "social participation" as "two important influences on health in explaining the hierarchy in health". Both are "crucially involved in the social hierarchy, because the lower people are in the hierarchy, the less autonomy and control they have, and the less able they are to participate fully in society."

185. He explains social participation as "being able to take your place in society as a fully paid-up member of society, as it were, to benefit from all that society has to offer. Now, in part that's social supports and social networks, but it also functions at a psychological level. It's self-esteem; it's the esteem of others. It's saying that I can benefit from the fruits that society has to offer." (see fn 45)

104. The same

186. Drug users are at the very bottom and, if it were possible to go lower, there you would find the dependent drug user with some other co-occurring mental health condition. This is wrong!, wrong! wrong!

Figure 28: Drug use is more prevalent in countries with highest levels of inequality



7.3.1 Bidirectional impact of risk factors: Risk factors for one condition reinforce risk factors for the other

187. Thus substance dependency is a risk factor for mental illness as can mental illness be a risk factor for a substance abuse disorder. In other words, the relationship between mental illness and drug abuse can be bidirectional and mutually reinforcing.

> "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."[105]

7.4 WHAT NEEDS TO BE DONE

7.4.1 Support establishment of low threshold services

188. Figure 29: Mental health indicators reported by MSICI frequently attending clients below reveals that clients of the Sydney MSIC have more severe mental health symptoms and impairment than patients within a mental health facility

> "service that facilitates sustained, ongoing contact with clients, MSIC is uniquely placed to assess and engage with PWID around mental health issues. Indeed, this potential is reflected both in the visit numbers of the frequent attendees described here (up to 321 within a 3-month period) and in the 100 % response rate of clients invited to participate in this study."

189. The King's Cross medically supervised injecting centre has successfully engaged with a cohort of people with severe mental health conditions: People who inject drugs "have elevated rates of mood, anxiety, personality and psychotic disorders; post-traumatic stress disorder (PTSD); and higher rates of trauma exposure, suicidality and self-harm" (fn 72 p. 67 above). The conditions are listed in the following table of mental health indicators of "frequently attending clients".

105 . Richard P. Mattick and Susannah O'Brien, "Alcohol and drug use disorders and the anxiety disorders: co-occurrence, relationship, assessment and treatment implications" in Steve Allsop ed, *Drug use and mental health: effective responses to co-occurring drug and mental health problems,* (2008) p. 129.

Figure 29: Mental health indicators reported by MSICI frequently attending clients

Table 1 Mental health indicators reported by MSIC frequently attending clients ($N = 50$)

Mental health indicator	% sample
Any mental health diagnosis by a doctor (lifetime)	82
Mood disorder (lifetime)	64
Anxiety disorder (lifetime)	46
Psychotic illness (lifetime)	32
Post-traumatic stress disorder (lifetime)	12
Attention deficit hyperactivity disorder (lifetime)	10
Personality disorder (lifetime)	8
History of suicide attempt/s	54
History of self-harm	44
Currently receiving support from mental health services	24

SOURCE: Goodhew M, Salmon AM, Marel C, Mills KL, Jauncey M., Mental health among clients of the Sydney medically supervised injecting Centre (MSIC). *Harm Reduct J* 2016;13:29, p.2.

190. The Swiss trial of heroin assisted treatment provides another example of the success of another low threshold service to attract and engage with a highly marginalised, treatment resistant, population of illicit drug users with severe co-occurring mental health conditions . The Swiss trial tracked over 18 months a sub-group of more than 200 patients displaying 3 syndromes.

> "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. The schizophrenic psychoses diagnosed at outset (N equals eight), five stayed on the program for at least 18 months. This matches the mean retention rate in the program, in contrast to the high drop-out rates of dual diagnosis patients in general. Affective disorders required psychiatric treatment considerably less often after the second month on the program. The same applies to personality disorders and other behavioural disturbances. The corresponding data for schizophrenia shows no reduced need for treatment. . . . Follow-up this analysis over 18 months showed a reduction in depressive syndromes. Anxiety and delusional syndromes 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 improvements after the 12th month of treatment.[106]

191. As an aid to both recovery from substance dependency and other mental health conditions, the committee should support:

- the establishment and expansion of a range of low threshold services in Canberra including;
    - a clinically supervised drug consumption service,
    - services that engage with rough sleepers like the Early Morning Centre hosted by the City Uniting Church; and
    - the dispensation at the centre of effective pharmacotherapies;
    - peer to peer support services such as are delivered by the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA).

7.4.2 Ensure that a mental health clinician is employed at the clinically supervised drug consumption site.

192. The experience of the Kings Cross medically supervised injecting centre shows the importance of including on staff a mental health clinician with the human capacities able to engage with "difficult" clients with co-occurring conditions. Securing the person with the right qualities is crucial. Such clients "often encounter multiple barriers to accessing relevant services, ranging from clinician attitudes to the systems within which they work.

7.4.3 Ensure that a mental health clinician is available for training of and consultation by NSP services

193. Recommendation from experience of the Sydney Medically supervised Injecting Centre (fn 72, p. 67).

7.4.4 Establishing regular onsite psychiatric clinics for clients unwilling to access mainstream health services

194. Recommendation from experience of the Sydney Medically supervised Injecting Centre (fn 72, p. 67).

7.4.5 Reduce stigma by health professionals

195. The marginalisation and stigmatisation experienced by drug users seeking help from health professionals and other service providers is compounded by the less extensive but nevertheless real perceived discrimination by mental health professionals: that perception disinclines family members from engaging with the mental health system.

106. A. Uchtenhagen, and others, fn 69, pp.51-53.

> "While most people with mental illness report being treated positively by health professionals, a significant minority (about one in ten) consider they have experienced discrimination from a health professional. This can manifest as disrespectful or condescending behaviour from the health professional, treating people with mental illness dismissively, or disbelieving or judging them. Such action by health professionals discourages people from seeking help when they need it, alters the type of help they seek and the symptoms they describe, increases levels of psychological distress, lessens adherence to treatment regimes, and exacerbates mental illness. It can also contribute to diagnostic overshadowing — with the health professional neglecting people's physical health once they have been diagnosed with mental illness." (vol.1, p. 39)

196. To reduce stigma the Productivity Commission recommended: "the training and professional development of health students and practising health professionals (both within and outside mental health) should include interaction with people with a mental illness outside of a clinical environment (such as the Recovery Camp model for alternate clinical placements for students)" (the same).

7.4.6 Care coordinators

197. The Productivity Commission recommended that "care coordinators " should be supported. Both consumers and their carers need someone on their side to navigate an alien, often antagonistic, fractured "system" spanning a multiple of medical and psychosocial services that all need to be coordinated. In the words of the Commission:

> "Care coordinators would work directly with the consumers, their families and carers, clinicians (or clinical coordinator) and providers from other sectors, to establish the types of services needed and provide access to those services. The level of support would be adjusted according to need — for people with the most complex needs, the care coordinator should bring together a care team, comprising the various services the individual requires, and put in place a detailed plan for their support. (vol. 1, p. 40).

7.4.7 Involuntary treatment: what scope is there for it?

198. In the drug and alcohol sector there is little if any sympathy for involuntary treatment. Its introduction as part of treatment for substance dependency would pose serious challenges:

- The very essence of person centred care requires the subject of that care willingly engaged in that person's own treatment.
- Detoxes and rehabs are not set up as secure facilities;
- Much of the group therapy of residential care facilities would be disrupted by the presence of an unwilling resident
- In particular the most effective treatment for methamphetamine dependency which is currently not supported by pharmacotherapy is Cognitive Behavioural Therapy (CBT). CBT requires willing cooperation.

- Exercise of an authority to consign a person to involuntary care is likely to fracture bonds of trust and communication which, in the long run must be maintained and strengthened if the dependent drug user is to overcome their dependency and be reintegrated into the community.

199. A 2007 research paper of the Australian National Council on Drugs (*Compulsory treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*) concluded as follows regarding civil commitment that:

> A major criticism pertains to the lack of empirical evidence of effectiveness. While there is some evidence, mainly anecdotal, that civil commitment for short periods can be an effective harm reduction mechanism, there is little evidence to support its effectiveness in rehabilitating or achieving long-term behavioural change. Many argue that depriving an individual of his/her liberty cannot be ethically justified if the intervention is not known to be of benefit. For this reason, there is substantial support in Australia for a model of short-term involuntary care for the purpose of reducing serious harm (e.g. protecting the user in life-threatening situations), restoring decision-making capacity and providing an opportunity to motivate the user to continue treatment on a voluntary basis. There is considerably less support for a longer-term model aimed at rehabilitation. This is well reflected in the New South Wales Standing Committee on Social Issues comprehensive review of the *Inebriates Act* 1912 (NSW).

200. In the light of the considerable evidence before the New South Wales ice inquiry, it opted to maintain voluntary treatment (Vol 2, para. 11.172): ""The evidence received at the Decriminalisation Roundtable was strongly against implementation of a mandatory health or social response as part of a decriminalisation model." (vol. 2 para., 11.169).

201. In the words of a consultant addiction psychiatrist giving evidence to the New South Wales ice enquiry "there is a lack of evidence supporting involuntary treatment for substance use disorders in general, and ATS-related use disorders specifically". The report went on to directly quote psychiatrist as follows:

> "[B]est practice treatment for ATS-related use disorder (and substance use disorders more broadly) involves a voluntary framework based on behaviour change principles, enhancement of motivation and readiness to change. This framework is underpinned by promoting intrinsic motivation." (Vol 2, para. 11.165).

202. Prof Alison Ritter of the Drug Policy Monitoring Project at the University of New South Wales argued for voluntary treatment for ice dependency but added

> 'We have mandatory mechanisms for drug courts, for people with drug offending and serious offending. We have a prison-based mandatory program in the [Compulsory Drug Treatment Correctional Centre]. We have a civil commitment program – the [Involuntary Drug and Alcohol Treatment]. Those mandatory mechanisms are available for people who are either at risk of harm

> to self or others or engaged in serious offending. They work well. We don't need that in the context of simple use/possess. What we need is voluntary options and good triage.'

203. All this is not to deny there is a case for coercive models of care in limited extreme circumstances where people have no insight into their condition. Capacity already exists in the ACT in the criminal justice system including the drug Court and through the civil commitment procedure under section 80 of the *Mental Health Act 2015*. These are framed for people likely to take their own life or inflict "serious harm on the person or another person."

204. It is intolerable that people with continuing roaring ice addictions and chaotic behaviours should be discharged by the mental health system to the care of their parents who have no capacity to help them.

205. These situations speak to the imperative need for:

- A mental health workforce skilled to identify which behaviours of a dependent drug user are attributable to that dependency and which to some other underlying mental health condition.
- a truly integrated mental health and substance dependency system so that rehabilitative drug treatment can be provided in the Adult Mental Health Unit or Dhulwa; and
- generous support for carers to cope with their situation;
- assessing the desirability of establishing a New South Wales style involving involuntary treatment facility in the ACT.

7.4.8 Respite care involving involuntary treatment

206. For all the foregoing reservations, there is a case for the ACT to explore the establishment of a New South Wales style involving involuntary treatment (IDAT). The IDAT Program is an AoD treatment program that provides medically supervised withdrawal, rehabilitation and supportive interventions for patients with severe substance dependence. The NSW Mental Health Coordinating Council describes its short term nature as follows:

> The IDAT Program provides short term care to protect the health and safety of people with severe substance dependence who have experienced, or are at risk of, serious harm and whose decision making is considered to be compromised due to their substance use. It includes an involuntary supervised withdrawal component. Participants are usually referred through their local health district.
>
> Under the IDAT Program, an Accredited Medical Practitioner at the IDAT Facility can issue a Dependency Certificate that means the person who is subject to the certificate can be detained for up to twenty eight (28) days in the first instance as an involuntary patient.
>
> There is an option to extend the Dependency Certificate for up to a total treatment period of three (3) months in extreme circumstances where

withdrawal, stabilisation and discharge planning may take longer. The IDAT Program also provides three (3) to six (6) months of voluntary community-based treatment and support following discharge.

An Accredited Medical Practitioner from one of the IDAT units conducts an assessment, and if all the eligibility criteria are met, will issue the person with a Dependency Certificate. If a Dependency certificate is issued, and a bed is available, the person can be admitted for treatment. Local health districts can arrange transportation to the treatment unit.

Within seven (7) days of admission, the Dependency Certificate is reviewed by a magistrate in an informal hearing usually at the treatment unit. Legal aid is available through duty solicitors for the reviews held before the visiting magistrate. Contact Law Access on 1300 888529* for more information.

At the end of the involuntary treatment, the patient is discharged and transitioned to community care. If you are unhappy with the visiting magistrate's decision, you can apply to the NSW Civil and Administrative Tribunal (NCAT) for a review of the decision.[107]

207. Drug dependency is a chronic relapsing condition. Relapses are to be expected. Indeed it is said that they should be regarded not as failures but as steps along the way to recovery. If the dependent drug user can desist from using for a day, why not two days and if two days what about four days? and so on and so forth. IDAT is no more a long-term solution to drug dependency than is a commitment to AHMU but it appears to provide a much-needed respite for carers to explore options for themselves and their family member when the client is released. It should with with empathetic, skilled clinicians give the consumer a glimpse of possibilities and of hope. It would however, have to be done well so as to foster trust and communication with carers rather than rupture them.

8. The financial unviability of current Drug Policy

8.1 Dimension of the drug trade and its costs

208. You should disabuse yourself of any illusion that the subject of your inquiry is a niche one concerning merely the personal suffering of a misguided minority of Canberrans who have got into trouble with drugs and their desperate parents. The issue you are addressing connects the suburban streets of Canberra to very dark corners of serious and organised crime. In 2001, the National Crime Authority in 2001 described its reach as "pervasive, multi-faceted and [that it] carries enormous social and economic costs. Significantly, the cost is not just in direct monetary terms but in terms of lost productivity, health, violence and well being. Another cost is the diminution of societal security, both in perception and reality."[108]

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107 Fn 93. p. 64.

108. National Crime Authority, *NCA Commentary 2001* (August 2001) p. 13 at http://www.nca.gov.au/html/index.html visited 19/12/01.

209. "There is every indication that the reach of organised crime is growing. No field where large sums of money can potentially be made escapes its gaze "contaminate and corrupt the structures of government, legitimate commercial and financial business, and society at all its levels." (§1.5, p.16, fn 5,16)

210. The grim assessment of 20 years ago by the National Crime Authority have been re-echoed time and again since then.

211. The Australian Bureau of Statistics has commissioned an attempt to estimate the size of the illegal drug economy in accordance with methods recommended by the OECD. In 2012 the Bureau researchers came up with an estimate of the total value of domestic and imported drug supply in 2010 of $7.574 billion.[109]

212. In 2015 the Australian Crime Commission estimated that illicit drug activity by serious and organised crime cost $4.4 billion. This accounted for "money lost to the economy through international payments for illicit drug importations. It also covers costs associated with the health impacts of illicit drug use, including injury, treatment costs, lost output of drug users while in treatment, and deaths." To these costs should be added consequential serious and organised crime costs from "The impact of illicit drug abuse from conventional crimes committed by illicit drug users (such as burglaries, robberies, assaults, domestic violence) . . . . The criminal justice systems, and therefore Australian taxpayers, bear a significant proportion of the costs of illicit drug crime."[110]

213. Consequential serious and organised crime costs adds a loss of $6.2 billion to the cost of illicit drug activity. And the estimated costs continue to mount. Prevention and Response costs are a further $15 billion as "annual costs to government, the private sector and the community in anticipating, preventing and responding to serious and organised crime." Examples of these are given as:

- Australian Government agencies $4 billion
- law enforcement $3.3 billion
- Security industry $2.4 billion
- financial insurance sector $2.3 billion
- general community $2.2 billion (fn 110 at p.10).

Adding these various amounts one can consider that the cost of serious and organised crime in Australia amounts to $25.6 billion of which a large proportion would relate to illicit drugs..

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109. Adam Gajewski and Derick Cullen, Australian Bureau of Statistics – Macro Economic Research Drug Policy Modelling Program Symposium 16 March 2012 at https://dpmp.unsw.edu.au/sites/default/files/dpmp/resources/ABS%20report.pdf

110. Australian Crime Commission, *The costs of serious and organised crime in Australia 2013–14* (Australian Crime Commission, Canberra, 2015) p. 8 at https://www.acic.gov.au/sites/default/files/2016/06/the_costs_of_serious_and_organised_crime_in_australia_2013-14.pdf?v=1467258021 visited 28/05/2019.

214. In 2018 the New South Wales Crime commission reported that:

> "Organised and serious crime in NSW is driven by the profit motive, primarily generated by the illicit drug trade, where violence and retribution within the criminal milieu pervades. Money laundering of illicit profits has infiltrated legal as well as illegal commercial enterprises and hundreds of millions of dollars is circulating within the economy of NSW as a result of organised and serious crime activity. Legitimate commercial activity, businesses, individuals and the revenue are all consequentially significant victims. It is those activities that the Commission targets."[111]

215. The ACT economy represents only a small element of the Australian national economy (Gross State Product being 2.1% of the Australian Gross Domestic Product).[112] Even so the costs of illicit drug policy constitute a large burden on the ACT taxpayers. The most wide-ranging estimate of social costs of abusive of alcohol, tobacco is dated. It was published in 2008 using 2004/05 figures.[113] And
216. The study determined that State and territories bore all the crime and health costs of illicit drugs accessible in 2004/05 (amounting to $2,264.8 million).[114]

217. Applying to the State and Territory social costs[115] estimated by Collins and Lapsley the proportion that ACT Grows State Product bears to the national Gross Domestic product, one can arrive at a crude guess of the share of illicit drug social costs borne by the ACT.

Table 1: ACT 2.1% share of various illicit drug costs and turnover

	National estimates	**ACT share @ 2.1%**
Health outlays	$ 35,100,000.00	$ 737,100.00
Road accidents	$ 17,300,000.00	$ 363,300.00
Crime outlays	$ 2,212,300,000.00	$ 46,458,300.00

111. New South Wales Crime Commission, *Annual Report 2017–18* (NSW Crime Commission, Sydney, October 2018) p.2 at https://www.crimecommission.nsw.gov.au/files/annual-reports/annual-report-2017-2018.pdf visited 28/5/2019

112. ACT Treasury, *Gross State Product — 2019-20* ABS Release: Australian National Accounts: State Accounts 20 November 2020 at https://apps.treasury.act.gov.au/__data/assets/pdf_file/0010/399979/GSP.pdf/_recache visited 10/06/2021.

113. David J. COLLINS & Helen M. Lapsley (2008), *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05* (National Drug Strategy monograph series no. 64, Commonwealth Dept. of Health and Ageing, Canberra, 2008) at http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mono64/$File/mono64.pdf visited 16/02/2012

114. David J. Collins & Helen M. Lapsley, *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05* (National Drug Strategy monograph series no. 64, Commonwealth Dept. of Health and Ageing, Canberra, 2008) at http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mono64/$File/mono64.pdf visited 16/02/2012

115. Fn 113 at tables 46 & 47, p.91.

Total social cost outlays	$ 2,264,800,000.00	$ 47,560,800.00
Costs of serious & organised crime	$ 25,600,000,000.00	$ 537,600,000.00
Size of Illegal drug economy	$ 7,574,000,000.00	$ 159,054,000.00

218. Back in 2001, Gary Crook, QC, the chairman of the National Crime Authority argued "that the time has now arrived where, in order to properly combat organised crime, there is a requirement for a whole of government, rather than a solely law enforcement based, approach." "The fight against organised crime," he added, "will benefit from a whole of government approach." (fn 108 at p. 9)

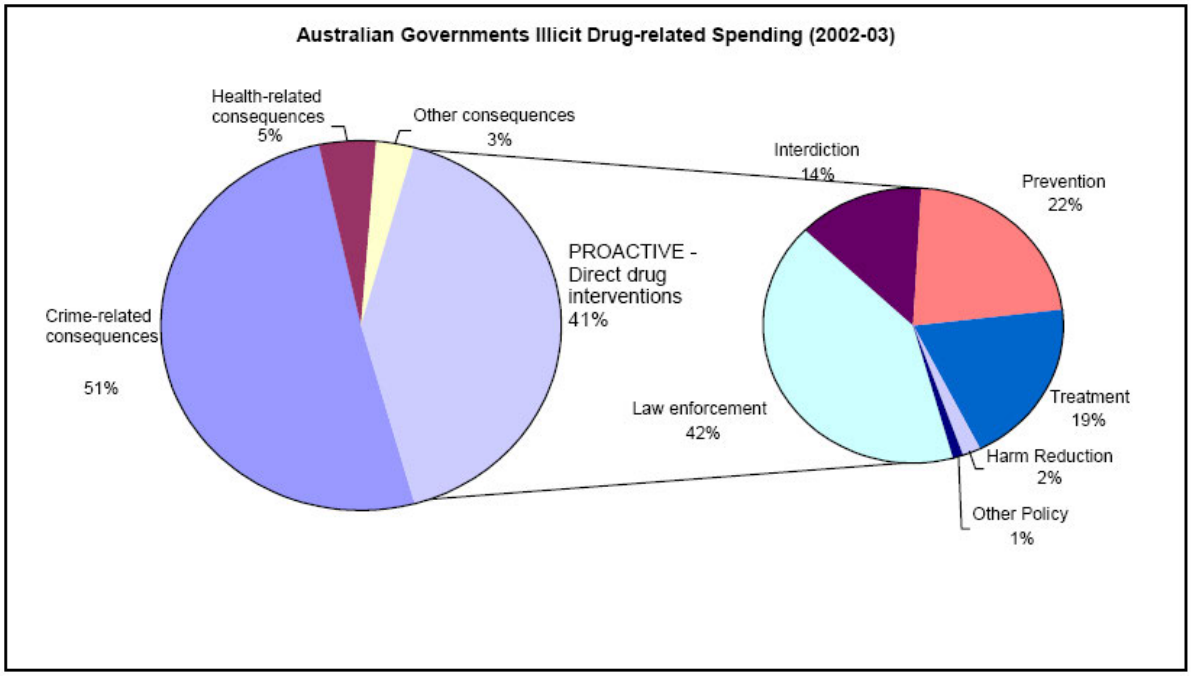
219. You, honourable members, are at the cutting-edge of the fight against serious and organised crime. There is no time to waste. The bad situation is getting worse:" The New South Wales Crime Commission reported in 2017-18 that "Organised and serious crime has grown dramatically over the last five to eight years" (fn 111 p. 2, p.96). A couple of years later the commission assessed that " . . . organised crime groups see the most growth and profit through the importation and sale of prohibited drugs."[116]

220. It borders on the incomprehensible to understand why governments should insist that police forces around the country should continue to direct their grossly overstretched resources to chasing drug users rather than focusing on these large-scale corrupters of good government, the economy, business and society as a whole.

221. As far as Families and Friends know, expenditure is still disproportionately flitted away on counter-productive drug law enforcement. In other words, that the proportions illustrated in the following chart still represent the reality of priority by governments.

116. New South Wales Crime Commission, *Annual Report 2019–2020* (NSW Crime Commission, Sydney, October 2020) pp. 22 at file:///C:/Users/Bill/Downloads/NSW%20Crime%20Commission%20Annual%20Report%202019-2020.pdf visited 10/06/2021.

Figure 30: Illicit Drug-related spending of Australian Governments 2002-03



Source: T. MOORE, *Bulletin No. 2: Australian government spending estimates,* DPMP Bulletin Series (Turning Point Alcohol and Drug Centre, Fitzroy, 2005) at http://www.turningpoint.org.au/research/dpmp_bulletin/res_dm_bulletins.htm

8.2 A PUBLIC HEALTH APPROACH WILL PRODUCE SAVINGS.

8.2.1 Incarceration.

British Columbia imprisonment rate 66 per 100,000 v. ACT rate 133.8; ACT daily average for 2019-20 was 444[117]. There would be 225 fewer prisoners/day in ACT if BC rate applied. This would produce an annual saving of $34.64m.

8.2.2 Net savings with heroin assisted treatment in Swiss cost benefit analysis.

222. In Switzerland, treatment in the form of heroin prescription is estimated to have produced a net saving to the community of 45 Swiss Francs per user per day.

> "The average cost in the ambulatory treatment centres is estimated at 51 francs per patient per day. The general economic benefit flowing from saving realised in criminal prosecutions and prison sentences and from the improvement in the level of health is estimated at 96 francs. After deduction of the costs, an average benefit of 45 francs per patient per day is obtained"[118]

117. Productivity Commission: *Report on Government Services 2021*, chapter 8: Corrective services — Data tables contents table 8A.4 at file:///C:/DRUGS/Federal%20Government/ProductivityComsn/Rogs/rogs-2021-partc-section8-corrective-services-interpretative-material.pdf visited 10/06/2021

118. Switzerland, Federal Office of Public Health, *Treatment with prescription heroin, Arguments concerning the popular vote on the Urgent Federal Ordinance on the medical prescription of heroin (treatment with medically prescribed heroin) on 13 June 1999* being

> The greater part of the economic benefits related to "savings in criminal investigations in prison days, followed by improvements in the state of health.[119]

8.2.3 Mental health costs

223. The documented improvement in mental health of people successfully engaged in treatment for their substance dependency suggests the possibility of substantial savings if an effective integration is achieved of drug and alcohol and mental health services. Addressing shared key drivers like stigma and providing complementary psychosocial support would alleviate those conditions. The Productivity Commission has described the cost of mental health to the Australian economy in the following blunt terms:

> "The cost to the Australian economy of mental illness and suicide is estimated (conservatively, given data limitations) to be up to about $70 billion per year. We currently spend at least $0.5 billion per year on attempting to lessen the prevalence of mental ill-health and prevent suicide, and $9.2 billion per year treating people who have nevertheless developed mental illness. These costs have been rising over time, with no clear indication that the mental health of the population has improved. Additional to this is a further (largely avoidable) cost of approximately $150 billion per year associated with diminished health and reduced life expectancy for those living with mental illness (table 1).
>
> "These are large numbers. In total, mental illness, on a conservative basis, is costing Australia about $200-220 billion per year. To put that in context, this is just over one-tenth of the size of Australia's entire economic production in 2019. The cost is between $550 million and $600 million *per day*. Not all of this cost is avoidable, but there is considerable scope for Australia to do better" (fn 89 at p.9, p.78).

8.2.4 Diseases of Dispair and Misuse of prescription analagesics

224. The increasing average age of recent drug users bears witness to the advent in Australia of the epidemic sweeping the United States of misuse of prescription analgesics. While the wastewater analyses show a reassuring decline, similar misuse is of extremely potent fentanyl and still powerful oxycodone is clearly

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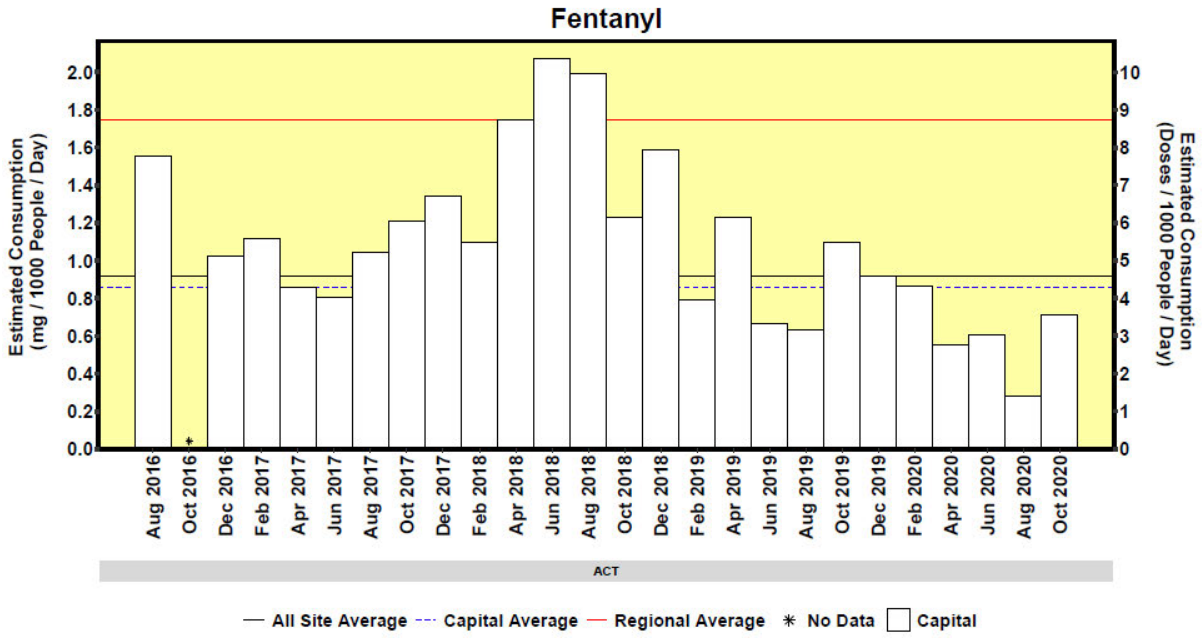
translation of Suisse, Office fédéral de la santé publique, *Traitement avec prescription d'héroïne: Argumentaire concernant la votation populaire sur l'arrêté fédéral urgent sur la prescription médicale d'héroïne (traitement avec prescription médicale d'héroïne) du 13 juin 1999* (GEWA, Zollikafen, avril 1999) and
Felix Gutzwiller & Thomas Steffen, *Cost-benefit analysis of heroin maintenance treatment* (Karger, Basel, Freiburg, Paris &c, 1999) being vol. 2 of A. Uchtenhagen, F. Gutzwiller, A. Dobler-Mikola, T. Steffen, M. Rihs-Middel, Medical prescription of Narcotics

119. A. Uchtenhagen, A. Dobler-Mikola, T. Steffen, F. Gutzwiller, R. Blättler & S. Pfeifer, *Prescription of narcotics for heroin addicts: main results of the Swiss national Cohort Study* (Karger, Basel, Freiburg, Paris &c, 1999) being vol. 1, p. 8 of A. Uchtenhagen, F. Gutzwiller, A. Dobler-Mikola, T. Steffen, M. Rihs-Middel, Medical prescription of Narcotics

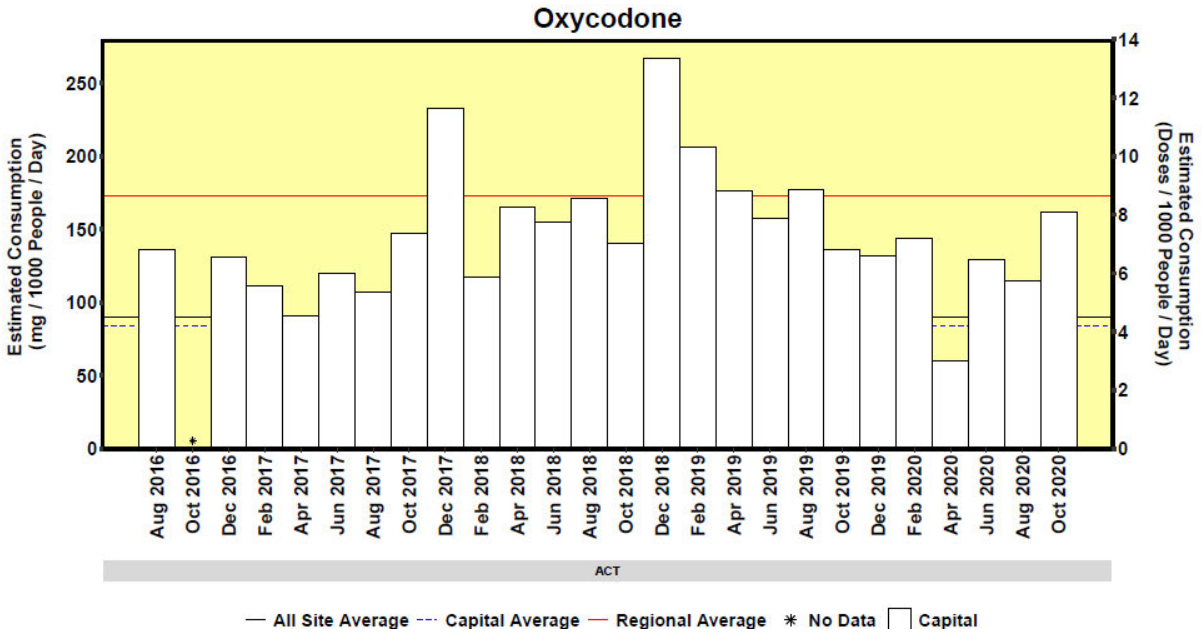
circulating in the ACT. When these are not accessible because of restrictions on prescription and doctor shopping, people in desperate search for relief from chronic pain can be expected to have recourse to illicit opiates.

Figure 31: ACT Wastewater analysis of fentanyl



SOURCE: ***Australian Criminal Intelligence Commission, National Wastewater Drug Monitoring Program report 12, 2021,*** **at https://www.acic.gov.au/sites/default/files/2021-02/australian_capital_territory_-_12.pdf visited 26/02/2021.**

Figure 32: ACT Wastewater analysis of Oxycodone



SOURCE: ***Australian Criminal Intelligence Commission, National Wastewater Drug Monitoring Program report 12, 2021,*** **at**

https://www.acic.gov.au/sites/default/files/2021-02/australian_capital_territory_-_12.pdf visited 26/02/2021.

Misuse of these powerful analgesics can have economy-wide effects. 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"[120] 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."[121]

A public health approach would dictate that the health system needs to devote more resources to providing pain relief and to address the situation of disadvantage and hopelessness that drives the epidemic in the United States. Addressing these issues will ultimately save a lot of money.

Bill Bush
President
Families & Friends for Drug Law Reform,
22/06/2021

120. Nabarun Dasgupta, Leo Beletsky, and Daniel Ciccarone, Opioid Crisis: No Easy Fix to Its Social and Economic Determinants, *Am J Public Health*. Published online ahead of print December 21, 2017: e1–e5. doi:10. 2105/AJPH.2017.304187.

121. 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