Parliamentary Joint Committee on Law Enforcement

Inquiry into crystal methamphetamine (ice)
Final Report

March 2018

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PO Box 6100
Parliament House
CANBERRA ACT 2600
Telephone: (02) 6277 3419
Email: le.committee@aph.gov.au
Internet: www.aph.gov.au/le_ctte

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Committee membership

Members

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Senator Barry O'Sullivan	NATS, QLD (from 12.9.16 – 16.8.17; from 3.10.17 – 12.2.18)

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Ms Sophie Dunstone, Secretary

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Ms Cathy Nembu, Acting Principal Research Officer (from 23.10.18)

Ms Nicola Knackstredt, Senior Research Officer

Mr Joshua Wrest, Senior Research Officer

Ms Sophie Clark, Administrative Officer (to 4.8.17)

Ms Jo-Anne Holmes, Administrative Officer (from 4.9.17)

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Acronyms

ABC	Australian Broadcasting Corporation
ACCHO	Aboriginal Community Controlled Health Organisation
ACIC	Australian Criminal Intelligence Commission [formerly the Australian Crime Commission (ACC)]
ACON	AIDS Council of New South Wales
ACT	Australian Capital Territory
ADF	Alcohol and Drug Foundation
AFP	Australian Federal Police
AFAO	Australian Federation of AIDS Organisations
AHCWA	Australian Health Council of Western Australia
Ai Group	Australian Industry Group
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANAO	Australian National Audit Office
APS	Australian Psychological Society
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
ATDC	Alcohol, Tobacco and other Drugs Council of Tasmania
AOD	alcohol and other drugs
AVIL	Australian Injecting & Illicit Drug Users League
BBV	blood borne virus
BI	brief intervention
CAA	Confiscated Assets Account
CDT	Commission for Dissuasion of Drug Addiction
CEO	Chief Executive Officer
COAG	Council of Australian Governments

DPMP	Drug Policy Modelling Program
DoH	Department of Health
DUMA	Drug Use Monitoring in Australia
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GP	general practitioner
HIV/AIDS	human immunodeficiency virus and acquired immune
IDRS	Illicit Drug Reporting System
IHRA	International Harm Reduction Association
LDAT	Local Drug Action Team
LGBTQI	lesbian, gay, bisexual, transgender, queer or questioning, and intersex
MATES	Methamphetamine Treatment Evaluation Study
MDAF	Ministerial Drug and Alcohol Forum
MHC	Mental Health Commission
MSIC	medically supervised injecting centre
NADA	Network of Alcohol and other Drugs Agencies
NAPWHA	National Association of People with HIV Australia
NATSILS	National Aboriginal and Torres Strait Islander Legal Service
NDARC	National Drug and Alcohol Research Centre
NDS	National Drug Strategy
NDSC	National Drug Strategy Committee
NIAS	National Ice Action Strategy
NIT	National Ice Taskforce
NSPs	needle and syringe exchange programs
NSW	New South Wales
NT	Northern Territory
PDOC	primary drug of concern
PHN	Public Health Network

PJCLE	Parliamentary Joint Committee on Law Enforcement
PoC Act	*Proceeds of Crime Act 2002*
QNADA	Queensland Network of Alcohol and Other Drug Agencies
SA	South Australia
SICAD	Servico de Intervencao nos Comportamentos Aditovos e nas Dependencias/General-Directorate for Intervention on Addictive Behaviours and Dependencies
UNAIDS	United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UWA	University of Western Australia
VAADA	Victorian Alcohol and Drug Association
WA	Western Australia
WAAC	Western Australian AIDS Council
WANADA	Western Australian Network of Alcohol & Other Drug Agencies
WAPHA	Western Australian Primary Health Alliance
WHO	World Health Organisation

Recommendations

Recommendation 1

2.53 The committee recommends that the Department of Health and the Australian Institute of Health and Welfare establish an expert group and progress their work to develop an alcohol and other drugs treatment waitlist item as part of the Alcohol and Other Drug Treatment Services National Minimum Data Set.

Recommendation 2

2.81 The committee recommends that Commonwealth, state and territory health departments ensure adequate pre- and post-care services are provided in partnership with residential treatment programs.

Recommendation 3

2.85 The committee recommends that Australian governments individually and collectively develop and implement plans to increase the capacity of residential rehabilitation across Australia in a way that ensures equitable access.

Recommendation 4

2.109 The committee recommends that the Commonwealth, state and territory governments, as a matter of priority, establish a national quality framework for all alcohol and other drug treatment services including public, not-for-profit and for-profit residential rehabilitation.

Recommendation 5

2.111 The committee recommends that the development of a national quality framework for alcohol and other drug treatment services is undertaken in partnership with representatives of the alcohol and other drug treatment sector.

Recommendation 6

2.150 The committee recommends Australian governments, in partnership with the Australian Institute of Health and Welfare, establish nationally consistent datasets and regular reporting of illicit drug use in Australia's correctional facilities.

Recommendation 7

3.38 The committee recommends that Australian governments continue to advance collaboration with Indigenous communities and Indigenous health experts to provide culturally and linguistically appropriate alcohol and other drug treatment services.

Recommendation 8

3.48 The committee recommends Australian governments ensure specialised alcohol and other drug treatment services are available to people with young children in all jurisdictions.

Recommendation 9

4.52 The committee recommends that the Commonwealth government ensures that future public awareness campaigns engender compassion towards drug users, and are targeted at and inform those people with the objective of encouraging them to seek treatment and support.

Recommendation 10

4.55 The committee recommends that the Australian Press Council develops and implements media reporting standards for coverage of drug use.

Recommendation 11

5.28 The committee recommends that the Department of Health considers using 2016 Census and National Wastewater Drug Monitoring Program data to determine the allocation of National Ice Action Strategy funding for 2019–20.

Recommendation 12

5.36 The committee recommends that the Department of Health ensures that Public Health Network's conduct future tender processes with realistic timeframes and at appropriate times of year.

Recommendation 13

5.73 The committee recommends that the Commonwealth, state and territory governments re-balance alcohol and other drug funding across the three pillars of the National Drug Strategy (supply, demand and harm reduction strategies).

Recommendation 14

5.75 The committee recommends that the Commonwealth government refers to the Productivity Commission an inquiry into the costs and benefits of the National Drug Strategy as it is currently implemented.

Recommendation 15

5.87 The committee recommends that the Commonwealth government, under section 298 of the *Proceeds of Crime Act 2002*, ensures Confiscated Assets Account funds are equitably allocated to crime prevention, law enforcement, drug treatment and diversionary measures.

Chapter 1
Introduction

Conduct of the inquiry

1.1 On 18 March 2015, the Parliamentary Joint Committee on Law Enforcement (the committee) initiated an inquiry into crystal methamphetamine (ice), which lapsed at the end of the 44th Parliament. Submissions had been received and a number of hearings held at the time the inquiry lapsed.

1.2 On 12 October 2016, during the 45th Parliament, the committee re-instated the inquiry. The committee resolved that documents received in the 44th Parliament, including Hansard transcripts and submissions, would be considered in respect of the re-instated inquiry. The committee also accepted additional submissions.

1.3 The terms of reference for the inquiry were as follows:

> Pursuant to the committee's functions set out in paragraph 7(1)(g) of the Parliamentary Joint Committee on Law Enforcement Act 2010, the committee will examine the criminal activities, practices and methods involved in the importation, manufacture, distribution and use of methamphetamine and its chemical precursors, including crystal methamphetamine (ice) and its impact on Australian society.
>
> In particular, the committee will examine:
>
> 1. the role of Commonwealth law enforcement agencies in responding to the importation, manufacture, distribution and use of methamphetamine and its chemical precursors;
> 2. the adequacy of Commonwealth law enforcement resources for the detection, investigation and prosecution of criminal activities involving the importation, manufacture, distribution and use of methamphetamine and its chemical precursors;
> 3. the effectiveness of collaborative arrangements for Commonwealth law enforcement agencies with their regional and international counterparts to minimise the impact of methamphetamine on Australian society;
> 4. the involvement of organised crime including international organised crime and outlaw motorcycle gangs in methamphetamine related criminal activities;
> 5. the nature, prevalence and culture of methamphetamine use in Australia, including in indigenous, regional and non-English speaking communities;
> 6. strategies to reduce the high demand for methamphetamines in Australia; and
> 7. other related issues.

1.4 On 6 September 2017, the committee tabled its first report. That report primarily considered law enforcement responses to the crystal methamphetamine

problem in Australia. It also detailed background information on crystal methamphetamine and its use in Australia, and Australia's drug strategies. The committee made eight recommendations:

1. All progress reports and the mid-point review provided to the Ministerial Drug and Alcohol Forum and Council of Australian Government on the implementation of the National Drug Strategy 2017–2026 and its sub-strategy, the National Ice Action Strategy (NIAS), are made publicly available, and include but are not limited to:
    - reporting on the implementation and achievement of actions outlined in the NIAS, with reference to qualitative and/or quantitative key performance indicators as appropriate;
    - reporting on steps taken to enhance co-operation between health and law enforcement agencies;
    - data on the prevalence of crystal methamphetamine use, particularly among vulnerable groups;
    - information on new and existing treatment options, their accessibility and costs (to both government and patients);
    - statistics from the justice system, including the number of crystal methamphetamine prosecutions, convictions and rates of recidivism in each Australian jurisdiction;
    - reporting on the implementation and efficacy of drug courts and drug diversionary programs;
    - reporting on local initiatives implemented through the Primary Health Networks; and
    - the quantum of funding derived from proceeds of crime and allocated to initiatives to address crystal methamphetamine use.
2. Commonwealth, state and territory governments commit long term funding for the implementation, maintenance and ongoing use of the National Criminal Intelligence System (NCIS).
3. Commonwealth, state and territory governments, as a matter of urgency, agree and enact nationally consistent unexplained wealth legislation.
4. Subsequent to a national review of drug diversionary programs articulated by the National Ice Taskforce (NIT) and in the NIAS, states and territories commit to improving, expanding, or where no drug diversionary program(s) currently exists, implementing such programs across their jurisdictions.
5. Australian governments implement the electronic End User Declaration System as soon as practicable.
6. The Commonwealth government strengthens eligibility criteria for Aviation Security Identification Cards (ASIC) and Maritime Security Identification Cards (MSIC) to address current inadequacies, particularly

the use of criminal intelligence where a person may have links with serious and organise crime.

7. The Australian government expand its leadership in relevant international fora and considers:
    - strengthening ties with countries in the Asia Pacific, beyond existing ties with China, Cambodia and Thailand;
    - collaborating to develop regional law enforcement and health and welfare responses to crystal methamphetamine;
    - sharing its practices with a particular focus on demand reduction and harm reduction; and
    - enhancing co-operation with the United Nations Office on Drugs and Crime (UNODC). And,
8. Australian law enforcement agencies, in addition to the number and volume of drug seizures, assess and report on the availability, purity and price of illicit drugs, particularly at the street level, to better determine the impact of law enforcement and other strategies on the illicit drug market.[1]

1.5 As at 26 March 2018, the Commonwealth government had not responded to the committee's first tranche of recommendations.

1.6 Lists of submitters, additional documents, answers to questions on notice and the details of public hearings can be found in the opening chapter and appendices of the first report.

1.7 This second report should be considered alongside the committee's first report, in particular, chapter 2 (the overview of crystal methamphetamine and its use in Australia) and chapter 3 (Australia's drug strategies). As per the definitions provided in the first report, this second report refers to crystal methamphetamine, methamphetamine or amphetamine, as appropriate, unless directly quoting evidence where another name for the drug was used.

1.8 The purpose of this second report is to examine treatment and harm reduction measures that are in place in Australia to assist crystal methamphetamine users, their families and communities. This report also considers the funding of treatment services as part of the NIAS and the decriminalisation of illicit drugs, drawing from the committee's visit to Portugal.

1.9 Although many of the issues outlined in this second report are outside the committee's core law enforcement focus, the evidence before the committee reveals a consistent message articulated by alcohol and other drug (AOD) experts, governments, the NIT and law enforcement agencies, that is: a person's drug use is a health issue and for this reason, Australian governments and law enforcement agencies cannot arrest their way out of it.

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1 Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp xi–xii.

1.10 That said, many submitters and witnesses acknowledged the important role of law enforcement agencies, for example in targeting serious and organised crime groups and outlaw motorcycle gangs, which are primarily responsible for the importation and distribution of illicit drugs, including crystal methamphetamine. However, many submitters and witnesses questioned the effectiveness of law enforcement responses as a means of addressing problematic drug use and the possession of small quantities of illicit drugs. This report outlines evidence that argues that treatment and harm reduction measures, not law enforcement, are more appropriate responses.

1.11 While numerous submitters and witnesses argued that treatment and harm reduction measures play an essential role in assisting individuals with problematic drug use, historically law enforcement, or supply reduction policies, have received the majority of AOD funding in Australia. Chapter 5 of this report considers the three pillars of Australia's National Drug Strategy (NDS) and calls for the rebalancing of funding across these three pillars: supply, demand and harm reduction measures. It also considers AOD funding more broadly, AOD funding announced as part of the NIAS and the use of the confiscated assets to resource AOD treatment services.

1.12 The report concludes with discussion of the committee's visit to Portugal and consideration of Portugal's response to problematic drug use: decriminalisation. Although decriminalisation exists in many different policy contexts in numerous countries (including Australia), evidence to the committee frequently identified Portugal's decriminalised drug policy as a model of best-practice. This report concludes with the committee's consideration of decriminalisation within the Australian context.

Update on methamphetamine use in Australia

1.13 As already noted, the committee considered methamphetamine use in Australia in its first report. Since the committee's first report was published, the National Drug and Alcohol Research Centre (NDARC) released preliminary findings for the Illicit Drug Reporting System (IDRS).[2] The IDRS is a national illicit drug reporting system to identify illicit drug trends in Australia. The preliminary findings will inform the final figures for 2017, which are due to be released in early 2018.[3]

2 Nationally, the National Drug and Alcohol Centre (NDARC) surveyed 888 people in 2017 (877 people in 2016), of that total: 67 per cent were male; 98 per cent came from an English speaking background; 19 per cent were Aboriginal and/or Torres Strait Islander; 60 per cent were single; 87 per cent were heterosexual; and 84 per cent were unemployed. 38 per cent of participants had participated in the survey for 2016 and participants were primarily recruited through needle and syringe programs and by word of mouth. See NDARC, *Australian Drug Trends 2017: Preliminary findings from the Illicit Drugs Reporting System*, October 2017, pp 4–5, https://ndarc.med.unsw.edu.au/resource/illicit-drug-reporting-system-idrs-2017-key-findings (accessed 18 October 2017).

3 NDARC, *Australian Drug Trends 2017: Preliminary findings from the Illicit Drugs Reporting System*, October 2017, p. 1.

1.14 Patterns of methamphetamine use show that: 71 per cent of participants had reported use of methamphetamine (in any form) in 2017, a decline when compared to 2016 (75 per cent). The NDARC reported that this decline is largely due to a decrease in the use of crystal methamphetamine (68 per cent in 2017 compared to 73 per cent in 2016). The results show, however, that frequency of methamphetamine use remained stable, with 61 per cent of participants reporting 'weekly or more often' use (59 per cent in 2016).[4]

1.15 There was a decline in the number participants that reported crystal methamphetamine's purity as high (30 per cent in 2017 compared to 37 per cent in 2016); however, no decline was seen in the median price per point (the median national price remained at $50 for all forms of methamphetamine).[5] Participants described the availability of methamphetamine (all forms) as 'easy' or 'very easy' to obtain, consistent with 2016 findings.[6]

1.16 Across all drug types, cannabis remained the drug most commonly used on a regular (weekly and daily) basis. Heroin was the next most frequently used drug and the most commonly nominated drug of choice. Thirty-two per cent of participants reported methamphetamine as their drug of choice.[7]

1.17 The NDARC's Senior Drug and Alcohol Drug Research Officer, Ms Amanda Roxburgh, told the national broadcaster, the Australian Broadcasting Corporation (ABC), that these findings show that many at-risk methamphetamine users are not seeking treatment services and that:

> …one of the big things is stigma, methamphetamine and particularly crystal methamphetamine is highly stigmatised in [Australia]. It means people aren't likely to come talk about their crystal methamphetamine use. We really do need to get people in; it's been relatively low across Australia.[8]

1.18 The issue of stigma is considered in chapter 4 of this report.

National Wastewater Drug Monitoring Program

1.19 In November 2017, the Australian Criminal Intelligence Commission (ACIC) released its third report as part of the National Wastewater Drug Monitoring Program (wastewater program). The third report found that methamphetamine remained the

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4 NDARC, *Australian Drug Trends 2017: Preliminary findings from the Illicit Drugs Reporting System*, October 2017, p. 2.

5 NDARC, *Australian Drug Trends 2017: Preliminary findings from the Illicit Drugs Reporting System*, October 2017, p. 17.

6 NDARC, *Australian Drug Trends 2017: Preliminary findings from the Illicit Drugs Reporting System*, October 2017, p. 2.

7 NDARC, *Australian Drug Trends 2017: Preliminary findings from the Illicit Drugs Reporting System*, October 2017, p. 2.

8 Stephen Smiley, 'Ice use down but risky behaviour among ecstasy users', *ABC Radio: AM*, 3 October 2017, http://www.abc.net.au/radio/sydney/programs/am/ice-use-down-but-risky-behaviour-among-ecstasy-users/9009846 (accessed 18 October 2017).

most prevalent[9] illicit drug tested[10] as part of the wastewater program, for both capital and regional testing sites. South Australia recorded the highest level for a capital city, and Western Australia recorded the highest level for a regional site.[11] The ACIC found:

> Comparing the latest findings of drug use with previous data for sites in Queensland and Western Australia, current methylamphetamine levels have shown an overall decline since historical highs in October 2016. The South Australian level also showed a decline during the past year, except for the August 2017 collection when levels returned to previous highs. Methylamphetamine levels in Victoria remained steady.[12]

International Engagement Methamphetamine Disruption Strategy

1.20 On 19 September 2017, the Commonwealth Law Enforcement International Engagement Methamphetamine Disruption Strategy (international methamphetamine strategy) was launched. The purpose of this strategy is to enhance the relationships and co-operation between domestic and international partners, with a primary aim of 'disrupting the supply and demand of methamphetamine and its precursors in Australia'.[13]

1.21 Participating agencies[14] will facilitate the international methamphetamine strategy by:

- better understanding the international methamphetamine environment;

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9 It should be noted that cannabis is not tested as part of the National Wastewater Drug Monitoring Program (wastewater program). Other wastewater analysis, such as the South Australian (SA) wastewater program includes cannabis as a tested drug. See SA Health, *Drug use in Adelaide Monitored by Wastewater Analysis*, October 2017, http://www.sahealth.sa.gov.au/wps/wcm/connect/f801a20045027ebea445f4005ba75f87/Standard+report+October+2017+data.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-f801a20045027ebea445f4005ba75f87-m3EwM.l (accessed 21 February 2018).

10 The wastewater program tested for the following substances: methylamphetamine, amphetamine, cocaine, 3,4-methylenedioxymethylampethamine (MDMA), 3.4-methylenedioxyamphetamine (MDA), heroin, JWH-018, JSWH-073, mephedrone, methylone, oxycodone, fentanyl, nicotine and alcohol. See Australian Criminal Intelligence Commission (ACIC), *National Wastewater Drug Monitoring Program–Third report*, November 2017, p. 8, https://www.acic.gov.au/sites/g/files/net3726/f/national_wastewater_drug_monitoring_program_report_3.pdf?v=1513140704 (accessed 21 December 2017).

11 ACIC, *National Wastewater Drug Monitoring Program–Third report*, November 2017, p. 16.

12 ACIC, *National Wastewater Drug Monitoring Program–Third report*, November 2017, p. 16.

13 Australian Federal Police (AFP), 'International methamphetamine strategy launched, taking the fight against illicit drugs offshore', *Media release*, 19 September 2017, https://www.afp.gov.au/news-media/media-releases/international-methamphetamine-strategy-launched-taking-fight-against (accessed 21 December 2017).

14 The AFP, the Attorney-General's Department, the Department of Immigration and Border Protection, Department of Defence, Department of Foreign Affairs and Trade, Department of Prime Minister and Cabinet, Department of Health, Australian Transaction Reports and Analysis Centre, Australian Border Force, and the ACIC.

- enhancing co-operation between law enforcement and border security;
- providing targeted capacity building and capability development; and
- maximising advocacy and political engagement with international partners.[15]

Structure of the report

1.22 This report considers the following issues in five chapters.

1.23 Chapter 2 considers treatment options and access to treatment for AOD use. It provides an update on the NIAS, followed by a brief overview of Australia's treatment profile for amphetamine in 2015–16. This is followed by a discussion of some key issues, including:

- waiting lists for AOD treatment services;
- residential treatment services, including demand for and availability of such facilities;
- private treatment facilities and the need for a national quality framework;
- mandatory residential treatment; and
- methamphetamine use and treatment in Australia's correctional facilities.

1.24 The chapter concludes with an update on pharmacotherapy treatment of meth/amphetamine addiction.

1.25 Chapter 3 examines additional issues for two of Australia's at-risk communities: rural and remote communities and Indigenous Australians. The chapter also considers support and treatment services for families with children, followed by consideration of initiatives to address methamphetamine use in at-risk workplaces.

1.26 Chapter 4 considers harm reduction initiatives together with further commentary on rebalancing Australia's drug harm minimisation policy. This chapter also looks at the stigmatisation of drug users in the media and calls for the establishment of national guidelines for press reporting on AOD issues. It also discusses education initiatives to improve the public's understanding of crystal methamphetamine and other drugs; needle and syringe programs; and safe injecting rooms. The chapter concludes with consideration of harm reduction measures in the context of the darknet.

1.27 Chapter 5 first considers the NDS and the prioritisation and funding across the three pillars of the NDS (demand, supply and harm reduction strategies). It then considers the funding of AOD services as part of the NIAS, specifically:

- the rollout and distribution of funding to the Public Health Networks (PHNs);
- the allocation of funding;

15 AFP, 'International methamphetamine strategy launched, taking the fight against illicit drugs offshore', *Media release*, 19 September 2017.

- the allocation of NIAS funding to regions with more problematic crystal methamphetamine use;
- the timing of and timeframe for AOD service providers to tender for NIAS funding;
- delays in the distribution of NIAS funding; and
- concerns about the transparency of NIAS funding.

1.28 Finally, chapter 5 considers use of the *Proceeds of Crime Act 2002* Confiscated Assets Account (CAA), and the distribution of funding from the CAA to law enforcement and AOD treatment services.

1.29 Chapter 6 considers decriminalisation, the committee's visit to Portugal and the appropriateness of decriminalisation in the Australian context.

Chapter 2

Demand and treatment policies

2.1 This chapter's theme aligns with demand reduction measures in the National Drug Strategy (NDS), but does not provide a detailed description of how alcohol and other drug (AOD) treatment services are implemented and funded across all jurisdictions in Australia, as this is outside the scope of this report.

2.2 The chapter provides a brief overview of the AOD treatment sector, followed by an update on Australia's amphetamine treatment profile for 2015–16 and discussion of the implementation of the National Ice Action Strategy (NIAS).

2.3 The chapter then turns to the issues raised by submitters after the release of the National Ice Taskforce's (NIT) final report and the NIAS, specifically:

- waiting lists to access AOD treatment services;
- residential treatment services;
- private/for-profit treatment services;
- mandatory residential treatment; and
- methamphetamine use and treatment in correctional facilities.

2.4 The chapter concludes by outlining the most recent developments in pharmacotherapy treatment options for crystal methamphetamine use.

Overview of the alcohol and other drug treatment sector

2.5 Australia's AOD treatment sector is complex and diverse. The regulation of the AOD sector is largely the responsibility of each state and territory, and each jurisdiction has its own AOD policies. The interplay between Commonwealth, state and territory funding and policies make the AOD sector a complex policy area. Within each jurisdiction, there are numerous AOD treatment options, primarily separated between specialist and generalist systems of care.

2.6 The specialist AOD treatment system provides drug withdrawal support, psycho-social therapies, residential rehabilitation and pharmacotherapy maintenance. The generalist service system is primarily distinguished by services administered through primary care (general practitioners (GPs)) and general hospitals. The general service system provides treatment types, such as GPs offering pharmacotherapy

maintenance and brief interventions, clinical psychologists proving psycho-social therapy and general hospitals providing withdrawal services.[1]

2.7 There is a range of AOD treatments available in Australia. The primary treatment categories are:

- withdrawal or detoxification programs;
- psycho-social therapies (such as counselling or psychotherapy);
- residential rehabilitation; and
- pharmacotherapy maintenance.[2]

2.8 Within these four key categories are assessments, case management and support, information and education, and aftercare services. These services can be provided via telephone, outreach, group-based and on-line programs.[3]

2.9 This diversified AOD treatment sector provides drug users with an array of treatment options. The Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC) highlighted the importance of this diversity. It explained that drug users access the treatment sector at various points and have numerous needs.[4] Those presenting with a drug issue are very likely to have other associated issues, for example:

> There are some people who will need housing first and then we will fix the drug issue later, or there are some people that have a mental health issue first and then we will fix the AOD issue later, or we need to fix the alcohol and other drugs issue first and then fix the other things after that. I do not think there is any one type of person that actually comes in. I think that people come in with a range of many different types of issues, so we need to have choice in terms of treatment options. There are certain places that some people would not want to go to, so it is about providing choice. I would currently say that we do need more choice and we need more treatment in our treatment mix.[5]

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1 Professor Alison Ritter, Dr Lynda Berends, Dr Jenny Chalmers, Mr Phil Hull, Dr Kari Lancaster and Ms Maria Gomez (Ritter et al.), *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre (NDARC), July 2014, p. 25, http://www.health.gov.au/internet/main/publishing.nsf/content/FD5975AFBFDC7013CA258082000F5DAB/$File/The-Review-of-alcohol-and-other-drug-treatment-services-in-Australia.pdf (accessed 21 December 2017).

2 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 25.

3 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 25.

4 Dr Jacqueline Hallam, Policy and Research Officer, Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC), *Committee Hansard*, 24 March 2017, p. 8.

5 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 8.

2.10 This treatment mix is implemented and funded by Commonwealth, state and territory governments. The National Drug and Alcohol Research Centre's (NDARC) Drug Policy Modelling Program conducted a review of Australia's AOD treatment services (New Horizons report) from July 2014. The report highlighted the complexities of AOD funding in a federated system and attempted to detail the roles of and funding arrangements across Australian jurisdictions. In general terms, the report explained the shared responsibility for healthcare services across Australia:

> States and territories have responsibility for hospital services, the Commonwealth is responsible for funding medical services, and there is shared responsibility for community care and disability services. In more common terms, the Commonwealth funds primary care and pharmaceuticals (through Medicare and [the Pharmaceutical Benefits Scheme]) and the states/territories manage hospitals (with pooled funding from the Commonwealth and state).[6]

2.11 The New Horizons report added that the division of responsibilities between these two levels of government is hard to clarify, and debate about the roles and responsibilities of governments is common.[7] Further, the broad distinction 'does not assist in clarifying respective roles in AOD treatment funding or provision, as it is neither primary care nor hospital services'.[8] The Commonwealth government, however, plays a vital role in allocating funding to the AOD sector (as of 2014 the Commonwealth government provided 39 per cent of all government funding). Further, the NDARC identified four key Commonwealth responsibilities:

- advancing national priorities;
- providing leadership in planning;
- addressing service quality; and
- supporting equity.[9]

2.12 According to the NDARC:

> These responsibilities are fulfilled through investment in direct service delivery and capacity building projects, along with leadership for the nation in planning, quality frameworks and ensuring equity.[10]

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6 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 248.

7 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 248.

8 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 248.

9 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 254.

10 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 265.

2.13 Professor Steve Allsop, from the National Drug Research Institute (NDRI) at Curtin University, discussed the complexities of AOD use, its treatment and how to adequately respond to methamphetamine use in Australia. Professor Allsop opined that key challenges in responding to methamphetamine problems are 'about establishing well-resourced, evidence-based and enduring prevention strategies'.[11] An adequate response is not driven by warnings to the public about the dangers of crystal methamphetamine use; instead, it is about developing:

> …coordinated investment in addressing the social and other determinants of drug use and methamphetamine use in particular. It is about schooling; it is about employment opportunities; it is about poverty; it is about availability—there are a wide range of factors that need to be addressed.[12]

2.14 In addition, Professor Allsop argued that governments need to 'ensure more and enhanced access to treatment' services.[13] He noted that many people, especially in remote areas, are not able to access timely help when it is needed.[14] Further, governments need to ensure access to treatment that is effective; that is evidence-based treatment:

> ...that addresses the wide range of harms that arise from methamphetamine use, whether that be infectious disease, other physical health problems, and mental health problems; and it means ensuring that access to quality of life is a major focus of treatment outcomes. It is not just about stopping someone using drugs; it is about improving the quality of their lives. It is about establishing effective evidence-based pharmacotherapies…which is a significant gap in our available treatment package at the moment.[15]

2.15 Professor Allsop felt that there needs to be a system in place:

> …that is responsive to changes in patterns of drug use and related problems, because they do change. We do not want to lock ourselves into one way of doing things, addressing one single drug. Most people with drug problems do not have one single drug problem; they have an array of social, legal and other problems, but often they use other substances as well.[16]

Amphetamine treatment profile in 2015–16

2.16 In 2017, the Australian Institute of Health and Welfare (AIHW) published the *Alcohol and other drug treatment services in Australia 2015–16 report*. The report estimates that 134 000 clients had received treatment in 2015–16, an increase since 2013–14 (119 000). This total equates to 1 in 180 people seeking AOD treatment

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11 Professor Steve Allsop, Project Leader, National Drug Research Institute (NDRI), Curtin University, *Committee Hansard*, 3 May 2017, p. 31.

12 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 31.

13 Professor Allsop, NDRI, Committee Hansard, 3 May 2017, p. 31.

14 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 31.

15 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 31.

16 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 32.

services in 2015–16. Fourteen per cent of those presentations were by Aboriginal and Torres Strait Islander peoples.[17]

2.17 AOD service providers facilitated approximately 207 000 treatment episodes in 2015–16, an average of 1.5 episodes per client.[18] Seventy-nine per cent of treatment episodes were closed within three months.[19] Eleven per cent of clients that received treatment in 2015–16, had received treatment in 2013–14 and 2014–15.[20]

2.18 The AIHW reported that the number of treatment episodes for amphetamines had increased by 175 per cent over the past five years, more than doubling from 16 875 treatment episodes in 2011–12 to 46 441 in 2015–16.[21] There were 67 789 closed treatment episodes for amphetamine use in 2015–16.[22] Of this total, 46 441 (23 per cent) treatment episodes listed amphetamine as the principal drug of concern, and 21 348 (11 per cent) as the additional drug of concern.[23]

2.19 Despite the increase in amphetamine presentations, alcohol remained the most prevalent reason for treatment episodes (32 per cent); however, over the past five years alcohol has decreased by 6 per cent.[24] In contrast, treatment for cannabis has increased by 40 per cent over the same five year period.[25]

2.20 The AIHW reported that Indigenous Australians (782 per 100 000 people), who sought treatment for amphetamine as the principal drug of concern were more likely to receive treatment than non-Indigenous Australians (115 per 100 000 people).[26] The AIHW reported that:

> Although a small number of episodes were reported nationally for Indigenous clients for whom amphetamines were a principal drug of concern (almost 7,000), this represents a larger proportion of the Indigenous population across Australia compared with the non-Indigenous population.[27]

2.21 Treatment providers also saw increases in the number of episodes for clients injecting (38 per cent of episodes), and smoking and inhaling (50 per cent of episodes)

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17 Australian Institute of Health and Welfare (AIHW), *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii, https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2015-16/contents/table-of-contents (accessed 21 December 2017).

18 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

19 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

20 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

21 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 16.

22 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 18.

23 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 18.

24 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

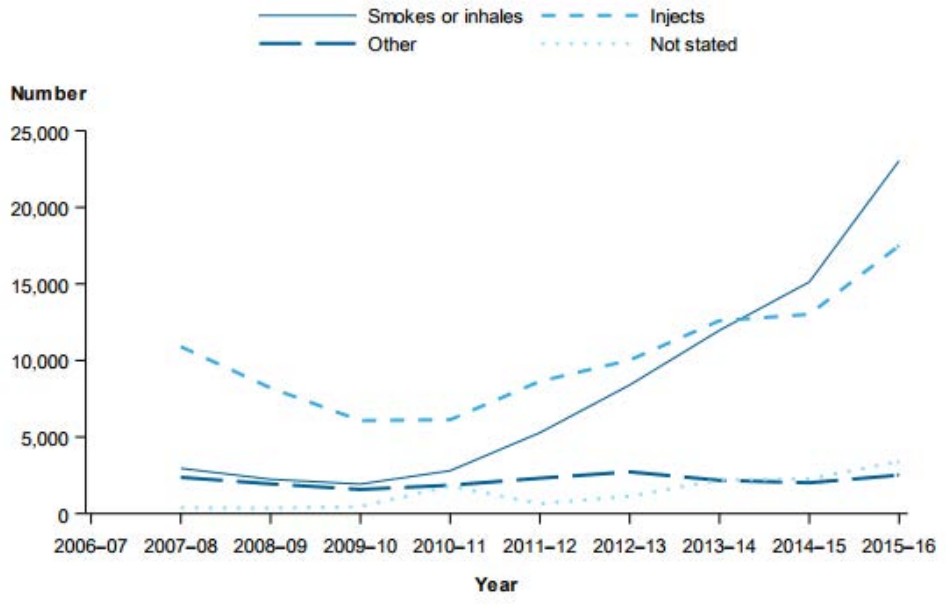
25 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

26 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

27 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

amphetamine.[28] More than four times as many clients were smoking or inhaling amphetamine in 2015–16 as in 2011–12.[29] Figure 1 shows closed treatment episodes with amphetamine as the principal drug of concern, by the method of use.

Figure 1: Closed treatment episodes for own drug use with amphetamine as the principal drug of concern, by method of use, 2006–07 to 2015–16[30]



Note: 'Other' includes 'ingests', 'sniffs' and 'other'.

2.22 In 2015–16, 69 per cent of amphetamine treatment episodes were for male clients.[31] Most clients that had registered amphetamine as the principal drug of concern were aged 20–39 (74 per cent), followed by those aged 40–49 (16 per cent).[32] For Indigenous Australians, the proportion of clients that sought treatment between the ages of 10–19 was higher compared with non-Indigenous clients of the same age, 10 per cent and 6 per cent respectively.[33]

2.23 Amphetamine users were primarily self-referred or referred by a family member (42 per cent) to treatment services, followed by referrals from health services (24 per cent) and diversionary programs (18 per cent).[34]

2.24 The most common treatment type in 2015–16 for amphetamine use was counselling (38 per cent, which had declined over the past five years (45 per cent in

28 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

29 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

30 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 30.

31 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

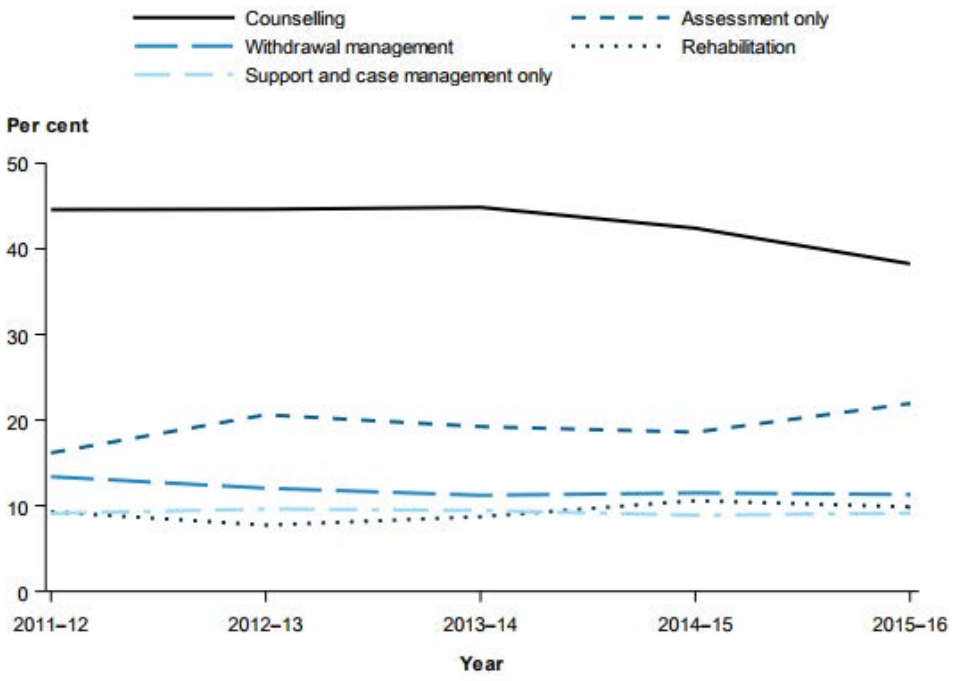
32 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

33 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 27.

34 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 28.

2011–12)),[35] followed by assessment only (22 per cent) and withdrawal management (11 per cent).[36] Treatment programs were more likely to be conducted in a non-residential treatment facility (68 per cent).[37] Figure 2 shows closed treatment episodes with amphetamine as the principal drug of concern, with the top five treatment types received between 2011–12 to 2015–16. Figure 3 shows the main treatment types and selected drug of concern, including amphetamine, from 2013–14 to 2015–16.

Figure 2: Closed treatment episodes with amphetamine as the principal drug of concern, by the top five treatment types, 2011–12 to 2015–16[38]



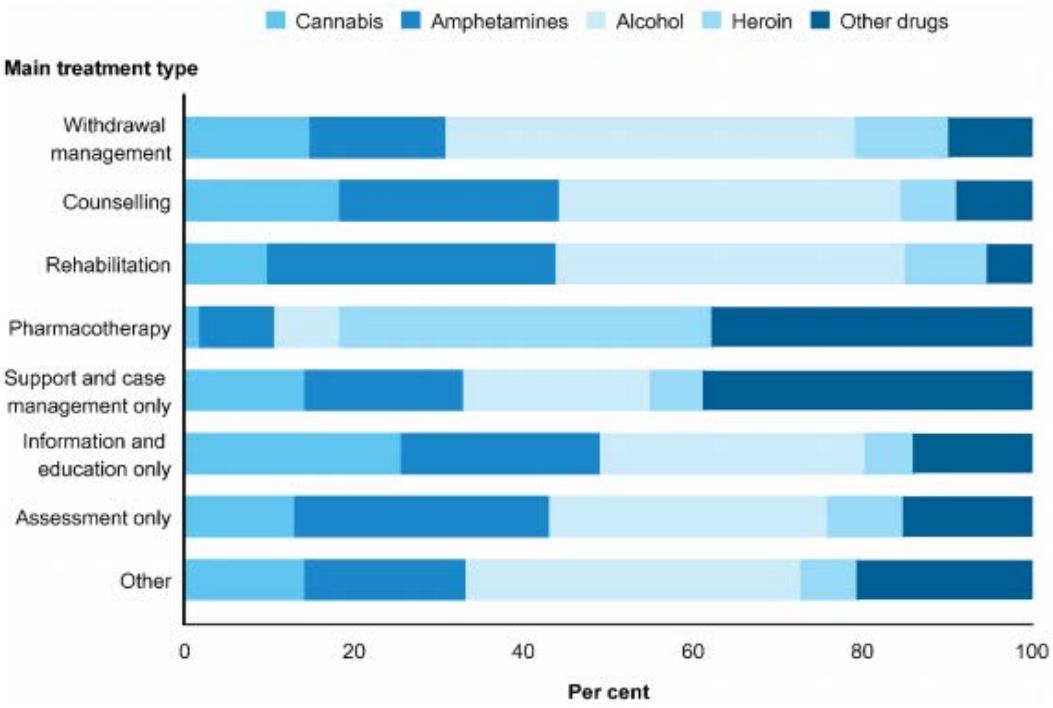
35 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 28.

36 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 28.

37 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 28.

38 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

Figure 3: Clients received treatment in all three years, 2013–14, 2014–15 and 2015–16, by main treatment type and selected drugs of concern (%)[39]



2.25 Fifty-two per cent of closed treatment episodes with amphetamines listed as the principal drug of concern lasted less than one month.[40] Twenty-three per cent were closed within a day and were mostly for assessments only.[41] The median duration of a treatment episode for amphetamine was 28 days, but varied depending on treatment type.[42] For example, the median timeframe for counselling services was 57 days, seven days for withdrawal management, and one day information and education.[43]

2.26 The majority of closed treatment episodes (62 per cent) were completed at the expected cessation time.[44] In these instances, a higher success rate was reported for those clients that were self- or family referred (41 per cent).[45] Twenty-four per cent of closed treatment episodes ended unexpectedly.[46]

Update on the implementation of the National Ice Action Strategy

2.27 Upon their release part way through the committee's inquiry, the NIT and the NIAS addressed a range of issues that had been identified by submitters and witnesses

39 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 48.

40 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

41 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

42 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

43 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

44 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

45 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

46 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 29.

during the course of the inquiry. As already stated in the committee's first report, the committee supports all 38 recommendations in the NIT's final report and the NIAS in its entirety.

2.28 As of 3 July 2017, the following treatment and demand reduction objectives under the NIAS had been implemented:

- Work by the Alcohol and Drug Foundation (ADF) to establish 220 Local Drug Action Teams (LDATs) across Australia by 2020 is underway. The first round saw the establishment of 40 teams across Australia, representing 160 partnerships across local councils, service providers, schools, police and non-government organisations. The objective of the LDATs is to work together to address the harms of drugs, especially crystal methamphetamine, on local communities.[47] Applications are currently open for the third round of the program.[48]
- On 21 March 2017, the ADF launched the *Tackling Illegal Drugs* module as part of its Good Sports Program. The $4.6 million in program funding is intended to help communities build the capacity and confidence to address local illicit drug issues and harms within sporting communities. Over 1200 sporting clubs, many of which are from rural and remote communities, are delivering this initiative.[49]
- On 3 April 2017, the government launched the *Cracks in the Ice* online toolkit. It provides publicly accessible, factual and evidence-based information about crystal methamphetamine to community groups, local councils, parents, friends, teachers, students and frontline service providers.[50]
- The allocation of funding for treatment services through the Public Health Networks (PHNs) (see chapter 5 for further details).[51]
- In October 2016, Turning Point launched the expanded Counselling Online service to provide free counselling for people using AOD, their family and friends.[52]
- In September 2016, the NDARC released the revised *National Comorbidity Guidelines*. The purpose of these guidelines is to increase 'the knowledge and awareness of co-occurring mental health condition in alcohol and other drug treatment settings, improve the confidence and skills of AOD workers, and

47 Department of Health (DoH), *National Ice Action Strategy,* 3 July 2017, http://www.health.gov.au/internet/main/publishing.nsf/Content/MC15-009596-national-ice-taskforce (accessed 7 December 2017).

48 Alcohol and Drug Foundation (ADF), *Local Drug Action Team Program,* https://adf.org.au/programs/local-drug-action-teams/ (accessed 7 December 2017).

49 DoH, *National Ice Action Strategy*, 3 July 2017.

50 DoH, *National Ice Action Strategy*, 3 July 2017.

51 DoH, *National Ice Action Strategy*, 3 July 2017.

52 DoH, *National Ice Action Strategy*, 3 July 2017.

increase the uptake of evidence-based care'.[53] The revised guidelines include the most up-to-date evidence of best-practice, and were updated in consultation and collaboration with clinicians, researchers, consumers and carers from across Australia. The NDARC is currently developing an online training tool to accompany the second edition of these guidelines.[54] And,

- From 1 July 2016, the Commonwealth government allocated $1.7 million over four years for the University of Adelaide to continue to develop and expand its Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and Brief Intervention (BI) (ASSIST-BI) across the primary health, mental health, and emergency care sectors and the community correctional setting. The ASSIST-BI is a tool for health professionals to screen for hazardous or harmful use of illicit drugs, tobacco and alcohol.[55] Presently, ASSIST-BI is 'the only screening instrument responsive to changes in drug use patterns as it screens for the use of alcohol, tobacco, amphetamines, cannabis, cocaine, inhalants, opioids, sedatives and hallucinogens'.[56]

Committee comment

2.29 The committee urges Commonwealth, state and territory governments to continue to implement the recommendations and strategies established by the NIT and NIAS as a matter of priority.

Key issues: treatment and demand reduction measures

2.30 This section considers a number of key issues faced by the AOD treatment sector. Many of these issues remain unresolved, despite the initiatives implemented as part of the NIAS.

Waiting lists for alcohol and other drug treatment services

2.31 A concern consistently expressed to the committee during the course of the inquiry is the long waiting lists faced by individuals seeking to access AOD treatment services, particularly residential treatment facilities. Centracare,[57] the National Association of People with HIV Australia and Positive Life NSW,[58] The Salvation Army,[59] the Ted Noffs Foundation,[60] Professor Nadine Ezard,[61] the Queensland

53 DoH, *National Ice Action Strategy*, 3 July 2017.

54 DoH, *National Ice Action Strategy*, 3 July 2017.

55 DoH, *National Ice Action Strategy*, 3 July 2017.

56 DoH, *National Ice Action Strategy*, 3 July 2017.

57 Ms Helene Nielson, Assistant Executive Manager, Centracare, *Committee Hansard*, 28 July 2015, p. 45 and p. 47.

58 Mr Craig Cooper, Secretary, Treasurer and Chief Executive Officer, National Association of People with HIV Australia and Positive Life NSW, *Committee Hansard*, 29 July 2015, p. 21.

59 Ms Kathryn Wright, Territorial Drug and Alcohol Director, The Salvation Army, *Committee Hansard*, 29 July 2015, p. 29.

60 Mr Mark Ferry, Chief Operating Officer, Ted Noffs Foundation, *Committee Hansard*, 29 July 2015, p. 52.

Network of Alcohol and Other Drug Agencies[62] and Queensland Health[63] all voiced concern about long waiting lists for residential rehabilitation and counselling services for people presenting with crystal methamphetamine and other AOD issues.

2.32 Long waiting lists are largely due to the number of people seeking access to limited AOD treatment services. Research by the NDARC in 2014 estimated that approximately 200 000 people access AOD treatment services in Australia each year.[64] Despite the significant number of people that are provided with support, the NDARC conservatively estimated that unmet demand (the 'number of people in any one year who need and would seek treatment') is between '200 000 and 500 000 people *over and above* those in treatment in any one year'.[65] The New Horizons report remarked that overall 'there is substantial unmet demand for AOD treatment' in Australia.[66]

2.33 Prior to the release of the NIT final report/NIAS, the Victorian Alcohol and Drug Association (VAADA) expressed concern about waiting times and access to treatment:

> The waiting times, however, are often lengthy and difficult for people, and that creates a range of waiting lists and threshold problems for people coming in and not being able to come in when the availability is there.
>
> Whatever the perception, there is a need to reaffirm the efficacy of the AOD treatment sector in addressing issues related to methamphetamine dependence and, moreover, ensuring that treatment is readily available to the community when people require it.[67]

2.34 In 2017, ATDC advised the committee that there remains a need to address long waiting lists for people accessing AOD treatment services in both Tasmania and around the country.[68] People based in regional and remote areas are particularly impacted because they do not have the treatment options available to people based in urban areas such as Hobart.[69] The ATDC noted that, anecdotally, people are waiting

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61 Professor Nadine Ezard, St Vincent's Hospital, *Committee Hansard*, 29 July 2015, p. 73

62 Ms Rebecca MacBean, Chief Executive Officer, Queensland Network of Alcohol and Other Drug Agencies (QNADA), *Committee Hansard*, 30 July 2015, p. 3.

63 Mrs Rebecca Armitage, Allied Health Manager, Metro North Mental Health, Alcohol and Drug Service, Queensland Health, *Committee Hansard*, 30 July 2015, p. 27.

64 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 13.

65 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 13.

66 Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, NDARC, July 2014, p. 183.

67 Mr Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association (VAADA), *Committee Hansard*, 27 July 2015, p. 31.

68 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 10.

69 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 10.

up to eight to 10 weeks for treatment services, such as counselling, case management or other support services.[70] Specifically, the ATDC reported that the north-west coast area of Tasmania has minimal access to AOD and mental health services.[71]

2.35 The committee questioned Holyoake Tasmania about reports of it having to send people to mainland Australia for AOD treatment services.[72] Holyoake Tasmania confirmed this and advised that it was doing so because there are insufficient detoxification beds available in the state.[73]

2.36 In a position paper from August 2017, the Australian Medical Association (AMA) re-iterated calls to increase the availability of treatment services to address long wait times. The AMA stated that the 'lack of treatment services affects patient outcomes'[74] and 'waiting for extended periods of time to access treatment can reduce an individual's motivation to engage in treatment':[75]

> In most instances demand for treatment outweighs its availability. This can mean people wait for extended periods to access treatment, which can results in withdrawal and deteriorations in motivation to engage in treatment. Timeliness in accessing suitable treatment is vital.[76]

2.37 Professor Allsop commended efforts by the Commonwealth, state and territory governments to address the demand for treatment services; however, Professor Allsop argued there remains 'an enormous unmet need, and it is in the access to that service'.[77] Professor Allsop added that it was not just about the location of a service, but also the hours it is open, and whether it meets the needs of the individual or particular group seeking to access the service.[78]

2.38 On 30 May 2017, the Senate Standing Committee on Community Affairs (Community Affairs Committee) and the Department of Health (DoH) discussed the collection of national data on average wait times for accessing residential

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70 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 11.

71 Dr Hallam, ATDC, *Committee Hansard*, 24 March 2017, p. 11.

72 Ms Sarah Charlton, Chief Executive Officer (CEO), Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 16.

73 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 16.

74 Australian Medical Association (AMA), *Harmful substance use, dependence and behavioural addiction (Addiction) – 2017*, AMA position, https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017 (accessed 29 November 2017).

75 AMA, 'Substance abuse needs mature policy approach', *Media release*, 14 August 2017, https://ama.com.au/ausmed/substance-abuse-needs-mature-policy-approach (accessed 29 November 2017).

76 AMA, *Harmful substance use, dependence and behavioural addiction (Addiction) – 2017*, AMA position, https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017 (accessed 29 November 2017).

77 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 38.

78 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 38.

rehabilitation services. The DoH informed the Community Affairs Committee that it did not collect this data 'in a detailed or quotable form' and added that '[w]aiting times are not actually captured in the alcohol and drug national minimum dataset at this particular point in time, but that is certainly an item that we are developing currently'.[79]

2.39 On 5 January 2018, the DoH subsequently advised the Community Affairs Committee that funding had been allocated to the AIHW 'to support the development of this data item through the Alcohol and Other Drug Treatment Services National Minimum Data Set Working Group'.[80] The DoH added that 'the expert group to guide the data development has yet to be established' and for that reason 'a work plan including timelines for development has not yet been drafted'.[81]

The window of opportunity

2.40 The committee heard that timely access to treatment services is vital because it creates a 'small window of opportunity where people are addicted to ice are ready' to undergo treatment:[82]

> …cognitively, for many of them, they are absolutely unaware of the damage they are doing to themselves and to their families. So, a capacity to reflect and say, 'I need to change this,' for many people with an ice addiction is not going to happen. They have no concept and no insight into what is going on. They need the motivation to change. When they have a window of opportunity—perhaps they have been well for a while and a critical incident happens and they realise that something has to change—at the moment we cannot get them quick help in Australia.[83]

2.41 The Australian Psychological Society (APS) explained that often the trigger for an individual to seek the support of AOD treatment services is a significant event or a realisation that something has to change. Access to AOD treatment services, however, is difficult and can take weeks or months before anything is in place. During this time, the window of opportunity can pass.[84]

2.42 The issue of having a limited window of opportunity was also raised by Professor Allsop, who opined that if an individual arrives at an emergency department:

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79 Mr David Laffan, Assistant Secretary, Drug Strategy Branch, Population Health and Sport Division, DoH, Senate Standing Committee for Community Affairs, *Committee Hansard*, 30 May 2017, p. 71.

80 DoH, answers to question on notice, No. SQ17-001525, 30 May 2017 (received 5 January 2018).

81 DoH, answers to question on notice, No. SQ17-001525, 30 May 2017 (received 5 January 2018).

82 Dr Louise Roufeil, Executive Manager Professional Practice, Australian Psychological Society (APS), *Committee Hansard*, 27 July 2015, p. 60.

83 Dr Roufeil, APS, *Committee Hansard*, 27 July 2015, p. 60.

84 Dr Roufeil, APS, *Committee Hansard*, 27 July 2015, p. 60.

> …you do not want the emergency department to phone up a treatment service and hear the treatment service say, 'Yes, we can see them in four weeks' time.' That is a missed opportunity. If a GP raises drug use with one of their patients, they need to be able to get that person into treatment immediately. So we need to be able to get people into treatment, and then to have clinicians who are able to retain, engage and support people whose relationships and capacity to form relationships might have taken a battering, and then to make sure that those treatment services understand the more prolonged nature of methamphetamine, the impact on relationships—perhaps sometimes suspicion and agitation—and how to manage these things. I think there has been an enormous amount of work done, and the treatment services that we have available now are much more easily accessible and much more capable of responding. But, at the end of the day, there are still far more people in need than we have treatment places for, so sometimes people end up in prison, in the justice system, quite simply because we could not get them into treatment. People end up with their problems becoming worse, both for them and for their families, quite simply because we could not get them into treatment.[85]

2.43 The committee heard that some organisations have the capacity to provide preliminary support to people during the period they are waiting to access a treatment service. For example, the Palmerston Association provides waitlist groups and phone support services for those waitlisted,[86] as does The Salvation Army.[87]

Initiatives to reduce waiting times

2.44 The NIT recognised that 'unmet demand is a longstanding issue' and supported 'further investment to strengthen the capacity of services to respond more effectively and ensure that more people are getting the help and support they need, when they need it'.[88]

2.45 The NIT, however, did caution against the investment of resources into more costly and less-effective models of treatment. In its final report, the NIT argued that such investments are unlikely to have a significant impact on the AOD sector, and that funds should be dispersed by those with knowledge of local needs.[89] Subsequently, the NIT recommended that:

> The Commonwealth, state and territory governments should further invest in alcohol and other drug specialist treatment services. This investment must:
>
> - target areas of need—this includes consideration of regional and remote areas and Indigenous communities

85 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 38.

86 Palmerston Association, *Submission 100*, p. 3.

87 Ms Wright, The Salvation Army, *Committee Hansard*, 29 July 2015, p. 29.

88 National Ice Taskforce (NIT), *Final Report*, p. 131.

89 NIT, *Final Report*, p. 132.

- be directed toward evidence-based treatment options and models of care for every stage of a patient journey
- involve consultation across the Commonwealth, states and territories and the alcohol and other drug sector
- be subject to a robust cost-benefit evaluation process
- ensure service linkages with social, educational and vocational long-term supports.[90]

2.46 In response to this recommendation, the Commonwealth government announced that $241.5 million would be invested in AOD treatment service delivery via PHNs, expanding early intervention initiatives through online counselling and information, and providing $13 million to introduce new Medicare Benefits Scheme items for Addiction Medicine Specialists to increase treatment availability.[91] These announcements were incorporated in the NIAS.

Committee comment

2.47 It is apparent to the committee that delaying a drug user's access to AOD treatment services significantly undermines their chance of achieving a successful treatment outcome. The small window of opportunity when a drug user is seeking support and treatment must be capitalised upon. Long waiting lists to access services are a major problem, and governments and the AOD treatment sector must continue to address this issue.

2.48 Investment in AOD treatment services is central to addressing Australia's capacity to respond to crystal methamphetamine abuse. Failure to provide sufficient treatment options to meet demand may, as noted by Professor Allsop, result in further pressure on police resources, the justice system and the prison system. This is already borne out in the substantial increase in the number of defendants finalised for a principal illicit drug offence in Australia's criminal courts over recent years.[92] It also results in negative impacts on the physical and mental health of illicit drug users, and places additional stressors on their families and communities. The committee believes that these issues can be substantially diminished with timely access to AOD treatment services.

2.49 The committee commends the work of governments, across all jurisdictions, to provide additional funding to the AOD treatment sector. These additional funds allow a greater number of drug users (an additional 15 000 clients between 2013–14 and 2015–16)[93] to access treatment services and support. In particular, the committee

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90 NIT, *Final Report*, p. 132.

91 Commonwealth of Australia, *Taking action to combat ice*, December 2015, p. 2, http://www.health.gov.au/internet/main/publishing.nsf/content/396377B005C71DD0CA257F100005FD5C/$File/combat%20ICE%20glossy.pdf (accessed 21 December 2017).

92 See Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice): First report*, September 2017, pp 167–168.

93 See paragraph 2.16. AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. vii.

applauds the Commonwealth government for additional AOD funding announced as part of the NIAS. However, the committee considers that further additional funding for the AOD sector is warranted: chapter 5 considers this issue in greater detail, in particular the prioritisation of government funding towards law enforcement (supply reduction) measures rather than treatment (demand) and harm reduction measures. That chapter also considers whether additional funding could be directed to AOD treatment services via the Confiscated Assets Account under the *Proceeds of Crime Act 2002.*

2.50 During the course of the inquiry, some submitters and witnesses complained that since the implementation of the NIAS, wait lists remain. The committee suggests that insufficient time has elapsed since the implementation of the NIAS for a meaningful assessment to be made of its impact on waiting times, and that it may take some time for additional treatment services to come online and an impact to be seen.

2.51 As recommended in its first report, the committee does expect that thorough and transparent progress reports on the implementation of the NIAS will be made publicly available and will include assessments of the effectiveness of the NIAS, and AOD policies more broadly. Such an assessment will require reliable national data on unmet demand for treatment services and the length of time people are waiting to access such services. Currently, as the DoH advised the Community Affairs Committee, this data is not collected.

2.52 This committee commends the work commenced by the DoH and AIHW to collect data on demand and waiting times for treatment services. The committee considers that the collection of this data will be key to assessing the effectiveness of measures to reduce waiting times, and enable informed decisions to be made about future policies and their funding. The committee therefore recommends that the DoH and AIHW establish an expert group and progress the development of an AOD treatment waitlist dataset item as a matter of priority.

Recommendation 1

2.53 The committee recommends that the Department of Health and the Australian Institute of Health and Welfare establish an expert group and progress their work to develop an alcohol and other drugs treatment waitlist item as part of the Alcohol and Other Drug Treatment Services National Minimum Data Set.

Residential treatment services

2.54 Residential (inpatient) rehabilitation services are AOD treatment services offered in a residential facility for an extended period of time. The purpose of these services is to help clients cease their AOD use, and to address the psychological, legal, financial, social and physical impacts of problematic drug use.[94]

94 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 64.

2.55 Data from 2015–16 shows that residential treatment accounted for 14 per cent of treatment episodes for clients presenting with AOD issues.[95] During this period, 35 per cent of closed residential treatment episodes lasted one to three months, and 31 per cent lasted two to 29 days.[96] Table 1 shows the number of closed treatment episodes provided in residential rehabilitation, by duration from 2011–12 to 2015–16.

Table 1: Closed episodes provided for own drug use with main treatment type of rehabilitation, by duration, 2011–12 to 2015–16[97]

Duration	2011–12	2012–13	2013–14	2014–15	2015–16
1 day	379	346	377	397	593
2–29 days	2994	2461	3329	3315	3717
30–90 days	2903	2814	3479	4050	4207
91–182 days	1465	1552	1959	2013	2172
183–364 days	697	630	765	928	782
365+ days	227	186	257	334	403
Total	8665	7989	10 166	11 047	11 874

2.56 Some research has demonstrated a strong economic case in favour of residential rehabilitation. For example, the VAADA submitted that:

- research from the Australian National Council on Drugs (2012) showed for Indigenous populations, a saving of $111 458 per offender is made when a person is dealt with in a residential rehabilitation facility compared with imprisonment. A further saving of $92 759 is made when improved health-related quality of life and lower mortality rates are taken into account;[98] and
- a 2013 study found for every person that is provided with residential rehabilitation 'there is a conservative new economic benefit of approximately $1 [million]'.[99]

2.57 The APS informed the committee that psychological treatment offered during residential rehabilitation is effective because of the challenges users face when they

95 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 10.

96 AIHW, *Alcohol and other drug treatment services in Australia 2015–16*, 2017, p. 64.

97 AIHW, *Alcohol and other drug treatment services in Australia 2015–16: Data tables: SE State and territory (episodes)*, 28 June 2017, https://www.aihw.gov.au/getmedia/d7fda0d8-12f5-4dba-a1eb-7d1468fd9525/SE-State-and-territory-episodes.xls.aspx (accessed 15 February 2018).

98 VAADA, *Submission 95*, p. 7.

99 VAADA, *Submission 95*, p. 7.

remain in the community. Dr Louise Roufeil commented that it was far harder for an addicted crystal methamphetamine user:

> …to walk back into their community or the people they used to socialise with and not give in again. Residential rehabilitation is incredibly difficult to access for young people and for adults at the moment, and the ongoing psychological care to support people until they are at a point that the addiction is under control is very difficult to access.[100]

2.58 The NDRI referred to the role of residential treatment in the treatment 'mix' available to consumers.[101] In this context, the NDRI highlighted a number of important considerations when treating methamphetamine users, including:

- the long withdrawal and recovery period and the high relapse rate for methamphetamine users (especially crystal methamphetamine users). This is relevant because it is 'crucial to ensure services are funded to reflect 14–day withdrawal, longer-term treatment (12–18 months) and especially assertive follow-up/aftercare';[102] and
- the need for funding and evaluating to be directed towards innovative withdrawal treatment models (such as step-up/step-down)[103] that include a combination of non-residential and residential treatment, along with additional psychological intervention trials.[104]

2.59 A Turning Point study into patient pathways in AOD treatment, as part of the *Patient Pathways National Project* (2014), confirmed the importance of residential treatment in a patient's treatment journey, especially for methamphetamine use.[105] The study found that rates of abstinence during the 30 day period prior to a follow-up were higher for participants that used long-term residential treatment as part of their primary treatment (56 per cent), compared to outpatients (33 per cent) and acute withdrawal (30 per cent). Further:

> Participants who had been in residential rehabilitation at any point in either the year preceding their [primary index treatment] or the year following had significantly greater rates of abstinence at follow-up. Abstinence rates in the past month were highest when the [primary drug of concern (PDOC)] was meth/amphetamine (61%), followed by opioids (45%); cannabis (34%) and lowest for alcohol (28%). Fourteen percent of the sample reported complete

100 Dr Roufeil, APS, *Committee Hansard*, 27 July 2015, p. 54.

101 NDRI, *Submission 113*, p. 6.

102 NDRI, *Submission 113*, p. 6.

103 UnitingCare ReGen, *Submission 22*, p. 7.

104 NDRI, *Submission 113*, p. 6.

105 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xii, http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/$File/Patient%20Pathways%20National%20Project.pdf (accessed 21 December 2017).

> abstinence from their PDOC throughout the entire follow-up year, and this was highest when the primary drug was meth/amphetamine (26%, a rate markedly higher than reported in the [Methamphetamine Treatment Evaluation Study (MATES)] cohort study in 2012). Taking a conservative estimate and assuming all participants who withdrew or were lost to follow-up were still using their PDOC, the rate of treatment success in the entire baseline sample (excluding those known to be deceased or incarcerated at follow-up) was 38% with 27% abstinent from their PDOC in the 30 days prior to follow-up.[106]

2.60 The study highlighted the effectiveness of residential treatment and engagement with mutual aid groups[107] as part of a patient's treatment.[108] For this reason, the study recommended increasing the availability of rehabilitation places, and reducing waiting times for long-term residential care as means of improving outcomes for drug users.[109] Further, the study noted that:

> …it is crucial that funders and specialist service providers recognise the critical role that rehabilitative services play in a comprehensive specialist treatment system, particularly for individuals who have greater levels of complexity. The qualitative findings indicate that long waiting times for access to residential treatment are a key barrier to treatment engagement. It is imperative that such unmet needs are addressed, and that the benefits of residential rehabilitation are promoted among clinicians and clients.[110]

2.61 The NIT's final report discussed the role of residential rehabilitation for the treatment of crystal methamphetamine and the long-held belief that it is the most effective way to achieve abstinence.[111] The NIT stated that residential rehabilitation for crystal methamphetamine:

> …and other methamphetamine users, even residential rehabilitation, as a single course of treatment, achieves low rates of sustained abstinence or reductions in use. A lack of extended follow-up is likely to be a factor behind these low success rates.[112]

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106 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xii.

107 Mutual aid groups, or self-help groups, are community-based groups that offer collective AOD support services. Typical mutual aid groups are Alcoholics Anonymous or Narcotics Anonymous. See Recovery Connect, *Mutual Aid Groups*, https://www.recoveryconnection.com/in-recovery/mutual-aid-groups/ (accessed 15 February 2017).

108 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xiii.

109 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xvi.

110 Turning Point, *A Study of patient pathways in alcohol and other drug treatment*, Patient Pathways National Project, Final Report, June 2014, p. xvi.

111 NIT, *Final Report*, p. 122.

112 NIT, *Final Report*, p. 122.

2.62 It agreed that residential treatment has an important place in the treatment of crystal methamphetamine use, but that budget constraints mean 'few residential rehabilitation places can be funded in comparison to less intensive forms of treatment'.[113] Therefore, the NIT suggested that:

> The challenge for policy makers is to fund a mix of services that balances the availability of treatment with effectiveness and population need. In terms of effectiveness, residential rehabilitation on its own does not deliver particularly high rates of long-term abstinence or reductions in use, despite short-term positive results.[114]

2.63 The NIT referenced the NDARC's *Methamphetamine Treatment Evaluation Study* from 2010, which compared abstinence rates for people who had attended residential treatment facilities for methamphetamine use (248 people in total) with a control group that received no treatment (101 people) or had received detoxification (112 people).[115] That study found that:

- three months after participants had received treatment, 47 per cent of the treatment group were no longer abstinent compared with 82 per cent of the control group;
- a year after the commencement of treatment, 80 per cent of those who attended residential rehabilitation facilities were no longer abstinent, compared with 93 per cent from the control group; and
- at the three year mark, 88 per cent of residential rehabilitation attendees were no longer abstinent, compared with 93 per cent of the control group.[116]

2.64 The study concluded that the absence of long-term follow-up support was the most likely contributor to people failing to remain abstinent.[117] It added that specialist treatment programs are usually provided for a maximum of 12 months, 'which does not account for the extended withdrawal and recovery period associated with ice'.[118]

2.65 The study continued:

> …poor outcomes were observed for heavier injecting methamphetamine users and those with psychotic symptoms and high levels of psychological distress on entry to treatment. On the other hand, around one-third of methamphetamine users recovered without further drug treatment. Positive outcomes were associated with longer and more intensive treatment programs. These findings highlight the chronic and relapsing nature of methamphetamine dependence for a large proportion of methamphetamine users, and a need for a more intensive and sustained treatment approach for

113 NIT, *Final Report*, p. 128.

114 NIT, *Final Report*, p. 128.

115 NIT, *Final Report*, p. 128.

116 NIT, *Final Report*, p. 128.

117 NIT, *Final Report*, p. 128.

118 NIT, *Final Report*, p. 128.

> this population, with a particular emphasis on follow-up care and relapse prevention.[119]

2.66 The NIT highlighted in its final report the importance of having the 'right mix' of treatment service options to meet the needs of the community:

> …especially in light of the resource constraints currently facing the specialist AOD sector. Services need to be able to adapt their treatment programmes to incorporate interventions that are evidence-based for treating ice and other methamphetamine dependence. This includes moderately-intensive lower-cost interventions, such as cognitive behavioural therapy with contingency management and follow-up support, which can be delivered in both a residential and non-residential setting. Residential rehabilitation for ice and other methamphetamine users should be targeted towards those with more severe dependence and health needs, and those with more significant social disadvantage.[120]

2.67 The NIT also recommended that the Commonwealth government fund research into evidence-based treatment for methamphetamine including treatment settings (such as residential and non-residential treatments).[121]

2.68 UnitingCare ReGen's 'Step-up, Step-down' model was a treatment model referenced often by submitters and by the NIT. This model is a stepped care approach for methamphetamine use, and includes:

- Assessment, clinical review and care planning to identify people suitable for non-residential withdrawal support from nursing professionals.
- Those found suitable are provided with home-based withdrawal support while on a waiting list for a residential withdrawal service. Non-residential support includes:
    - education on harm reduction strategies and self-care;
    - motivational interview and counselling support;
    - advice on the withdrawal experience and residential care services;
    - liaison with general practitioners and linking consumers with other support services; and
    - family support services during home-based withdrawal.
- A consumer admission into a residential withdrawal service is provided for up to 10 days. A 'consumer's participation in the program during the first few

119 NDARC, *Methamphetamine treatment evaluation study (MATES): Three-year outcomes from the Sydney site*, 2010, https://ndarc.med.unsw.edu.au/resource/methamphetamine-treatment-evaluation-study-mates-three-year-outcomes-sydney-site (accessed 11 December 2017).

120 NIT, *Final Report*, p. 122.

121 NIT, *Final Report*, p. 156.

days of withdrawal would be relaxed if required to accommodate a methamphetamine "crash" period'.[122]

- Residential support is followed by a step-down service that includes:
  - continued withdrawal information and management; and
  - counselling and case management support that links with other services when required.[123]

2.69 UnitingCare ReGen asserted that this model better prepares consumers for residential treatment and reduces the likelihood that a resident has used methamphetamine in the 24 hours leading up to their admission.[124] It also reduces the amount of time a consumer spends in residential care (6.3 days on average), and achieves better physical and mental health results at the three-month follow-up.[125]

Demand for residential rehabilitation

2.70 Evidence to the committee demonstrated that demand for residential treatment services has increased. For example, the Palmerston Association reported that in 2015–16, 180 people participated in its residential program representing an increase of 18 per cent from the previous year.[126] It also observed an increase in the number of people seeking treatment for methamphetamine more broadly: 53 per cent of residents reported methamphetamine as their primary drug of concern (38 per cent in 2013–14).[127] By way of contrast, alcohol accounted for 28 per cent in 2015–16 (47 per cent in 2013–14).[128]

2.71 The Palmerston Association recognised this increase as part of a growing awareness in the community about the impact methamphetamine use has on individuals and families.[129] The VAADA attributed the increase to the paucity of publicly funded residential beds and increased public perception that residential treatment is the ideal form of treatment.[130]

2.72 As foreshadowed earlier, the committee also heard that there is a lack of residential treatment services across the nation. This shortage is particularly acute in regional and remote regions.[131]

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122 UnitingCare ReGen, *Submission 22*, p. 7.

123 UnitingCare ReGen, *Submission 22*, p. 7.

124 UnitingCare ReGen, *Submission 22*, p. 8.

125 UnitingCare ReGen, *Submission 22*, p. 8.

126 Palmerston Association, *Submission 100*, p. 2.

127 Palmerston Association, *Submission 100*, p. 2.

128 Palmerston Association, *Submission 100*, p. 2.

129 Palmerston Association, *Submission 100*, p. 2.

130 VAADA, *Submission 95*, p. 7.

131 VAADA, *Submission 95*, p. 7.

2.73 The Western Australian Network of Alcohol & Other Drug Agencies (WANADA) and the VAADA reported that the Western Australian (WA) and Victorian governments, respectively, have made additional investments in residential rehabilitation services. The WANADA informed the committee that WA's 2016 methamphetamine strategy[132] included an additional $6.2 million over two years for 60 rehabilitation service beds (52 assigned to residential rehabilitation and eight for low-medical withdrawal).[133] The VAADA reported that the Victorian government had provided funding for an additional 18–20 residential beds in the Grampians region.[134] Further, the Victorian Department of Health is set to provide an additional 100 residential rehabilitation beds by March 2018.[135] Other initiatives announced by the Victorian government include:

- a rapid withdrawal and rehabilitation model for complex clients in hospital;
- a new advisory service for individuals in urgent need of locating a suitable service; and
- measures to tackle poor quality or unsafe services by private rehabilitation clinics.[136]

2.74 Similar investments have been undertaken by other state and territory governments:

- In June 2017, the South Australian (SA) government announced its $8 million Ice Action Plan to increase the number of residential rehabilitation beds in regional areas by 15.[137]
- In 2016, the New South Wales (NSW) government announced $75 million over four years for AOD treatment services including detoxification and treatment programs for young people and pregnant women.[138]

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132 WA's Methamphetamine Action Plan Taskforce is tasked with informing the WA government on how to distribute the $131.7 million committed to the plan. See Noor Gillani, 'Taskforce seeks input over meth scourge', *The West Australian*, 18 February 2018, https://thewest.com.au/news/kalgoorlie-miner/taskforce-seeks-input-over-meth-scourge-ng-b88747039z (accessed 21 February 2018).

133 Western Australian Network of Alcohol & Other Drug Agencies (WANADA), *Submission 107*, p. 9.

134 VAADA, *Submission 95*, p. 7.

135 Department of Health (Vic), *Residential treatment services*, https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-residential-treatment (accessed 30 November 2017).

136 Department of Health (Vic), *Residential treatment services*, https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-residential-treatment (accessed 30 November 2017).

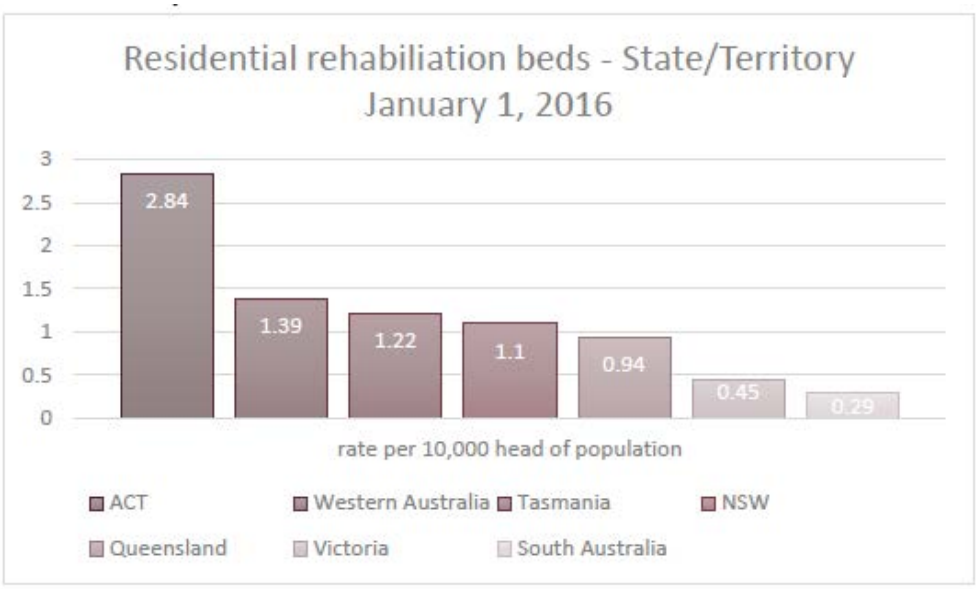
137 Angelique Donnellan, 'Ice problem in SA to be tackled by Government's $8 million 'Stop the Hurt' strategy', *ABC News*, 15 June 2017, http://www.abc.net.au/news/2017-06-15/sa-government-pledges-eight-million-dollars-tackle-ice-problem/8622024 (accessed 21 December 2017).

- On 2 June 2017, NSW opened its first youth drug detoxification clinic in the Illawarra.[139] This facility can house up to 10 youths aged 16 to 24 years old.[140]
- In 2015, the Tasmanian government invested $4.8 million for AOD treatments, including 12 new residential rehabilitation beds in the north-west of the state.[141]

Availability of residential rehabilitation

2.75 The VAADA submitted that the Australian Capital Territory (ACT) has the highest number of residential rehabilitation beds per 10 000 people, whereas SA has the lowest. Figure 4 shows the number of residential rehabilitation beds available per 10 000 head of population as of 1 January 2016.

Figure 4: number of residential rehabilitation beds available per 10 000 head of population as of 1 January 2016[142]



2.76 According to VAADA, the lack of residential rehabilitation beds has a number of negative consequences. These include unmet demand being met by the expansion of unregulated private rehabilitation facilities, acute health issues due to untreated dependency resulting in preventable mortality, and demand on the justice system.[143]

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138 Chloe Hart, 'NSW's first youth drug detox clinic opens in Knights Hill', *ABC News*, 2 June 2017, http://www.abc.net.au/news/2017-06-02/nsw-first-ice-drug-clinic-helps-youth-in-crisis/8585768 (accessed 30 November 2017).

139 Ms Hart, 'NSW's first youth drug detox clinic opens in Knights Hill', *ABC News*, 2 June 2017.

140 Ms Hart, 'NSW's first youth drug detox clinic opens in Knights Hill', *ABC News*, 2 June 2017.

141 NIT, *Final Report*, p. 201.

142 VAADA, *Submission 95*, p. 8.

143 VAADA, *Submission 95*, p. 8.

2.77 The VAADA therefore recommended that the Commonwealth government develop a plan to increase the capacity of residential rehabilitation facilities. This plan would need to be adequately resourced, address existing gaps, meet current demand by region and promote partnerships with existing service providers.[144]

Committee comment

2.78 Residential treatment is a vital component of the AOD treatment sector. It provides 24-hour care in a safe space, and removes drug users from the environment that may contribute to their problematic drug use. Residential treatment also demonstrates broader economic benefits for Australian communities, and if best-practice principles are applied, has better health outcomes for drug users.

2.79 Although effective, treatment in residential rehabilitation facilities cannot be a stand-alone treatment option. This form of treatment must be provided in conjunction with sufficient pre- and post-care services (such as non-residential nursing support, ongoing counselling and educational services). Without ongoing support, then long-term abstinence from drug use may be undermined.

2.80 The NIT and NIAS both highlight the importance of offering a diversified treatment mix. The committee echoes these sentiments and recommends that Commonwealth, state and territory health departments ensure adequate pre- and post-care services are provide in partnership with residential treatment programs to promote on-going abstinence by AOD users. This best-practice measure should also be applicable to the for-profit and not-for-profit residential treatment sectors.

Recommendation 2

2.81 The committee recommends that Commonwealth, state and territory health departments ensure adequate pre- and post-care services are provided in partnership with residential treatment programs.

2.82 The committee is concerned that demand for residential treatment services outweighs supply. This is a particular concern for those seeking residential treatment in regional and remote communities. It also impacts on the availability and waiting times to access other treatment services, as well as the likelihood of treatment success.

2.83 The committee commends those Australian governments that have invested additional resources to increase the capacity of residential treatment services in their jurisdictions. However, there is disparity in the number of residential rehabilitation beds available per 10 000 head of population in different jurisdictions. As discussed in the following section of this chapter, a consequence of limited residential treatment facilities is growth in for-profit residential services, which may not apply best-practice treatment principles and can be prohibitively expensive.

2.84 The committee recommends that individually and collectively the Commonwealth, state and territory governments develop and implement plans to increase the capacity of residential rehabilitation across Australia in a way that ensures equitable access, particularly for those in regional and remote areas.

144 VAADA, *Submission 95*, p. 8.

Recommendation 3

2.85 The committee recommends that Australian governments individually and collectively develop and implement plans to increase the capacity of residential rehabilitation across Australia in a way that ensures equitable access.

Private treatment services

2.86 Residential rehabilitation is provided by public, not-for-profit and private/for-profit providers. Private residential rehabilitation centres play an important role in the ecology of AOD treatment services. However, media reports and evidence submitted to the committee have shown that the private sector is largely unregulated and, as a result, may be detrimental to their health and wellbeing, and also to their financial situation.

2.87 This issue received national attention on 12 September 2016 when the Australian Broadcasting Corporation's (ABC) *Four Corners* aired an investigation into the private rehabilitation sector amid concerns about the cost of treatment services and the lack of regulation in the industry.[145] *Four Corners* found that high demand for residential rehabilitation facilities has forced families to turn to private rehabilitation centres.[146] At some of these facilities, families were paying up to $30 000 for a single stay.[147] While some of these centres are effective, others appear to be focused on profits without being able to demonstrate results for patients.[148]

2.88 *Four Corners* reported that each year there are more than 32 000 requests for residential rehabilitation placements, far outweighing the approximately 1500 publicly funded drug and alcohol rehabilitation beds available. Professor Dan Lubman, a psychiatrist and addiction medicine specialist told *Four Corners* that people expect treatment offered in a paid facility to be better than a publicly funded centre; however, these services are 'often worse than what is offered in the public system'.[149] Further, there are no minimum standards for these facilities, which has meant that people are:

> …offering legitimate treatments or claiming to offer legitimate treatments that are not based on evidence, that aren't supported by the literature, aren't covered by an appropriate clinical quality and government standards.[150]

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145 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', *ABC*, 12 September 2016, http://www.abc.net.au/4corners/rehab-inc.-promo/7827128 (accessed 30 November 2017).

146 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', ABC, 12 September 2016.

147 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', ABC, 12 September 2016.

148 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', *ABC*, 12 September 2016.

149 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', *ABC*, 12 September 2016.

150 Four Corners, 'Rehab Inc: The high price parents pay to get their kids off ice', *ABC*, 12 September 2016.

2.89 Submitters and witnesses similarly warned that the lack of residential rehabilitation places has led to the expansion of the unregulated private rehabilitation market. For example and as stated in paragraph 2.75, the VAADA observed that one of the negative consequences of unmet demand for public residential rehabilitation services has been the expansion of unregulated private rehabilitation facilities.[151]

2.90 The WANADA expressed concern about the growth of the unregulated private rehabilitation sector, and stated that there needed to be a way to:

> …demonstrate the application of evidence-based practice for treatment services. People at some services—the one that you mentioned in terms of the *Four Corners* report—spend a significant amount of money, but there is no guarantee that this is evidenced. There was one more recently about a service in Western Australia on *Australian Story*. While it is not necessarily big outlays, there is concern that there is no requirement for accreditation of private services that are not receiving government funding. We are concerned that evidence-based practice is not being monitored when it is in place. WANADA's interest is in meeting the community needs through an evidence-based practice approach.[152]

2.91 UnitingCare ReGen opined that the lack of accountability for the private AOD treatment sector has been a longstanding concern in the industry.[153] It acknowledged that there are private services that provide good quality care; however, the lack of 'regulations or requirements for transparency allows some services to make unfounded marketing claims of success'.[154] For example, marketing that targets and exploits vulnerable families who are seeking a cure for their loved one, and thus 'helps justify the often exorbitant fees charged by these services'.[155] It also reinforces the belief that you 'get what you pay for' as services that are publicly funded do not charge, or charge at a minimum cost, and do not undertake similar marketing strategies.[156]

2.92 The rise in private AOD services, according to UnitingCare ReGen, is due to the rise in community concern about methamphetamine and the lack of capacity within the publicly funded treatment system to accommodate those seeking these

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151 VAADA, *Submission 95*, p. 8.

152 Ms Jill Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 27.

153 Laurence Alvis, CEO, UnitingCare ReGen, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016, http://www.regen.org.au/news-advocacy/regen-in-the-media/781-decline-of-mainstream-media-a-boon-for-for-profit-drug-services-a-bust-for-informed-debate-11-08-16 (accessed 1 December 2017).

154 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

155 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

156 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

services. The committee also heard concerns about the role of the media in uncritically promoting private AOD services.[157]

2.93 UnitingCare ReGen recommended the Commonwealth, state and territory governments commit to developing a nationally consistent regulatory framework for private AOD treatment providers, similar to that already in place for private hospitals. These standards and compliance requirements should promote transparency, service quality and ethical practices to 'help prevent unethical practice within the sector and, most importantly, improve the effectiveness of services for vulnerable individuals and families'.[158]

2.94 In its report, the NIT recommended (Recommendation 17) the development of a national quality framework that sets standards for:

- the delivery of evidence-based treatment services with clear expectations of the quality standards for each type of service;
- workforce capabilities matched to service-type and population need;
- cross-agency partnerships and collaborations; and
- the monitoring and evaluation of the quality framework's outcomes and effectiveness to inform continuous quality improvements.[159]

2.95 The committee questioned the DoH about the *Four Corners* report and the private rehabilitation sector. The DoH informed the committee that it was working with the Ministerial Drug and Alcohol Forum (MDAF), and with colleagues from the states and territories to develop a national quality framework for AOD services.[160] A limiting factor for the Commonwealth government is that regulation of these services is the remit of the states and territories, such that the Commonwealth government does not have a regulatory role.[161] The DoH, however, stated that this division of responsibility makes a national quality framework:

> …the important piece that holds this together. But a couple of things have been done in response to the Ice Taskforce around the comorbidity guidelines and things like that. Trying to provide as much guidance so that there is national consistency in treatment services has been an objective there.[162]

2.96 The DoH added that the national framework is being applied to the public sector, and then 'we will look to see how we can extend that across the private

157 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

158 Alvis, *Decline of mainstream media a boon for for-profit drug services; a bust for informed debate*, 11 August 2016.

159 NIT, *Final Report*, p. x.

160 Dr Wendy Southern, Deputy Secretary, DoH, *Committee Hansard*, 24 March 2017, p. 23.

161 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 23.

162 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 23.

sector'.[163] The committee reminded the DoH that the topic addressed in the *Four Corners* program was about private clinics and the damage that is being done by these unregulated service providers. In response, the DoH confirmed that this issue had been discussed by the National Drug Strategy Committee (NDSC) and the MDAF, largely 'in the context of the quality framework and what we can do there and a conversation for individual jurisdictions to have about how they could regulate the private sector'.[164]

2.97 In a 16 December 2016 communique, the MDAF identified as a priority the implementation of a quality framework 'to provide consistent and appropriate treatment in accordance with best practice'.[165]

2.98 On 27 March 2017, the Australian Network of State and Territory Alcohol and Other Drug Peaks (Network of Peaks) released a press release on the national AOD quality framework. The Network of Peaks, drawing from previous attempts by governments to develop a national quality framework for the AOD sector, advocated for a quality framework that:

- is driven by the AOD sector and is a working collaboration with the health departments;
- involves leadership from the AOD peaks and national AOD research centres and is governed by a working group that reports to the NDSC (with co-chairing arrangements shared between a non-government representative and a NDSC representative);
- is aligned with, and a component of, the National AOD Treatment Framework (that needs to be developed first); and
- has clear deliverables that includes start and end dates with adequate resources.[166]

2.99 The Network of Peaks highlighted the need for there to be a clear difference between a national AOD quality framework (focused on compliance and monitoring of evidence-informed practice) and accreditation (continuous quality improvement around systems management).[167]

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163 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 24.

164 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 24.

165 Ministerial Drug and Alcohol Forum, *Ministerial Drug and Alcohol Forum Communique*, 16 December 2016, http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/MDAF%20Communique.pdf (accessed 1 December 2017).

166 Australian Network of State and Territory Alcohol and Other Drug Peaks (Network of Peaks), *A national alcohol and other drug quality framework brief 1: For AOD peak bodies' State, Territory and Australian health department contacts*, 27 March 2017, http://www.atoda.org.au/wp-content/uploads/2017/03/AOD-Peaks-Quality-Framework-Statement-Final-270317.pdf (accessed 1 December 2017).

167 Network of Peaks, *A national alcohol and other drug quality framework brief 1: For AOD peak bodies' State, Territory and Australian health department contacts*, 27 March 2017.

2.100 The Commonwealth government last considered a national AOD quality framework in 2013–14. Turning Point, together with the DoH, set out to establish a national quality framework for the AOD treatment sector by developing guidelines that:

- complemented other models and frameworks with which the AOD sector complies;
- were adaptable, flexible and suitable for the range of AOD issues and service types, including Indigenous-specific services;
- considered the needs of clients with comorbidities and the need to maintain the capacity of services to manage these clients;
- considered all sources of funding;
- described quality standards for all service types;
- established clear guidelines, policies and procedures to achieve and maintain quality standards;
- incorporated accreditation models currently in place; and
- considered accreditation and minimum qualifications.[168]

2.101 The outcome of this project is not known to the committee.

2.102 The conduct of private rehabilitation facilities has been in the spotlight in Victoria. As of 1 December 2017, the Victorian Health Complaints Commissioner (Complaints Commissioner) had received 26 complaints about private rehabilitation clinics.[169] Issues most commonly brought to the Complaint Commissioner's attention were:

- exploitative billing practices (for example treatment costing up to $30 000);
- lack of informed consent for clients' financial and treatment decisions;
- safety concerns;
- the effectiveness of treatment;
- the cleanliness of treatment facilities; and
- the inappropriate discharge of patients.[170]

2.103 In a media release, the Complaints Commissioner reminded general health service providers not covered under the Australian Health Practitioner Regulation

168 Turning Point, *National Project: The AOD quality framework project–the development of a quality framework for Australian governments funded drug and alcohol treatment services,* July 2013–June 2014, http://www.turningpoint.org.au/Research/Clinical-Research/CR-Projects/The-AOD-Quality-Framework-Project.aspx (accessed 10 January 2018).

169 Health Complaints Commissioner, *Private drug and alcohol rehabilitation*, 1 December 2017, https://hcc.vic.gov.au/news/105-private-drug-and-alcohol-rehabilitation (accessed 6 December 2017).

170 Health Complaints Commissioner, *Private drug and alcohol rehabilitation*, 1 December 2017.

Agency (AHPRA) of their obligations under the general code of conduct, which took effect on 1 February 2017.[171] The *Code of Conduct for General Health Services* establishes standards such as safe and ethical conduct, appropriate treatment advice, and requirements not to misinform clients and not to financially exploit clients.[172]

2.104 On 16 February 2018, the Victorian government announced $550 000 in further funding to the Complaints Commissioner 'to conduct a wider investigation into the private drug and alcohol counselling sector in Victoria'.[173]

Committee comment

2.105 As discussed earlier, there is a shortage of places available in residential treatment services across most Australian jurisdictions. In turn, this has led to the growth in for-profit residential rehabilitation services. The committee is supportive of for-profit residential rehabilitation; however, these services must be regulated to ensure best-practice treatment principles are applied in a cost-effective manner with the objective of achieving positive health outcomes for its residents.

2.106 The committee is very concerned by the allegations raised by *Four Corners* and by the Victorian Health Complaints Commissioner. These allegations indicate a need for the development of a national AOD quality framework that ensures best-practice across the AOD treatment sector. A national AOD quality framework must be applicable to public, not-for-profit and for-profit residential rehabilitation service providers.

2.107 Although the Commonwealth government does not have a regulatory role in relation to drug treatment centres, it can facilitate a national dialogue and development of regulations. The Commonwealth's responsibilities include advancing national priorities, providing leadership in planning, addressing service quality and supporting equity. All of these responsibilities are relevant to the development of a quality framework to regulate all residential rehabilitation service providers. Indeed, the regulatory framework governing private hospitals is an example of the Commonwealth's role in facilitating a similar national initiative. Such an approach can be applied to the AOD treatment sector.

2.108 The NIT recommended that the Commonwealth government fund research into evidence-based treatment for methamphetamine, in particular for best-practice measures in treatment facilities (both residential and non-residential).[174] The

171 Health Complaints Commissioner, *Code of Conduct for General Health Services,* 1 December 2017, https://hcc.vic.gov.au/sites/default/files/code_of_conduct_full_text_a3_poster.pdf (accessed 6 December 2017).

172 Health Complaints Commissioner, *Code of Conduct for General Health Services,* 1 December 2017.

173 Health Complaints Commissioner, *Commissioner investigates drug & alcohol services,* 16 February 2018, https://hcc.vic.gov.au/news/125-commissioner-investigates-drug-alcohol-services (accessed 21 February 2018).

174 This recommendation is considered further in the context of private treatment services.

committee supports the NIT's recommendation and further recommends that following this research, and as a matter of priority, the Commonwealth, state and territory governments establish a national quality framework for all AOD treatment services including public, for-profit and not-for-profit residential rehabilitation.

Recommendation 4

2.109 The committee recommends that the Commonwealth, state and territory governments, as a matter of priority, establish a national quality framework for all alcohol and other drug treatment services including public, not-for-profit and for-profit residential rehabilitation.

2.110 Further, development of the framework must take into account the expertise of those working in the AOD field, as well as lessons learnt from previous attempts to develop a national quality framework. For this reason, the committee recommends the development of a national quality framework in partnership with representatives of the AOD treatment sector.

Recommendation 5

2.111 The committee recommends that the development of a national quality framework for alcohol and other drug treatment services is undertaken in partnership with representatives of the alcohol and other drug treatment sector.

Mandatory residential treatment

2.112 Compulsory or mandatory treatment describes those circumstances where an individual is compelled to undergo an AOD treatment program, often in lieu of criminal sanctions. These mandatory treatment programs are often court mandated, for example through a drug court[175] or form part of a drug diversionary scheme.

2.113 The following section considers evidence to the committee, which provides a range of views on the role and appropriateness of mandatory residential treatment. While some submitters were supportive of mandatory residential treatment, others were critical and argued there is minimal evidence to support it.

2.114 Professor Paul Dietze from the Burnet Institute informed the committee that mandatory (residential) treatment was 'particularly fraught' and that he was not aware of any evidence that this treatment option benefits illicit drug users. The primary problem with this approach, according to Professor Dietze, is that 'it is very difficult to keep someone in against their will...[as] you would essentially be imprisoning them'.[176] Further, Professor Dietze referred to rehabilitation centres in South East Asia that have been demonstrated to violate human rights and have very limited success,

175 Australian Institute of Criminology, *Australian responses to illicit drugs: Drug Courts*, http://www.aic.gov.au/criminal_justice_system/courts/specialist/drugcourts.html (accessed 16 January 2018).

176 Professor Paul Dietze, Deputy Director, Burnet Institute, *Committee Hansard*, 9 September 2015, p. 6.

stating that 'there are alternatives that people can engage in well before you would engage in a compulsory treatment'.[177]

2.115 When asked about the merits of custodial mandatory treatment of young people, Dr Roufeil from the APS responded that it was better than other alternatives, but '[t]here will always be problems when [treatment] is mandated' and for that reason, '[i]t is not ideal'.[178] Dr Roufeil further considered that, if a court-mandated custodial system was in place, it would need to be informed by evidence-based interventions, such as a therapeutic diversionary approach, rather than a supportive approach.[179]

2.116 Holyoake Tasmania commented on the effectiveness of mandatory treatment more broadly, in the context of Tasmania's court-mandated treatment program. When asked whether people seeking treatment come with a willingness to admit that they have a problem, Holyoake Tasmania replied that almost all are willing, but those who are court-mandated clients are generally not successful:

> Look, to be perfectly honest, whilst I appreciate that that is a process that is one step closer to perhaps assisting people rehabilitate, there are a significant number of those court-mandated clients who just seek to come to have a box ticked and learn how not to get caught next time. That is the truth. You cannot make somebody rehabilitate from drugs; they have to want to do it. That is the truth.[180]

2.117 When asked about forced rehabilitation (residential treatment), Holyoake Tasmania conveyed that it has limitations, and ultimately:

> ...forced rehabilitation does not work…These court-mandated clients are not all doomed to fail—I do not mean that—but they are more likely to fail because you are more likely to achieve your goals if you truly want to achieve them rather than you have been forced.
>
> …
>
> Look, if you locked people up, you might get a very small percentage of people who see the light when they are locked up, but most of them will be resentful. No, it does not work. Look at prohibition. That is not how it works.[181]

2.118 A similar line of questioning was put to the Palmerston Association. In response, its CEO, the Honourable Sheila McHale pointed out that the WA government was considering mandatory residential rehabilitation and the Palmerston Association 'stops short' of rejecting this option in its entirety, but:

> …quite frankly there is very scant evidence to show that it does work. One of the fundamental motivators for recovery to work is actually motivation

177 Professor Dietze, Burnet Institute, *Committee Hansard,* 9 September 2015, p. 6.

178 Dr Roufeil, APS, *Committee Hansard,* 27 July 2015, pp 60–61.

179 Dr Roufeil, APS, *Committee Hansard,* 27 July 2015, p. 61.

180 Ms Charlton, Holyoake Tasmania, *Committee Hansard,* 24 March 2017, p. 19.

181 Ms Charlton, Holyoake Tasmania, *Committee Hansard,* 24 March 2017, p. 19.

> of the individual him or her self. I always thought that the call for mandatory reporting was a cry for help from parents, that they just wanted somebody to take away the family member and sort them out. Mandatory rehab will not alleviate those sorts of anxieties in the way that it was being looked at because it is actually quite a convoluted process. Here in WA, I think the number of beds that was being considered was about four, so it is a drop in the ocean and on that basis we would work with government to have a look at it. But there is a high degree of scepticism as to whether it will work or not. We did not want to throw the idea out without having the government do some more work on it.[182]

2.119 The WA Primary Health Alliance (WAPHA) argued 'that a voluntary approach seeking to have treatment is highly correlated to getting a good treatment outcome'[183] and that 'treatment efficacy is much greater'.[184] The WAPHA agreed that 'it is hard to get people to treatment that may not have that insight at a certain point' but:

> …we have to keep in context though they are small in number but very visual. Those people who are quite unwell, are having a psychosis impact from their use and do not have the insight of wanting treatment are small in number but high impact in terms of need and demand.[185]

2.120 The WAPHA recognised the problems families face when dealing with a family member using crystal methamphetamine and acknowledged mandatory residential treatment may provide them with a sense of safety. That said:

> …the evidence about that type of treatment being successful is not strong. It is not to say that it will not work for some people, but for people to be willing to accept the issue will have greater treatment efficacy than being dragged against their will. I appreciate that, on occasion, for people's own safety, you may need to not necessarily require their treatment but contain them in a way that is safe for them for a period, and that often does happen in a hospital in an acute unit. But my sense is that, in an overarching way, while conversely it would work for some I think the efficacy of it working for the population is not well tested.[186]

2.121 Although the WAPHA asserted that there is no evidence to support mandatory residential treatment, it did acknowledge that it may be appropriate in limited circumstances, for example if a person's mental health and wellbeing are at risk and there is potential for self-harm.[187] In these instances:

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182 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

183 Ms Learne Durrington, WA Primary Health Alliance (WAPHA), *Committee Hansard*, 24 March 2017, p. 19.

184 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 19.

185 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 19.

186 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 19.

187 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 20.

> …a mandatory type of treatment would create safety for a person but whether it would create a good outcome in terms of treatment, the numbers would have to be tested. I imagine they would be quite low, because we are actually asking people to change their behaviour, to have insight into their behaviour and the triggers. Very few people do that well in an environment where it is involuntary.[188]

2.122 The WANADA rejected mandatory residential treatment as a viable option for dealing with AOD dependent individuals.[189] It argued that there is no point pursuing mandatory treatment because there is not sufficient access to voluntary residential treatment services.[190] The result, in WANADA's view, is that mandatory residential treatment:

> …will result in people who would otherwise want to get in voluntarily, or whatever, getting themselves in circumstances so that they will be put into compulsory treatment. We need adequate voluntary services to start with, and then let us look at that as an option. I understand the evaluation from New South Wales is looking positive in terms of its compulsory treatment. I know that Western Australia went down that track—even drafting legislation…with the last government—but it is an expensive process, which could, at this stage, contribute to increasing access by people who are actually self-motivated to access treatment.[191]

2.123 WANADA referred to drug diversionary programs and cited the positive outcomes of these, acknowledging there is a:

> …degree of mandated, coerced treatment that is having some great outcomes, which is not necessarily a specific focussed program. I know this new state government is talking about prison-based alcohol and other drug services for men and women—significant numbers: 250 men, 60 women. We do not have a therapeutic community in our prisons in Western Australia. Most other jurisdictions have prison therapeutic communities. Let us start in the obvious places. We already have the facility—they have got the beds in prison—so let us support a therapeutic approach to addressing the more than 70 per cent of people in prison with alcohol and other drug issues who would benefit from treatment. Let us start there. Let us start with voluntary.[192]

2.124 In August 2017, the WA government announced it would allocate $9.6 million to establish the state's first AOD rehabilitation prison.[193] An existing

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188 Ms Durrington, WAPHA, *Committee Hansard*, 24 March 2017, p. 20.

189 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

190 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

191 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

192 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

193 Angie Raphael, 'Labor pledges $9.6m to WA's first drug and alcohol rehab prison', *The Age*, 27 August 2017, http://www.theage.com.au/wa-news/labor-pledges-96m-to-was-first-drug-and-alcohol-rehab-prison-20170827-gy54qs.html (accessed 25 October 2017).

minimum security male prison (Wandoo Reintegration Facility) will be converted into an AOD rehabilitation prison for women.[194] The 80-bed facility is part of the WA's *Methamphetamine Action Plan*.[195]

2.125 Ms Jennifer Bowles, an advocate for mandatory residential treatment and a former magistrate with the Children's Court of Victoria,[196] outlined her research into the effectiveness of mandatory residential treatment for young people. Ms Bowles reviewed mandatory residential treatment programs in Sweden, England, Scotland and New Zealand. Her research found that court sanctioned mandatory residential treatment for young people 'is as effective as voluntary treatment, provided the facilities had key essential qualities',[197] namely that these facilities are: therapeutic and not punitive; and training and education is available to residents.[198] Ms Bowles acknowledged human rights concerns and high costs associated with implementing mandatory treatment.[199]

2.126 While advocating for mandatory residential treatment, Ms Bowles qualified that she is not critical of existing voluntary services, but is critical of a model that expects:

> …children as young as 13, 14 or 15 to go independently and say to their mates down at the railway station, the park or wherever they might be, 'I'm just going off to see my drug and alcohol counsellor.' They just do not do it. They cannot even get to court on time, let alone worry about getting to a drug and alcohol counsellor. My concern is that the voluntary model works for some but, for the vast majority of the really serious young people we are seeing, it does not work.[200]

2.127 Mandatory residential treatment was addressed in the NIT's final report. The NIT provided an overview of existing mandatory residential treatment legislation in

194 Raphael, 'Labor pledges $9.6m to WA's first drug and alcohol rehab prison', *The Age*, 27 August 2017.

195 Raphael, 'Labor pledges $9.6m to WA's first drug and alcohol rehab prison', *The Age*, 27 August 2017.

196 Ms Jennifer Bowles, *Submission 74*, p. 6.

197 Ms Jennifer Bowles, *Committee Hansard*, 27 July 2015, p. 18.

198 Ms Bowles, *Committee Hansard*, 27 July 2015, p. 18.

199 Ms Bowles, *Committee Hansard*, 27 July 2015, p. 18.

200 Ms Bowles, *Committee Hansard*, 27 July 2015, p. 20.

NSW, Victoria, Tasmania and the Northern Territory.[201] The NIT did not make a conclusion on the merits of mandatory residential treatment; however, it did note the high costs associated with this treatment and questioned whether these costs can be justified 'given the limited resources and lack of a robust evidence base'.[202] The NIT acknowledged concerns that mandatory treatment 'may diminish the capacity for treatment to be delivered flexibly and in a manner that enables the individual to own their problem'.[203] Finally, issues arising from an ethical and human rights perspective were also raised as a potential concern.[204] The NIT noted the complexity of mandatory treatment and referred to research that suggests:

> …while there is some evidence mandatory treatment for short periods can be an effective way to reduce harm, there is little evidence to support its effectiveness in rehabilitating or achieving long-term behavioural change.[205]

2.128 Mandatory residential treatment was not referenced in the NIAS.

Committee comment

2.129 The committee understands why many people—often outside the AOD treatment sector—hold the view that mandatory residential treatment is a viable option for drug users. The committee has heard numerous accounts where families have reached the limits of their capacity to support loved ones through their drug addiction. In these instances, it is not surprising that families and communities support mandatory treatment.

2.130 Evidence to the committee was largely critical of mandatory residential treatment, with many submitters and witnesses arguing it is not an effective response to problematic AOD use. As discussed in this chapter, many experts recognise that motivation to undertake AOD treatment must come from the individual, and cannot be enforced upon them. Without this underlying motivation, the success of treatment is limited. However, there may be a role for mandatory residential treatment in instances where a person is likely to harm themselves or others around them.

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201 New South Wales, Victorian and Tasmanian legislation provides for mandatory treatment for people with AOD dependence issues. The Northern Territory legislation provides for mandatory treatment for people with volatile substance misuse, such as solvents and petrol, as well AOD dependencies. Limitations are in place under each jurisdiction's legislation, such as a requirement for a person to be at risk of serious harm and if less restrictive treatment is not available to that person. Substance dependence must also be severe, and mandatory treatment considered beneficial to the person. Detention periods vary, depending on each jurisdiction, and may be extended with the approval of an authorised officer (for example a magistrate or responsible medical officer). See NIT *Final Report*, 2015, p. 63.

202 NIT, *Final Report*, 2015, pp 63–64.

203 NIT, *Final Report*, 2015, pp 63–64.

204 NIT, *Final Report*, 2015, pp 63–64.

205 NIT, *Final Report*, 2015, p. 64.

Methamphetamine use and treatment in correctional facilities

2.131 During the course of the inquiry, the use of methamphetamine in correctional facilities was identified as a significant problem. In 2015, the AIHW reported in *The health of Australia's prisoners 2015* (the AIHW prisoners' health report) that 67 per cent of all prisoners had used an illicit drug in the 12-months prior to entering a correctional facility.[206] The AIHW report also found:

- the most commonly used illicit drug was methamphetamine, with 50 per cent of respondents reporting its use over the reporting period;[207]
- ten per cent of prisoners discharged[208] from correctional facilities reported using an illicit drug whilst in prison;[209] and
- six per cent reported injecting drugs[210] of which four per cent of discharged prisoners reported sharing a needle whilst in prison.[211]

2.132 In 2015, the ACT was the only jurisdiction that had announced a needle and syringe exchange program (NSP)[212] in its correctional facilities.[213]

2.133 Although the AIHW prisoners' health report indicated problematic drug use existed in correctional facilities, the AIHW noted limitations with the report's data. For example, in 2015, NSW did not provide discharge data and no drug use data was provided by Victoria. Further, drug use data is self-reported and the AIHW concluded that it is likely that current illicit drug use in correctional facilities is 'underestimated because prisoners can be reluctant to disclose this kind of information'.[214]

2.134 The issue of illicit drug use in correctional facilities was canvassed by submitters and witnesses. Mr Craig Cumming, from the Centre for Health Services Research at the University of Western Australia, noted that methamphetamine had

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206 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 96, https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/contents/table-of-contents (accessed 21 December 2017).

207 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 97.

208 New South Wales does not provide discharge data, and Victoria did not collect data for these indicators. Data is self-reported, and therefore likely to be underestimated. See AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

209 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

210 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

211 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 103.

212 Harm reduction services in correctional facilities are discussed further in chapter 4 of this report.

213 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

214 AIHW, *The health of Australia's prisoners 2015*, 2015, p. 102.

become the most prevalent illicit drug used by the prison population.[215] Through his engagement with prisoners, Mr Cumming had found people:

> …attribute their incarceration to using methamphetamine. Sometimes that is because they have committed the property crime to fund their habit or they have dealt in drugs because it is the only way they can afford to take them. At other times they have committed a violent offence or an offence against a person because of the state they were in due to being intoxicated.[216]

2.135 Mr Cumming also noted that many prisoners use methamphetamine as a form of self-medication.[217]

2.136 The Penington Institute argued that the notion that correctional facilities are drug-free spaces is a myth that must be rejected in order 'to have a mature conversation around' the issue,[218] and:

> Our prisons are still chock-a-block with people with drug addiction problems. In fact, there is an ice problem inside our prisons as well; people are not only being incarcerated with drug addiction, but continuing their drug addiction whilst inside.[219]

2.137 While it is known that prisoners use methamphetamine in correctional facilities, the committee heard there are inadequate treatment options available to them. Mr Cumming referred to the WA's Office of the Inspector of Custodial Services' report that 'medical and health services are not up to standard'.[220] He emphasised the importance of establishing treatment services in the prison system because this is a:

> …subset of the population that we know are the most afflicted with this problem, and the one area where they could be helped is the area where they are not getting helped—when they go to prison.[221]

2.138 The South Australian Network of Drug and Alcohol Services opined that it is essential for AOD treatment services to be offered in Australia's correctional facilities:

> In South Australia it is extremely difficult to get treatment services into prisons. I think that is probably problematic across the whole of the country. I think there is a really important space there for non-government organisations that have very good skills in working with people with drug and alcohol problems to be able to work with people in Corrections and to make those connections and to be able to do work with people whilst they

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215 Mr Craig Cumming, University of Western Australia (UWA), *Committee Hansard*, 3 May 2017, p. 33.

216 Mr Cumming, UWA, *Committee Hansard*, 3 May 2017, pp 33–34.

217 Mr Cumming, UWA, *Committee Hansard*, 3 May 2017, p. 34.

218 Mr John Ryan, CEO, Penington Institute, *Committee Hansard*, 27 July 2015, p. 10.

219 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 13.

220 Mr Cumming, UWA, *Committee Hansard*, 3 May 2017, p. 38.

221 Mr Cumming, UWA, *Committee Hansard*, 3 May 2017, p. 38.

> are incarcerated. A person should not go into prison as a drug addict and come out of prison still with the same problem, having had continuous use through that.[222]

2.139 The lack of funding to support prison treatment programs is, in Holyoake's view, a major problem.[223] Of its annual funding of $100 000, none was made available to prison AOD treatment programs.[224] Holyoake's employees:

> …go into prisons and we get no money. No-one gives us any money to do that, at all, no-one. We could have three groups running at the moment. The need in prison is so strong. What I think the general public do not understand, or maybe the government does not understand, is that whole revolving-door thing. These guys and girls, mostly guys, come in and out and in and out. Crime and drugs are so deeply related that you have to do something to break that cycle or it is just going to keep happening.[225]

2.140 The WANADA discussed prison treatment programs in the context mandatory residential treatment facilities in WA. It argued that rather than investing in mandatory facilities, money should be directed to establishing AOD treatment services in WA's prisons.[226] The WANADA informed the committee that WA did not have therapeutic options for prisoners and investment needs to be made to address 'the more than 70 per cent of people in prison with alcohol and other drug issues who would benefit from treatment'.[227]

2.141 The committee heard examples of services available in some correctional facilities. The Queensland Network of Alcohol and Other Drug Agencies referred to the ACT's Alexander Maconochie Centre as a potential AOD treatment model.[228] The Alexander Maconochie Centre's Solaris program provides therapeutic assistance to people who have six months or less of their sentence remaining. Through the program, prisoners receive help to address the issues that contributed to their drug use, with the aim to assist prisoners once they are released from the correctional facility.[229]

2.142 The National Aboriginal and Torres Strait Islander Legal Service (NATSILS) spoke of the Northern Australian Aboriginal Justice Agency's prison support program and post-release program. According to NATSILS, these initiatives have reduced recidivism and have made sure upon their release people are supported in the

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222 Mr Michael White, Executive Officer, South Australian Network of Drug and Alcohol Services, *Committee Hansard*, 28 July 2015, p. 52.

223 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

224 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

225 Ms Charlton, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

226 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

227 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

228 Ms MacBean, QNADA, *Committee Hansard*, 30 July 2015, p. 3.

229 Ms MacBean, QNADA, *Committee Hansard*, 30 July 2015, p. 3.

community.[230] Although successful, NATSILS also noted a lack of funding for similar services in Central Australia[231] and recommended:

> …there needs to be a focus on resources: what their current state is, and what needs to happen to increase them—so resources both in the community and resources within the prison system that are specifically focused on dealing with substances, and that recognise the priority needs in particular communities and cater specifically for the particular substances around which there is most need in that particular community.[232]

2.143 The NIT's final report considered AOD treatment in the corrections system. It recognised that all states and territories provide AOD treatment programs in their correctional system; however, the focus and design of these programs varies. Broadly, these treatment programs consist of:

- harm reduction measures to enhance awareness about the physiological effects of AOD misuse;
- psycho-educational activities aimed at improving prisoners' understanding and awareness of the link between drug misuse and crime;
- therapeutic programs for groups to address AOD misuse, withdrawal, behaviour development, emotional management, relapse prevention and enhancing problem-solving and communication skills;
- the separation of prisoners from prison culture in order to undergo a dedicated therapeutic treatment program; and
- detoxification programs.[233]

2.144 The NIT reported that the most effective treatment programs available in correctional facilities are based on therapeutic community models. The NIT's report listed numerous programs available in correctional facilities in each of the states and territories.[234] It concluded that these programs could be improved by offering enhanced transitional services, such as pre-release and post-release programs.[235] These transitional programs have been demonstrated to halve the risk of recidivism for participants.[236]

2.145 The NIT also highlighted evidence that suggested that appropriate access to psychostimulant and other non-opioid drugs treatment services in correctional

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230 Mr Mark O'Reilly, Representative, National Aboriginal and Torres Strait Islander Legal Services (NATSILS), *Committee Hansard*, 30 July 2015, p. 12.

231 Mr O'Reilly, NATSILS, *Committee Hansard*, 30 July 2015, p. 12.

232 Mr O'Reilly, NATSILS, *Committee Hansard*, 30 July 2015, p. 12.

233 NIT, *Final Report*, p. 82.

234 NIT, *Final Report*, pp 83–84.

235 NIT, *Final Report*, p. 85.

236 NIT, *Final Report*, p. 85.

facilities is poor.[237] Indeed, the committee received similar evidence: for example, Rural Health Tasmania reported that NSW correctional facilities offered and placed non-opioid dependent inmates (such as methamphetamine users) onto opioid replacement therapy programs.[238]

2.146 The NIT opined that the design of correctional facility AOD treatment programs should align with best-practice approaches and be available to all correction-based populations.[239] The NIT subsequently recommended that '[u]nder the National Drug Strategy framework, state and territory governments should increase the focus on evidence-based approaches to treatment in correctional facilities and youth justice centres'.[240]

2.147 The NIAS noted that AOD programs are delivered in Australia's correctional facilities, but such programs were not included under the strategy itself.[241] NIAS funding guidelines for PHNs specifically prevents funds being directed to AOD treatment programs in correctional facilities.[242]

Committee comment

2.148 Evidence presented to this inquiry indicates a lack of understanding about illicit drug use in Australia's correctional facilities. The AIHW prisoners' health report provides an important insight into illicit drug use in correctional facilities; however, the committee is concerned that some jurisdictions provide incomplete data to the AIHW. This issue is further compounded by the likelihood of prisoners not fully disclosing their illicit drug use.

2.149 Acknowledging that self-reported data under-reports drug use, it is vital that accurate and comprehensive data is provided to the AIHW by all states and territories so that governments and AOD treatment service providers have sufficient information to develop treatment programs for Australia's prisoners. For this reason, the committee recommends Australian governments, in partnership with the AIHW, establish nationally consistent datasets and regular reporting of illicit drug use in Australia's correctional facilities.

237 NIT, *Final Report*, p. 85.

238 Rural Health Tasmania, *Submission 4*, p. 8.

239 NIT, *Final Report*, p. 85.

240 NIT, *Final Report*, p. 85.

241 Council of Australian Governments (COAG), *National Ice Action Strategy (NIAS)*, 2015, p. 13.

242 DoH, *Drug and Alcohol Treatment Services Workshop*, PHN National Forum, 23 March 2016, p. 23, http://www.health.gov.au/internet/main/publishing.nsf/Content/00069147C384180DCA257F14008364CB/$File/Drug%20and%20Alcohol%20Treatment%20Services%20Workshop-Department%20of%20Health.pdf (accessed 18 January 2018).

Recommendation 6

2.150 The committee recommends Australian governments, in partnership with the Australian Institute of Health and Welfare, establish nationally consistent datasets and regular reporting of illicit drug use in Australia's correctional facilities.

2.151 The lack of appropriate AOD treatment services available in Australia's correctional facilities is of concern. It is evident that prisoners are more likely to enter the corrections system with an existing illicit drug problem and that their drug use may become more problematic whilst detained in a correctional facility. This is a particular concern for those with methamphetamine addictions, because evidence suggests the availability and use of methamphetamine in correctional facilities is common.

2.152 The committee advocates for AOD treatment programs aimed at prisoners during, prior to and after their release. The committee does not consider it appropriate that people leave correctional facilities with more problematic drug use patterns or with a related health issue due their drug use, as a result of their imprisonment. For these reasons, the committee supports the NIT's recommendation for state and territory governments to increase the focus on evidence-based approaches to AOD treatment services in correction facilities and youth justice centres.

2.153 Although the committee is supportive of AOD treatment programs being offered in correctional facilities, it is outside the Commonwealth government's jurisdiction and is ultimately a service that is offered and funded by state and territory governments.

Pharmacotherapy

2.154 Pharmacotherapy describes treatments where an illicit drug is replaced with a legally prescribed and dispensed substitute. In Australia, the most common pharmacotherapy treatment is methadone for people with opioid addiction.[243] According to Harm Reduction Victoria, pharmacotherapy enables the drug user to:

> …stabilise their condition, allowing them to devote more time to managing or repairing their lives. Once stabilised, clients may find they wish to strive for a drug-free existence by slowly reducing their dosage – or else they may be satisfied with a maintenance program.[244]

2.155 Although pharmacotherapy is available for people with opioid addiction, there is currently no pharmacotherapy substitute for people with meth/amphetamine addiction, including crystal methamphetamine. This means treatment options are restricted to behavioural therapies or drug detoxification programs. The absence of

243 Harm Reduction Victoria, *What is Pharmacotherapy?*, http://hrvic.org.au/pharmacotherapy/general-information/what-is-pharmacotherapy/ (accessed 20 December 2017).

244 Harm Reduction Victoria, *What is Pharmacotherapy?*, http://hrvic.org.au/pharmacotherapy/general-information/what-is-pharmacotherapy/ (accessed 20 December 2017).

pharmacotherapy treatment may undermine the effectiveness of treatment for people presenting with the most severe meth/amphetamine addictions.

2.156 Professor Rebecca McKetin is one of Australia's leading experts in meth/amphetamine treatment and is currently trialling two new medications for methamphetamine dependence: lisdexamfetamine and n-acetylcysteine.[245] Professor McKetin advised that the two trials have been funded by the National Health and Medical Research Council (NHMRC).[246] One trial is using lisdexamfetamine, a long-acting form of amphetamine, in substitution therapy to minimise:

> …the harms associated with illicit use by giving people a prescription drug, which has a lot less harm associated with it. The drug trial I am leading is looking at a drug that should reduce people's desire to continue to use methamphetamine and, hopefully, reduce the severity of the psychiatric effects that they experience from using the drug.[247]

2.157 Lisdexamfetamine is already available on the market to treat obesity, narcolepsy and attention deficit hyperactivity disorder (ADHD). The second drug being trialled by Professor McKetin is n-acetylcysteine, which is currently used to treat chronic obstructive pulmonary disease and paracetamol overdose.[248]

2.158 Professor McKetin explained the effect of these drugs on a patient, in the context of their crystal methamphetamine use:

> Neither of those drugs perfectly replicate that effect. The lisdexamfetamine is a long-acting drug. It does not produce the high that crystal meth gives people but it will, in having some similar actions, reduce their propensity to need to go out and use the drug. It will stop the cravings, stop some of the awful effects someone gets when they stop using. It is a little bit like we have buprenorphine for opioid addiction—it has a different pharmacological action but similar enough that it stops people needing to go out and get the illicit drug. The drug that I am using is quite a novel drug. It has a very different action. It does not have any action that is similar to methamphetamine whatsoever. What it does is it acts as a buffer in the brain to bring their brain state back to something that is a little bit more similar to what it was like before they started using the drug.
>
> When you start using the drug and you take it once, you get high. But what happens over time is your brain adapts and it learns. It is those plastic changes in the brain that are targeted by this particular medication. It actually acts as a buffer against those changes so people do not get the same cravings they would get when they are addicted to the drug. Normally they go into withdrawal, start craving, and then go back and use the drug. When

245 NDRI, *Staff profile: Associate Professor Rebecca McKetin*, http://db.ndri.curtin.edu.au/staff/staff.asp?persid=537 (accessed 20 December 2017).

246 Professor Rebecca McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

247 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

248 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

> they are on this medication, the cravings that they normally get going into that withdrawal phase would be less severe and so they are more in control of their drug use.[249]

2.159 Due to the availability of these two drugs on the market and the commercial production of these drugs, Professor McKetin opined that the use and production of these drugs would be a cost-effective solution to treat amphetamine addiction if shown to be effective.[250] It would also reduce the time required to achieve regulatory approvals.[251] However, if found effective 'it would still be a long way before we would be able to put something into practice'.[252]

2.160 While pharmacotherapy is an effective treatment option for people with drug addictions, Professor McKetin advised the committee that there is a role for both this form of therapy and psychological interventions, and that they 'would go hand in hand'.[253] Professor McKetin explained that:

> …you get the best results when you put the two together. With the pharmacotherapeutic options, not everyone wants to take a drug and they may not be so severely dependent that it is actually appropriate, and it would also depend on the type of drug. The lisdexamfetamine is more suited to people who are very heavily dependent and using every day whereas the drug that I am trialling might be suitable for someone who is using in a binge pattern because it does not have any psychoactive effect in and of itself; all it does is help the person resist the temptation to use. There are different places for pharmacotherapy for different people, and different types of therapies that could work along side the psychological interventions.[254]

2.161 Professor McKetin's colleague, Professor Allsop, emphasised her comments and stated that 'it is not either/or with these treatments' and their use 'depends on individual need'.[255] Further, Professor Allsop asserted that pharmacotherapy treatments should be equally considered alongside other treatments, and policymakers must not debate whether one treatment is better than another, but instead focus on what treatment is most suited to each individual:

> It is probably better to conceptualise the psychosocial interventions. Depending on need, some people may have a range of other problems that merit intensive counselling support. Other people might not need that, but certainly might need investment in improving the quality of their life, their access to employment and the way in which their family works. There are a

249 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

250 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

251 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

252 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 35.

253 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 36.

254 Professor McKetin, NDRI, *Committee Hansard*, 5 May 2017, p. 36.

255 Professor Allsop, NDRI, *Committee Hansard*, 5 May 2017, p. 36.

> lot of people affected by methamphetamine whose relationships have taken a heck of a battering. Most interventions that are effective tend to combine a range of counselling, social interventions, housing, employment, recreational opportunities, family life and the support of families. And, depending on the individual needs, pharmacotherapies are sometimes part of that. So it is not about it is this treatment or that treatment. Unfortunately, one of the things that has happened commonly in the debate in the drug field has been, 'My treatment is better than yours,' rather than trying to work out what treatment might work best for what person under what circumstance.[256]

256 Professor Allsop, NDRI, *Committee Hansard*, 5 May 2017, p. 36.

Chapter 3

At-risk communities, people with children and workplace initiatives

3.1 The committee's first report identified a number of at-risk communities within Australia that are more prone to developing problematic crystal methamphetamine use.[1] This chapter considers treatment and support initiatives available to two of these at-risk communities: regional and remote communities, and Aboriginal and Torres Strait Islander peoples.

3.2 This chapter also discusses support services for people with children, particularly women, seeking to undergo alcohol and other drug (AOD) treatment; and initiatives aimed at workplaces with a high-risk of employees using crystal methamphetamine.

3.3 The National Ice Taskforce (NIT) and the National Ice Action Strategy (NIAS) developed a number of strategies specifically aimed at addressing crystal methamphetamine use in at-risk communities, families and workplaces. The NIT's final report recommended the following:

- Governments to develop online toolkit to provide information and support to families and communities to better respond to problems caused by crystal methamphetamine use (Recommendation 1).[2]
- Provide additional funding to communities to develop locally-based solutions to crystal methamphetamine use and other AOD issues (such as the Good Sports Program) (Recommendation 2).[3]
- Governments working with accreditation associations and training organisations to ensure health professionals (such as general practitioners, regional and remote health professionals, and Indigenous health workers) receive relevant education and training on crystal methamphetamine and other psychostimulant use (in both urban and regional and remote settings) (Recommendation 5).[4]
- Governments develop 'workforce development pathways and career options for more Indigenous Australians' in the AOD sector and 'strategies to ensure the workforce is appropriately supported and sustainable over the long term' (Recommendation 8).[5]

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1 See Parliamentary Joint Committee on Law Enforcement (PJCLE), *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 21–30.

2 National Ice Taskforce (NIT), *Final Report*, p. vii.

3 NIT, *Final Report*, p. vii.

4 NIT, *Final Report*, p. vii.

5 NIT, *Final Report*, p. vii.

- Develop specific crystal/methamphetamine resources for regional and remote communities that inform teachers, parents, families and students (Recommendation 9).[6]
- Develop a comprehensive, evidence-based two-year prevention communication plan that includes targeted activities for people living in regional and remote areas, Indigenous communities, young people and lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) people. This plan should be evaluated after two years and used to inform future communication strategies (Recommendation 10).[7]
- Governments and industry groups develop a pilot workplace program for high-risk industries (Recommendation 11).[8]
- Governments should agree to a whole-of-government approach to AOD prevention with a specific focus on vulnerable populations (including Indigenous Australians) that works with vulnerable communities and groups to address risk factors that lead to drug misuse, and roll-out of parenting and early childhood programs that developed resilience in young children in disadvantaged communities (Recommendation 12).[9]
- Governments to further invest in specialist AOD treatment services that specifically target regional and remote areas (Recommendation 18).[10] And,
- Governments, in consultation with Aboriginal Community Controlled Organisations and communities, to improve access to integrated, evidence-based, culturally appropriate services for Indigenous Australians (Recommendation 22).[11]

3.4 These recommendations informed the strategies in the NIAS.[12]

3.5 Some submitters and witnesses raised concerns about treatment options and support services for some at-risk groups and communities. These are discussed in the following sections.

Regional and remote communities

3.6 Regional and remote communities face unique challenges in regard to crystal methamphetamine use. The committee's first report showed that methamphetamine use in regional and remote areas is high, especially in Western Australia (WA) and

6 NIT, *Final Report*, p. viii.

7 NIT, *Final Report*, p. viii.

8 NIT, *Final Report*, p. viii.

9 NIT, *Final Report*, p. ix.

10 NIT, *Final Report*, p. x.

11 NIT, *Final Report*, p. xi.

12 Council of Australian Governments (COAG), *National Ice Action Strategy (NIAS)*, pp 24–25.

South Australia (SA).[13] Illicit drug use in these communities is further compounded by social disadvantage, lack of employment opportunities and limited access to AOD treatment services.[14] The committee heard evidence that called for improved data collection and AOD treatment services to regional and remote communities.

Improved data collection

3.7 A consistent concern expressed to the committee was the lack of data and a poor understanding of methamphetamine use in regional and remote communities. Although the National Wastewater Drug Monitoring Program (wastewater program) provides valuable insight into illicit drug use at selected testing sites, the committee heard that gaps remain.

3.8 The National Drug and Alcohol Research Centre (NDARC) submitted that there is a lack of understanding 'about the nature of methamphetamine use amongst rural and regional populations'.[15] This poor understanding extends to the 'supply chains and market routes which would inform strategic policing' in regional and remote communities.[16]

3.9 The Alcohol, Tobacco and other Drugs Council Tasmania (ATDC) similarly highlighted the need for better data on regional and remote areas. The ATDC argued that current policies and the allocation of AOD funding is:

> …made in the context of scant data on Tasmanian drug use and service usage. The collection of data and information is a fundamental component that scaffolds any service system. Such evidence works to enhance the responsiveness of service provision. Data provides a rich asset about the services that are being provided by organisations and to whom and whether successful outcomes are being achieved for individuals and the broader community. Information on region specific drug trends also adds value in service design processes and underwrites responsible decisions around the distribution of public funds.[17]

3.10 The ATDC expressed concern that calls for enhanced treatment and policing have been made based on anecdotal reports, and:

> …to date, there has been a lack of any rigorous research conducted in these regional areas of Tasmania to support these claims. The ATDC wishes to highlight that the lack of data necessarily impedes responsible allocation of public funds into law enforcement, and health initiatives.[18]

3.11 The NIT recommended the expansion and improvement of data sources available for illicit drug trends. Specifically, it recommended:

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13 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 25–26.

14 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 25–26.

15 National Drug and Alcohol Research Centre (NDARC), *Submission 85*, p. 1.

16 NDARC, *Submission 85*, p. 1.

17 Alcohol, Tobacco and other Drugs Council Tasmania (ATDC), *Submission 97*, p. 5.

18 ATDC, *Submission 97*, pp 5–6.

- the establishment of the wastewater program;
- the expansion of sites for the Drug Use Monitoring in Australia (DUMA) program;
- a national system to gather and share ambulance data; and
- commissioning the Australian Institute of Health and Welfare (AIHW) to conduct the household survey on a more regular basis and to strengthen its methodology, including the use of online distribution methods.[19]

3.12 The NIAS included an announcement that there would be an increase in the quality and quantity of drug data use in Australia via the aforementioned recommendations, as well as enhancing national treatment data.[20]

Improved services in regional and remote communities

3.13 Attracting qualified AOD treatment staff, securing AOD funding, and access to treatment services are additional challenges for regional and remote communities when seeking to assist drug users.[21]

3.14 Professor Steve Allsop from the National Drug Research Institute (NDRI) discussed the difficulties attracting suitably qualified AOD staff to regional and remote communities. One challenge, according to Professor Allsop, is the lack of popularity and attractiveness of the profession.[22] Another challenge for professionals is working in very remote locations with limited clinical support and supervision,[23] which is compounded by the uncertainty of funding in the AOD sector:

> If we asked the Sir Charles Gairdner emergency department to apply for funding every year, they would be unsure of whether or not they were going to be able to employ staff in three months' time. So I recognise that there is a need for government to ensure value for money and that a quality service is delivered, but we also need to recognise that if we want to retain quality staff in very difficult circumstances—not uniquely but particularly in the remote and rural areas—we need to come up with a process that delivers quality, value for money and flexibility for government but also ensures security. Otherwise you simply cannot retain staff generally in this field and particularly in rural and remote areas, because of all the additional challenges that exist there.[24]

3.15 Professor Allsop recommended that funding be set aside to deliver AOD services more effectively in regional and remote regions across Australia, in particular

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19 NIT, *Final Report*, p. xiv.

20 COAG, *National Ice Action Strategy (NIA*S), p. 25.

21 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 25–26.

22 Professor Steve Allsop, Project Leader, National Drug Research Institute (NDRI), Curtin University, *Committee Hansard*, 3 May 2017, p. 39.

23 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 39.

24 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, pp 39–40.

for the Northern Territory (NT), Queensland, WA and northern parts of SA. He added that it is not just about setting up another rehabilitation clinic in a rural town, but:

> …looking at how we deliver services remotely, whether that be through online interventions or whether that be using telemedicine approaches. For example, there is a service in Western Australia, Women's Health Care House, who have delivered services to remote areas using local expertise but also using expertise within the metropolitan area to supplement that, using technology. I think we have to look at better and more innovative ways of delivering services. Yes, those rural and remote areas do need more services, but they also need a wider range of options. We have to explore how we do that, not state by state but collectively for those of us who have similar challenges.[25]

Committee comment

3.16 Regional and remote communities in Australia face unique and complex challenges regarding drug use and access to AOD treatment services. The primary issue is to understand the nature of illicit drug use in regional and remote communities. Without a thorough understanding of illicit drug use, the development of appropriate responses is hindered. For this reason, the committee supports calls for the collection of improved drug use data in regional and remote communities, in particular, through the AIHW's household survey to ensure it adequately targets and reaches regional and remote communities. Access to this data will help community leaders, health experts and police develop informed, evidence-based responses to drug use issues in these communities.

3.17 The committee supports the NDRI's comments that more needs to be done to retain qualified professionals in the AOD treatment sector, especially for those professionals based in regional and remote communities. The allocation of funding to regional and remote communities, through initiatives such as the NIAS, will help retain professionals. Commonwealth, state and territory governments should also ensure secure, longer term funding to AOD treatment service providers, especially those in regional and remote communities.

3.18 Finally, insufficient access to AOD treatment services is a part of a broader issue related to the complexity of providing adequate health services to regional and remote communities in Australia. The NIT and NIAS recognised this issue, and the formula for allocating NIAS funding included preferential weightings for regional and remote Australia.[26] The committee supports this and the innovative delivery of AOD treatment services through technology, such as online interventions and telemedicine.

Treatment services for Aboriginal and Torres Strait Islander peoples

3.19 The committee's first report discussed Aboriginal and Torres Strait Islander peoples as an at-risk community for problematic crystal methamphetamine use.[27] The

25 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 40.

26 See chapter 5, pp 4–6.

27 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 27–29.

committee considered in that report the rates of crystal methamphetamine use in Indigenous communities, in particular for young Indigenous people.[28]

3.20 The following section considers AOD treatment for Indigenous Australians, and concerns regarding accessibility, culturally appropriate services and the need for further investment and training in the sector.

3.21 According to the Australian Health Council of Western Australia (AHCWA), Indigenous communities face a number of barriers to addressing AOD issues, including:

- the lack of opportunities for children to access appropriate AOD treatment programs;
- unemployment;
- few holistic service providers; and
- under-resourcing of the sector.[29]

3.22 The AHCWA also reported that available AOD services often lack consistency, adequate communication and collaborative partnerships.[30] The AHCWA added that there are resources being directed to them, but there are no 'effective outcomes because no-one is getting community agreement to work with an individual'.[31] A risk, according to AHCWA, is that Aboriginal people can become overwhelmed by service providers, and the recipients of those services can form barriers to effective treatment.[32] The AHCWA spoke of the importance of cultural context and effective communication in these settings, and that currently Aboriginal people:

> …are not co-designers of their programs. We are not co-commissioners of some of their programs.
>
> Our communication is around body language not dialogue with English. We have language barriers and we also have a number of socioeconomic impacts that are contributing factors as to our social and emotional wellbeing, and appearances and abilities to get change in our behaviours as well. What people do not understand are the complexities around our culture. It is particularly hard for younger generations to make that change. People do not understand the cultural obligations that they have to their families, particularly if they are entering the workforce. We live a very dynamic, complex life. However, we know the dynamics that we are

28 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report*, September 2017, pp 27–29.

29 Ms Michelle Nelson-Cox, Chairperson, Aboriginal Health Council of Western Australia (AHCWA), *Committee Hansard*, 3 May 2017, p. 46.

30 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

31 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

32 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

> dealing with in terms of service providers and the quality of care that we deliver to our people.[33]

3.23 The importance of co-designed AOD treatment programs was also raised by the WA Primary Health Alliance (WAPHA). In WAPHA's view, AOD treatment programs for Indigenous communities must be co-designed with the community to provide:

> …a sense of ownership of the service, be committed to what it is seeking to achieve and provide local leadership with their community members so that the service is not running at odds with the community but is well integrated. If we are to prevent the trajectory of young people then community ownership becomes key.[34]

3.24 The WAPHA has established differentiated Aboriginal-specific services, separate from mainstream services. These specific services are tailored to the needs of Aboriginal people, which are integrated and linked with both urban and rural-remote communities.[35] Indigenous people in WA are also able to access mainstream services.[36]

3.25 The AHCWA called for funding to be directed to the underlying factors that contribute to AOD dependency in Indigenous communities, and the development of community-led, holistic strategies that target AOD use.[37] Further, it was proposed that these services must be culturally appropriate and enhance the capacity of the Aboriginal Community Controlled Health Organisations (ACCHOs).[38] AHCWA endorsed:

> …increasing support for community-based and community-led services which will reduce the long-term cost and greatly benefit individuals, families, and communities impacted by methamphetamine use, thus delivering better, healthier communities.[39]

3.26 Despite existing investment in AOD treatments for Indigenous communities, the AHCWA was of the view that:

> …the primary focus of government responses relate to investment in law and other mechanisms, the cost of which is significant, and which do little to address the causal factors of alcohol and drug use. From our experience and perspective, this approach is consistent across both state and Commonwealth government investment in our services with regard to A&D

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33 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

34 Ms Learne Durrington, Chief Executive Officer (CEO), WA Primary Health Alliance (WAPHA), *Committee Hansard*, 3 May 2017, p. 18.

35 Ms Durrington, WAPHA, *Committee Hansard*, 3 May 2017, p. 18.

36 Ms Durrington, WAPHA, *Committee Hansard*, 3 May 2017, p. 18.

37 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 42.

38 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 42.

39 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 42.

> services and programs. AHCWA, whilst supporting the need for law and order intervention, particularly for those involved in trafficking and large-scale drug supplies, propose a marked shift in the approach to methamphetamine use in the community.[40]

3.27 The benefits of prioritising health focused investments, rather than law enforcement measures was discussed in chapter 2. As noted, research by the Australian National Council on Drugs showed that for Indigenous Australians, there is a saving of $111 458 per offender if a person is dealt with in a residential rehabilitation facility compared to imprisonment.[41] A further saving of $92 759 is made when accounting for improved health-related quality of life and lower mortality rates.[42]

3.28 The AHCWA pointed out that since 2015, it has not seen a 'marked shift towards investment for community interventions'.[43] Whilst Commonwealth and state strategies aimed at early intervention, prevention, treatment and support services are encouraging, AHCWA expressed frustration because it is 'yet to really see that trust and faith provided by commissioning bodies to our sector'.[44]

3.29 When asked what the biggest challenge is for delivering culturally relevant services to Aboriginal communities, the AHCWA responded that one of the barriers had been its ability to provide:

> …sustained investment resources for us to deliver on-ground programs that are going to provide full complementary social determinant programs, and to have them tailor made to fit the individual. We already know the history of the family dynamics. Our particular sector has delivered more than six intergenerations of care to a particular family group, which no other service provider is able to perform. We meet the outcomes, and, importantly, the number of service activities that we deliver goes above and beyond what we get resourced to do; it exceeds the quality performance around ensuring that we make a positive change within our individuals. We are constantly confronted with some of our barriers, but one of our biggest barriers is not having culturally appropriate resources in some of the regions at a localised level, as opposed to some of our Aboriginal community members coming down to access these major facilities in some of the regional towns or in urban towns in particular.[45]

3.30 The AHCWA described the Narrogin region of WA, a township 192 kilometres southeast of Perth. AHCWA advised that a number of recorded drug

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40 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 42.

41 Victorian Alcohol and Drug Association (VAADA), *Submission 95*, p. 7

42 VAADA, *Submission 95*, p. 7.

43 Mr Shaun Wyn-Jones, Senior Policy Officer, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

44 Mr Wyn-Jones, AHCWA, *Committee Hansard*, 3 May 2017, p. 46.

45 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 47.

users in that region were travelling to Broome to access the only Aboriginal community controlled rehabilitation centre in WA.[46] The AHCWA added that this highlights the difficulty for Aboriginal people accessing appropriate, quality care:

> …of the differences within the cultural delivery of those models of programs and…that family is returning back into the same environment. It will enable them to have a sustainable revitalised change in life. Having that treatment away from country does not have the same impact on them returning back to their country.[47]

3.31 The NDRI identified two issues faced by the Indigenous AOD treatment sector. The first is paucity of data on the use of amphetamines in Indigenous communities. Although research into amphetamine use is conducted, it is understood that the results are under-estimated and are not representative. The second issue is that many Indigenous service providers 'are skilled in treating alcohol related problems, fewer have the skills to address the issues arising from illicit drug use'.[48]

3.32 Both the NIT and the NIAS considered the unique challenges faced by Indigenous communities in Australia and ways to address AOD use. The NIAS specified actions that included:

- increased investment in Indigenous-specific AOD services;
- investment in remote Indigenous sporting clubs, as part of the Good Sports Programme;[49] and
- research into methamphetamine use in Indigenous communities.[50]

3.33 $78.6 million of NIAS funding was allocated to Indigenous-specific services, which was informed by the DoH's engagement with local Aboriginal and Torres Strait Islander communities, through the PHNs,[51] and by using population figures derived from the 2013 Estimated Residential Population.[52] Culturally appropriate mainstream treatment services are also available to Indigenous Australians. Performance reporting requires PHNs to provide evidence to the DoH that culturally appropriate services for Indigenous Australians are provided under the Drug and Alcohol Treatment Program.[53]

3.34 Since the release of the NIAS, the Commonwealth government has made a number of investments in Indigenous-related AOD treatment services. Some of the most recent initiatives include:

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46 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 47.

47 Ms Nelson-Cox, AHCWA, *Committee Hansard*, 3 May 2017, p. 47.

48 NDRI, *Submission 113*, p. 5.

49 COAG, *NIAS*, p. 24.

50 COAG, *NIAS*, p. 25.

51 Dr Wendy Southern, Deputy Secretary, DoH, *Committee Hansard*, 24 March 2017, p. 21.

52 DoH, answer to question on notice, no. 5, 24 March 2017 (received 10 May 2017).

53 DoH, answer to question on notice, no. 1, 24 March 2017, p. 1 (received 10 May 2017).

- on 4 September 2017, $1 million of Commonwealth funding was invested in a Kimberley post-residential rehabilitation program, to support individuals transitioning out of residential rehabilitation and back into their communities;[54]
- from 2016–17, an investment of $9.1 million targeting crystal methamphetamine dependency, mental health, suicide prevention and chronic disease will be made available through the North Coast Primary Health Network;[55] and
- on 15 December 2017, it was announced that a further 14 NT Aboriginal health services staff would undertake specialised leadership and management training (at a total cost of $715 535) and that this new funding would be shared amongst four NT Indigenous health services.[56]

Committee comment

3.35 Indigenous communities in Australia face heightened risk of people developing problematic amphetamine use. To address AOD use in these communities, it is vital that AOD treatment services are culturally and linguistically appropriate and are provided in partnership with communities.

3.36 The committee supports the work of Commonwealth, state and territory governments in developing and investing in culturally appropriate AOD treatment services for Indigenous communities. The NIAS, in particular, dedicated funds and implemented measures that ensure PHNs allocate funding and services to Indigenous Australians.

3.37 Although there is recognition, support of and investment in culturally appropriate and co-designed AOD treatment services, the AHCWA's evidence indicates that demand for culturally appropriate and locally available treatment services remains. For this reason, the committee recommends Australian governments continue to develop culturally and linguistically appropriate AOD treatment services, in partnership with Indigenous communities and Indigenous health experts.

Recommendation 7

3.38 The committee recommends that Australian governments continue to advance collaboration with Indigenous communities and Indigenous health experts to provide culturally and linguistically appropriate alcohol and other drug treatment services.

54 The Hon. Ken Wyatt AM, Minister for Indigenous Health, 'Kimberley post-residential rehabilitation program supports sustained recovery', *Media release*, 4 September 2017.

55 The Hon. Ken Wyatt, AM, Minister for Indigenous Health, 'Ice dependence, chronic disease among targets of North Coast Health Blitz', *Media release*, 6 November 2017.

56 The Hon. Ken Wyatt AM, Minister for Indigenous Health, 'More Indigenous Health Leaders for Remote Australia', *Media release*, 15 December 2017.

Treatment and support services for people with children

3.39 A number of submitters and witnesses discussed treatment and support services for people with children, especially women.

3.40 Professor Allsop and Mr Craig Cumming identified people with young children, particularly women, as a vulnerable group. Mr Cumming explained that parents, primarily women with children, often have privacy concerns when accessing AOD treatment services, and fear losing custody of their children if they access these services.[57]

3.41 Professor Allsop spoke of parents' fears for their children; that is, if they access treatment services, do they risk losing their children, or what happens if a drug user attends a residential or day treatment service?[58] He added that some services have specifically designed programs to provide care facilities for children 'to enhance access to treatment for young families'.[59] One example of this type of treatment service in WA is Cyrenian, which according to Professor Allsop 'has a facility specifically for women with young children. I think it is a very good example of how the sector can and does respond to these challenges'.[60]

3.42 More broadly, the committee heard that there is a lack of support for families that are dealing with a family member using crystal methamphetamine. For example, the Palmerston Association noted that there was 'very little for families' and that '[w]e need to look at the culture and the attitudes that exist to enable families to seek support'.[61] Problems of stigma and discrimination have meant that families 'mostly suffer in silence'.[62] Often families do not raise their issue with a professional service:

> …because they think their son or daughter might be whisked off by the police and put into prison. They do not want that; they just want to get their son or daughter back. That is how families see it: they have lost their child to this drug. So we need to create an environment where people can actually come and seek support.
>
> No, there is not enough focus on families. Families suffer in silence. They either suffer in silence or they suffer in violence when their son, daughter, family member, husband or partner is having a psychotic episode. We need to provide more information, better ways of communicating and understanding and the skills to actually say: 'No. I love you dearly, but can't

57 Mr Craig Cumming, Research Associate, Centre for Health Services Research (CHSR), School of Population Health, University of Western Australia, *Committee Hansard*, 3 May 2017, p. 39.

58 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 39.

59 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 39.

60 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 39.

61 The Hon. Sheila McHale, CEO, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

62 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

> give you any more money. I can't take out another mortgage on this house.' That is the reality for many families.[63]

3.43 Professor Allsop spoke of the need to enhance the 'access of support for families and others affected by an individual's drug use', and although there has been a 'significant increase in the investment in treatment services…we also need to recognise the needs of other people who are affected by a person's use.[64]

3.44 The committee asked the Department of Health (DoH) about the NIAS's consideration of family-friendly and youth-friendly treatment services. In response, the DoH advised that it is the responsibility of each PHN to undertake a needs assessment for its region and as part of that process:

> …look at existing services in their geographic area, both Commonwealth and state funded, work with peak bodies and others within their PHN to determine where the gaps were, and then commission accordingly. It is a question of whether youth services or family-friendly services came up as a gap in the planning. I am not sure if it did. That would be the part of the process where those issues need to be raised.[65]

3.45 The NIAS includes actions such as the Positive Choices online AOD information portal, and a national phone line for AOD information, counselling and other support services.[66] Other phone support services for families and their children are listed on the Alcohol and Drug Foundation's website, which includes a number of organisations that specialise in youth and family support (such as the Parent and Family Drug Support Line, Ted Noffs Foundation helpline, Headspace, Kids Help Line, Family Drug Support and Family Drug Help).[67]

Committee comment

3.46 It is vital that families are adequately and appropriately supported in circumstances where a parent or child is dealing with a methamphetamine dependency issue. Failure to do so has adverse outcomes for the drug user and their family.

3.47 The committee is particularly concerned about reports that parents, in particular women with young children, are opting not to undergo treatment out of fear of losing their children. The committee is, however, encouraged that specialised AOD treatment services are available to people with young children and that this issue appears to be getting more explicit consideration in some states and territories. The committee supports these types of AOD treatment facilities and recommends Australian governments ensure such services are provided in all jurisdictions.

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63 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

64 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 31.

65 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 26.

66 COAG, *National Ice Action Strategy*, 2015, p. 24.

67 Alcohol and Drug Foundation, *Help and support services*, https://adf.org.au/help-support/support-services-directory/ (accessed 21 February 2018).

Recommendation 8

3.48 The committee recommends Australian governments ensure specialised alcohol and other drug treatment services are available to people with young children in all jurisdictions.

At-risk workplaces

3.49 During the course of the inquiry the committee heard that there are some workplaces more at risk of employees using crystal methamphetamine. For this reason, some submitters and witnesses advocated for drug testing to occur in these at-risk workplaces.

3.50 Holyoake Tasmania referred to the use of crystal methamphetamine in the hospitality industry. Anecdotally, Holyoake Tasmania has found that there is a high rate of use in Hobart's hospitality industry due to long working hours:

> …we are finding quite a few people who are working in pubs and clubs, that type of thing, who are having long or late shifts, are using ice and it is becoming problematic. They were using speed but they cannot get speed now so they are using ice.[68]

3.51 Fly-in fly-out workers were also identified as a group with a slightly greater risk of being exposed to, and using crystal methamphetamine.[69]

3.52 The Penington Institute described some of the drivers behind crystal methamphetamine use in some industries, such as the perception that it increases productivity and alleviates boredom, and the culture of some workplaces:

> People think that they can do more work, work longer, work harder, especially if they are piece workers. Fruit pickers et cetera think that they can pick more fruit if they are on ice. They make a flawed assumption around the mathematics, which is that they will use ice in order to generate more income. What ends up happening is that they develop an addiction, lose whatever income, lose their tolerance et cetera. It is a false equation, but, nonetheless, some people use it to increase their productivity. Some people use it to address boredom in their work role, and some people use it because it is part of the culture of their workplace—for example in the hospitality industry, where people are working night shifts until 3 am or whatever and their customers are quite possibly using the same substances, there is a culture that develops. So it is absolutely not just about the trades or the building industry—even though that is a very high profile issue—or the trucking industry.[70]

3.53 The Penington Institute cautioned against the assumption that only "blue-collar" workers are using crystal methamphetamine:

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68 Ms Sarah Charlton, CEO, Holyaoke Tasmania, *Committee Hansard*, 24 March 2017, p. 18.

69 Mr David Taylor, Policy Officer, Victorian Alcohol and Drug Association (VAADA), *Committee Hansard*, 27 July 2015, p. 36.

70 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 12.

> It is people on the land, on the farming lands, as much as it is people in factories et cetera. I should say that it is also an issue on Collins Street as well. I have heard lots of stories from people that work in the corporate sector around ice use in the business community. It is absolutely not just blue-collar workers.[71]

3.54 In 2015, the Australian Industry Group (Ai Group) called for workplace AOD testing as a means to address the safety issues caused by illicit drug use in workplaces. It recommended that crystal methamphetamine use can be tackled by:

> …firstly, recognising that drug and alcohol testing at the workplace is a key action that employers can take to protect the safety of employees and the community; secondly, conducting work health and safety campaigns aimed at educating the community about the risks created by ice use, particularly in operating machinery and vehicles; thirdly, encouraging law enforcement agencies to provide liaison services and dedicated hotlines for not only employees but employers impacted by ice, including, of course, regional and remote locations; and, fourthly, developing education resources to assist employers to deal with the impacts of ice in their workplaces.[72]

3.55 The Ai Group's 2016 submission repeated calls for drug testing in workplaces. It claimed that the NIT and the NIAS are inadequate responses to drug use in the workplace, stating that neither adequately deals with the impact of crystal methamphetamine or other drugs on workplaces, and the 'strict statutory obligations employers have to provide healthy and safe workplaces'.[73] The Ai Group recommended the following amendments to the *Fair Work Act 2009* (Cth):

- section 194 'so that enterprise agreements cannot contain terms that restrict drug and alcohol testing at the workplaces';
- subdivision D of Division 3, Part 2–3 'to prevent modern awards including terms dealing with drug and alcohol testing' to prevent limitations or restrictions on AOD testing; and
- other amendments that ensure 'procedural errors by an employer would not result in reinstatement or compensation for a former employee if there is a valid substantive reason for dismissal' to 'prevent a dismissal of an employee for a serious breach of work health and safety requirements from being overturned due to procedural deficiencies'.[74]

3.56 Professor Nadine Ezard, St Vincent's Hospital, raised concerns about workplace testing because it 'encourages subversion of the system if there is going to

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71 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 12.

72 Mr Stephen Smith, Head, National Workplace Relations Policy, Australian Industry Group (Ai Group), *Committee Hansard*, 29 July 2015, p. 63.

73 Ai Group, *Submission 112*, p. 2.

74 Ai Group, *Submission 112*, p. 2.

be a punitive response to the work-based testing'.[75] Rather than a punitive response, Professor Ezard suggested that the most effective model is:

> …where the health system is separate from employment such that people are directed to the health system but the results from the health system are not sent back to the employer. That is a very useful way of detecting people's use and responding early.[76]

3.57 Professor Ezard added that there should be trained health professionals permitted to engage with high-risk workplaces, such as mining and commercial driving, to provide health-focused interventions.[77]

3.58 The NIT considered ways to address illicit drug use in at-risk industries. It found that there is a lack of evidence 'regarding the effectiveness of workplace prevention activities' due to 'challenges associated with conducting controlled outcome and effectiveness evaluations in the workplace'.[78] The NIT argued that despite this lack of evidence, preventative activities should not be overlooked and workplaces are an effective setting for preventative and intervention strategies.[79] The NIT was in favour of a pilot program partnership between the Commonwealth, state and territory governments and industry groups designed for high-risk industries.[80] According to the NIT, this program should:

- be developed in consultation with AOD experts;
- be rolled out across high-risk industries and for an appropriate length of time to monitor its outcomes; and
- incorporate a robust evaluation of the methodology used to inform future workplace AOD prevention strategies.[81]

3.59 The use of drug testing in workplaces was briefly considered by the NIT, which recognised that this:

> …is a sensitive and complex issue, which should be underpinned by a clearly defined and agreed rationale, developed in consultation with the workforce. Identifying lower-cost drug testing options would enhance the usefulness of drug testing as a tool in a range of contexts, particularly for roadside drug testing.[82]

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75 Professor Nadine Ezard, Clinical Director, Alcohol and Drug Service, St Vincent's Hospital, St Vincent's Health Australia, *Committee Hansard*, 14 October 2015, p. 15.

76 Professor Ezard, St Vincent's Health Australia, *Committee Hansard*, 14 October 2015, p. 15.

77 Professor Ezard, St Vincent's Health Australia, *Committee Hansard*, 14 October 2015, p. 15.

78 NIT, *Final Report*, p. 119.

79 NIT, *Final Report*, p. 119.

80 NIT, *Final Report*, p. 119.

81 NIT, *Final Report*, p. 119.

82 NIT, *Final Report*, p. 154.

3.60 In response to the NIT's recommendations, the NIAS noted that preventative AOD programs in workplaces are already run by employers and state and territory governments.[83] It also acknowledged that government needs to expand efforts 'in high-risk workplaces so they are better able to prevent ice use and respond to ice when it emerges as an issue'.[84] An action under the NIAS is to '[d]evelop strategies to increase prevention and education about ice in high-risk industries such as mining, construction and transport'[85]; however, the NIAS did not address the role of drug testing in workplaces.

Committee comment

3.61 A range of industries, both "blue-collar" and "white-collar", are susceptible to problematic AOD use. Crystal methamphetamine use has been specifically identified in hospitality, transport, agriculture, construction and mining, as well as corporate environments, for reasons such as perceived increases in productivity and alertness.

3.62 A gap in the nation's response to AOD use in these industries is the development of evidence-based workplace preventative activities. The NIT recognised this need and recommended the development of a pilot program that develops a workplace preventative strategy to be implemented across high-risk industries. The NIT emphasised that this program must be thoroughly evaluated to inform future workplace prevention activities.

3.63 In response to this recommendation, the NIAS called for the development of strategies aimed at education about and prevention of crystal methamphetamine use in high-risk industries.

3.64 The committee is supportive of the measures outlined by the NIT and in the NIAS, and is of the view that governments and industry should implement strategies to address AOD use in at-risk workplaces.

3.65 The committee can see the appeal of drug testing in the workplace; however, such an approach must be given careful consideration in consultation with employees so that consequences both intended and unintended are identified and resolved, taking into account the rights and responsibilities of employers and employees alike. The committee has a preference for the development and implementation of preventative strategies in at-risk workplaces so that employees with AOD use issues are directed to treatment and support services in the first instance.

83 COAG, *NIAS*, p. 23.

84 COAG, *NIAS*, p. 23.

85 COAG, *NIAS*, p. 24.

Chapter 4

Harm reduction measures

4.1 Harm reduction is described as:

> …an approach rooted in public health and human rights. It aims to improve the lives of people who are affected by drugs or drug policies through evidence-based programming and approaches, ideally that are developed in partnership with people who use drugs.[1]

4.2 A number of submitters and witnesses argued in support of increasing the amount of government funding for harm reduction, one of the three pillars of Australia's drug policy.

4.3 This chapter considers the definition of harm reduction; examines the benefits of the government's harm minimisation policy; discusses current approaches to harm reduction; and considers possible improvements in harm reduction to reduce the risks for users of crystal methamphetamine.

4.4 Finally, the chapter concludes with consideration of a submission to the committee's inquiry into the impact of new and emerging information and communication technology on Australian law enforcement agencies. This submission, from Dr James Martin, a senior Lecturer in Criminology at the Department of Security Studies and Criminology at Macquarie University, argues in favour of a harm reduction approach to drug trading via the darknet.

Defining harm reduction

4.5 The Australian National Drug Strategy (NDS) comprises of three pillars:

- demand reduction;
- supply reduction; and
- harm reduction.[2]

4.6 The NDS states that '[s]trategies to prevent and minimise alcohol, tobacco and other drug problems should be balanced across the three pillars'.[3]

4.7 The NDS provides the following definition of 'harm reduction':

> Harm reduction strategies identify specific risks that arise from drug use. These are risks that can affect the individual who is using drugs, but also others such as family members, friends and the broader community. Harm reduction strategies encourage safer behaviours, reduce preventable risk

1 Cohealth, *Submission 110*, p. 4.

2 Commonwealth of Australia, *National Drug Strategy 2017–2026*, p. 6.

3 Commonwealth of Australia, *National Drug Strategy 2017–2026*, p. 6.

> factors and can contribute to a reduction in health and social inequalities among specific population groups.[4]

4.8 According to the NDS '[h]arm reduction requires commitment from government and non-government programs, industry regulation and standards, and targeted communication strategies'.[5] Strategies affecting harm reduction include:

- reducing risks associated with particular context, including creating safer settings;
- safe transport and sobering up services;
- protecting children from another's drug use;
- protecting the community from infectious disease including blood borne virus [(BBV)] prevention;
- reducing driving under the influence of alcohol or other drugs; and
- availability of opioid treatment programs.[6]

4.9 Victoria Police identified the following examples of prevention and harm reduction activities in that state:

- Provide users with referrals to treatment and other health services
- Increased focus on drug diversions.
- Regional youth officers to actively discuss drug-related harm issues in presentations with school children
- Run Passive Alert Detection Dog operations at major festivals and events where applicable
- Ensure child protection agencies are advised to conduct a health assessment and care for children at risk who are identified at clandestine drug laboratories.
- Use roadside drug detection as an opportunity to identify and intervene with individuals testing positive to use of [Aboriginal and Torres Strait Islander] (e.g. referrals to treatment and other support services)
- Work with other government agencies to identify the issues and impact of ATS use within the community, educate users and link in with community messaging[7]

4.10 Dr Terry Goldsworthy and Adjunct Teaching Fellow Laura McGillivray outlined an international definition of harm reduction:

> The International Harm Reduction Association [(IHRA)] (2015) defines harm reduction by its aims to as the "reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption". The IHRA identify that

4 Australian government, *National Drug Strategy 2017–2026*, p. 13.

5 Australian government, *National Drug Strategy 2017–2026*, p. 14.

6 Australian government, *National Drug Strategy 2017–2026*, p. 14.

7 Victoria Police, *Submission 59*, p. 24.

> features of harm reduction are framed within a human rights perspective as it focuses on the prevention of harm, rather than the prevention of drug use in those who continue to use.[8]

The benefits of harm reduction

4.11 There is a substantial amount of evidence that demonstrates 'that drug treatment and harm reduction are effective and cost-effective'.[9] For example, Dr Alex Wodak AM has stated that:

> A review of the effectiveness and cost-effectiveness of needle syringe programmes in Australia estimated that these had prevented 25,000 HIV and 21,000 hepatitis C infections (by 2000), 4500 deaths from HIV and 90 deaths from hepatitis C (by 2010) resulting in savings (by 2000) of between AU$ 2.4 and AU$7.7 billion from an investment between 1991 and 2000 of AU$ 130 million (Health Outcomes International Pty Ltd., The National Centre For HIV Epidemiology and Clinical Research, & Drummond, 2002). A subsequent study confirmed these findings estimating that an investment of AU$ 243 million between 2000 and 2009 achieved short-term health savings of AU$ 1.28 billion. Thus for every AU$ 1, invested savings amounted to AU$ 4 in healthcare costs and with overall savings of AU$ 27. (National Centre for HIV Epidemiology and Clinical Research, 2009).[10]

4.12 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray also described some benefits of harm reduction:

> Harm reduction allows for input from a variety of theoretical perspectives to inform interventions, rather than being bound to one course of action. The view has been advocated across a variety of disciplines including psychology, nursing and social work because it is a form of health promotion whereby working to reduce drug-related harms simultaneously promotes health and wellbeing (McVinney, 2008). Therefore, given the growing intersection between these disciplines, services and methylamphetamine users, harm reduction appears to promote relevant and viable strategies.
>
> Harm reduction has been found to be particularly effective in preventing HIV in injecting drug users. With the increase in crystal methylamphetamine or 'ice' users and therefore exposure to BBVs such as HIV, improving harm reduction services across Australia is a viable approach because it has proven to be successful, safe and cost-effective (Wodak & Maher, 2010) (World Health Organisation, United Nations Office on Drugs and Crime, & United Nations Programme on HIV/AIDS, 2009). This joint WHO, UNODC and UNAIDS (2009) review into needle and syringe programs (NSPs) concluded with the recommendation that

8 Dr Terry Goldsworthy and Adjunct Teaching Fellow Laura McGillivray, *Submission 70*, p. 11.

9 Dr Alex Wodak AM, 'The abject failure of drug prohibition', *Australian & New Zealand Journal of Criminology*, vol. 47, no. 2, 2014, p. 195.

10 Wodak, 'The abject failure of drug prohibition', *Australian & New Zealand Journal of Criminology*, vol. 47, no. 2, 2014, pp 195–196.

> countries affected or threatened by HIV and other BBVs among injecting drug users should rapidly establish and expand NSPs as a viable response to the problem. Similarly, early data from the War on Drugs suggest that policies which deny injection equipment and income support for injecting drug users will increase their risk of contracting HIV and therefore must be reconsidered from a public health perspective (Bluthenthal, Lorvicka, Krala, Erringera, & Kahna, 1999).[11]

4.13 The NSW Users and AIDS Association spoke to the economic benefits of harm reduction, noting that '[h]arm reduction programs and peer education are highly effective and cost effective, with the NSP program returning $4 in value for every dollar spent'.[12] The Western Australian Network of Alcohol and other Drug Agencies (WANADA) also highlighted the economic benefits of harm reduction approaches:

- for every $1 invested in treatment services, more than $7 is returned to the community through health and social benefits; and,
- for every $1 spent on needle and syringe exchange programs, the community saves $27 in future cost.[13]

4.14 The committee heard about the benefits of other approaches to combatting crystal methamphetamine use. For example, while recognising 'the need to provide harm reduction strategies such as needle and syringe exchange programs or adequate treatment for people with drug use problems', the Australian Drug Foundation (ADF) advocated for an "upstream" approach, which would prevent 'people from commencing drug use rather than waiting for their drug use to become a problem that requires reactive "downstream" approaches'.[14]

4.15 However, as the National Association of People with HIV Australia (NAPWHA) observed, '[a] basic tenant of harm reduction is that there hasn't been, is not now, and never will be a drug-free society', a sentiment also expressed by Cohealth.[15] The NAPWHA explained that the risks associated with 'an overemphasis on drug and alcohol prohibition as a policy goal comes at the expense of more effective harm reduction strategies', stating:

> There will always be a tension between the national harm reduction agenda and the criminalisation of illicit substances. The negative consequence of this is stigmatisation of the user and create health access and equity problems for the health system more broadly.[16]

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11 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray, *Submission 70*, p. 12.

12 NSW Users and AIDS Association, *Submission 91*, p. 4.

13 Western Australian Network of Alcohol and other Drug Agencies (WANADA), *Submission 107*, p. 7.

14 Australian Drug Foundation (ADF), *Submission 51*, p. 12.

15 Cohealth, *Submission 110*, p. 4.

16 National Association of People Living with HIV Australia (NAPWHA), *Submission 104*, p. 4.

Current approach to harm reduction

4.16 The NDS includes the following table, which provides 'a comprehensive summary of examples of harm reduction approaches'.[17]

Table 2: Examples of evidence-based and practice-informed approaches to harm minimisation [18]

Approach	Strategies
Safer settings	• Chill-out spaces • Availability of free water at licensed venues • Information and peer education • Emergency services responses to critical incidents • Maintenance of public safety
Diversion	• Diversion from the criminal justice system to treatment services
Blood borne virus prevention	• Hepatitis B vaccination • BBV and sexually transmitted infection testing, prevention, counselling and Treatment • Peer education
Safer injecting practices	• Diversity and accessibility of needle and syringe programs • Medically supervised injection centres and drug consumption rooms • Peer education • Prevent and respond to overdose including increased access to naloxone • Police policy to exercise discretion when attending drug overdoses • Non-injecting routes of administration
Replacement therapies	• Pharmacotherapy for opioid maintenance and other drug use

4.17 Many submitters and witnesses criticised the current approach to harm reduction. Indeed, the Scarlet Alliance observed that '[a]lmost every' one of the inquiry's terms of reference go to supply reduction or demand reduction, which:

17 Commonwealth of Australia, *National Drug Strategy 2017–2026*, p. 14.

18 Commonwealth of Australia, *National Drug Strategy 2017–2026*, pp 50–51.

> …is typical of existing efforts to address crystal methamphetamine use in Australia, which emphasise supply and demand reduction from a law enforcement approach at the expense of accurate and honest information and effective harm reduction approaches.[19]

4.18 Dr Wodak similarly remarked that the inquiry's terms of reference illustrate 'the unbalanced approach to drug policy in Australia'.[20]

4.19 Dr Wodak acknowledged that 'Commonwealth law enforcement agencies do have a role in responding to the importation, manufacture, distribution and use of methamphetamine and its chemical precursors', but considered that 'the excessive fiscal and rhetorical reliance on law enforcement has proved to be an expensive way of making a bad problem worse'.[21] Dr Wodak therefore suggested that rather than increasing existing law enforcement measures, Australia should:

> …increase the emphasis on demand reduction and harm reduction as these are more effective, safer and more cost effective than drug law enforcement and therefore provide a better return on investment from scarce resources. Drugs should be re-defined as primarily a health and social issue rather than primarily a law enforcement issue.[22]

4.20 In terms of the government's approach to harm reduction, the NAPWHA submitted that, although the national Intergovernmental Committee on Drugs 'considers harm reduction as amongst its central goals, in practice Australia's drug and alcohol policy has primarily focussed on decreasing supply of illicit substances to the community', and provided the following example:

> …a 2013 report by the National Substance and Alcohol Research Centre noted that of the $1.7 billion spent in the 2009/10 financial year, only $36.1 million or 2.1 per cent was spent on harm reduction initiatives (not including drug treatment programs).[23]

4.21 The Network of Alcohol and other Drugs Agencies (NADA) observed that harm reduction initiatives were not included in the final report of the National Ice Taskforce (NIT), which it stated is inconsistent 'with the three pillars approach of the National Drug Strategy' and 'does not recognise the benefits of harm reduction strategies in reducing social costs'.[24] The NADA, together with the Network of AOD Peaks, therefore recommended that 'harm reduction initiatives are included as a matter of priority'.[25]

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19 Scarlet Alliance, *Submission 12*, p. 2. See also Hepatitis NSW, *Submission 38*, p. 2.

20 Dr Wodak, *Submission 79*, p. 2.

21 Dr Wodak, *Submission 79*, p. 3.

22 Dr Wodak, *Submission 79*, p. 3.

23 NAPWHA, *Submission 104*, p. 4 (citation omitted).

24 Network of Alcohol and other Drugs Agencies (NADA), *Submission 96*, p. 7.

25 NADA, *Submission 96*, p. 7.

4.22 The Australian Injecting & Illicit Drug Users League similarly criticised the lack of focus on harm reduction in the government's response to the NIT's report, and consequently called for 'a long overdue increase in funding for harm reduction approaches'.[26]

4.23 The former head of the NIT, Mr Ken Lay, commented that in his personal view, 'there is a real attraction to harm reduction'[27] and if 'you invest in front end, you need to invest in harm reduction, you need to invest in education and you need to wrap services around people who are basically sick – they're not criminals'.[28]

4.24 Indeed, a recurring criticism of the current approach is the uneven distribution of government funding between the three pillars of the government's drug policy.[29] As discussed in chapter 5 (at paragraph 5.59), of the total $1.7 billion spent on illicit drug programs by all governments, 64.1 per cent (over $1 billion) was dedicated to law enforcement policies, whereas:

- 9.7 per cent (approximately $156.8 million) was spent on prevention activities;
- 22.5 per cent (approximately $361.8 million) was spent on treatment services;
- 2.2 per cent ($36.1 million) was spent on harm reduction measures; and
- 1.4 per cent ($23.1 million) on other activities.[30]

4.25 According to the Queensland Network of Alcohol and Other Drug Agencies (QNADA), the imbalance in investment between 'law enforcement responses' and harm minimisation 'is impeding our ability to reduce the demand for methamphetamine'.[31] The QNADA therefore recommended that 'the committee consider the distribution of government funding between supply, demand and harm reduction policy approaches to the issue of methamphetamine use in Australia'.[32]

4.26 NAPHWA observed that 'nearly two-thirds of the total spending on drug-related issues is spent on law enforcement, compared to other drug-related

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26 Australian Injecting & Illicit Drug Users League (AIVL), *Submission 105*, p. 3.

27 Goya Dmytryshchak, 'We probably weren't brave enough on injecting rooms', says Victoria's former police chief Ken Lay', *The Age*, 22 July 2017, http://www.theage.com.au/victoria/we-probably-werent-brave-enough-on-injecting-rooms-says-victorias-former-police-chief-ken-lay-20170722-gxgn84.html (accessed 11 January 2018).

28 Dmytryshchak, 'We probably weren't brave enough on injecting rooms', says Victoria's former police chief Ken Lay', *The Age*, 22 July 2017.

29 See, for example, Western Australian AIDS Council (WAAC), *Submission 28*, p. 1; NADA, *Submission 96*, p. 3; Mr Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Committee Hansard*, 27 July 2017, p. 31.

30 Alison Ritter, Ross McLeod and Marian Shanahan, National Drug and Alcohol Research Centre (NDARC), *Drug Policy Modelling Program Monograph Series: government drug policy expenditure in Australia – 2009/10*, June 2013, p. 1.

31 Queensland Network of Alcohol and Other Drug Agencies (QNADA), *Submission 20*, p. 3.

32 QNADA, *Submission 20*, p. 3.

interventions, such as harm reduction, rehabilitation, support programs and other initiatives', and argued:

> …it is worth looking at whether these measures have had sufficient impact on the use, supply and demand of these drugs and whether funding should be increased for prevention, treatment and harm reduction options, including substitution trials.[33]

4.27 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray advised that '[a] growing body of literature indicates that interrupting the drug market through enforcement has detrimental public health and social impacts'.[34] Their submission referenced evidence that suggested law enforcement measures, targeted at heroin in the early 2000s, led to an increase in the use of other drugs, such as cocaine and other stimulants.[35] Further, anecdotal evidence indicates that the heroin shortage shifted drug users to injecting stimulants because they were cheaper and more readily available.[36] The authors noted that law enforcement initiatives can have unintended consequences on harm reduction initiatives, such as:

> …disrupting the provision of health services to injecting drug users; increasing risky injecting behaviours exposing users to infectious diseases and overdose; and exposing previously unaffected communities to the harms associated with illicit drugs (Kerr, Small, & Wood, 2005) (Maher et al., 2007) (Bluthenthal et al., 1999).[37]

4.28 By contrast, the Australian Federation of AIDS Organisations (AFAO) did not consider that harm reduction necessarily conflicts with law enforcement, but rather, suggested 'that law enforcement should be done in such a way that people who have problematic ice use are directed to health assistance—that it is a public health approach'.[38]

4.29 Several submitters and witnesses discussed in detail some current harm reduction approaches. The following sections address those most frequently raised in evidence to the committee.

Proposed harm reduction strategies

4.30 The committee received a large amount of evidence which suggested further investment should be made in harm reduction measures. However, as

33 NAPWHA, *Submission 29*, p. 3.

34 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray, *Submission 70*, p. 13.

35 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray, *Submission 70*, p. 13.

36 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray, *Submission 70*, p. 13.

37 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray, *Submission 70*, p. 13.

38 Ms Linda Athalie Forbes, Manager, Policy and Communications, AFAO, *Committee Hansard*, 29 July 2015, p. 15.

Mr Matthew Y Frei and Dr Wodak have observed, '[r]edefining drug use as a health and social issue within a harm reduction framework will require progressive policy'.[39]

4.31 Mr Frei and Dr Wodak stated that:

> Consideration needs to be given to supervised consumption facilities in major drug "hot spots". Drug consumption rooms have the potential to offer information about harm reduction and treatment, to decrease the risk of overdose and other drug-related morbidity, and to reduce the negative impact on neighbourhood amenity. Just as we support [NSPs], we need to evaluate the provision of ice using equipment (such as glass pipes to attract and accommodate the significant proportion of marginalised users who inhale rather than inject methamphetamine) and encourage more disaffected ice users to seek health and social assistance.[40]

4.32 The Drug Policy Modelling Program (DPMP)—a project by the National Drug and Alcohol Research Centre (NDARC) at the University of New South Wales—discussed a number of harm reduction strategies, such as:

- limiting the stigmatisation of methamphetamine use;
- peer education;
- expanding NSPs to reduce the harms associated with injecting; and
- a more nuanced portrayal of the relationship between methamphetamine use and psychosis.[41]

4.33 The Victorian Alcohol and Drug Association (VAADA), 'the peak body for alcohol and other drug (AOD) services in Victoria',[42] recommended enhancement of the capacity of emergency services to work with AOD affected populations, including with respect to activity related to harm reduction and referral.[43]

4.34 The National Association of People Living with HIV Australia recommended the implementation of the following tailored harm reduction strategies:

> A. Advocate for decriminalisation of possession and use of current illicit substances to ensure harm reduction strategies can be successfully implemented, including support for interim measures that offer a therapeutic justice approach such as expansion of drug courts and diversion programs at the state and territory levels of government.
>
> B. Increase peer-to-peer education and resources on substance use. Messaging should be culturally appropriate for subpopulations of people

39 Matthew Y Frei and Alex D Wodak, 'Beyond ice: rethinking Australia's approach to illicit drugs', *The Medical Journal of Australia*, vol. 206, no. 4, 2017, p. 152.

40 Frei and Wodak, 'Beyond ice: rethinking Australia's approach to illicit drugs', *The Medical Journal of Australia*, vol. 206, no. 4, 2017, p. 152.

41 NDARC, University of New South Wales, *Submission 16*, pp 8–10.

42 Victorian Alcohol and Drug Association (VAADA), *Submission 14*, p. 3.

43 VAADA, *Submission 14*, p. 16.

> living with HIV and include information on poly substance use, safer injecting practices and alternative routes of administration;
>
> C. Stigma-free alcohol and drug services that are sensitive to the needs of people living with HIV and the subpopulations they may be a part of including gay and bisexual men, Aboriginal and Torres Strait Islander people, and people from Culturally and Linguistically Diverse communities; and
>
> D. Increased accessibility to and enhancement of [NSPs] including increased peer-to-peer distribution networks.[44]

4.35 Mr Matthew Creamer of the Western Australian AIDS Council (WAAC) sought to 'reinforce the importance of a harm reduction framework in respect to crystal methamphetamine in Australia' and raised 'three critical points for consideration' to be used 'when determining a harm reduction response to addressing community needs while delivering lasting outcomes':

- first, 'the need for an evidence-based response to the harms related to methamphetamine';
- second, that 'the evidence does not support the case that the number of users has increased', rather evidence demonstrates 'that there is higher usage amongst specific subpopulations'; and
- finally, that:

> …negative media attention on similar and related health issues, such as HIV perhaps or hepatitis or other chronic health conditions, impede health promotion activities, prevention initiatives and access to suitable health care and treatment options.[45]

4.36 The following sections examine some of the most significant harm reduction strategies suggested to the committee.

Messaging and stigma

4.37 Users of crystal methamphetamine are often the subjects of stigma, which may affect their willingness to seek assistance. For example, it was suggested to the committee that the 'well-intentioned harm minimisation program, "ice ruins lives"', has stigmatised crystal methamphetamine users, as '[p]eople are portrayed in those commercials as being off their head, punching everybody and being this, that and the other'.[46]

4.38 The NAPWHA considered that this particular campaign 'uses fear to stigmatise substance users, which may discourage people from seeking medical assistance', and instead advocated for:

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44 NAPWHA, *Submission 104*, p. 2.

45 Mr Matthew Creamer, Manager, Health Promotion, WAAC, *Committee Hansard*, 3 May 2017, pp 49–50.

46 Mr Anthony Maynard, Treataware Project Officer, NAPWHA, *Committee Hansard*, 29 July 2015, p. 22.

> A more compassionate approach with the community [which] could encourage reaching out to those who might be seeking help for their substance misuse. The image of a person affected by methamphetamine in an emergency department having a physical brawl with the police does not positively reinforce the notion of being able to seek help without intervention by law enforcement.[47]

4.39 In order to avoid creating such stigmatisation, the AFAO suggested learning from the experience with HIV and advocated that the 'primary driver of the response to problematic ice use' should be 'a national strategy that frames the response around public health and harm reduction, with health promotion targeting affected communities', elaborating:

> It is targeting that the HIV sector has learnt well and which applies. A failure to target was the problem with the initial response to HIV in Australia with the Grim Reaper campaign. We see similarities between what has been on television recently regarding ice and the Grim Reaper. The problem is that that sort of stuff does stigmatise communities that are truly affected by HIV and what can be related problems with problematic ice use. The big issue here is not to stigmatise and drive underground affected communities. It is to ensure that people in those communities are confident coming forward for treatment.[48]

4.40 The VAADA also recognised the 'need to ensure that adequate harm reduction measures and messaging are in place' for large populations that are in need of, but do not access treatment,[49] recommending that:

> This messaging must be evidence based and delivered in a manner and format which is accessible to at risk populations and AOD consumers. Credible messaging such as the least harmful means of consumption, highlighting potential risks associated with poly substance use, provision of sterile injecting equipment, hydration and reinforcing means of reducing harms through unsafe sexual practices must be accessible to all at risk populations. Ensuring that this messaging is available and accessible to at risk population is key to reducing the harms associated with this substance.[50]

4.41 While the National Drug Research Institute (NDRI) at Curtin University stated that '[m]ass media campaigns in isolation are not generally recommended for issues that affect a relatively small proportion of the population' as this may 'increase interest and uptake', it noted that evidence also suggests that 'mass media campaigns can be made effective' and 'are most likely to have impact if complemented by':

> …(i) other evidence based strategies that prevent drug problems emerging and developing; (ii) targeted strategies that aim to reach sub-populations

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47 NAPWHA, *Submission 104*, pp 4–5.

48 Ms Forbes, AFAO, *Committee Hansard*, 29 July 2015, pp 14–15.

49 VAADA, *Submission 14*, p. 14.

50 VAADA, *Submission 14*, p. 14.

> most at risk, particularly early in the development of problems to encourage them to seek treatment; and, (iii) a range of appropriate treatment options from brief and early intervention, to upskilling community-based services (such as GPs, community clinical psychologists) to respond, as well as enhancement and development of specialist AOD services and mental health services for those experiencing more severe problems. Targeted interventions are important because there are diverse needs among: those who don't use; those who use occasionally; those with severe problems; families; those who use in connection with their employment; those who use in the context of sexual risk taking; those in Aboriginal and Torres Strait Islander communities, etc.[51]

4.42 In respect of targeting sub-populations, Dr Louise Roufeil of the Australian Psychological Society (APS) informed the committee of the approach she would take as an academic:

> …the first thing I would do is go and ask them what is going to make the difference. I think part of the problem is that we do not know. I certainly, as a 54-year-old person working inner-city Melbourne, do not know what the message is that is going to get through to those young people. I think the answer is we have to ask them. That is the only way we are going to get messages that are going to appeal to them and make a difference. The message that gets through to them will not be the same as gets through to the FIFO worker who is using on their weak off. It is not going to be the same message as gets through to the recreational user on the weekend either. They are going to be three different messages. It is perhaps easier for us to understand what is going to work for the FIFO worker than what is going to help the 15-year-old not just in what the message is but also the medium through which it is delivered. It may not be TV.[52]

4.43 The NDRI also stated that 'the terms in which public debate about methamphetamine is being conducted' is a key issue that is 'not yet receiving enough attention'.[53] The NDRI considered that:

> Because of heightened public concern, great care needs to be taken when discussing methamphetamine use and its impact on the community (Moore & Fraser, 2015), which varies according to the very diverse patterns and contexts of its use and related problems.[54]

Media reporting guidelines

4.44 To help facilitate greater care and ensure appropriate, targeted and de-stigmatised messages are communicated to the public about AOD issues, the NDRI advocated for the implementation of media reporting guidelines.

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51 National Drug Research Institute (NDRI), Curtin University, *Submission 113*, pp 5–6.

52 Dr Louise Roufeil, Executive Manager Professional Practice, Australian Psychological Society (APS), *Committee Hansard*, 27 July 2017, p. 55.

53 NDRI, *Submission 10*, p. 21.

54 NDRI, *Submission 10*, p. 21.

4.45 Nationally endorsed media guidelines could be used to 'educate and inform discussions of methamphetamine and other drug issues in the public sphere', for use by, for example, 'journalists, policy makers and practitioners':

> This is important, because, notwithstanding the human rights issues, stigma and marginalisation can contribute to a low perception of risk ("I'm not like that"), reduced likelihood of treatment seeking and disinclination to offer support by clinicians. Standards of reporting, such as those in place in Australia for reporting suicide or depression, could be developed to reduce the risk that media commentary and indeed prevention strategies unintentionally contribute to stigma and discrimination that in turn result in poorer public health outcomes.[55]

4.46 The implementation of a similar strategy has been previously achieved by the Australian Press Council's (APC) Specific Standards on Coverage of Suicide (the Standards). The Standards are a set of legally binding guidelines to be upheld by members of the APC. The Standards 'are concerned with the coverage of suicide and related issues in print and online media'.[56]

4.47 The Standards are based on:

> …a body of research evidence that indicates that the way suicide deaths are reported in the media can have an impact on rates of suicidal behaviour in the community (through suicide deaths, attempts and ideation).[57]

4.48 The Standards are available at Appendix 1 in their entirety, but in summary include:

- General reporting guidelines on issues relating to suicide, how to improve the public's understanding of the issue, warning signs, deterrence measures for those contemplating suicide, and support for families and friends affected by suicide. The Standards also specify that caution is required for material that is likely to be read or seen by vulnerable people (in particular if it relates to peers or celebrities).
- Reporting of suicide, including identification of the individual, must only be done if at least one of the following criteria is satisfied:
    - clear and informed consent by relatives or close friends; or
    - identification of the individual is in the public interest.

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55 NDRI, *Submission 10*, p. 21.

56 Australian Press Council (APC), *Specific Standards on Coverage of Suicide*, 2 August 2011, p. 1.

57 The Royal Australian & New Zealand College of Psychiatrists, *Position Statement 70: Suicide Reporting in the Media*, August 2015, p. 1, available: https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/ps70-pdf.aspx (accessed 6 March 2018).

- Restrictions on the reporting of the method and location of a suicide, unless it is in the public interest to do so and outweighs the risk of causing further suicides.
- Reporting of suicide should not be sensationalised, glamorised or trivialised. Further, the media should not inappropriately stigmatise suicides or people involved in them and if appropriate, underlying causes such as mental illness should be mentioned.
- Media reports of suicide should not be given undue prominence (such as explicit headlines or images) and care should be taken to avoid harming those who have attempted suicide. And,
- Articles with material that relates to suicide must be accompanied by information about appropriate 24-hour crisis support services and other sources of assistance.[58]

Committee comment

4.49 The committee recognises that government messaging and media coverage, if implemented effectively, could significantly reduce the harm associated with the use of crystal methamphetamine by prompting drug users to seek treatment.

4.50 The committee is therefore concerned by evidence that government messaging and media coverage can stigmatise users of crystal methamphetamine. The use of stigmatising language, especially if it is sensationalised, marginalises drug users by reinforcing negative stereotypes. The result is discouragement of drug users seeking assistance for their AOD issues, to their detriment.

4.51 Instead of governments and the media using stigmatised messaging to deter illicit drug use, the committee supports an approach that engenders compassion towards drug users, and is targeted at and informs those people with the objective of encouraging them to seek treatment and support.

Recommendation 9

4.52 The committee recommends that the Commonwealth government ensures that future public awareness campaigns engender compassion towards drug users, and are targeted at and inform those people with the objective of encouraging them to seek treatment and support.

4.53 Indeed, lessons can be learnt from the national HIV campaign and the media guidelines about suicide. The implementation of the APC's Standards provide an excellent model for governments and media agencies to develop appropriate and compassionate coverage of drug-related content. The committee is therefore supportive of measures that:

- Provide general reporting guidelines on issues relating to drug use, measures to improve the public's understanding of why people use drugs, deterrence initiatives and support for families, friend and communities.

58 APC, *Specific Standards on Coverage of Suicide*, 2 August 2011, pp 1–2.

- Restrict media reporting that sensationalises, glamorises or trivialises drug use, and require reporting that does not stigmatise people who use drugs.
- Target at-risk individuals and communities. And,
- Require media reporting of drug use and related issues to be accompanied by information about AOD treatment services.

4.54 The committee recommends that the Australian Press Council develops and implements media reporting standards for coverage of drug use.

Recommendation 10

4.55 The committee recommends that the Australian Press Council develops and implements media reporting standards for coverage of drug use.

Education

4.56 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray suggested that health education, as a form of harm reduction, 'is considered a more beneficial, safe and effective approach to reducing the demand for illicit drugs like methylamphetamine, or at best reducing associated risky behaviours'.[59] They explained that:

> Education is fundamental for those drug users who are unlikely to cease use because it enables harm reduction to the user and the wider community. It encourages safer injecting and drug-taking practices and increases user exposure and access to much needed health services. Although there is yet to be rigorous evidence that education injecting drug users about HIV or associated drug issues helps to reduce the spread of such infections, it is considered a plausible and inexpensive strategy (Wodak & Maher, 2010). Evidence from US trials indicates behavioural interventions such as peer-education programs are proving beneficial for reducing the risk of HIV and hepatitis C acquisition (Garfein et al., 2007) (Latka et al., 2008).[60]

4.57 Peer education—'learning from one's peers' via 'spontaneous informal peer education; intentional informal peer education; or formal peer education'[61]—was also raised by a number of submitters and witnesses as an effective harm reduction strategy.[62]

4.58 For example, the Australian Injecting and Illicit Drug Users League argued that 'the lived experience of people who use or who have used methamphetamine is the greatest and perhaps most underutilised resource in creating effective responses to methamphetamine-related harms', elaborating:

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59 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray, *Submission 70*, p. 13.

60 Dr Goldsworthy and Adjunct Teaching Fellow McGillivray, *Submission 70*, p. 13.

61 DPMP, *Submission 16*, p. 9.

62 See for example, NSW Users and AIDS Association, *Submission 91*, p. 3; NAPWHA, *Submission 104*, p. 2.

> When implemented alongside other harm reduction initiatives, such as needle and syringe programs and opioid substitution therapy, peer-based responses of the community of people who use drugs in Australia has achieved some globally significant results…We have evidence that harms to the broader community are better managed through greater social inclusion, peer education and service responsiveness. This is backed up by the UN and WHO, who have consistently identified peer-based organisations as the best practice when working with highly marginalised people—particularly people who use drugs.[63]

4.59 Indeed, the DPMP highlighted that '[r]esearch in the drugs field has shown that peer education has been effective for mobilising change', referring to research from the United States and the United Kingdom, and submitted that:

> Peer education approaches have been shown to be effective for reaching people who may not be reached through other avenues (and, as such, can be used in such a way to link them with mainstream services) (AIVL, 2006). Peers may be regarded as more credible and trustworthy sources of information as they 'speak the same language' which is important for communication in situations where people may feel stigmatised (AIVL, 2006). Moreover, accumulated research evidence demonstrates that peer education and outreach interventions are effective for reaching people who use drugs who are not currently engaging with treatment (WHO, 2004) and is regarded as cost effective due to the use of volunteers (UNAIDS, 1999).[64]

4.60 The Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC) argued that a current gap in AOD policies, processes, program design and evaluation is the AOD users' voice.[65] The ATDC argued that a requirement of good policy is that it:

> …involves top down (expert) and bottom up (constituency, service user) perspectives working together. Ostensibly service users act to put a 'real world' perspective to research and expert opinion, ensuring that services are responsive and appropriate. *Any* approach that does not involve bottom up processes at each stage – from design to implementation to evaluation - will be, by its nature, compromised. The [AOD] consumer voice is not an optional 'add-on'- to the [AOD] service system, it is a critical part.[66]

4.61 The ATDC stated that without AOD users' perspectives, the policy making process and AOD treatment services are 'hampered in their quest for appropriate service provision'.[67]

4.62 Another harm reduction initiative, the Penington Insitute's Anex Bulletin, plays an important part in promoting drug education and harm reduction initiatives.[68]

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63 Ms Annie Madden, Executive Officer, AVIL, *Committee Hansard*, 25 November 2015, pp 6–7.

64 DPMP, *Submission 16*, p. 9.

65 Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC), *Submission 97*, p. 3.

66 ATDC, *Submission 97*, p. 3.

67 ATDC, *Submission 97*, p. 3.

This publication provides front line health professionals 'with the latest research and evidence-informed strategies on illicit drugs'.[69]

4.63 The committee had been informed that Commonwealth funding to the Anex Bulletin had been discontinued;[70] however, on 31 October 2017, the Penington Institute received notification that the DoH had extended its funding until June 2019.[71]

Committee comment

4.64 The committee recognises the benefits of education for decreasing the demand for and risks associated with the use of crystal methamphetamine. Evidence to the inquiry demonstrates AOD education services, when combined with peer-education, are an effective tool to address AOD use and target at-risk populations.

4.65 In addition to peer-education, the committee supports the ATDC's call for AOD consumers' perspectives to be integrated into the development and evaluation of AOD policy and treatment services. Failure to engage with illicit drug users' experiences in the AOD treatment system may undermine attempts by governments and services providers to develop effective treatment and harm reduction measures.

4.66 The committee supports the Penington Institute's Anex Bulletin and is pleased that the DoH has continued to fund it to 2019.

Needle and syringe programs

4.67 A number of submitters and witnesses supported an increased focus on needle and syringe programs (NSPs),[72] a harm reduction strategy which provides:

> …a range of services that aim to prevent the transmission of BBVs, including the provision of sterile injecting equipment, safer sex materials, information and education on reducing harms associated with injection drug use and referral to a range of health and welfare services. Injecting equipment provided by NSPs primarily includes sterile needles and syringes and containers for the safe disposal of used injecting equipment, and may also include other injecting equipment such as alcohol swabs and ampoules of sterile water.[73]

4.68 The first NSP in Australia began as a pilot program in Darlinghurst, Sydney, on 12 November 1986 in breach of the (then) provisions of the *Drugs Misuse and Trafficking Act 1985* (NSW):

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68 Penington Institute, *Submission 26*, p. 27.

69 Penington Institute, *Submission 26*, pp 27–28.

70 Penington Institute, *Submission 26*, p. 27.

71 Penington Institute, *In brief*, http://www.penington.org.au/anexbulletin/in-brief-3/ (accessed 23 February 2018).

72 See for example, AIVL, *Submission 34*, p. 5; DPMP, *Submission 16*, p. 9.

73 The Kirby Institute, *Needle and Syringe Program National Minimum Data Collection: National Data Report 2016*, 2016, p. 3.

> Those involved in the pilot argued that HIV was already being rapidly transmitted among [people who inject drugs (PWID)] in the community, supporting this claim with data from a survey of HIV among PWID in Sydney (Blacker, Tindall, Wodak, & Cooper, 1986). Subsequently, a study supported the case for a pilot involving the testing of returned syringes, which showed an increase in HIV prevalence over time (Wolk et al., 1988).[74]

4.69 Subsequently, in 1987, the New South Wales (NSW) government 'agreed…to begin establishing a needle and syringe program throughout NSW', a move that was followed in other states and territories such that 'by late 1988 a national NSP system was operating across Australia'.[75]

4.70 In 2015-16, 'Australia's network of NSP services was comprised of 102 primary, 786 secondary and 2,321 pharmacy NSPs…supplemented by 300 syringe dispensing machines (SDMs)'.[76]

4.71 Some submitters and witnesses also gave evidence about NSP programs in specific jurisdictions.

4.72 For example, the South Australian government set out the work it is undertaking in respect of NSPs:

> South Australia's Clean Needle Program provides access to sterile injecting equipment and other harm reduction services at a range of sites across the state. Clean Needle Program statistics indicate that amphetamines are the most commonly injected drug among the program's clients, with 46.6% of contacts in 2012-2013 identifying amphetamines as the intended drug to be injected (in the same period opiates accounted for 36.7%). Clean Needle Program sites include participating non-government organisations, pharmacies, non-metropolitan hospital emergency departments, and outreach services (e.g. for at-risk groups). In Adelaide clients can access sterile injecting equipment after-hours through vending machines and a primary Clean Needle Program site which operates 24 hours 7 days a week.
>
> SA Health's Clean Needle Program Peer Education project, delivered by Hepatitis SA, works to successfully engage identified priority populations in harm reduction strategies and aligns with the prevention actions within the National Hepatitis C Strategy 2014–2017.[77]

4.73 In Western Australia (WA), the Mental Health Commission (MHC) developed a 'key planning tool for the mental health, alcohol and other drug sector': the *Western Australian Mental Health, Alcohol and Other Drug Services Plan*

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74 Ms Annie Madden and Dr Alex Wodak, 'Australia's Response to HIV Among People Who Inject Drugs', *AIDS Education and Prevention*, vol. 26, no 3, 2014, p. 238.

75 Ms Madden and Dr Wodak, 'Australia's Response to HIV Among People Who Inject Drugs', *AIDS Education and Prevention*, vol. 26, no 3, 2014, p. 238.

76 The Kirby Institute, *Needle and Syringe Program National Minimum Data Collection: National Data Report 2016*, 2016, p. 1.

77 South Australian Government, *Submission 78*, p. 15.

2015-2025 (the Plan).[78] The Plan identifies harm reduction strategies, such as NSPs, as 'a long-standing, public health community support response for people with alcohol and other drug problems',[79] and aims to:

> Continue to expand harm-reduction services and further develop a high quality, personalised, effective and efficient community support service sector that provides individuals with support to create or rebuild a satisfying, hopeful and contributing life and provides carers, and families with support for their own wellbeing.[80]

4.74 One such community support service in WA is the WAAC NSP, which has been operating for over 28 years[81] and is used by 5000 individuals per annum.[82] Mr Creamer of the WAAC informed the committee that:

> Around 50 per cent of our clients regularly report methamphetamine as the last drug they injected. Many of our clients are very long-term. Importantly, the nature of our exchange service means that injecting equipment is returned to us for disposal rather than discarded. We have a 94 per cent exchange rate resulting in improved public health and community health outcomes. Other services delivered by us to marginalised and vulnerable individuals include one-on-one counselling, care and support with individual clients who many report methamphetamine or problematic methamphetamine use.[83]

4.75 As indicated above, funding for NSPs has a significant return on investment. Indeed, Hepatitis NSW noted that from 2000 to 2009, it is estimated that 'NSPs…directly averted' 32 050 new HIV infections and 96 667 new Hepatitis C infections.[84]

4.76 In its submission, Hepatitis NSW called for 'strengthening the NSP', which 'should be a focus of any response to injecting drug use in Australia, including crystal methamphetamine use', as:

> With new hepatitis C treatments currently being considered by the Commonwealth Government that are both more effective, but also more expensive, than the existing standard of care, the cost effectiveness of

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78 Government of Western Australia, *The Plan 2015 – 2025*, http://www.mentalhealth.wa.gov.au/about-us/strategic-direction/the-plan-2015-2025#main (accessed 23 November 2017).

79 Mental Health Commission, Government of Western Australia (MHC), *Better Choices. Better Lives.: Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, 2015, p. 36.

80 MHC, *Better Choices. Better Lives.: Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, 2015, p. 38.

81 Mr Creamer, WAAC, *Committee Hansard*, 3 May 2017, p. 49.

82 Mr Creamer, WAAC, *Committee Hansard*, 3 May 2017, p. 51.

83 Mr Creamer, WAAC, *Committee Hansard*, 3 May 2017, p. 49.

84 Hepatitis NSW, *Submission 38*, p. 3 (citations omitted).

> additional investment in, and expansion of, the needle and syringe program would likely be even higher today.[85]

4.77 The Penington Institute described NSPs as 'a key public health intervention to reduce the social and health burden of injecting drug use and the resurgence of crystal methamphetamine use brings new challenges to this sector'.[86] The Penington Institute discussed some shortcomings with respect to the current operation of NSPs, including that they are 'a one size fits all approach':

> There are numerous populations who inject that are less likely to access these services including women, young people, culturally and linguistically diverse populations, people who identify as ATSI and people who identify as gay or lesbian. NSPs require more consumer focused service delivery in order to ensure they meet the needs of diverse populations providing them with targeted harm reduction information and appropriate sterile injecting equipment.[87]

4.78 Further, the Penington Institute noted that, at present, 'there are no minimum training requirements for workers within the NSP sector in Australia', which is problematic because:

> …NSPs are typically accessed by people with a range of complex social and health needs including poverty, homelessness and mental health issues. Further, NSPs may be the only contact injectors have with the health system. It is thus essential that the NSP workforce has the capacity to provide appropriate and prompt referral and health advice as well as consistent, high quality and relevant information and support.[88]

4.79 The Penington Institute also identified that '[s]econdary NSP outlets are important services for people who use methamphetamine', as they 'play a vital role in regional and rural communities where there are fewer primary NSP'.[89]

4.80 The Penington Institute continued:

> …as secondary NSP outlets may be an adjunct to more mainstream services (such as community health services), there is the possibility that they are accessed by methamphetamine users who may not have contact with primary services. However, additional support is required for secondary NSP so that they may play a far greater role in brief counselling interventions and referral to other services, particularly AOD counselling and Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into Crystal Methamphetamine treatment. Until it is possible to have NSP-specific staffing permanently located at every NSP outlet, some

85 Hepatitis NSW, *Submission 38*, p. 3.

86 Penington Institute, *Submission 26*, p. 28.

87 Penington Institute, *Submission 26*, p. 28.

88 Penington Institute, *Submission 26*, p. 28.

89 Penington Institute, *Submission 26*, p. 28.

> level of dedicated NSP-trained support is needed at every NSP outlet across the system, commensurate with the level of NSP activity.[90]

4.81 The Penington Institute therefore made a number of recommendations to address these issues, including that resources for NSP workforces across Australia should be increased; and that 'strategies to provide 24-hour access to sterile injecting equipment such as NSP Secure Dispensing Units and outreach' should be developed and implemented.[91]

4.82 The AVIL noted 'a distinct lack of focus on those methamphetamine users who inject, as opposed to those who only smoke the drug'.[92] In terms of injecting crystal methamphetamine, the AVIL warned that:

> People who inject methamphetamine, as with any drug, are at an increased risk of [BBVs] including hepatitis C and HIV, and a variety of injecting related problems such as abscesses, vein collapse and localised infections. While harm reduction services exist in all major Australian cities, these have historically been targeted more towards opioid users; but now is the time to increase their capacity to address the issues related to methamphetamines.[93]

4.83 As noted in chapter 2, AIHW data shows that since 2009–10 there has been a significant increase in the number of people consuming amphetamines intravenously.[94]

4.84 Despite evidence being 'sparse', the committee heard that there are also risks associated with smoking ice, although the outlawing of glass pipes—which has occurred in NSW—is 'not in the spirit of harm reduction':[95]

> …glass pipes used to smoke crystal meth can sometimes involve cracked pipes and bleeding of the mouth and gums, and there is a potential [for hepatitis C] transmission risk there as well.[96]

4.85 The Scarlet Alliance raised the difficulty faced by prisoners who are dependent on crystal methamphetamine, and the inadequacy of the government response:

> Anecdotal evidence suggests that banning smoking in prisons is producing negative unintended consequences. Many prisoners chose to smoke rather than inject drugs in the prison setting to avoid contracting BBVs. Prisoners are switching to injecting due to the unavailability of lighters due to the implementation of no-smoking policies in prisons across Australia. Given

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90 Penington Institute, *Submission 26*, pp 28–29.

91 Penington Institute, *Submission 26*, p. 29.

92 AIVL, *Submission 34*, p. 5.

93 AIVL, *Submission 34*, p. 5.

94 See chapter 2, pp 12–15.

95 Mr Loveday, Hepatitis NSW, *Committee Hansard*, 29 July 2015, p. 60.

96 Mr Loveday, Hepatitis NSW, *Committee Hansard*, 29 July 2015, p. 57.

> the existing environment in Australian prisons, where there is no harm reduction approach and no [NSPs], the risk of transmission of BBVs is further increased.[97]

4.86 This was also reflected in the evidence from the AIDS Council of NSW:

> The need for safe injecting equipment is particularly clear in custodial settings with increasing rates of hepatitis C, particularly among Aboriginal and Torres Strait Islander people (The National Hepatitis C Strategy notes that 43% of Aboriginal and Torres Strait Islander people in custody are living with hepatitis C). There are currently no NSPs operating in any Australian prisons, despite growing evidence they are 'safe, beneficial and cost-effective' (Duvnjak, Wiggins and Crawford, 2016).[98]

Committee comment

4.87 The committee acknowledges the success of NSPs in reducing rates of infectious disease amongst injecting drug users, and the increasing number of crystal methamphetamine users accessing these services. The committee recognises that some of the risks faced by injecting users of crystal methamphetamine are reduced by NSPs, and supports the continued provision of these programs.

Safe injecting rooms

4.88 Australia's only medically supervised injecting centre (MSIC) in Kings Cross, NSW is a form of harm reduction strategy which 'is a compassionate and practical health service that seeks to connect with people and welcome them in a non-judgemental, person-centred way'.[99] As discussed in the following section, there are also plans to open a MSIC in Richmond, Victoria.

New South Wales

4.89 Australia's first MSIC opened in Kings Cross on 6 May 2001.[100] To this day, it is the only MSIC operating in the southern hemisphere.[101] This MSIC initially operated on a trial basis, with the following objectives:

> …to decrease drug overdose deaths; provide a gateway to drug treatment and counselling; reduce problems associated with public injecting and

97 Scarlet Alliance, *Submission 12*, p. 4.

98 AIDS Council of NSW (ACON), *Submission 102*, p. 5.

99 Uniting, *What the Uniting MSIC does*, https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/what-the-uniting-sydney-msic-does (accessed 27 November 2017).

100 Uniting, *The MSIC story*, https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/our-story (accessed 27 November 2017).

101 Uniting, *The MSIC story*, https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/our-story (accessed 27 November 2017).

> discarded needles and/or syringes; and reduce the spread of disease such as HIV and Hepatitis C.[102]

4.90 In 2010, and as a result of the success of the MSIC in Kings Cross, the NSW Parliament legislated for this MSIC to operate on an ongoing basis.[103]

4.91 Kings Cross MSIC provides services to users of substances including 'heroin, cocaine, prescription pain medication such as oxycodone and morphine, methamphetamines and benzodiazepines'.[104] To access the MSIC, clients must:

- be an injecting drug user;
- be 18 years of age or over;
- not be pregnant or accompanied by a child; and/or
- not be intoxicated.[105]

4.92 The benefits of the MSIC are set out in a KPMG evaluation report covering the MSIC's extended trial period from June 2007 to April 2010.[106] Previous independent evaluations and analyses commissioned by the NSW government, since the commencement of the trial in 2001, found:

> …that the MSIC positively impacts on clients, has a high level of support from local residents and businesses, has not been shown to cause an increase in local crime or drug use and saves at least $658,000 per annum over providing similar health outcomes through other means in the health system.[107]

4.93 The KPMG evaluation of the extended trial period found that:

- in respect of clients, 'the MSIC has reached a socially marginalised and vulnerable population group of long-term injecting drug users'; and

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102 KPMG, *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011): Final report*, 14 September 2010, p. ix.

103 Uniting, *Cross currents: The story behind Australia's first and only Medically Supervised Injecting Centre*, 2014, pp 32–33.

104 Uniting, *Cross currents: The story behind Australia's first and only Medically Supervised Injecting Centre*, 2014, p. 43.

105 Uniting, *Inside Uniting MSIC*, https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/inside-the-medically-supervised-injecting-centre (accessed 27 November 2017).

106 KPMG, *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011): Final report*, 14 September 2010.

107 KPMG, *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011): Final report*, 14 September 2010, p. ix.

- the trend in visits 'has remained relatively stable, with a modest downwards trend', consistent with findings from previous evaluations and the objectives of the trial.[108]

4.94 KPMG concluded that its findings are consistent with and build upon those findings in previous evaluation reports; that is, there is an overwhelming benefit of this service to both users and the community:

> The MSIC provides a service for, and was utilised by a socially marginalised and vulnerable population group, many of whom had not previously accessed drug treatment or support services.
>
> The MSIC provides a safe injecting environment and has a record of managing overdose events. Findings indicate that the MSIC provides a service that reduces the impact of overdose-related events and other health related consequences of injecting drug use for MSIC clients, and provides access to drug treatment with a high degree of uptake of referrals.
>
> Since the commencement of the MSIC, data sources indicate that there has been a decline in the total number of discarded needle and syringes collected in the vicinity of the MSIC and reduced sightings of public injecting. Results from a random survey of local Kings Cross residents and business operators indicate that there is strong support for the MSIC that has trended upwards over time. There was also consistent support for the MSIC voiced by relevant local service system representatives during interview (including NSW Ambulance, local Emergency Departments, NSW Police, public and private alcohol and drug services and mental health services). Further, interviews conducted with current and former clients of the MSIC described the positive impact of the MSIC's services.[109]

Victoria

4.95 On 31 October 2017, after initially opposing the establishment of an MSIC in that state,[110] the Victorian government announced an $87 million *Drug Rehabilitation Plan*, which 'builds on the work done through the *Ice Action Plan* to save lives, treat users, keep our streets safe, and to crack down on dealers'.[111]

4.96 This plan includes 'an initial two year trial of a medically supervised injecting room at the North Richmond Community Health Centre' which will commence

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108 KPMG, *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011): Final report*, 14 September 2010, p. ix.

109 KPMG, *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011): Final report*, 14 September 2010, p. xi.

110 AAP, 'Sydney injecting room a success: PM', *SBS*, 24 February 2017, http://www.sbs.com.au/news/article/2017/02/24/sydney-injecting-room-success-pm (accessed 27 November 2017).

111 The Hon. Daniel Andrews MP, Premier, 'More rehab beds, better treatment and safer streets', *Media Release*, 31 October 2017, p. 1.

operation in June 2018, with 'an option to extend the trial for a further three years'.[112] It also includes the establishment of '[n]ew residential rehabilitation facilities…in key regional areas to stop the devastating effects of ice and other drugs in communities across the state'.[113]

4.97 However, while the MSIC will be available to heroin users under medical supervision, and builds on the Victorian government's *Ice Action Plan*, 'the government has vowed to keep the drug ice out of the two-year trial'[114] at the North Richmond Community Health Centre as '[i]t's a different type of drug and a different type of risk…comes with it'.[115]

Committee comment

4.98 The committee recognises the important role the MSIC in Kings Cross in providing injecting drug users with a safe place to inject drugs. The MSIC also facilitates engagement with health professionals and access to treatment services with a high rate of uptake of referrals.

4.99 The committee welcomes the announcement by the Victorian government to introduce a MSIC in Richmond but suggests that access to this facility should not be limited to heroin users.

Harm reduction and the darknet

4.100 In addition to the harm reduction measures outlined above, the committee received evidence, as part of its inquiry into the impact of new and emerging information and communication technology on Australian law enforcement agencies, about harm reduction and trade in illicit drugs on the darknet. A submission from Dr James Martin, a senior Lecturer in Criminology at the Department of Security Studies and Criminology at Macquarie University, argues that 'Australian drug policy should aim to reduce drug related harms by ensuring that illicit drug markets function as safely as possible'.[116]

4.101 Dr Martin recognised that a logical response to the darknet's facilitation of drug trading is to enhance police resources and powers; however, he advised that research 'indicates that such a response would be costly, ineffective and likely to

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112 The Hon. Daniel Andrews MP, Premier, 'More rehab beds, better treatment and safer streets', *Media Release*, 31 October 2017, p. 1.

113 The Hon. Daniel Andrews MP, Premier, 'More rehab beds, better treatment and safer streets', *Media Release*, 31 October 2017, p. 1.

114 Noel Towell and Benjamin Preiss, 'Ice won't be allowed in Melbourne safe injecting room', *The Age*, 31 October 2017, http://www.theage.com.au/victoria/ice-wont-be-allowed-in-melbourne-safe-injecting-room-20171031-gzbydr.html (accessed 21 November 2011).

115 Noel Towell and Benjamin Preiss, 'Ice won't be allowed in Melbourne safe injecting room', *The Age*, 31 October 2017, quoting Mental Health Minister Martin Foley.

116 Dr James Martin, Senior Lecturer, Macquarie University, Submission to the Parliamentary Joint Committee on Law Enforcement (PJCLE), Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 3.

amplify, rather than reduce, a range of drug-related harms'.[117] Instead of pursuing a law enforcement response to this issue, Dr Martin made three recommendations that prioritise a harm reduction approach.

4.102 Dr Martin's first recommendation is for law enforcement agencies to de-prioritise investigations into 'darknet drug trading in comparison to conventional, street/inter-personal based drug trading' because the darknet drug trade 'is a safer, less harmful alternative for drug users'.[118] Dr Martin asserted that a drug user is not only more physically safe, but the drugs sourced through the 'darknet tend to be better quality and less adultered than drugs available via conventional means' and that:

> Customers have better access to information regarding the drugs they consume, as well more knowledge regarding safer usage practices than they would if purchased via conventional means.[119]

4.103 User feedback systems, similar to those used by Uber and Airbnb, provide drug users with information about the drugs they wish to purchase. Drug dealers also provide drug users with information about the strength and composition of the drugs they sell. Dr Martin noted that this system is 'far from perfect' but is 'preferable to the complete lack of knowledge consumers typically have when purchasing drug via conventional means'.[120] Drug user forums are also available for users to 'share information regarding safer usage practices'.[121] Dr Martin also argued that the darknet provides drug dealers with physical safety and anonymity thus reducing their 'exposure to violence at the hands of customers, competitors and other predatory criminals'.[122]

4.104 Dr Martin recommended that governments ensure that sentences imposed upon individuals found guilty of darknet drug trading do not exceed the penalties

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117 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 2.

118 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 3.

119 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 4.

120 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 4.

121 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 4.

122 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 5.

'imposed for conventional dealing offences of a similar scale'.[123] He warned that harsher penalties would create an 'incentive for dealers to engage in conventional, offline dealing that is associated with increased harms to the public'.[124]

4.105 Finally, Dr Martin recommended the prioritisation of 'demand and harm reduction drug strategies over supply-side intervention strategies'.[125] He was critical of the Commonwealth government's attempts to restrict supply of drugs via postal screening facilities, and argued that this does not deter online dealers, who implement more sophisticated practices to conceal drug consignments.[126] Further, Dr Martin contended that restricted importation of drugs via the darknet forces drug users to:

> …simply preference a domestic online or street dealer as an alternative source. Perversely, enhanced mail screening therefore protects the profits of local dealers and the organised crime groups who supply them, who are able to capitalise on the reduced foreign competition inadvertently afforded to them by Australian border protection agencies.[127]

Committee comment

4.106 The committee acknowledges the evidence of Dr Martin to the inquiry into the impact of new and emerging information and communication technology on Australian law enforcement agencies. His submission highlights the need for governments and law enforcement agencies to consider how the trade in illicit drugs via the darknet influences drug supply and demand in Australia.

123 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 5.

124 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 6.

125 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 6.

126 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 6.

127 Dr Martin, Macquarie University, Submission to the PJCLE, Inquiry into the Impact of New and Emerging Information and Communication Technology on Australian Law Enforcement Agencies, *Submission 9*, p. 6.

Chapter 5

Funding of alcohol and other drug services

5.1 This chapter reviews additional funding for the alcohol and other drug (AOD) treatment sector announced as part of the National Ice Action Strategy (NIAS). It also considers evidence regarding:

- the rollout and preparatory work required of the Public Health Networks (PHNs) to distribute NIAS funding;
- the formula used to determine the allocation of funding to PHNs and concerns that sufficient funding has not been allocated to regions with more problematic crystal methamphetamine use;
- the timing of the funding rollout and the short timeframe provided for AOD service providers to apply for NIAS funding;
- delays with the distribution of NIAS funding; and
- transparency of the funding arrangements.

5.2 The chapter concludes with a brief consideration of AOD funding more broadly, and concerns expressed by submitters and witnesses that funding to the AOD sector remains insufficient, particularly across the three pillars of the National Drug Strategy (NDS) (demand, supply and harm reduction). Finally, the chapter considers the use of the Confiscated Assets Account (CAA) under the *Proceeds of Crime Act 2002* (PoC Act) for drug treatment and diversionary measures.

National Ice Action Strategy funding

5.3 A core component of the NIAS was the announcement of $241.5 million in additional funding to PHNs for procuring AOD treatment services. In advance of funding being allocated, the PHNs undertook a planning and consultation process to increase their understanding of local AOD services and community needs.[1] The DoH required each PHN to complete a regional needs assessments and drug and alcohol treatment activity work plan, which identified the AOD treatment activities to be funded under the new model.[2]

5.4 In a PHN circular from February 2016, the DoH explained that there would be a phased implementation of the NIAS funding model. During this time, pre-existing

1 Department of Health (DoH), *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Circular1_AOD (accessed 21 July 2017).

2 DoH, *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016.

Commonwealth funded AOD services had their contracts extended for a further 12 months to the end of 2016–17.[3]

5.5 An important consideration for the DoH was how to distribute the $241.5 million funding to the PHNs. The circular stated that the DoH was looking at implementing a distribution model consistent with the existing funding methodology for PHNs.[4] The DoH would also target vulnerable population groups in most need of AOD treatment services.[5]

5.6 The DoH explained to the committee that the formula for allocating funds to each PHN was informed by the 2011 Census data,[6] and allocated:

> …on the basis of population rurality—the degree to which there were rural and regional populations in a particular PHN as well as an assessment of socioeconomic disadvantage and proportion of Indigenous population—so the $241 million was allocated on that basis.[7]

5.7 Of the $241.5 million funding to the PHNs, $78.6 million of NIAS funding was allocated to Indigenous-specific services. The allocation of this funding was informed by the DoH's engagement with local Aboriginal and Torres Strait Islander communities, through the PHNs,[8] and by using population figures derived from the 2013 Estimated Resident Population.[9] The DoH also ensured that culturally appropriate mainstream treatment services would be accessible to Indigenous Australians.[10] Routine performance reporting would require PHNs to provide evidence of culturally appropriate services for Indigenous Australians under the Drug and Alcohol Treatment Program.[11]

5.8 In allocating the remaining funding to PHNs, the government also considered other high-risk populations such as services for lesbian, gay, bisexual, transgender and intersex people.[12]

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3 DoH, *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016.

4 DoH, *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016.

5 DoH, *Drug and Alcohol Treatment Services PHN Circular 1–4 February 2016*, 4 February 2016.

6 DoH, answer to question on notice, no. 5, 24 March 2017 (received 10 May 2017).

7 Dr Wendy Southern, Deputy Secretary, DoH, *Committee Hansard*, 24 March 2017, p. 21.

8 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 21.

9 DoH, answer to question on notice, no. 5, 24 March 2017 (received 10 May 2017).

10 DoH, answer to question on notice, no. 1, 24 March 2017, p. 1 (received 10 May 2017).

11 DoH, answer to question on notice, no. 1, 24 March 2017, p. 1 (received 10 May 2017).

12 DoH, answer to question on notice, no. 1, 24 March 2017, p. 1 (received 10 May 2017).

5.9 The DoH provided PHNs with the autonomy to commission AOD services in their area.[13] However, the PHNs were restricted in the types of services which could be funded. These were limited to:

- early intervention services (including brief interventions);
- counselling services;
- withdrawal management services with pathways to post-acute withdrawal support;
- residential services and other intensive non-residential programs;
- post-treatment support and relapse prevention programs;
- case management, care planning and coordination services; and
- projects that support the workforce through 'activities which promote joint up assessment and referral pathways, quality improvement, evidence-based treatment, and service integration'.[14]

5.10 As of 5 May 2017, the 31 PHNs had collectively executed contracts for 208 drug and alcohol projects across Australia.[15] Twenty-nine PHNs had commenced supplying services in their areas, with a total of 165 projects being delivered.[16]

5.11 The period for the $241.5 million funding to the PHNs commenced in 2016–17 and will end in 2019–20.[17] A total of $177.1 million was committed for AOD treatment programs for 2016–17, 2017–18 and 2018–19.[18] The remaining $64.4 million was allocated to the PHNs for 2019–20.[19] The breakdown of funding by state and territory is listed in Table 3.

13 DoH, answer to question on notice, no. 1, 24 March 2017, p. 3 (received 10 May 2017).

14 DoH, answer to question on notice, no. 1, 24 March 2017, p. 3 (received 10 May 2017).

15 DoH, answer to question on notice, no. 1, 24 March 2017, p. 2 (received 10 May 2017).

16 DoH, answer to question on notice, no. 1, 24 March 2017, p. 2 (received 10 May 2017).

17 DoH, answer to question on notice, no. 4, 24 March 2017 (received 10 May 2017).

18 DoH, answer to question on notice, no. 4, 24 March 2017 (received 10 May 2017).

19 DoH, answer to question on notice, no. 4, 24 March 2017 (received 10 May 2017).

Table 3: PHN funding allocations by state/territory 2016–19[20]

State/territory	Mainstream Service Delivery	Indigenous Service Delivery	Total
New South Wales (10 PHNs)	$35,439,694.28	$16,758,997.61	$55,300,301.16
Victoria (6 PHNs)	$22,871,683.75	$3,869,862.99	$29,081,056.06
Queensland (7 PHNs)	$24,847,121.31	$15,545,038.65	$42,516,113.37
South Australia (2 PHNs)	$7,940,018,23	$2,993,277.20	$11,654,954.79
Western Australia (3 PHNs)	$11,716,966.42	$7,443,165.46	$20,219,586.79
Tasmania (1 PHN)	$3,515,997.71	$1,937,899.96	$5,693,440.29
Northern Territory (1 PHN)	$3,768,196.04	$5,847,592.68	$9,752,082.48
Australian Capital Territory (1 PHN)	$2,207,053.12	$503,233.85	$2,857,465.05
Contracted total	$112,304,730.87	$54,899,068.41	$117,075,000.00

5.12 The Senate Standing Committee on Community Affairs (Community Affairs Committee) discussed the allocation of NIAS funding during Senate Estimates on 30 May 2017. The DoH provided information on the weightings applied to the formula to determine the allocation of funds to each PHN:

> In terms of the weightings that were applied, I can tell you that non-Aboriginal or Torres Strait Islanders had a weighting of one. For Aboriginal and Torres Strait Islanders there was a weighting of three. For the different socioeconomic quintiles: for the most disadvantaged there was a weighting of two, for the second quintile there was a weighting of 1.5 and the remaining quintiles had a weighting of one. It also took into account the [Australian Standard Geographical Classification] remoteness areas. Major

20 DoH, answer to question on notice, no. 4, 24 March 2017, Attachment A (received 10 May 2017).

cities received a weighting of one,[21] then there was a stepped scale to very remote areas, which had a weighting of 2.5.[22]

5.13 The DoH subsequently provided additional information: each PHN was allocated $500 000 per annum (a base level funding of 3.2 per cent per PHN), totalling $6.4 million.[23] The remaining $97.3 million in mainstream funding to 2019–20 was allocated using 2011 Census population data and weighted according to socioeconomic disadvantage, remoteness and indigeneity.[24] A further $5.4 million has been reserved to respond to any emerging priorities in future years.[25] A breakdown of the percentage of funds allocated to each PHN is detailed in Table 4.

Table 4: Percentage of NIAS funding allocated to PHNs[26]

State/territory	PHN Name	Indigenous Funding	Base funding	Weighted funding[27]
NSW	Central and Eastern Sydney	2.1%	3.2%	4.9%
	Northern Sydney	0.4%	3.2%	2.5%
	Western Sydney	2.1%	3.2%	3.4%
	Nepean Blue Mountains	1.7%	3.2%	1.3%
	South Western Sydney	2.4%	3.2%	4.0%
	South Eastern NSW	2.9%	3.2%	2.7%
	Western NSW	4.9%	3.2%	2.2%
	Hunter New England and Central Coast	8.6%	3.2%	5.8%
	North Coast	3.8%	3.2%	2.8%
	Murrumbidgee	1.7%	3.2%	1.4%

21 There were five levels of weighting: 1 (major city), 1.2, 1.5, 2 and 2.5 (very remote location). See Mr David Laffan, Assistant Secretary, Drug Strategy Branch, Population Health and Sport Division, DoH, *Committee Hansard*, 30 May 2017, p. 87.

22 Mr Laffan, DoH, *Committee Hansard*, 30 May 2017, pp 86–87.

23 DoH, answers to questions on notice, no. SQ17-000589, (received 16 August 2017).

24 DoH, answers to questions on notice, no. SQ17-000589, (received 16 August 2017).

25 DoH, answers to questions on notice, no. SQ17-000589, (received 16 August 2017).

26 DoH, answers to questions on notice, no. SQ17-000589, (received 16 August 2017).

27 Weighted funding is determined by Indigenous population, socioeconomic disadvantage and rural and remoteness.

Victoria	North Western Melbourne	1.5%	3.2%	5.6%
	Eastern Melbourne	0.9%	3.2%	4.4%
	South Eastern Melbourne	1.1%	3.2%	4.8%
	Gippsland	0.7%	3.2%	1.3%
	Murray	2.0%	3.2%	3.0%
	Western Victoria	1.1%	3.2%	2.7%
Queensland	Brisbane North	2.7%	3.2%	3.2%
	Brisbane South	3.6%	3.2%	3.8%
	Gold Coast	1.2%	3.2%	1.9%
	Darling Downs and West Moreton	3.5%	3.2%	2.7%
	Western Queensland	2.0%	3.2%	0.9%
	Central Queensland and Sunshine Coast	4.2%	3.2%	5.1%
	Northern Queensland	11.1%	3.2%	5.1%
South Australia	Adelaide	2.7%	3.2%	4.5%
	Country SA	2.8%	3.2%	3.0%
Western Australia	Perth North	2.5%	3.2%	3.4%
	Perth South	3.0%	3.2%	3.4%
	Country WA	8.1%	3.2%	4.1%
Tasmania	Tasmania	3.5%	3.2%	3.0%
Northern Territory	Northern Territory	10.3%	3.2%	3.2%
Australian Capital Territory	Australian Capital Territory	0.9%	3.2%	1.1%
Total		**$76.8 million**	**$62 million**	**$97.3 million**

5.14 An additional $56.7 million of NIAS funding was reserved for non-treatment services (excluding the $241.5 million allocated to the PHNs). This has been allocated to:

- communities to deliver locally-based and tailored crystal methamphetamine preventative and educational activities ($24.9 million). Of this total, $19.2 million has gone to the establishment of 220 Local Drug Action Teams, $1.1 million for the expansion of the Positive Choices online portal and $4.6 million for the expansion of the Good Sports program;
- $13 million for the introduction of new Medicare Benefits Schedule items for addiction medicine specialists;
- $10.7 million for clinical research into new treatment options, the training of AOD professionals and the evaluation of clinical care for those people using methamphetamine. This includes $8.8 million for a new Centre for Excellence for the Clinical Management of Emerging Drugs of Concern, and the remaining amount to be allocated to the expansion of an early intervention tool and development of evidence-based guidelines; and
- $8.1 million to improve the Commonwealth's data sources on emerging trends in illicit drug use patterns, treatment options and early intervention of emerging drug threats.[28]

Allocation of funding to areas with high methamphetamine use

5.15 The committee heard concerns that NIAS funding had failed to target areas with the most severe illicit drug problems. This matter was discussed at length during the committee's hearing in Western Australia (WA).

5.16 The Palmerston Association argued that there was a disconnect between the usage rate of crystal methamphetamine in WA and the funding accolated to it:

> …[WA] not receiving a fair share of the national funds. We work on the basis of about 11 per cent of the share, given our population. We believe—and I am sure that the Department of Health could confirm this, because I may be wrong—that we are getting about nine per cent. That two per cent difference is a significant amount of money.[29]

5.17 The Palmerston Association asserted that WA should be getting more funding because:

- usage figures in WA are double the national average;
- the geographic size of the state; and
- the distribution of the state's population.[30]

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28 DoH, answer to question on notice, 30 May 2017, No SQ17-000699 (received 21 July 2017).

29 The Hon. Sheila McHale, Chief Executive Officer (CEO), Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

30 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 15.

5.18 Further, the Palmerston Association argued that future funding should be allocated on a needs basis and be informed by the best evidence, experts and policy work:

> Here in WA, the former state government developed its mental health, drug and alcohol plan. That is a very sound document that ought to inform funding and policy. That has identified where the need is and a plan to get there. As minister, if I knew that my public funds were being determined by some of the best research and the best thinkers, then I think that I would be quite happy. What I would not be happy with is a lot of money going into duplication of bureaucracies.[31]

5.19 This concern was shared by the Western Australian Network of Alcohol & other Drug Agencies (WANADA), which argued for additional weightings to be applied to areas with known drug use, based on evidence from the wastewater analysis.[32] The WANADA also called for more consideration of the geographic size of the state and the impact of distance on services to regional, rural and remote populations:

> Some of the services in Western Australia cover enormous geographic areas to provide those services. We know that people in regional, rural and remote areas are impacted by methamphetamine use. It is not just within metropolitan Perth. When you are driving hours and hours and hours within a single region to deliver services, then we need some additional weighting to ensure that there is some degree of equitable access to services for people in regional, rural and remote Australia, of which WA has its fair share.[33]

5.20 The WANADA argued that existing research conducted by the WA government should be relied upon to better inform the allocation of AOD funding to PHNs:

> I think we need a focus on meeting demand based on sound population planning, and research that has been undertaken and that has been refined for Western Australia by the state government—it was done by the previous state government and which is going to be supported by the current state government—is based on sound research and evidence. We have the demand; we know what the demand is; we need to meet this demand.[34]

5.21 The National Drug Research Institute (NDRI) held views similar to the WANADA and the Palmerston Association. Professor Rebecca McKetin of the NDRI stated that the level of problematic use should at least be considered, and stated:

> I used to work a lot in Sydney and I have moved from Canberra over to Western Australia in the last 12 months. The problem here is much greater than it is in a lot of those places and, as I said before, it is not uniform

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31 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 15.

32 Ms Jill Rundle, CEO, Western Australian Network of Alcohol & Other Drug Agencies (WANADA), *Committee Hansard*, 3 May 2017, p. 30.

33 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

34 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 30.

> across the country. It is affecting some communities very strongly and others not much at all. So in that equation there needs to be some index of the level of problematic methamphetamine use or drug use.[35]

5.22 Professor Steve Allsop, also of the NDRI, added that more consideration needs to be given to rural and remote communities, and argued for the setting aside of additional funds in order:

> …to deliver more effectively to rural and remote regions across Australia, particularly in the Northern Territory, Queensland, Western Australia and the northern parts of South Australia, where there are incredible challenges.[36]

NIAS funding for 2019–20

5.23 The DoH advised the Community Affairs Committee during Senate Estimates that the remaining funding for 2019–20 has been allocated to treatment services, but had 'not been committed to specific PHNs at this time'.[37] The Community Affairs Committee requested details about how the remaining funds would be allocated, and whether the same formula would be applied. The Community Affairs Committee also questioned whether it was appropriate to allocate the remaining NIAS funds based on Census data from 2011, noting up-to-date data is available through the wastewater analysis and the 2016 Census. In response, the DoH stated that it had consulted with experts, who:

> …thought [the formula] was a reasonable basis for allocating quite a large amount of money across 31 PHNs. I would think that the services themselves might then use some of that more granular data around the patterns of drug use in their communities, the drugs of concern and the subregions within a PHN—and that would be the level of data. I don't think we have put any money into an area where there is not some need for enhanced services. So I don't think there is a gross misallocation.[38]

5.24 The DoH subsequently advised the Community Affairs Committee that it was not considering changing the funding model to allocate the final year of funding to the PHNs for 2019–20.[39] Table 5 sets out the total remaining amount yet to be committed to the PHNs, along with the total amount of funding across the entire four year period.

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35 Associate Professor Rebecca McKetin, Senior Research Fellow, National Drug Research Institute (NDRI), Curtin University, *Committee Hansard*, 3 May 2017, p. 40.

36 Professor Steve Allsop, Project Leader, NDRI, Curtin University, *Committee Hansard*, 3 May 2017, p. 40.

37 Mr David Laffan, Assistant Secretary, DoH, *Committee Hansard*, 30 May 2017, p. 88.

38 Dr Lisa Studdert, First Assistant Secretary, Population Health and Sport Division, DoH, *Committee Hansard*, 30 May 2017, p. 87.

39 DoH, answer to question on notice, No. SQ17-00589, 30 May 2017 (received 21 July 2017).

Table 5: 2019–20 NIAS funding and total funding (four year total) by state and territory[40]

State/territory	2019–20 funding	Total funding (four year total)
New South Wales	$18,433,433.73	$73,733,734.92
Victoria	$9,693,685.35	$38,774,741.40
Queensland	$14,172,037.79	$56,688,151.16
South Australia	$3,884,984.93	$15,539,939.72
Western Australia	$6,739,862.26	$26,959,449.04
Tasmania	$1,897,813.43	$7,591,253.72
Northern Territory	$3,250,694.16	$13,002,776.64
Australian Capital Territory	$952,488.35	$3,809,953.40

Committee comment

5.25 The committee commends the Commonwealth government's substantial contribution of $241.5 million to AOD services as part of the NIAS.

5.26 The committee notes concerns that the funding for 2019–20 is informed by Census data from 2011. The most recent Census data for 2016 was released on 27 June 2017, and for this reason, the committee suggests that the DoH considers using 2016 Census data to inform the allocation of the remaining NIAS funds, rather than the 2011 data.

5.27 In addition to the use of 2016 Census, the committee is of the view that the remaining NIAS funding could also be informed by data from the wastewater analysis. The use of wastewater analysis data should assist in allocating resources to areas with known higher methamphetamine use.

Recommendation 11

5.28 The committee recommends that the Department of Health considers using 2016 Census and National Wastewater Drug Monitoring Program data to determine the allocation of National Ice Action Strategy funding for 2019–20.

Tender process

5.29 Submitters and witnesses to the inquiry raised concerns with respect to the timing of and short timeframe for the tender process.

40 DoH, answer to question on notice, No. SQ17-000597, 30 May 2017 (received 21 July 2017)

5.30 Holyoake Tasmania was critical of the NIAS tender process. It expressed concern about the short timeframe to apply for funding: from the announcement in December 2015 to the closure for applications on the 12 January 2016.[41] Holyoake Tasmania opined that this decision resulted in a:

> …rushed procurement process [that] did not enable an adequate time for competing organisations to thoroughly research and prepare tenders which will deliver the best possible outcomes for clients using ice or their families.[42]

5.31 The same concern was expressed by the Network of Alcohol and other Drug Agencies (NADA) about the tender process in New South Wales (NSW). NADA advised the committee that its members were only provided with:

> …three to four weeks over the Christmas and New Year period…to apply for grants in their on-line tender process. This severely weakens many NGO services position to compete in external tender processes as agencies staff are on holidays, partner agencies are also not as available for collaboration in the tender application and the Christmas period is generally a crisis time for clients and people seeking to access services placing extra demand on the personnel of drug treatment NGOs.[43]

5.32 NADA acknowledged community expectations that delivery of treatment services would occur promptly, but argued that:

> ….this timing problem should have been addressed between both the Australian Government and the PHNs so that timeframes for the roll out of competitive tendering could have been more realistic and less burdensome on services. A communication strategy developed in partnership with the Australian Government, PHNs and the Network of AOD Peaks could have gone to supporting realistic and appropriate timeframes, as well as community expectations on the commissioning of new services. This approach should be taken in the future.[44]

5.33 The committee queried the DoH on the timing of the tender process and the role it had in determining the timeframe. The committee asked the DoH about the tender process occurring over the Christmas period and whether it had impacted on service providers' ability to form partnerships. In response, the DoH advised that the tender process varied from PHN to PHN and that the:

> …commissioning periods varied quite considerably depending on how far forward each of the PHNs was in its planning process. Each PHN basically did its needs assessment for its region then determined how it was going to do its commissioning process. Apart from providing the broad guidelines

41 Ms Sarah Charlton, CEO, Holyoake Tasmania, *Committee Hansard*, 24 March 2017, p. 17.

42 Ms Charlton, Holyoake Tasmania, answer to questions on notice, 24 March 2017 (received 20 April 2017), p. 1.

43 Network of Alcohol and other Drug Agencies (NADA), *Submission 96*, p. 8.

44 NADA, *Submission 96*, p. 8.

> around the sort of services that could be funded under the program the department has not been involved in the commissioning process.[45]

5.34 The committee asked whether the DoH advised PHNs that the Christmas or Easter periods were not appropriate times for the PHNs to initiate tender processes. The DoH reassured the committee that it is in:

> …constant communication with the PHNs providing feedback on how things are going. The commissioning process is now in its second year with PHNs. Certainly we have opportunities to feed back to PHNs what works and what does not work. I guess that is something we have learned in the department over many years, that Christmas is a difficult period for commissioning.[46]

Committee comment

5.35 The committee sympathises with submitters and witnesses about the timing of the tender process and the short timeframe available to tender for NIAS funds. Individual PHNs have responsibility for their tender processes, however, the committee believes the DoH should ensure adequate time frames are in place and occur outside of holiday periods. Failure to do so may undermine service providers' ability to develop well-informed, collaborative tenders; the committee therefore supports NADA's proposal that future tender processes should have realistic timeframes and occur at appropriate times of year.

Recommendation 12

5.36 The committee recommends that the Department of Health ensures that Public Health Network's conduct future tender processes with realistic timeframes and at appropriate times of year.

Distribution of funding to AOD service providers

5.37 The delay with the rollout of NIAS funding through the PHNs was the subject of concern during the course of the inquiry, with both the Australian Medical Association (AMA) and the Palmerston Association criticising the delay. The AMA submitted that the NIAS was agreed by COAG on 11 December 2015 and that:

> A year later some of the most vital aspects, including expanded access to treatment and support for crystal methamphetamine users, has not progressed. While many PHNs will commence with their plans to expand treatment and support services on 1 January 2017, other PHNs have not finalised their plans and so will not be in a position to implement them. This is despite the commitment being made over a year ago.[47]

45 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 26.

46 Dr Southern, DoH, *Committee Hansard*, 24 March 2017, p. 26.

47 Australian Medical Association (AMA), *Submission 86*, p. 4.

5.38 A similar critique was outlined by the Palmerston Association: 'we are only now beginning to see some of the funding come through. The task force reported November 2015 or thereabouts. We are now 18 months later'.[48]

5.39 The Western Australian Primary Health Alliance (WAPHA) addressed the Palmerston Association's criticism regarding the delays distributing the NIAS funds, explaining that it was:

> …required to undertake a sequence of processes to ensure that commissioned services are purposed for the people and the place for which they will be provided. There are specific governance processes, mandated by the Commonwealth, to ensure that new treatment services can be provided that will not cause harm. The haste that is recommended by the Palmerston Association would subvert this process…A cautious and planned approach is necessary that upholds the integrity of the Commonwealth's mandated requirements.[49]

5.40 In some cases NIAS funding to AOD services was delayed for an extended period. For example, the Australian Capital Territory did not receive its additional funding (above the 3.2 per cent base level funding) until August 2017, almost two years after the Commonwealth government's announcement.[50] Similarly, Tasmania received its funding in April 2017, more than a year after the government announced the NIAS funding.[51]

Committee comment

5.41 The committee acknowledges that many in the AOD treatment sector would like NIAS funding distributed as quickly as possible; however, the committee agrees with WAPHA's view that a more measured and less hasty implementation is preferable.

5.42 It seems to the committee that better communication about the distribution of funding would have ameliorated some of the concerns. The committee suggests the Commonwealth government and PHNs proactively communicate to stakeholders about the distribution so as to manage the expectations of service providers and assist both service providers and communities to plan around the rollout of the funds.

Transparency

5.43 Both the Palmerston Association and WANADA expressed concerns about the transparency and governance of PHN funding. The Palmerston Association

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48 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

49 Ms Learne Durrington, The Western Australian Primary Health Alliance (WAPHA), correction of evidence, 3 May 2017, p. 2 (received 29 May 2017).

50 Daniel Burdon, '$2.8 million for ACT drug treatment flows two years after ice strategy announced', *The Age*, 31 August 2017, http://www.theage.com.au/act-news/28-million-for-act-drug-treatment-flows-two-years-after-ice-strategy-announced-20170831-gy7tzp.html (accessed 15 November 2017).

51 Sarah Fitzpatrick Gray and AAP, 'Federal funds to combat ice in Tassie', *Hobart Mercury*, 13 April 2017.

explained that it was unsure whether funding it had received through WA's PHNs (WAPHA) was NIAS funding or other AOD funding.[52] More broadly, the National Drug and Research Centre (NDARC) argued that AOD funding and commissioning of services in a federal system leaves service providers vulnerable.[53]

5.44 WANADA expressed a similar concern regarding the lack of transparency, particularly in instances of money received from a non-government commissioning body. The committee heard that when services receive funding from government, service providers are able to:

> …access information about what services are being funded and how much money they have received; you can even access what is in their contract. But when it comes through effectively a non-government commissioning body—…as a peak body I do not know where this money is actually going. In terms of the peak body being able to provide support for all of the services that are getting alcohol and other drug funding, I do not know how to support the capacity of those services, I do not know who they are. So there is no transparency about where it is going, what it is for, what the process is—all those sorts of things—at this stage. It is certainly something that I have requested, but I am yet to receive that information.[54]
>
> …
>
> In Western Australia…the Ice Taskforce money has been blended with mental health funding that the primary health care networks get as well. That is unique to WA. Again, I guess there are concerns there in terms of the transparency of this going to services that are delivering early intervention, brief intervention, where they should be providing it as a matter of course versus AOD specialist treatment services. But I do not know where the money has gone. I have no idea who has received the funding. At this stage, there is no transparency broadly, certainly with the not-for-profit sector.[55]

5.45 WAPHA responded to the criticisms about transparency and governance around commissioning of AOD activities, including the acquittal of the NIAS funding. It cited the PHN Grant Programme Guidelines[56] under the Drug and Alcohol Treatment Activity Work Plan as providing clear guidance on activities commissioned

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52 Ms McHale, Palmerston Association, *Committee Hansard*, 3 May 2017, p. 14.

53 National Drug and Research Centre (NDARC), *Submission 85*, p. 1.

54 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 29.

55 Ms Rundle, WANADA, *Committee Hansard*, 3 May 2017, p. 29.

56 Available at: DoH, *PHN Programme Guidelines*, 21 April 2017, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines (accessed 18 January 2018). Other resources available to inform PHNs on the commissioning processes are: *PHN Commissioning Resources*, 27 February 2017, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources (accessed 18 January 2018); *PHN Needs Assessment Guide*, 24 December 2015, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Needs_Assessment_Guide (accessed 18 January 2018).

by PHNs under the NIAS.[57] Further, WAPHA explained that 'WA PHNs are required to provide regular and detailed activity reports to the Commonwealth Department of Health on a six and 12 monthly basis'.[58]

5.46 A DoH circular of 4 February 2016 outlined the AOD funding arrangements for the NIAS.[59] It noted that the additional $245.1 million to the PHNs was not exclusively for crystal methamphetamine-specific services, but instead 'is intended to increase the capacity of the drug and alcohol treatment sector broadly, to adequately and effectively deliver treatment services':[60]

> New drug and alcohol treatment services refers to new investment in additional drug and alcohol treatment services commissioned through PHNs. PHNs role in commissioning treatment services at the local level will complement their new role in coordinating Commonwealth-funded mental health programmes at the local level, as well as build linkages with primary care.
>
> The new role of PHNs will also not impact on existing Indigenous-specific treatment services already contracted by the Department of Prime Minister & Cabinet through the *Indigenous Advancement Strategy*, but will build on this existing investment.[61]

5.47 Dr Jenny Chalmers, Professor Alison Ritter, Dr Lynda Berends and Dr Kari Lancaster considered the issue of transparency, accountability and AOD funding in an article in *Drug and Alcohol Review*.[62] Chalmers et al. demonstrated the complexities of the funding flows for AOD services and the tendency for there 'to be several layers of governance or intermediaries between the funding sources and the final use of funds or services funded'.[63]

5.48 They noted that Australia's increasingly decentralised health system, with multiple layers and partners, raises a concern about the efficiency and effectiveness of AOD funding.[64] The analysis by Chalmers et al. shows that source funders can be

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57 Ms Durrington, WAPHA, correction of evidence, 3 May 2017, p. 2 (received 29 May 2017).

58 Ms Durrington, WAPHA, correction of evidence, 3 May 2017, p. 2 (received 29 May 2017).

59 DoH, *Drug and Alcohol Treatment Services PHN Circular 1 – 4 February 2016*, 4 February 2016.

60 DoH, *Drug and Alcohol Treatment Services PHN Circular 1 – 4 February 2016*, 4 February 2016.

61 DoH, *Drug and Alcohol Treatment Services PHN Circular 1 – 4 February 2016*, 4 February 2016.

62 Dr Jenny Charmers, Professor Alison Ritter, Dr Lynda Berends and Dr Kari Lancaster (Charmers et al.), 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review*, 35, May 2016

63 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review*, 35, May 2016, p. 256.

64 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review*, 35, May 2016, p. 262.

'many times removed from service delivery, their decision making around the amount of funding disconnected from decisions about what is funded'.[65] The authors concluded that these 'decisions are crucial in determining performance, efficiency and affordability of AOD treatment' and cause challenges for AOD service providers that are forced to navigate 'multiple and sometimes competing funding and accountability frameworks'.[66]

5.49 The NDARC came to a similar conclusion, stating that a key challenge for the AOD sector is the:

> …fragmented approach to service planning and purchasing and the challenges associated with federalism where the two levels of government (federal versus state/territory) do not dovetail together. The states/territories fund the majority of alcohol and other drug treatment, including methamphetamine and are seen as the central planning unit for their jurisdiction.[67]

5.50 NDARC stated that, as a consequence of this contracting system, AOD treatment services providers are left very vulnerable (for example, as a result of inconsistent funding), an issue which requires sustained attention by policy makers and those implementing funding programs.[68]

Committee comment

5.51 It is apparent to the committee that there are valid concerns about transparency of NIAS funding, primarily due to existing transparency issues with AOD funding more generally.

5.52 As demonstrated by Chalmers et al., the funding of AOD services is complex. The committee is concerned that NIAS funding will be indistinguishable from existing funding, thus undermining the Commonwealth government's ability to assess the effectiveness of NIAS-funded AOD treatment services.

5.53 The committee, in its first report, recommended that progress reports and the mid-point review provided to the Ministerial Drug and Alcohol Forum and Council of Australian Governments on the implementation of the National Drug Strategy (NDS) 2017–2026 and the NIAS are made publicly available. As part of this recommendation, the committee included reporting of initiatives implemented through the PHNs.

5.54 Concerns expressed by WANADA, the Palmerston Association, the NDARC and research conducted by Charmers et al. all relate to a broader concern about

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65 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review*, 35, May 2016, p. 262.

66 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review*, 35, May 2016, p. 262.

67 NDARC, *Submission 85*, p. 1.

68 NDARC, *Submission 85*, p. 1.

transparency of AOD funding in a federated system. The committee acknowledges this issue, and agrees that transparency and accountability should be improved.

Rebalancing the three pillars of the National Drug Strategy

5.55 The NIAS funding is part of broader AOD funding committed by the Commonwealth government. Since 1 July 2016, the Commonwealth government has invested almost $685 million to reducing the impact of drug and alcohol abuse on individuals, families and communities.[69] Of this total, $544 million has been provided for treatment services, with approximately $75 million per annum, under the *Drug and Alcohol Program*, allocated to support existing AOD treatment services.[70] The PHNs will administer $42.6 million per annum of the $75 million.[71]

5.56 Although the Commonwealth government has made substantial investments in AOD services, the committee heard consistently from AOD service providers, researchers and peak body representatives that the sector is under-resourced. Charmers et al. noted that the AOD treatment sector 'is generally underfunded' but acknowledged that it was 'difficult to gain an appreciation of the total level of funding given the complexities of the [funding] arrangements'.[72]

5.57 The committee's first report expressed the view that, although law enforcement strategies play a vital role in combating the manufacture, importation and distribution of illicit drugs, there are limits to the success of law enforcement strategies in mitigating the effect of illicit drugs on individuals and community. A broad range of evidence from the NIT's final report, the Commonwealth government, law enforcement,[73] health professionals and AOD service providers supported the maxim that 'we cannot arrest our way out' of the illicit drug problem.[74]

5.58 Despite the recognised limitations of law enforcement approaches, law enforcement receives the largest proportion of government expenditure dedicated to addressing illicit drugs. For this reason, there are calls for the Commonwealth, state and territory governments to rebalance the distribution of funding across the three pillars of Australia's drug strategy.[75]

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69 DoH, answer to question on notice, SQ17-000497, Budget Estimates 2017–18.

70 DoH, answer to question on notice, SQ17-000497, Budget Estimates 2017–18.

71 DoH, answer to question on notice, SQ17-000497, Budget Estimates 2017–18.

72 Charmers et al., 'Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia', *Drug and Alcohol Review*, 35, May 2016, p. 261.

73 See for example, Deputy Commissioner Naguib (Nick) Kaldas, Deputy Commissioner, Field Operations, New South Wales Police Force, *Committee Hansard*, 29 July 2017, p. 4.

74 The Hon. Malcolm Turnbull MP, Prime Minister, 'Joint Doorstop Interview with Minister Keenan and Minister Nash', Sydney, 6 December 2015, https://www.malcolmturnbull.com.au/media/joint-doorstop-interview-with-minister-keenan-and-minister-nash-sydney (accessed 11 January 2018).

75 The three pillars of the National Drug Strategy are supply, demand and harm reduction measures. See Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice): First report*, September 2017, pp 55-57.

5.59 In 2009–10, Professor Alison Ritter, Dr Ross McLeod and Dr Marian Shanahan estimated that the Commonwealth, state and territory governments spent approximately $1.7 billion on illicit drug programs. The analysis[76] estimated that 64.1 per cent of this total (over $1 billion) was dedicated to law enforcement policies,[77] whereas:

- 9.7 per cent (approximately $156.8 million) was spent on prevention activities;
- 22.5 per cent (approximately $361.8 million) was spent on treatment services;
- 2.2 per cent ($36.1 million) was spent on harm reduction measures; and
- 1.4 per cent ($23.1 million) on other activities.[78]

5.60 The disparity between the funding traditionally allocated to law enforcement and that provided for treatment and harm reduction has led organisations such as the Network of Peaks to be critical of additional investment in law enforcement strategies that 'preferences supply reduction over demand and harm reduction'.[79]

5.61 The Ted Noffs Foundation highlighted the need for a balanced, co-ordinated approach to tackling the illicit drug problem:

> Law enforcement, including street-level policing, will not, by itself, counter the prevalence of illicit drug use. A coordinated, balanced strategy, involving prevention and treatment harms, as well as a resourced health sector, will always have the most positive effect. The Australian Crime Commission report into the methamphetamine market has highlighted that to deal with ice we need an overarching national strategy that includes the health sector, industry, educators and the not-for-profit sector. By acknowledging that law enforcement measures alone will not adequately address the problem, the Crime Commission has signalled to the Australian government that a significant and considered investment is required in early

76 Evidence presented by submitters shows original estimates from the Alison Ritter, Ross McLeod and Marian Shanahan et al. (Ritter et al.) report. On 20 August 2013 an addendum was issued due to amendments being made to the Australian Federal Police's allocation of resources towards illicit drug strategies. These changes resulted two scaled down estimates for law enforcement, one was 70 per cent the original estimate, the other was 50 per cent. This report has opted to use the 50 per cent estimate. See Ritter et al. *Government Drug Policy Expenditure in Australia – 2009/10,* Drug Policy Modelling Program Monograph 24, NDARC, June 2013, https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/24%20Government%20drug%20policy%20expenditure%20in%20Australia%20-%202009_10.pdf (accessed 17 November 2017).

77 Ritter et al. *Government Drug Policy Expenditure in Australia – 2009/10,* Drug Policy Modelling Program Monograph 24, NDARC, June 2013.

78 Ritter et al. *Government Drug Policy Expenditure in Australia – 2009/10,* Drug Policy Modelling Program Monograph 24, NDARC, June 2013.

79 Australian Network of State and Territory Alcohol and other Drug Peak Bodies (Network of Peaks), *Submission 108*, p. 8.

> intervention and treatment services. Currently, relative to law enforcement resourcing, funding for drug treatment services is woefully inadequate.[80]

5.62 Professor Nadine Ezard from St Vincent's Hospital also advocated for a rebalancing of funding across the three pillars:

> …with the three pillars of demand reduction, supply reduction and harm reduction we would really like to see adequate resourcing of the health system within those three pillars—within the demand reduction and harm reduction area. We need to be really making sure that when the proportional direction of resources is decided we get adequate resources into those two areas.[81]

5.63 The WANADA considered that law enforcement strategies need to operate in concert with harm reduction and treatment programs. It argued that a law enforcement approach would not deliver the health outcomes that are evidently needed; WANADA submitted that government policy should place an increased emphasis on demand and harm reduction initiatives[82] because:

> …for every treatment dollar spent, $7 is saved, and for every dollar spent in harm reduction, $27 is saved, so we have these broad areas. We would like to be able to—and I think it is important—demonstrate the value of what we are doing. Across the three pillars, the demand for services is inadequately met. It would be great to be able to say, 'With enough services, we will be able to contribute effectively to social cost savings.'[83]

5.64 WANADA highlighted that each year across Australia, between 200 000 and 500 000 people are unable to access the AOD treatment they seek.[84]

5.65 Professor Allsop from the NDRI argued that just because an illicit drug offence is a criminal offence, it does not mean the best response is a law enforcement response. Instead, policymakers need to address demand reduction because:

> If lots of people associated with methamphetamine end up in our criminal justice system, it still might mean that we need to get more people into treatment. It might mean that we need to have much more effective prevention strategies, so that we begin to reduce demand. It might mean that, instead of putting people into the criminal justice system, we divert them into treatment systems.[85]

5.66 Professor Allsop acknowledged and commended both federal and state governments that have:

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80 Mr Mark Ferry, Chief Operating Officer, Ted Noffs Foundation, *Committee Hansard*, 29 July 2015, p. 51.

81 Professor Nadine Ezard, Clinical Director, Alcohol and Drug Service, St Vincent's Hospital, St Vincent's Health Australia, *Committee Hansard*, 29 July 2015, p. 74.

82 WANADA, *Submission 107*, p. 7.

83 WANADA, *Submission 107*, p. 7.

84 WANADA, *Submission 107*, p. 7.

85 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 37.

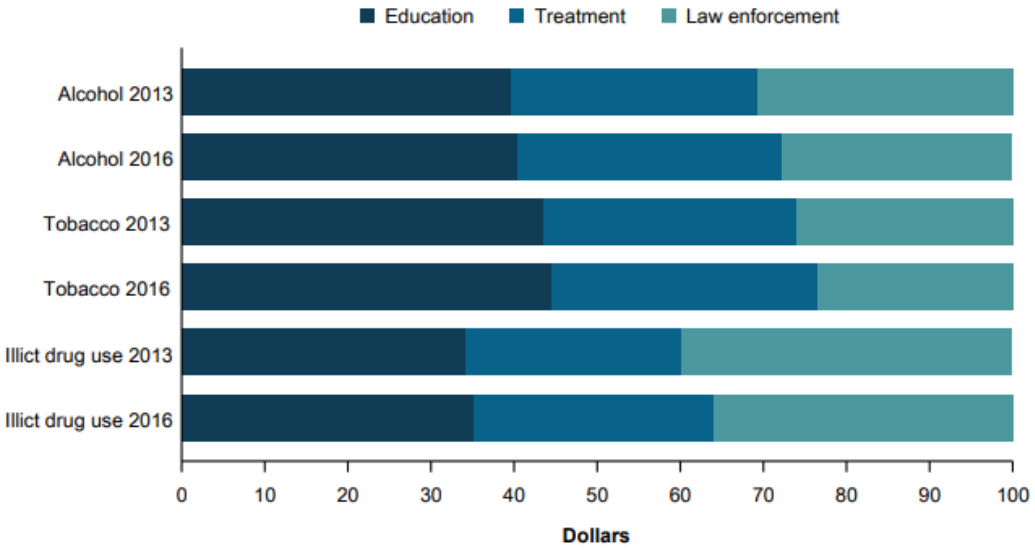
> …allocated increasing funds and resources to [treatment services]. The federal government and various state governments, including Western Australia, should be applauded for that. But the problem is that there is still an enormous unmet need, and it is in the access to that service.[86]

5.67 The AIHW's *National Drug Strategy Household Survey 2016* (household survey) revealed growing public support for the prioritisation of health and education policies over law enforcement. Participants were asked to distribute a hypothetical $100 across these three policy responses for alcohol, tobacco and illicit drugs, and found that irrespective of the type of drug:[87]

> …people thought that a greater proportion of funds should be allocated to education or treatment in 2016—making up about 64% to 77% of total dollars. Conversely, there was a significant decrease in the allotted dollars for law enforcement for all 3 drug types.[88]

5.68 Figure 5 shows the household survey's results of participants preferred distribution of the hypothetical $100.

Figure 5: Preferred distribution of a hypothetical $100 to reduce the use of selected drugs, people aged 14 or older, 2013–2016[89]



86 Professor Allsop, NDRI, *Committee Hansard*, 3 May 2017, p. 38.

87 Australian Institute of Health and Welfare (AIHW), *National Drug Strategy Household Survey 2016: Detailed findings*, 2017, p. 131, https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true (accessed 28 February 2018).

88 AIHW, *National Drug Strategy Household Survey 2016: Detailed findings*, 2017, p. 131.

89 AIHW, *National Drug Strategy Household Survey 2016: Detailed findings*, 2017, p. 132.

Committee comment

5.69 The Commonwealth government's investment of $241.5 million in AOD treatment services via the NIAS, together with a broader investment of $685 million, marks a significant step forward in the redistribution of resources across the three pillars of Australia's drug strategy. However, this additional funding may not necessarily result in the demand for treatment and harm reduction services being met.

5.70 While the NIAS funding goes some way to addressing the imbalances between the pillars of Australia's drug strategy, the committee acknowledges the need to ensure that policies and funding are not disproportionately weighted towards law enforcement.

5.71 Evidence in this report demonstrates the benefits of prioritising demand and harm reduction policies over law enforcement policies when it comes to assisting people to reduce or cease their illicit drug use. Again, the committee supports law enforcement's role in the NDS, but considers that police resources should be primarily aimed at those who profit from the importation, manufacture and distribution of illicit drugs (namely serious and organised crime groups and outlaw motorcycle gangs), rather than people that use or are found in possession of small quantities of illicit drugs.

5.72 Allocating funding in a way that prioritises law enforcement strategies above demand and harm reduction policies runs the risk of undermining the success of Australia's NDS. Therefore, the committee is of the view that the Commonwealth, state and territory governments must continue to re-balance funding across all three pillars of the NDS. The AIHW's household survey indicates a high level of public support for such an approach.

Recommendation 13

5.73 The committee recommends that the Commonwealth, state and territory governments re-balance alcohol and other drug funding across the three pillars of the National Drug Strategy (supply, demand and harm reduction strategies).

5.74 In addition to Commonwealth, state and territory governments re-balancing alcohol and other drug funding across the three pillars of the NDS, the committee recommends that the Commonwealth government refers to the Productivity Commission an inquiry into the costs and benefits of the National Drug Strategy as it is currently implemented.

Recommendation 14

5.75 The committee recommends that the Commonwealth government refers to the Productivity Commission an inquiry into the costs and benefits of the National Drug Strategy as it is currently implemented.

Confiscated Assets Account

5.76 A common concern expressed to the committee during the course of the inquiry was insufficient funding available for AOD treatment services.[90] To alleviate this financial pressure, and to provide an additional revenue stream for AOD treatment services, this section considers the use of the CAA to fund treatment services. The section below outlines the provision under the PoC Act to fund measures relating to treatment of drug addiction and diversionary measures, followed by listing the initiatives that have received PoC funding.

5.77 The PoC Act establishes a mechanism for confiscated assets to be re-invested in the community. Under section 298 of the PoC Act there is a provision for the Minister of Justice to 'approve a program for the expenditure of money standing to the credit of the [CAA]' for the following purposes:

- crime prevention measures;
- law enforcement measures;
- measures relating to treatment of drug addiction; and
- diversionary measures relating to illegal use of drugs.[91]

5.78 Despite the Act permitting the distribution of CAA funds for drug treatment and diversionary measures, it appears that a larger percentage of funds are directed to crime prevention and law enforcement measures. On 22 March 2017, the Australian National Audit Office (ANAO) released a report on PoC, which included consideration of how funds from the CAA are used. According to the ANAO, CAA funding has been provided to 'Commonwealth and state government entities, non-government organisations, community groups and local councils'.[92] Stand-alone project, grant programs, or the expansion or continuation of existing activities have received funding through the PoC's CAA.[93]

5.79 Between 2010–11 and 2015–16, the Minister for Justice approved $161 million in funding under section 298 of the PoC Act. The ANAO's analysis of this funding shows that law enforcement entities are the primary beneficiaries. The allocation of CAA funds, between 2010–11 and 2015–16 consisted of:

- $86.7 million directed to Commonwealth criminal intelligence and law enforcement entities ($51.3 million to the Australian Federal Police (AFP) and $28.9 million to the Australian Crime Commission (ACC)). The ANAO

90 See paragraphs 5.16–5.19, 5.29 and 5.69.

91 *Proceeds of Crime Act 2002*, s. 298.

92 Australian National Audit Office (ANAO), *Proceeds of Crime*, 22 March 2017, https://www.anao.gov.au/work/performance-audit/proceeds-of-crime (accessed 22 December 2017).

93 ANAO, *Proceeds of Crime*, 22 March 2017.

noted that '[o]f the funding going to the AFP and the [ACC], $30.0 million wholly or partly supports these entities' proceeds of crime operations';[94]

- $21.6 million to NSW, Victoria and Queensland to support various Commonwealth–State taskforces dedicated to waterfront crime; and
- $52.7 million allocated to non-government or community organisations, as well as local councils. The bulk of this money ($37.4 million) was dedicated to funding the Safer Streets program. Table 6 shows a breakdown of this funding.[95]

94 ANAO, *Proceeds of Crime*, 22 March 2017.

95 ANAO, *Proceeds of Crime*, 22 March 2017.

Table 6: Funding to non-government and community organisations and local councils, 2010–11 to 2015–16[96]

Recipient	Project(s)	Total funding ($ million)
Various local councils and non-government and community organisations (including Neighbourhood Watch Australasia and Youth off the Streets	Enhancing security and safety of community through improved environmental design; closed circuit TV monitoring; security infrastructure; lighting and early intervention and crime prevention activities (Safer Streets programme)	37.4
Youth Off the streets	Early intervention outreach activities (National Crime Prevention Fund)	5.0
Various local councils and non-government and community organisations	Graffiti Prevention	3.0
Police-citizens youth clubs/Blue Light organisations	Early intervention outreach activities	1.9
Anti-slavery Project; Australian Catholic Religious Against Trafficking Human; Project Respect and Scarlet Alliance	Various anti-people trafficking activities	1.6
Neighbourhood Watch Australasia	Establish national office and undertake various activities with police and communities	1.5
Various non-government and community organisations	Improve security and domestic violence crisis accommodation facilities	1.0
Crime Stoppers	Dob-in-a-dealer	1.0
Firearm Safety Foundation Victoria	Improve firearm safety	0.3

5.80 The Attorney-General's Department released a *Proceeds of Crime Act 2002 Funded Projects* report on 2 March 2015.[97] This report detailed the names, amount

96 ANAO, *Proceeds of Crime*, 22 March 2017.

97 Attorney-General's Department (AGD), *Proceeds of Crime Act 2002 Funded Projects*, March 2015, https://www.ag.gov.au/CrimeAndCorruption/CrimePrevention/Documents/POCA%20Funded%20Projects.pdf (accessed 11 January 2018).

provided and project description of projects funded under the PoC Act. Under community programs (completed projects), the report listed a number of projects related to drug treatment programs, such as:

- drug treatment programs in correctional facilities;
- Indigenous drug treatment programs;
- youth focused AOD programs;
- culturally and linguistically diverse AOD programs; and
- residential AOD treatment services.[98]

5.81 No AOD treatment program was listed as an active project in this report. Active projects included:

- Safer Street Programme (Round One);
- Graffiti Prevention Reduction and/or Removal Funding 2012;
- Police and Youth funding 2011;
- National Crime Prevention Fund 2013;
- Neighbourhood Watch Australasia; and
- People trafficking/Labour exploitation projects.[99]

Committee comment

5.82 The need for greater funding for AOD treatment services was a key theme communicated to the committee during the course of its inquiry. As discussed earlier in this chapter and in chapter 2, despite substantial investments by the federal, state and territory governments, high demand and long waiting lists for accessing AOD treatment services remain.

5.83 The drug policy expenditure analysis conducted by the NDARC shows that AOD expenditure is heavily weighted towards law enforcement measures (64.1 per cent in total), whilst preventative (9.7 per cent), treatment (22.5 per cent) and harm reduction measures (2.2 per cent) are allocated far less.

5.84 It appears that the allocation of funds from the CAA reflects a similar prioritisation of law enforcement measures over treatment initiatives. This prioritisation has occurred despite section 298 of the PoC Act permitting CAA funds to be allocated to drug treatment and diversionary measures.

5.85 The committee understands the complex environment in which law enforcement agencies operate, and that law enforcement activities require significant resources. The committee does not question the effectiveness of law enforcement activities funded under the CAA. However, the committee suggests that serious

98 AGD, *Proceeds of Crime Act 2002 Funded Projects*, March 2015, pp 17–51.

99 AGD, *Proceeds of Crime Act 2002 Funded Projects*, March 2015, p. 2.

consideration is given to the benefits that could be achieved by allocating CAA funding to drug prevention and treatment services.

5.86 For this reason, the committee recommends that the Commonwealth government, under section 298 of the PoC Act, ensures CAA funds are allocated to crime prevention, law enforcement, drug treatment and diversionary measures more equitably. The committee also calls for state and territory governments to examine their PoC legislation so that funding is equitably allocated to law enforcement and AOD treatment measures.

Recommendation 15

5.87 The committee recommends that the Commonwealth government, under section 298 of the *Proceeds of Crime Act 2002*, ensures Confiscated Assets Account funds are equitably allocated to crime prevention, law enforcement, drug treatment and diversionary measures.

Chapter 6

Decriminalisation

6.1 This chapter considers decriminalisation of illicit drugs and briefly compares that with legalisation. The chapter then considers Portugal's drug framework and the circumstances that led to its implementation. Finally, the chapter considers Australia's current drug policies and the appropriateness of decriminalisation in Australia

What is decriminalisation?

6.2 Decriminalisation is an approach where the legal penalties for the use and/or possession of illicit drugs are reduced. This is achieved by changing the laws for drug use and/or possession offences from criminal offences to civil/administrative offences (such as a fine), or diverting drug users away from the justice system and into education or treatment programs (known as a diversionary programs).[1] Under decriminalised models, the sale or supply of illicit drugs generally remains a criminal offence.[2]

6.3 Critics of decriminalisation argue that it does not adequately address the core issue of the black market and that serious and organised crime groups will nevertheless sell illicit drugs.[3] Others argue that a decriminalised drug policy will lead to an increase in the use of illicit drugs and that lesser penalties 'suggest that society approves of drug use'.[4]

6.4 Professor Alison Ritter from the National Drug & Alcohol Research Centre (NDARC) challenged the assumption that drug use will increase under a decriminalisation model because it assumes criminal penalties operate as a deterrent for some people.[5] The NDARC noted that research in a number of countries that have implemented decriminalisation policies has:

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1 The Parliamentary Joint Committee on Law Enforcement's (PJCLE) first report for the inquiry into crystal methamphetamine discusses the current status of drug diversionary schemes in Australia. The committee recommended that, subsequent to the national review of drug diversionary programs articled by the National Ice Taskforce and in the National Ice Action Strategy (NIAS), states and territories commit to improving, expanding, or where no drug diversionary program(s) currently exists, implementing such programs across their jurisdictions.

2 Professor Alison Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, National Drug & Alcohol Research Centre (NDARC), 22 April 2016, https://ndarc.med.unsw.edu.au/blog/decriminalisation-or-legalisation-injecting-evidence-drug-law-reform-debate (accessed 4 August 2017).

3 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

4 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

5 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

> …consistently found that decriminalisation is not associated with significant increases in drug use. And in instances where just cannabis has been decriminalised it has not led to increases in use of other drugs such as ecstasy or heroin.[6]

6.5 Professor Ritter was of the view that decriminalisation 'has the potential to reduce the burden on police and the criminal justice system' and 'removes the negative consequences (including stigma) associated with criminal convictions for drug use'.[7] According to the NDARC, research shows that decriminalisation policies can lead to less use of police, courts and prisons. For example, in California, the total law enforcement cost before and after the decriminalisation of cannabis were '$17 million in the first half of 1975 (before decriminalisation) to $4.4 million in the first half of 1976 (after decriminalisation)'.[8] Another benefit, according to the Global Commission on Drug Policy, is that police in a jurisdiction with decriminalisation 'have reported improved community relations as a result of the reform'.[9]

6.6 Another consideration in favour of decriminalisation is that it 'improves the employment prospects and relationships with significant others for those detected with drugs' because:

> …individuals who avoid a criminal record are less likely to drop out of school early, be sacked or to be denied a job. They are also less likely to have fights with their partners, family or friends or to be evicted from their accommodation as a result of their police encounter.[10]

6.7 With regard to the Portuguese model, the NDARC found that drug use rates have not risen, and that there have been 'measurable savings to the criminal justice system'.[11]

6.8 An important qualifier concerning decriminalisation is that its success is reliant upon additional investment in health and social services. As noted by the Global Commission on Drug Policy, decriminalised drug policies do not stand alone and:

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6 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4, https://dpmp.unsw.edu.au/sites/default/files/dpmp/resources/Decriminalisation%20briefing%20note%20Feb%202016%20FINAL.pdf (accessed 4 August 2017).

7 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

8 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4.

9 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalisation*, 2016, p. 21, http://www.globalcommissionondrugs.org/reports/advancing-drug-policy-reform/ (accessed 20 November 2017).

10 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4.

11 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

> …should not be overstated in terms of its impact on public health; it is only with substantial investments in harm reduction and treatment services that the health problems primarily associated with problematic use can be mitigated. However, an environment where drug use is not criminalized can reduce the stigma and fear of prosecution, leading to people feeling more able and comfortable to call on services for support should they require it.[12]

Barriers to the implementation of decriminalisation

6.9 Professor Ritter discussed a number of barriers to the implementation of decriminalisation. One is a lack of understanding about what decriminalisation entails; that is, many people think that decriminalisation equates to legalisation.[13] Another barrier is differential support for decriminalisation: some national surveys have shown that Australians support decriminalisation of cannabis but this support does not extend to other drug types.[14] Professor Ritter also identified a lack of political will as a barrier.[15]

6.10 With respect to public support, the AIHW's *National Drug Strategy Household Survey 2016* asked participants what action should be taken against people found in possession of illicit substances. The survey found most participants believed that drug users should be referred to treatment or an education program for drugs except cannabis.[16] For cannabis, survey participants supported a caution, warning or no action (42 per cent in 2013, 47 per cent in 2016).[17]

6.11 For meth/amphetamine possession, less than five per cent of participants supported a caution, warning or no action at all; however, around 45 per cent of survey participants supported meth/amphetamine users being referred to a treatment or education program.[18] Twenty four per cent of participants supported prison sentences for the possession of meth/amphetamine. Figure 6 shows the support for actions taken against people found in possession of selected illicit drugs for personal use in 2016.

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12 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalisation,* 2016, p. 20.

13 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

14 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

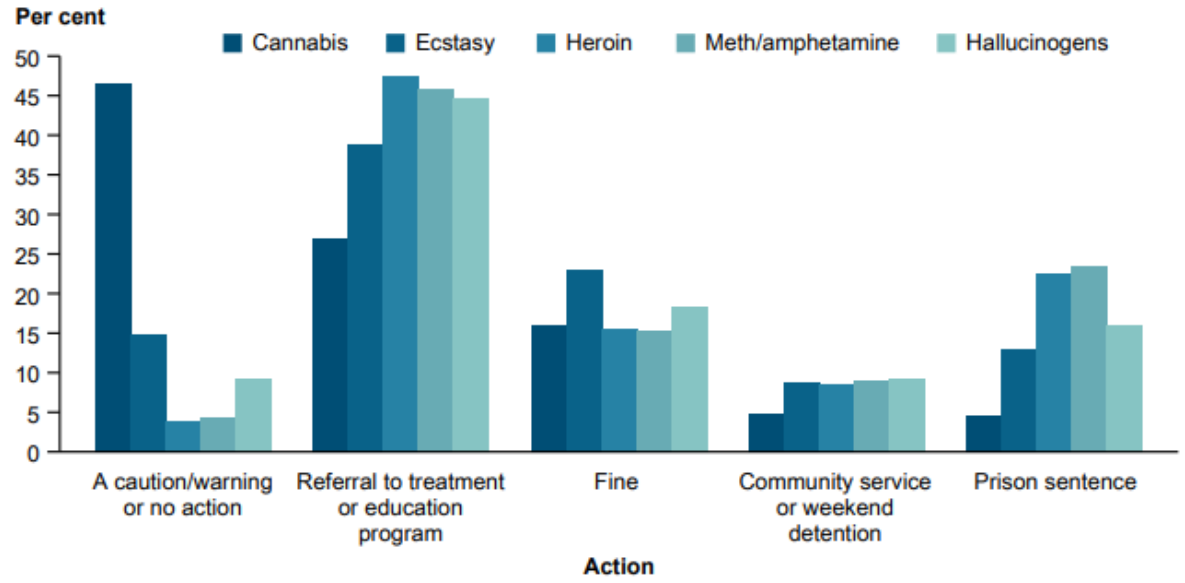
15 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

16 Australian Institute of Health and Welfare (AIHW), *National Drug Strategy Household Survey 2016: Detailed findings*, 2017, p. 130, https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true (accessed 28 February 2018).

17 AIHW, *National Drug Strategy Household Survey 2016: Detailed findings*, 2017, p. 131.

18 AIHW, *National Drug Strategy Household Survey 2016: Detailed findings*, 2017, p. 131.

Figure 6: Support for actions taken against people found in possession of selected illicit drugs for personal use, people aged 14 or older, 2016 (%)[19]



Decriminalisation models

6.12 There are two forms of decriminalisation: de jure decriminalisation (the result of changes to legislation) and de facto decriminalisation (where legislation may prohibit an illicit substance, but the relevant laws are not enforced in practice).[20]

6.13 The NDARC discussed the distinction between these two forms:

- De jure decriminalisation can occur through:
  - removing criminal penalties;
  - replacing criminal penalties with civil penalties (such as a fine) and criminal penalties may be applied if a person fails to comply with the civil penalty; and
  - replacing criminal penalties with administrative penalties (such as a ban on attending a designated site).[21]
- De facto decriminalisation can occur through:
  - non-enforcement of the law (through police discretion or police or prosecutorial guidelines); and

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19 AIHW, *National Drug Strategy Household Survey 2016: Detailed findings*, 2017, p. 131.

20 Peter Homel and Rick Brown, *Marijuana legislation in the United States: An Australian perspective*, Trends & issues in crime and criminal justice, No. 535, June 2017, AIC, p. 2, http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi535.pdf (accessed 4 August 2017).

21 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 2.

- referral of offenders to education/treatment instead of court (eligibility tends to be subject to criteria: such as that this be a first/second offence and criminal penalties may be enforced for non-compliance).[22]

6.14 A criticism of de facto decriminalisation is that it relies upon the application of police and judicial discretion. The NDARC was of the view that this model:

> …creates higher risk of inequality in terms of who avoids criminal sanctions: such as exclusion of disadvantaged and minority groups or geographic differences in policing.[23]

6.15 Another risk arising from de facto decriminalisation is 'net widening', in which:

> …more people are sanctioned after than before reform, due to the greater ease with which police can process minor drug offences. The extent of this depends on the specific choice of policy design and how the reform is implemented (eg whether the consequences for non-compliance are more severe than the original offence; the extent of police discretion).[24]

6.16 In contrast, the NDARC argued that de jure decriminalisation has a much lower risk of inequality[25] but acknowledged that any reform that uses criteria to target particular groups of people or drug types risks inequitable outcomes.[26]

6.17 The NDARC highlighted that 'the way in which decriminalisation is implemented is very important',[27] and if implemented properly decriminalisation will:

> …not lead to increases in crime (through perceptions of weaker laws). Indeed, people who do not receive a criminal record are much less likely to engage in future crime or have subsequent contact with the criminal justice system, even when you take into account their previous offending history. There is also no evidence that decriminalisation will lead to other types of crime, such as supply or drug-related crime.[28]

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22 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 2.

23 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4.

24 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 3.

25 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4.

26 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4.

27 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 3.

28 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 3.

Countries that have adopted a decriminalised model

6.18 Numerous countries have implemented decriminalised drug policies in various ways, including:

- the USA (11 states);
- Netherlands;
- Switzerland;
- France;
- Germany;
- Austria;
- Spain;
- Portugal;
- Belgium;
- Italy;
- Czech Republic;
- Denmark;
- Estonia;
- Ecuador;
- Armenia;
- India;
- Brazil;
- Peru;
- Columbia;
- Argentina;
- Mexico;
- Paraguay;
- Uruguay;
- Costa Rica;
- Norway; and
- Jamaica.[29]

6.19 In 2015, Ireland announced its intention to decriminalise possession of all drugs.[30] On 30 November 2017, the Irish Minister of State announced that legislation

29 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4.

to decriminalise drugs (including heroin, cocaine and cannabis) for personal use could be enacted by early 2019.[31] The Irish government established a special working group to investigate 'alternative approaches to the possession of drugs for personal use'.[32]

6.20 In December 2017, Norway's parliament adopted a decriminalisation model.[33] Norway, the first Scandinavian country to adopt decriminalisation, will implement reforms that 'aim to transfer responsibility for drug policy from the justice system to the health system'.[34]

6.21 A number of Australia's states and territories have also adopted de jure and de facto decriminalisation models. This is discussed further in paragraphs 6.73–6.77.

Legalisation

6.22 Decriminalisation is not legalisation, and it is important to understand the differences between these two legal frameworks. Drug legalisation is where criminal and civil offences for the use/possession (and production/sale) of a drug are removed (rather than reduced to civil/administrative penalties).

6.23 Drug legalisation laws vary, for example they can be:

- limited to use/possession for small amounts of a drug(s) but not extended to the sale or production of a drug (for example, Uruguay's cannabis legalisation laws);[35]
- inclusive of possession/use and the production and sale of that drug (such as cannabis legislation in California);[36] or

30 Kitty Holland, 'Legislation to decriminalise drugs could come in early 2019', *The Irish Times*, 30 November 2017, https://www.irishtimes.com/news/social-affairs/legislation-to-decriminalise-drugs-could-come-in-early-2019-1.3311583 (accessed 18 December 2017).

31 Kitty Holland, 'Legislation to decriminalise drugs could come in early 2019', *The Irish Times*, 30 November 2017.

32 Kitty Holland, 'Legislation to decriminalise drugs could come in early 2019', *The Irish Times*, 30 November 2017.

33 Rebecca Flood 'Norway becomes first Scandinavian country to decriminalise drugs in historic vote', *The Independent*, 15 December 2017, http://www.independent.co.uk/news/health/norway-parliament-drugs-decriminalise-recreational-cocaine-heroin-marijuana-a8111761.html (accessed 18 December 2017).

34 Rebecca Flood 'Norway becomes first Scandinavian country to decriminalise drugs in historic vote', *The Independent*, 15 December 2017.

35 Melia Robinson, 'This South American country has decriminalised all drugs for 40 years, *Business Insider*, 10 June 2016, http://www.businessinsider.com/uruguay-has-decriminalized-all-drugs-for-40-years-2016-6/?r=AU&IR=T (accessed 28 February 2018).

36 Jeremy B White, 'Californians to have marijuana offences wiped from records after drug is legalised, *Independent*, 31 January 2018, http://www.independent.co.uk/news/world/americas/california-marijuana-law-weed-cannabis-illegal-criminal-record-wiped-san-francisco-a8188356.html (accessed 28 February 2018).

- restricted[37] to specific medical/scientific purposes, such as Australia's medicinal cannabis schemes.[38]

6.24 The primary argument in favour of legalisation is that it eliminates, or significantly reduces the black market for illicit drugs and severely undermines the business and profits of serious and organised crime groups. Another argument in favour of legalisation is that it shifts the problem, and its response, away from law enforcement and towards a health response.[39]

6.25 Proponents of drug legalisation also argue that the revenue generated from the sale of illicit drugs through a regulated government body would be accrued much in the same way as gambling, alcohol and tobacco. Professor Ritter identified research by the NDARC that shows that revenue for the state of New South Wales (NSW) could be as high as $600 million per year for a regulated cannabis market.[40]

6.26 Professor Ritter explained that critics of legalisation argue that it would result in a significant increase in the use of those drugs.[41] Further, Professor Ritter advised that the consumption of alcohol and tobacco as legal drugs are 'associated with an extensive economic burden to society – including hospital admissions, alcoholism, treatment programs and public nuisance', and that legalising illicit drugs would add to the economic burden.[42]

6.27 The moral argument against legalisation is that illicit drugs are immoral, anti-social and not accepted in today's society. A legalised model would 'send the wrong message'.[43]

6.28 Professor Ritter noted that there is no direct evidence to support the benefits of legalisation because 'no country[44] has legalised drugs yet. But suppositions can be

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37 On 24 February 2016, the Commonwealth Parliament passed amendments to the *Narcotics Drugs Act 1967* to establish licensing and permit schemes for the legal cultivation and production of cannabis and cannabis resin for medical and scientific purposes. Amendments were also made to the *Therapeutic Goods Act 1989.* See Parliament of Australia, Narcotic Drugs Amendment Bill 2016 Summary, 2016, https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r5609 (accessed 28 February 2018).

38 Therapeutic Goods Administration, *Access to medicinal cannabis products*, 14 February 2018, https://www.tga.gov.au/access-medicinal-cannabis-products (accessed 28 February 2018).

39 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

40 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

41 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

42 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

43 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

made about the extent of cost-savings to society'.[45] She referenced NDARC research on a regulated cannabis market that suggested 'there may not be the significant savings under a legalised regime that some commentators have argued. But these are hypothetical exercises'.[46]

6.29 The experience in the US in relation to the legalisation of cannabis provides an example of the complexities that can arise from legalisation in a federated system. Legalisation of recreational cannabis[47] has occurred in eight states[48] of the US since 2012.[49] Although legal in those states, the AIC reported that there have been no legislative changes at a national level, which has 'led to a number of legislative, regulatory and social ambiguities and tensions of the kind that inevitably arise when communities move to address significant social issues in different ways and at different times'.[50]

6.30 The Canadian parliament is currently considering legislation that would establish a restricted[51] legal cannabis framework. Bill C-45, if passed, would provide 'legal access to cannabis and to control and regulate its production, distribution and

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44 Although no country has legalised drugs, certain states in the United States have legalised cannabis for recreational use. See paragraph 6.23 for further information. Both Uruguay and the Netherlands have strict (de facto) laws in place surrounding the use and sale of cannabis. See Brookings Institute, *Uruguay's Drug Policy: Major Innovations, Major Challenges*, July 2016, https://www.brookings.edu/wp-content/uploads/2016/07/Walsh-Uruguay-final.pdf (accessed 28 February 2018); and, Government of Netherlands, *Toleration policy regarding soft drugs and coffee shops*, https://www.government.nl/topics/drugs/toleration-policy-regarding-soft-drugs-and-coffee-shops (accessed 28 February 2018).

45 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

46 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

47 Medicinal cannabis legislation has been in place in a number of states since 1996. In 2016 there were 30 US states and the Federal District of Columbia that had enacted laws to allow the medical use of cannabis. See Homel and Brown, *Marijuana legislation in the United States: An Australian perspective*, Trends & issues in crime and criminal justice, No. 535, June 2017, AIC, p. 4, http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi535.pdf (accessed 4 August 2017).

48 Alaska, California, Colorado, Maine, Massachusetts, Nevada, Oregon and Washington.

49 Homel and Brown, *Marijuana legislation in the United States: An Australian perspective*, Trends & issues in crime and criminal justice, No. 535, June 2017, AIC, p. 1.

50 Homel and Brown, *Marijuana legislation in the United States: An Australian perspective*, Trends & issues in crime and criminal justice, No. 535, June 2017, AIC, p. 1.

51 Bill C-45 will establish strict cannabis framework that will restrict its sale to young people, protect public health and public safety measures, and deter criminal activity by imposing serious criminal penalties for those operating outside the legal framework. See Parliament of Canada, House of Commons of Canada, Bill C-45, 27 November 2017, http://www.parl.ca/DocumentViewer/en/42-1/bill/C-45/third-reading (accessed 28 February 2018).

sale'.[52] The proposed legalisation scheme only applies to cannabis and cannabis products regulated by the state, and the state will continue to criminalise illicit cannabis trade and consumption. [53]

The Portuguese model

6.31 On 24 to 30 September 2017, the committee visited Portugal to inquire into the country's decriminalised drug model. During the visit, the committee met with representatives from:

- the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);
- the Maritime Analysis and Operations Centre (Narcotics);
- the Centre for Integrated Responses, Regional Health Administration of Lisbon;
- the Commission for the Dissuasion of Drug Addiction;
- the Portuguese Judicial Police;
- the Portuguese Association for Victim Support;
- the Bank of Portugal;
- the General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD);
- the National Program on Mental Health, General-Directorate for Health;
- Casa de Vila Nova (drop-in centre and shelter), Division for Regional Coordination for Addictive Behaviours and Dependencies Intervention, Northern Region Health Administration;
- the Integrated Program for Community Support, Porto; and
- the Guarda Nacional Republicana.

Development and implementation

6.32 In 2001, Portugal decriminalised the use and possession of all illicit drugs. This legislative change was implemented alongside a substantial investment in drug treatment, harm reduction and social re-integration policies.[54] These measures were also implemented within a broader expansion of the Portuguese welfare state. Decriminalisation is recognised as playing an important role in transforming drug use

52 Parliament of Canada, House of Commons of Canada, Bill C-45, 27 November 2017, http://www.parl.ca/DocumentViewer/en/42-1/bill/C-45/third-reading (accessed 28 February 2018).

53 Parliament of Canada, House of Commons of Canada, Bill C-45, 27 November 2017, http://www.parl.ca/DocumentViewer/en/42-1/bill/C-45/third-reading (accessed 28 February 2018).

54 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4.

in Portugal; however, the success of the legislative changes would not have occurred had it not coincided within the framework of 'wider health and social reforms'.[55]

6.33 In the years preceding the implementation of its decriminalisation policy, there was a widespread public perception that drug-related issues were Portugal's main social problem.[56] At the time, the EMCDDA reported that Portugal had equal to or above average rates of problematic drug use and drug-related harms (particularly for heroin use)[57] and more patients were seeking treatment services.[58] Subsequently, the Portuguese government appointed an expert committee comprising doctors, sociologists, psychologists, lawyers and social activists, tasked with analysing Portugal's drug issues and formulating recommendations to develop a national strategy.[59]

6.34 Eight months later, the expert committee recommended that the most effective way to limit drug consumption and reduce the number of dependent persons was to decriminalise drug use and possession for both "hard" and "soft" drugs.[60] Along with legislative changes, the expert committee recommended that the government focus on:

> …preventative and educational, harm reduction, broadening and improving treatment programs for drug dependent persons, and activities that helped at-risk groups and current drug users maintain or restore their connections to family, work and society.[61]

6.35 A central tenet of Portugal's new drug strategy was that:

> …drug use is not good, drugs are not an absolute evil that require high levels of incarceration of drug users as is seen in various "war on drugs" policies elsewhere…trying to create a "drug-free" society was an illusion

55 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight*, June 2014, pp 1–2, https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf (accessed 20 November 2017).

56 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use*, Global Drug Policy Program, June 2011, p. 18, https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf (accessed 4 August 2017).

57 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use*, Global Drug Policy Program, June 2011, p. 19.

58 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use*, Global Drug Policy Program, June 2011, p. 20.

59 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use*, Global Drug Policy Program, June 2011, p. 21.

60 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use*, Global Drug Policy Program, June 2011, pp 23.

61 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use*, Global Drug Policy Program, June 2011, pp 21–22.

> that would never become reality—like creating a society where drivers will not exceed the speed limit.[62]

6.36 This philosophy was intended to capture the diverse reasons for people's drug use, such as personal difficulties, social factors, and recreation and pleasure. The expert committee concluded that:

> …repressive punishment has no rational explanation and is disproportionate against an action that may be unhealthy for the user but is usually not directly harmful or hostile towards others.[63]

6.37 The expert committee argued that under criminal law, drug use and possession hindered people with drug abuse issues from seeking treatment, making them afraid to ask for medical assistance out of fear of punishment and that a criminal record would impact their ability to get jobs and participate in society.[64] According to the Cato Institute, the prime rationale for the decriminalised drug policy was the eradication of barriers that had existed for users to seek treatment:

> …enabling effective treatment options to be offered to addicts once they no longer feared prosecution. Moreover, decriminalization freed up resources that could be channelled into treatment and other harm reduction programs. [Further, the] removal of the stigma attached to criminal prosecution for drug usage would eliminate a key barrier for those wishing to seek treatment.[65]

6.38 Portugal's decriminalisation policy maintains prohibition, but removes drug use from the criminal law framework. This change created the 'legal framework for implementing policies to reduce the harm caused by drug consumption and to socially reintegrate drug dependent persons'.[66]

Legal framework

6.39 Portugal's drug strategy was implemented with the passing of Act No. 30/2000 (Law 30/2000) on 29 November 2000. The Act partially repealed section 40 of Law-Decree No. 15/1993 (Portugal's drug law), which had the effect of

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62 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use,* Global Drug Policy Program, June 2011, p. 22.

63 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use,* Global Drug Policy Program, June 2011, p. 22.

64 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use,* Global Drug Policy Program, June 2011, p. 22.

65 Glen Greenwald, *Drug Decriminalisation in Portugal: Lessons for creating fair and successful drug policies*, Cato Institute, 2009, p. 7, https://www.cato.org/publications/white-paper/drug-decriminalization-portugal-lessons-creating-fair-successful-drug-policies (accessed 21 November 2017).

66 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use,* Global Drug Policy Program, June 2011, p. 22.

changing the use of narcotics and psychotropic substances from criminal offences to administrative/civil offences. [67]

6.40 Law 30/2000 stipulates the amount of a drug a person may possess for personal use (higher amounts are deemed to be for supply) and are considered to be the amount for one person's consumption over a ten-day period.[68] Table 7 shows the amount a user can have in his or her possession under Law 30/2000.

Table 7: Illicit substances and volumes (grams) for possession offences under Law 30/2000[69]

Illicit substance	**Grams**
Heroin	1
Methadone	1
Morphine	2
Opium	10
Cocaine (hydrochloride)	2
Cocaine (methyl ester benzoylecgonine)	0.3
Cannabis (leaves, flower or fruited dons)	25
Cannabis (resin)	5
Cannabis (oil)	2.5
LSD	0.1
MDMA	1
Amphetamine	1

6.41 Under section 4 of Law 30/2000, if police authorities find drugs in a user's possession, they are required to submit an incident report to the local Commission for

67 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations,* additional information received 24 to 30 September 2017, p. 1.

68 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations,* additional information received 24 to 30 September 2017, p. 1.

69 Servico de Intervencao nos Comportamentos Aditovos e nas Dependencias/General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD), *Interventions on Addictive Behaviours and Dependencies,* 12 September 2017, additional information received 24 to 30 September 2017, p. 13.

the Dissuasion of Drug Addiction (CDT).[70] Police authorities are empowered to detain a user 'in order to ensure that he or she appears before the [dissuasion] commission'.[71] According to the General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD), the purpose of each CDT is to:

> …ensure the implementation of decriminalisation Law through the proceedings of administrative offences and the application of measures and penalties foreseen in the Law. These services advocate an integrated approach, centred on health promotion and encouraging motivation to behaviour change of individuals referred by security forces or courts in the context of an episode of possession or use of illicit psychoactive substance.[72]

6.42 The primary goal of the CDT process, according to both Portuguese and European officials, is:

> …to avoid the stigma that arises from criminal proceedings. Each step of the process is structured so as to de-emphasize or even eliminate any notion of "guilt" from drug usage and instead to emphasize the health and treatment aspects of the process.[73]

6.43 CDTs receive drug users instead of criminal courts, with the aim to inform about and dissuade people from drug use. CDTs have the power to impose civil sanctions for non-compliance (for example, if a drug user continually ignores a CDT's ruling) and refer consenting persons to treatment services (treatment is not mandatory).[74] Each CDT is made up of three individuals: a legal expert and two positions selected from medical doctors, psychologists, social service workers and experts from the AOD field.[75]

6.44 Drug users are questioned by a CDT to determine: whether they are a drug addict; the substance(s) consumed; the circumstances of when the user was in contact with police; and the user's economic situation.[76] A therapist may be called upon to

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70 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations,* additional information received 24 to 30 September 2017, pp 1–2.

71 SICAD, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances,* additional information received 24 to 30 September 2017, p. 4.

72 SICAD, *Promote the reduction of the consumption of psychoactive substances and prevent addictive behaviours and decrease dependencies,* additional information received 24 to 30 September 2017, p. 17.

73 Greenwald, *Drug Decriminalisation in Portugal: Lessons for creating fair and successful drug policies,* Cato Institute, 2009, p. 26.

74 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use,* Global Drug Policy Program, June 2011, p. 23.

75 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations,* additional information received 24 to 30 September 2017, p. 2.

76 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations,* additional information received 24 to 30 September 2017, p. 2.

assist the user during this examination.[77] Finally, the CDT or user may request medical examinations (urine/blood tests) to determine the drug(s) consumed.[78]

6.45 If a CDT determines that a user is not a drug addict, it may issue an administrative (monetary or non-monetary) penalty. The sanctions for each case are determined on an individual basis according to the need(s) of the individual in question. The primary aim is to facilitate the prevention of drug use. The CDT does not issue monetary penalties if a user is deemed to be a drug addict.[79]

6.46 Article 15 of Law 30/2000 determines the penalties available to the CDTs. It specifies that:

- non-addicted users are eligible for sentences that require a payment/fine, or a non-pecuniary penalty;
- addicted users are only eligible for non-pecuniary penalties;
- a CDT may determine a penalty that accords with the aim of preventing the consumption of narcotics and psychotropic substances;
- the application of a penalty is determined is informed by:
    - the seriousness of the act;
    - the degree of fault;
    - the type of plants, substances or preparations consumed;
    - the public or private nature of the consumption;
    - for non-addicted users, the occasional or habitual nature of drug use; and
    - the personal circumstances (economic and financial) of the user.[80]

6.47 The upper and lower limits of monetary fines are found under Article 16, with the upper limit determined by the national minimum monthly wage. Non-monetary penalties available include:

- warnings;
- banning from the exercise of a licensed profession (for example a doctor, lawyer or driver in circumstances where drug use could jeopardise the wellbeing of a third party/consumer);

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77 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations*, additional information received 24 to 30 September 2017, p. 2.

78 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations*, additional information received 24 to 30 September 2017, p. 2.

79 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations*, additional information received 24 to 30 September 2017, p. 2.

80 SICAD, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, additional information received 24 to 30 September 2017, p. 6.

- banning from visiting certain places;
- prohibiting the user from engaging with certain persons;
- prohibiting international travel;
- presenting oneself periodically to the dissuasion commission;
- restricting or removing the right to access firearms;
- seizing a user's belongings that may present a risk or harm to the user or community, or which may encourage user to commit a crime; or:
- '…privation from the right to manage the subsidy or benefit attributed on a personal basis by public bodies or services, which shall be managed by the organisation managing the proceedings or monitoring the treatment process, when agreed to by the consumer'.[81]

6.48 A CDT may also request a user to donate a sum of money to a charitable organisation, or undertake community service.[82]

6.49 A CDT may also suspend penalties.[83]

6.50 CDTs may enact a provisional suspension of their proceedings in the following circumstances:

- when a user, with no prior record of a drug offence, is deemed to be a non-addicted drug user;
- when a addicted drug user, with no prior record of a drug offence, agrees to undergo treatment; or
- when an addicted drug user, with a prior record of drug offence, agrees to undergo treatment.[84]

6.51 Proceedings may be suspended for up to two years, with an option of a further 12-month extension if authorised by the CDT.[85] Proceedings of the CDT may be filed

81 SICAD, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, additional information received 24 to 30 September 2017, p. 6.

82 SICAD, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, additional information received 24 to 30 September 2017, p. 6.

83 SICAD, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, additional information received 24 to 30 September 2017, p. 6.

84 SICAD, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, additional information received 24 to 30 September 2017, p. 5.

85 SICAD, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, additional information received 24 to 30 September 2017, p. 6.

and not re-opened, if a non-addicted user does not re-offend, or an addicted user undergoes uninterrupted treatment.[86]

6.52 SICAD provides technical and administrative support to the CDTs. SICAD provides nationally consistent guidelines to ensure uniform application of Law 30/2000 and manages the national database regarding information about 'the administration offence proceedings opened within an episode of consumption or possession for use of illicit psychoactive substances'.[87]

A successful model?

6.53 Portugal's decriminalised model is largely referred to as a model of best-practice.[88] Supporters of decriminalisation argue that since its implementation, Portugal has seen a drop in the number of drug-related deaths and HIV/AIDS notifications, and drug use has broadly remained stable or declined. The NDARC wrote in its 2016 briefing paper on decriminalisation that the Portuguese model has:

> …demonstrated reductions in the burden on the criminal justice system, reductions in problematic drug use, reductions in drug-related HIV and AIDS, reductions in drug-related deaths, and lower social costs of responding to drugs.[89]

6.54 Although there is substantial commentary advocating for Portugal's decriminalised model, it is important to acknowledge it was largely a response to heroin use, and not methamphetamine, and there are differing views about its success.

Impact on drug use

6.55 Since 2001, there have been conflicting accounts of the effect that decriminalisation has had on drug usage rates in Portugal.[90] Usage rates vary depending on the dataset and age group.

6.56 The United Kingdom's Transform concluded that:

- Portugal's levels of drug use are below the European average;
- the most at risk population, people aged between 15–24, have shown a decline in drug use;

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86 SICAD, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, additional information received 24 to 30 September 2017, p. 6.

87 SICAD, *Promote the reduction of the consumption of psychoactive substances and prevent addictive behaviours and decrease dependencies*, additional information received 24 to 30 September 2017, p. 19.

88 For example, the president of the International Narcotics Control Board in 2015 said Portugal's policy as 'a model of best practices'. See Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalisation,* 2016 Report, p. 20.

89 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 4.

90 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight*, June 2014, p. 2.

- lifetime drug use amongst the general population[91] has slightly increased, but remains comparable with nearby countries;
- past-year and past-month[92] drug use amongst Portugal's general population has decreased;
- usage rates amongst adolescents decreased for a number of years following decriminalisation, however, rates have risen to 2003 levels;
- rates of problematic drug use and injecting drug use have decreased (data from 2000 to 2005); and
- the continuation of drug use (the proportion of the population that have reportedly used drug and continue to do so) has decreased.[93]

6.57 Transform explained that the removal of criminal sanctions did not cause an increase in drug use and:

> There is essentially no relationship between the positiveness of a country's drug laws and its rates of drug use. Instead, drug use tends to rise and fall in line with broader cultural, social or economic trends.[94]

6.58 A paper by Caitlin Elizabeth Hughes and Alex Stevens published in *Drug and Alcohol Review* demonstrated trends for recent and current drug use amongst Portugal's general population (15 to 64 years old). This data indicated a minimal change between 2001 and 2007. Lifetime use, which represents the rate of discontinued drug use for those that have tried a drug but have not used in recent years, had increased. Hughes and Stevens argued that this trend reinforces that the growth in lifetime use is indicative of short-term experimental use.[95] Further, the authors concluded that while there has been an increase in recent and current drug use for 25 to 34 year olds, there has been 'an overall positive net benefit for the Portuguese

91 Transform added that lifetime use is considered to be the least accurate measure of a country's current drug use situation.

92 Transform noted that these two measures are viewed as the best indicators of drug use trends.

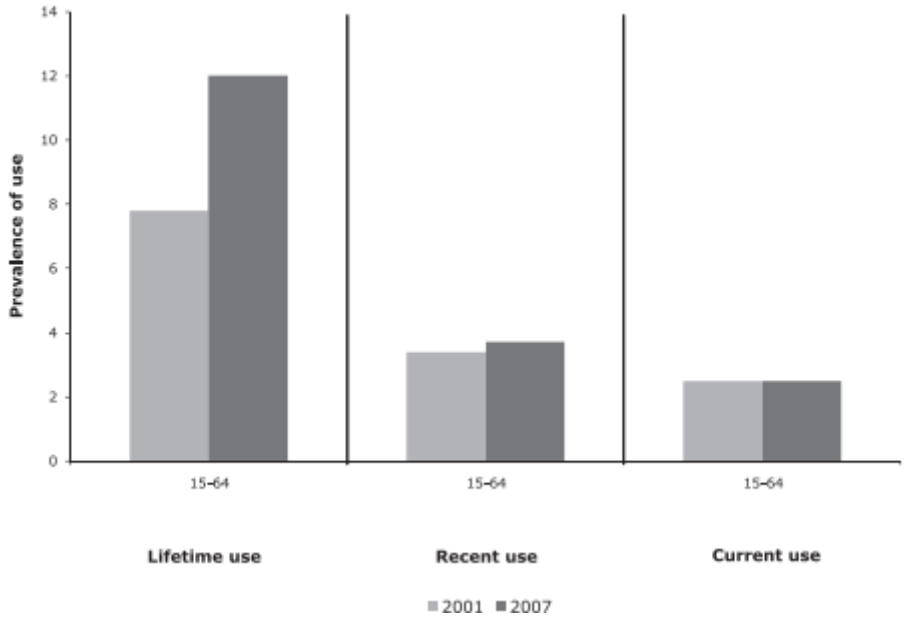
93 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight,* June 2014, p. 2.

94 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight,* June 2014, p. 2.

95 Caitlin Elizabeth Hughes and Alex Stevens, 'A resounding success or a disastrous failure: Re-examining the interpretations of evidence on the Portuguese decriminalisation of illicit drugs, *Harm Reduction Digest–44,* Drug and Alcohol Review, January 2012, p. 105, https://kar.kent.ac.uk/29901/1/Hughes%20%20Stevens%202012.pdf (accessed 23 November 2017).

community'.[96] Figure 7 shows a comparison between 2001 and 2007 prevalence of use data in Portugal.

Figure 7: Prevalence of use (lifetime, recent and current), 2001 and 2007[97]



Health outcomes

6.59 The Portuguese government implemented decriminalised drug laws alongside a substantial investment and expansion of treatment services aimed at drug users (such as opiate substitution and needle exchange programs). For this reason, the positive health outcomes cannot be fully explained by decriminalisation. However, evidence suggests decriminalisation allowed drug users to actively seek treatment options without the fear of criminal penalties. According to the Cato Institute, enabling drug users to seek treatment services in a decriminalised framework 'enables the management and diminution of drug-related harms' and resulted in an increase in the number of people seeking treatment in a post-decriminalised setting.[98] This setting has drastically reduced drug-related harms.[99]

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96 Hughes and Stevens, 'A resounding success or a disastrous failure: Re-examining the interpretations of evidence on the Portuguese decriminalisation of illicit drugs, *Harm Reduction Digest–44*, Drug and Alcohol Review, January 2012, p. 105, https://kar.kent.ac.uk/29901/1/Hughes%20%20Stevens%202012.pdf (accessed 23 November 2017).

97 Hughes and Stevens, 'A resounding success or a disastrous failure: Re-examining the interpretations of evidence on the Portuguese decriminalisation of illicit drugs, *Harm Reduction Digest–44*, Drug and Alcohol Review, January 2012, p. 105.

98 Greenwald, *Drug Decriminalisation in Portugal: Lessons for creating fair and successful drug policies*, Cato Institute, 2009, p. 15.

99 Greenwald, *Drug Decriminalisation in Portugal: Lessons for creating fair and successful drug policies*, Cato Institute, 2009, p. 15.

6.60 In 1999, Portugal had the highest rate of HIV amongst its injecting drug users in the European Union. Since decriminalisation, Portugal has seen a significant decline in the number of HIV cases amongst people who inject drugs.[100] Transform reported that between 2001 and 2012, the number of newly diagnosed HIV cases fell from 1016 to 56.[101] The number of AIDS cases over that same period fell from 568 to 38.[102] Similar trends were seen with cases of Hepatitis C and B. These trends have occurred despite there being an increase in the number of people accessing treatment services.[103]

6.61 Figure 8 shows Portugal's HIV/AIDS notifications between drug users and non-drug users from 2000 to 2006. This data indicates an overall reduction for both drug users and non-drug users; however, the decline has been more drastic for drug users.[104]

100 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight*, June 2014, p. 3.

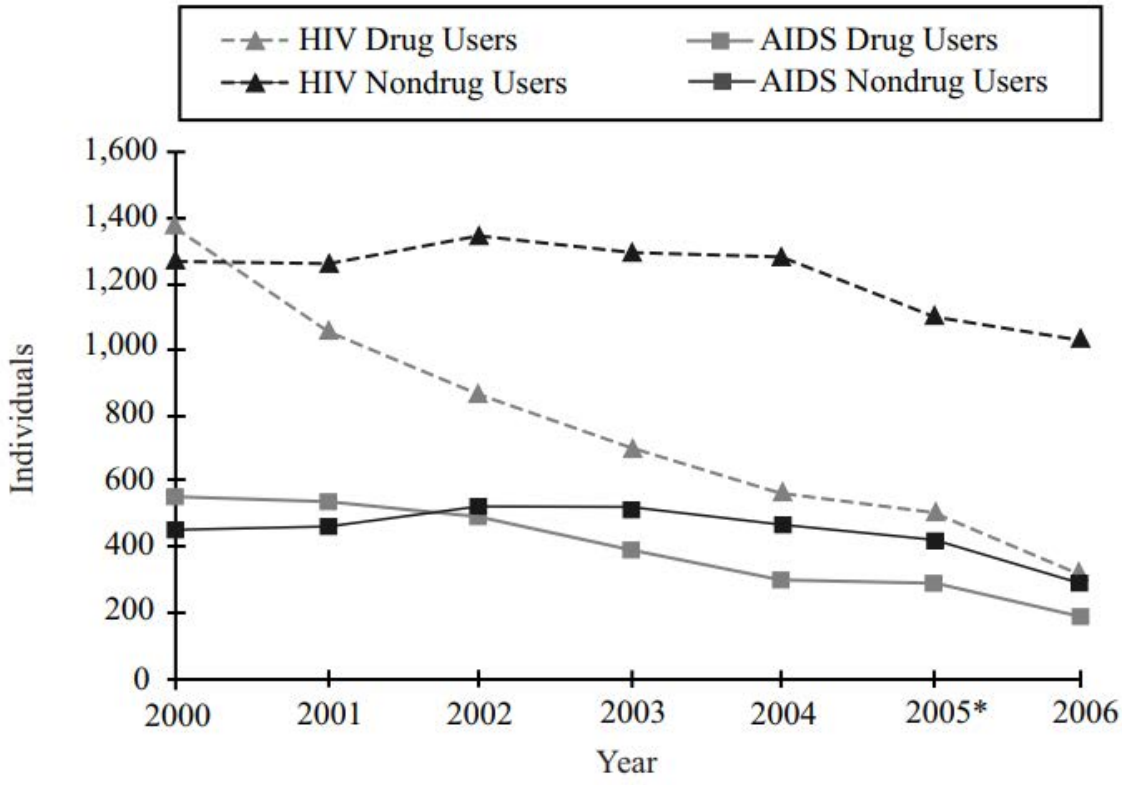
101 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight*, June 2014, p. 3.

102 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight*, June 2014, p. 3.

103 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight*, June 2014, p. 3.

104 Greenwald, *Drug Decriminalisation in Portugal: Lessons for creating fair and successful drug policies*, Cato Institute, 2009, p. 17.

Figure 8: Portugal's HIV/AIDS notification between drug users and non-drug users, 2000–06[105]



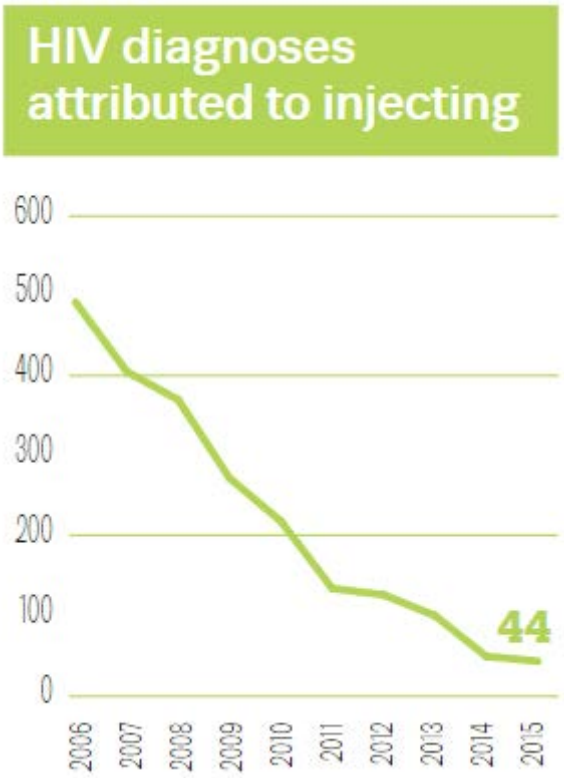
6.62 According to the EMCDDA, since 2006 there has been a continual decline in the number of HIV diagnoses attributed to injecting drugs.[106] In 2015 the number reached a low of 44 cases.[107] Figure 9 shows Portugal's HIV diagnosis rate attributed to injecting drugs from 2006 to 2015.

105 Greenwald, *Drug Decriminalisation in Portugal: Lessons for creating fair and successful drug policies*, Cato Institute, 2009, p. 17.

106 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Portugal Country Drug Report 2017*, http://www.emcdda.europa.eu/countries/drug-reports/2017/portugal_en (accessed 22 November 2017).

107 EMCDDA, *Portugal Country Drug Report 2017.*

Figure 9: Portugal's HIV diagnosis attributed to injecting drugs, 2006–15[108]



Drug-related deaths

6.63 Evidence suggests drug-related deaths in Portugal have declined since decriminalisation; however, there are limitations to the available data.[109] Documents provided by SICAD show the number of overdoses has drastically fallen between 2008 and 2014.[110] In 2008, there were reportedly 94 overdose deaths, and in 2014, this total had declined to 33.[111] This total accounted for only 15 per cent of all drug-related deaths.[112] Transform reported that deaths due to drug use had decreased from approximately 80 in 2001, to 16 in 2012.[113]

108 EMCDDA, *Portugal Country Drug Report 2017.*

109 Hughes and Stevens, 'A resounding success or a disastrous failure: Re-examining the interpretations of evidence on the Portuguese decriminalisation of illicit drugs, *Harm Reduction Digest–44*, Drug and Alcohol Review, January 2012, p. 105.

110 SICAD, *Interventions on Addictive Behaviour and Dependencies*, additional information received 24 to 30 September 2017, p. 32.

111 SICAD, *Interventions on Addictive Behaviour and Dependencies*, additional information received 24 to 30 September 2017, p. 32.

112 SICAD, *Interventions on Addictive Behaviour and Dependencies*, additional information received 24 to 30 September 2017, p. 32.

113 Transform Drug Policy Foundation, *Drug decriminalisation in Portugal: setting the record straight*, June 2014, p. 3.

6.64 The Portuguese National Statistics Institute refers to 'the number of people that have been determined by doctors according to International Classification of Disease protocols to have died from drugs'.[114] This data shows the number of people that died due to drug use had decreased from 2001 to 2005, and then increased from 2005 to 2008. Hughes and Stevens observed that this decline cannot be solely attributed to decriminalisation and that expanded health services also provide a plausible explanation.[115] However, they noted that:

> …a key goal of the reform had been to reduce social stigma and thereby facilitate access to Portuguese drug treatment and harm reduction services…drug treatment access in Portugal expanded considerably post-reform. This provides partial evidence that the reform may have contributed to the observed declines.[116]

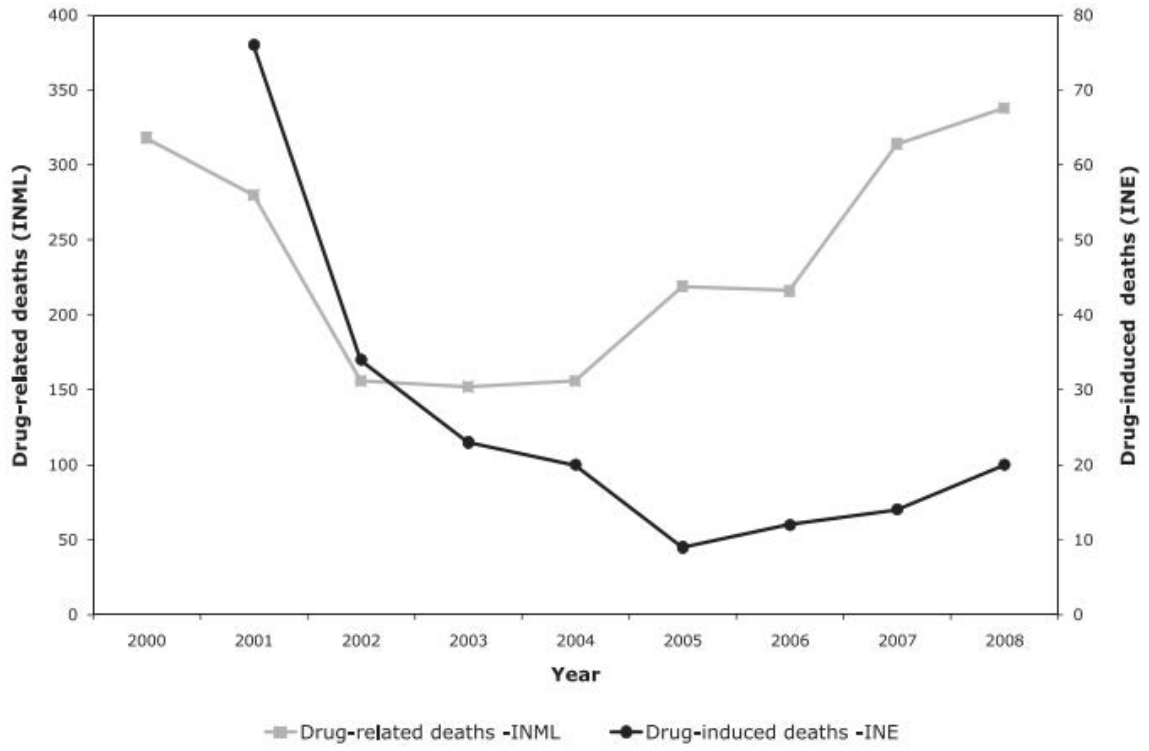
6.65 Figure 10 shows drug-related deaths and drug-induced deaths in Portugal between 2000 and 2008.

114 Hughes and Stevens, 'A resounding success or a disastrous failure: Re-examining the interpretations of evidence on the Portuguese decriminalisation of illicit drugs, *Harm Reduction Digest–44*, Drug and Alcohol Review, January 2012, p. 108.

115 Hughes and Stevens, 'A resounding success or a disastrous failure: Re-examining the interpretations of evidence on the Portuguese decriminalisation of illicit drugs, *Harm Reduction Digest–44*, Drug and Alcohol Review, January 2012, p. 108.

116 Hughes and Stevens, 'A resounding success or a disastrous failure: Re-examining the interpretations of evidence on the Portuguese decriminalisation of illicit drugs, *Harm Reduction Digest–44*, Drug and Alcohol Review, January 2012, p. 108.

Figure 10: Drug related deaths and drug induced death in Portugal, 2000–08[117]

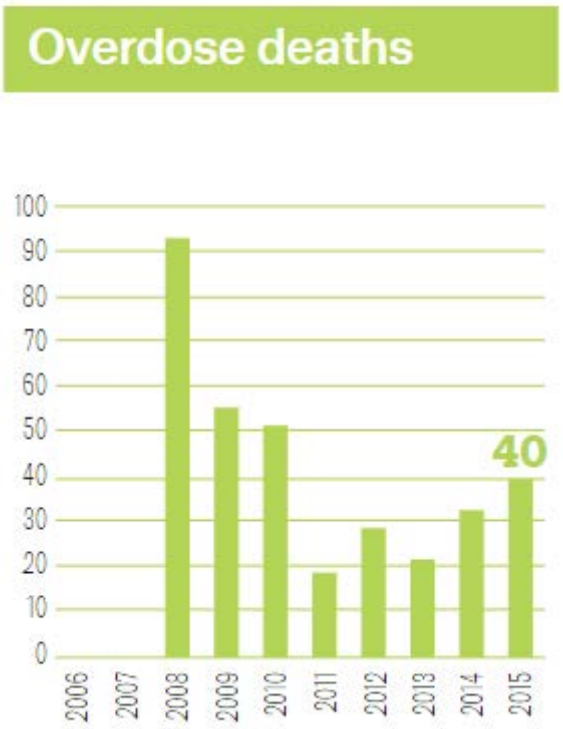


6.66 The EMCDDA 2017 drug report for Portugal shows that overdose deaths have reduced significantly since 2008, but have steadily increased since a low in 2011.[118] Figure 11 shows EMCDDA drug overdose deaths in Portugal between 2006 and 2015.

117 Hughes and Stevens, 'A resounding success or a disastrous failure: Re-examining the interpretations of evidence on the Portuguese decriminalisation of illicit drugs, Harm Reduction Digest–44, Drug and Alcohol Review, January 2012, p. 108.

118 EMCDDA, *Portugal Country Drug Report 2017*, http://www.emcdda.europa.eu/countries/drug-reports/2017/portugal_en (accessed 22 November 2017).

Figure 11: Overdose deaths in Portugal, 2006–15[119]



Law enforcement

6.67 The two primary concerns about the Portuguese model, prior to its introduction, were that it would lead to an increase in drug use, and that Portugal would become a drug paradise, facilitating "drug tourism" where foreigners would travel to Portugal use drugs without risk of serious conflict with the law.[120] The Portuguese Judicial Police,[121] which shared these concerns, advised the committee that many of the concerns about decriminalisation had not eventuated.[122] The Judicial Police reported that the vast majority of Portuguese law enforcement officers 'now consider that the solutions adopted by [Law 30/2000] were the right ones'.[123]

6.68 With regard to drug tourism, data from the Institute on Drugs and Drug Addiction of Portugal for 2001–05 showed that approximately 95 per cent of

119 EMCDDA, *Portugal Country Drug Report 2017*.

120 Open Society Foundation, *Drug Policy in Portugal: The benefits of Decriminalizing drug use*, Global Drug Policy Program, June 2011, p. 24.

121 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations*, additional information received 24 to 30 September 2017, p. 4.

122 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations*, additional information received 24 to 30 September 2017, p. 4.

123 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations*, additional information received 24 to 30 September 2017, p. 4.

individuals cited for drug offences were Portuguese and few came from other European Union states.[124]

6.69 Since the implementation of Law 30/2000, Portuguese law enforcement agencies and courts have seen a 'significant savings in human and material resources, apart from a decrease in the level of conflicts [in regard to] police action in the streets'.[125] Most critically, '[d]rug users stopped being looked at as criminals'[126] and police resources have been re-directed to target drug trafficking.[127]

6.70 The Global Commission on Drug Policy has stated that decriminalisation for drug use and possession effectively:

> …free up police time, allowing them to focus on more serious crimes such as property and violent crimes. Portugal witnessed a decline in the number of criminal drug offenses from approximately 14,000 per year in 2000 to an average of 5,000-5,500 per year after decriminalization, and the number of people incarcerated for low-level drug offending fell from 44 percent of all prisoners in 1999 to 24 percent by 2013, resulting in a substantial reduction in prison overcrowding.[128]

Social costs

6.71 In the first 10 years of decriminalisation, Portugal saved 18 per cent in social costs.[129] According to the Global Commission on Drug Policy, these saving were largely due to the opportunity for drug users to maintain an income and productivity:

> …as a result of individuals avoiding imprisonment for drug possession, and indirect health costs such as the reduction of drug-related deaths and HIV rates. There were, furthermore, direct savings to the criminal justice system resulting from decriminalization, something a number of other jurisdictions have experienced.[130]

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124 Greenwald, *Drug Decriminalisation in Portugal: Lessons for creating fair and successful drug policies,* Cato Institute, 2009, p. 6 and p. 8.

125 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations,* additional information received 24 to 30 September 2017, p. 3.

126 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations*, additional information received 24 to 30 September 2017, p. 3.

127 Policia Judiciaria, Ministerio da Justica, *Police Action in Drug Use Situations*, additional information received 24 to 30 September 2017, p. 3.

128 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalisation,* 2016, p. 21.

129 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalisation,* 2016, p. 21.

130 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalisation,* 2016, p. 21.

Overview of Australia's current illicit drug laws

6.72 Use and possession laws are primarily the responsibility of the states and territories, not the Commonwealth. According to the NDARC's 2016 briefing paper, most states and territories have laws in place that make drug use and possession a criminal offence that can be sanctioned with up to two years prison.[131]

6.73 The states and territories have adopted elements of both de jure and de facto decriminalisation:

- All Australian states and territories provide diversion programs for cannabis use.
- South Australia (SA), the Australian Capital Territory (ACT) and the Northern Territory (NT) have adopted de jure decriminalisation for cannabis use and possession.[132] In these jurisdictions, people are issued a fine ($100 to $300) rather than a criminal sanction.[133]
- De facto policies exist in all states and territories to various degrees. Victoria, Western Australia (WA), Tasmania, SA, the NT and the ACT have enacted de facto policies for the use and possession of other illicit drugs.
- Queensland and NSW have only implemented de facto reform for cannabis use and possession, compulsory criminal sanctions remain for all other illicit drugs.[134]

6.74 Table 8 details current decriminalisation approaches in each state and territory, separated into de jure and de facto, and cannabis and other drugs (for people aged 18 years and over).[135]

131 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 5.

132 Professor Ritter, *Decriminalisation or legalisation: injecting evidence in the drug law reform debate*, NDARC, 22 April 2016.

133 NDARC's submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 164, March 2017, p. 3.

134 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 5.

135 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 5.

Table 8: State and territory decriminalisation approach by type and drug[136]

	De jure reform		De facto reform	
	Cannabis	**Other illicits**	**Cannabis**	**Other illicits**
NSW			✓	
Qld			✓	
Vic			✓	✓
SA	✓			✓
WA			✓	✓
Tas			✓	✓
ACT	✓		✓	✓
NT	✓			✓

De facto policies

6.75 State and territory de facto policies (where drug use remains a criminal offence) are police referral programs where drug users undergo education, assessment and/or treatment. Users' eligibility for these programs is often limited, for example a user may need to admit to an offence and be a first or second time offender.[137] These initiatives are commonly known as drug diversionary schemes and can exist alongside other initiatives such as cautioning schemes and drug courts.

6.76 Drug courts are designed to direct offenders to treatment as part of the judicial process.[138] Drug courts divert drug offenders into treatment and, according to St Vincent's Health Australia, are an 'effective and less expensive option that offers the best chance of recovery when compared to the expensive option of incarceration'.[139] NSW, Victoria, WA and SA have had specialised drug courts since the late 1990s and early 2000s.[140] Queensland reinstated its Drug and Alcohol Court on

136 NDARC, *Decriminalisation of drug use and possession in Australia – A briefing note*, Drug Policy Modelling Program, 2016, p. 5.

137 NDARC, submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 164, March 2017, p. 3.

138 Queensland Network of Alcohol and Other Drug Agencies (QNADA), *Submission 20*, p. 4.

139 St Vincent's Health Australia, *Submission 18*, p. 22.

140 Australia's first drug court opened in NSW in 1999. South Australia and Western Australia have had drug courts since 2000, Victoria since 2002. See Ryan Kornhauser, 'The effectiveness of Australia's drug courts', *Australian & New Zealand Journal of Criminology*, Vol. 51(1), p. 77, 2018.

29 January 2018.[141] The NT,[142] ACT[143] and Tasmania[144] have diversionary programs available through the regular court structure.

6.77 In relation to drug courts, St. Vincent's Health Australia remarked:

> In our opinion, there should be greater utilisation of treatment and rehabilitation programs for offenders with drug-related crimes; however, what is required is a long-term approach to ensure effectiveness. Currently, many individuals who are referred for treatment on short term orders are not provided the opportunity for the necessary extended support which is required when using drugs. As health professionals, it is our view that effective treatment of addictions can only be achieved when adequate resources enable relationships to be maintained long enough to make a difference psychologically, physiologically and socially.[145]

6.78 St Vincent's Health Australia also observed that:

> …courts require research data to inform the most effective sentencing options for encouraging recovery or responses which do not require incarceration to rehabilitate drug users who interact with the justice system. This is why having a systemic and national approach to data measures would enable the right policies to be put in place.[146]

6.79 The committee considered diversionary programs in its first report.[147]

De jure policies

6.80 As noted in paragraph 6.73, de jure policies for cannabis use and possession (in small quantities) have been adopted in SA, the ACT and the NT. However, there have been a growing number of calls for the adoption of de jure decriminalisation in all jurisdictions across Australia for all illicit drug types.

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141 Queensland Courts, *Queensland Drug and Alcohol Court,* http://www.courts.qld.gov.au/courts/drug-court (accessed 21 March 2018).

142 The NT has an Infringement Notice System, and for young offenders a cautioning system available through police and the court. See NT Government, *Young people: diversion programs,* https://nt.gov.au/law/young-people/young-people-diversion-programs (accessed 21 March 2018).

143 The ACT has a Court Alcohol and Drug Assessment Service (CADAS) scheme in use by its Magistrates, Children's and Supreme courts. See ACT Health, *Diversionary services,* http://www.health.act.gov.au/our-services/alcohol-and-other-drugs/diversion-services (accessed 21 March 2018).

144 Magistrates Court of Tasmania, *Doing a drug treatment order,* http://www.magistratescourt.tas.gov.au/about_us/criminal_division/drug_treatment_orders (accessed 21 March 2018).

145 St Vincent's Health Australia, *Submission 18,* p. 22.

146 St Vincent's Health Australia, *Submission 18,* p. 22.

147 PJCLE, *Inquiry into crystal methamphetamine (ice): First Report,* September 2017, pp 105–110.

6.81 For example, in 1992, the Australian Parliamentary Group for Drug Law Reform was launched, which in 1993 endorsed the Charter for Drug Law Reform (the Charter). The Charter had the short term goal of seeking the 'abolition of criminal sanctions for the personal use of drugs of dependence and psychotropic substances throughout Australia'.[148]

6.82 In 2012, Australia21 released a report on its second roundtable discussion on drug law reform. The roundtable considered new approaches to policy about illicit drugs in Australia, and comprised 22 experts and youth representatives who considered international approaches to drug use (including Portugal) and Australia's current policies. The report made a broad range of recommendations and outlined specific reform options. One reform option was the removal of 'sanctions for personal use and possession of drugs and drug-using paraphernalia'.[149]

6.83 In 2016, the Parliament of Australia hosted a cross-party Parliamentary Drug Summit. The summit brought together international and Australian representatives from the health sector, non-government organisations, law enforcement and academia to consider harm minimisation and drug law reform. It called for the removal of criminal sanctions for personal drug use along with other harm reduction and treatment initiatives.[150] In the same year, the NSW Parliament also hosted a Parliamentary Cross-Party Harm Minimisation Roundtable to consider and advocate for drug law reform in NSW.[151]

6.84 On 29 March 2018, the Victorian Parliamentary Law Reform, Road and Community Safety Committee (the Victorian committee) will report on its inquiry into drug law reform.[152] A significant number of submissions to that inquiry overwhelmingly support de jure decriminalisation of drug use and possession.

6.85 The National Drug Research Institute's (NDRI) submission to the Victorian committee expressed concern that a criminalised drug policy contributes to harmful and counterproductive stigmatisation of drug users.[153] NDRI research conducted between 2014 and 2017, showed that drug users have 'a range of negative and

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148 Australian Drug Law Reform Foundation, *Charter*, https://adlrf.org.au/charter/ (accessed 23 November 2017).

149 Australia21, *Report on the second Australia21 Roundtable on illicit drugs held at The University of Melbourne on 6 July 2012*, September 2012, p. 38.

150 Drug Policy Forum, *Parliamentary Drug Summit 2016*, http://www.drugpolicyreform.com.au/ (accessed 23 November 2017).

151 Parliament of New South Wales, *Illegal drug use and possession: Current policy and debates, https://www.parliament.nsw.gov.au/news/Pages/IllegaldruguseandpossessionCurrentpolicyanddebates.aspx* (accessed 24 November 2017).

152 Law Reform, Road and Community Safety Committee, Parliament of Victoria, *Inquiry into drug law reform*, https://www.parliament.vic.gov.au/lrrcsc/inquiries/article/2809 (accessed 24 November 2017).

153 The National Drug Research Institute's (NDRI) submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 136, p. 5.

discriminatory experiences with police and the criminal justice system'; that criminalisation is a 'key driver of the stigma surrounding drug consumption'; and that 'stigmatisation was considered unlikely to diminish to any significant degree until the laws surrounding drug use were revised'.[154] The NDRI concluded that overall, there is a:

> …need to address the relationship between stigma and institutional and legal conditions. Measures that treat stigma only as an individual issue that can be tackled through education and interaction with stigmatised individuals ignore its institutional dimension and are thus less likely to eradicate the pernicious forms of stigma inherent in institutional processes. This points to a need to take seriously increasing calls for decriminalisation/drug law reform.[155]

6.86 The NDARC's submission to the Victorian committee highlighted decriminalisation of illicit drug use and possession as law reform that should be considered. It outlined the weaknesses of current de facto approaches, in particular the strict eligibility requirements that limit access to drug diversionary schemes 'particularly for people who are more marginalised and/or in need of diversion into treatment and rehabilitation'.[156] It then outlined the benefits of de jure drug policy and noted that the Portuguese experience:

> …illustrates the benefits of applying decriminalisation to all illicit drugs. If further shows how drug law reform can be a tool not only reduce adverse impacts on those detected by police, but also to foster a more public-health approach towards drugs, including by reducing the stigma and discrimination of people who use drugs and facilitate access to harm reduction and treatment services…It would be prudent for Victoria to follow the international and domestic examples, and calls of bodies including the World Health Organisation, and decriminalise use and possession for personal use of all illicit drugs.[157]

6.87 Uniting Care ReGen recommended the removal of criminal penalties for individual use and possession of all illicit drugs, to be replaced with civil penalties or diversionary programs into treatment and/or drug educational programs.[158] In Uniting Care ReGen's view, decriminalisation has the 'clearest evidentiary support' and:

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154 NDRI's submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 136, p. 5.

155 NDRI's submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 136, p. 6.

156 NDRARC's submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 164, p. 6.

157 NDRARC's submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 164, p. 6.

158 UnitingCare ReGen, Submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, Submission no. 168, p. 1.

> There is established public support for such a move and a growing recognition amongst policy makers of the need to adopt a policy approach that recognises illicit drug use a health issue, not a criminal matter.[159]

6.88 The Alcohol and Drug Foundation's (ADF) submission to the Victorian committee encouraged governments to 'act with caution' before proceeding with the liberalisation of drug laws.[160] The ADF's submission noted researchers' concerns that the outcomes of drug liberalisation are difficult to predict, and such measures may not be readily reversible and may entrench 'undesirable social norms'.[161] The ADF, however, discusses the Portuguese approach and stated that this option 'would require a large expansion of drug treatment and education services although the cost would likely be defrayed by cost savings in the judicial and custodial systems'.[162]

6.89 Addiction medicine doctor Associate Professor Nadine Ezard reflected upon her experience witnessing 'first-hand the increased harm to individuals, and their communities, of criminalising drug use'.[163] Professor Ezard noted that communities are adversely impacted by criminalisation because of the increased stigma and marginalisation of people who use drugs, 'and resources consumed by law enforcement activities would be more effectively allocated to treatment services, reinforce limited access to and uptake of treatment'.[164] She concluded that those jurisdictions with de jure policies for cannabis use and possession 'have far lower proportion of use/possess offenders referred by police to courts, than states without'.[165]

6.90 In its final report, the National Ice Taskforce (NIT) noted that decriminalisation was 'raised at some community meetings and in some submissions.

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159 UnitingCare ReGen, Submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, Submission no. 168, p. 1.

160 The Alcohol and Drug Foundation's (ADF) submission refers to the Portugal's drug policy as a depenalisation, citing that it is commonly confused with the term decriminalised. See ADF, Submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, Submission no. 218, p. 9.

161 ADF submission refers to Portugal's drug policy as a depenalisation, citing that it is commonly confused with the term 'decriminalised'. See ADF, Submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, Submission no. 218, p. 9.

162 ADF, Submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 218, p. 9.

163 Associate Professor Nadine Ezard, Submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 221, p. 1.

164 Associate Professor Ezard, Submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 221, p. 1.

165 Associate Professor Ezard, Submission to the Parliament of Victoria's Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform*, Submission no. 221, p. 1.

However, it was not discussed at length in meetings and it was not a prevalent theme in the consultations'.[166]

Committee comment

6.91 The committee's visit to Portugal provided it with valuable insight into that country's decriminalised drug framework. The Portuguese model offers an alternative to criminalisation and the "war on drugs". Whilst maintaining criminal sanctions against individuals and organised crime groups responsible for the trafficking of drugs, Portugal's drug users are treated with compassion. They are supported by police and the CDTs to receive education about the harms of drug use and attend voluntary treatment. Portugal has created an environment the purpose of which is to improve drug users' health, irrespective of whether or not they continue to use drugs, and that enables drug users to pursue treatment for their drug use without fear of criminal sanctions. The Portuguese drug framework has reduced the spread of HIV/AIDS and improved mortality rates, and appears to have the support of law enforcement agencies.

6.92 While decriminalised drug policies are demonstrated to have a positive impact on health outcomes for drug users, decriminalisation is not a "silver bullet". Reform to decriminalise drug use must occur in conjunction with investment in treatment services to ensure drug users are able to transition into treatment services without delay. The committee agrees with analyses that attribute the success of Portugal's approach to this combination of drug law reform and investment in treatment services.

6.93 As discussed earlier in this report, the committee believes that additional funding and increased capacity is needed in Australia's drug treatment sector. This should occur irrespective of whether illicit drugs, or particular illicit drugs, are decriminalised now or in the future in Australian jurisdictions. However, a substantial increase in the capacity and availability of treatment services would be necessary if Australia transitioned to a decriminalised model such as Portugal's.

6.94 The committee has not reached a concluded view about the appropriateness of decriminalisation of methamphetamine or a broader range of illicit drugs in Australia. The committee is cognisant of the jurisdictional challenges that arise in a federated system and the legal complexity and ambiguity that might be created if the Commonwealth and states and territories take different approaches. The committee is also cautious about endorsing the Portuguese model for implementation in Australia: the Portuguese experts and agencies with which the committee met repeatedly emphasised that the Portuguese approach was one intended to address heroin use, and not methamphetamine, and that the availability of pharmacotherapy to treat heroin use makes treating that drug addiction a different proposition to methamphetamine.

6.95 If Australian governments are of a mind to give serious consideration to decriminalisation in Australia, the committee suggests that the approach taken in Portugal of appointing an expert panel comprising doctors, sociologists, psychologists, lawyers, AOD treatment specialists and law enforcement

166 NIT, *Final Report*, p. 170.

representatives is an excellent example. The primary objective of such an expert panel would be to develop a strategy that aims to improve health outcomes for Australian drug users.

6.96 Successful implementation of decriminalisation in Australia would require the engagement and commitment of the Commonwealth and state and territory governments. Political will and leadership would be essential to building public understanding of and support for such an approach. The success of research examining pharmacotherapies for methamphetamine users, such as that of Professor Rebecca McKetin (see chapter 2), would also have a bearing on the timing and appropriateness of decriminalisation of methamphetamine in Australia.

6.97 What is clear to the committee is that the current approach in Australia is not working. Methamphetamine abuse can have devastating effects on individuals, their families and communities, and has broader social and economic impacts. When former law enforcement officers and law enforcement agencies themselves are saying that Australia cannot arrest its way out of the methamphetamine problem, that view must be taken seriously.

6.98 The committee urges Australian governments to implement the recommendations in this and the committee's first report. Improvements can and must be made in addressing methamphetamine use in Australia; in the committee's opinion, this should be done by shifting the focus on methamphetamine from a law enforcement problem to a health issue within an environment where treatment and support are readily available and without stigmatisation. Concerted attention must also be paid to improving the services and support available to Indigenous drug users, drug users in regional and remote areas, prisoners and drug users with young children. Achieving this necessitates changes as articulated in the committee's recommendations.

Mr Craig Kelly MP
Chair

Appendix 1

Australian Press Council's Specific Standards on Coverage of Suicide

General reporting and discussion

1. General reporting and comment on issues relating to suicide[1] can be of substantial public benefit. For example, it may help to improve public understanding of causes and warning signs, have a deterrent effect on people contemplating suicide, bring comfort to affected relatives or friends, or promote further public or private action to prevent suicide.

2. Subject to careful compliance with the following Standards, the Council does not wish to discourage material of this nature. Extra caution is required when the material is likely to be read or seen by people who may be especially vulnerable (e.g., because of their age or mental health) and relates to suicides by their peers or by celebrities.

Reporting individual instances

3. In deciding whether to report an individual instance of suicide, consideration should be given to whether at least one of the following criteria is satisfied:

(a) clear and informed consent[2] has been provided by appropriate relatives or close friends[3]; or

(b) reporting the death as suicide is clearly in the public interest[4].

4. In deciding whether also to report the identity of the person who has died by suicide, account should be taken of whether at least one of the following criteria is satisfied:

(a) clear and informed consent has been provided by appropriate relatives or close friends; or

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1 References above to suicide apply also to attempted suicide. References to reports include all types of report (including of court proceedings or inquests) and headlines, text, images and sounds.

2 A matter is in the public interest if it is of substantial and widespread significance, not merely something in which many people may be interested. It may often be helpful for the assessment to be made at editorial level after seeking advice from an appropriate mental health expert. It may also be necessary to consult police, school principals, public health authorities or other people with special knowledge of the likely impacts of publication in the particular case.

3 A person can give informed consent to a report if they are reasonably aware of the circumstances to which it relates and the likely consequences for them of it being published. This may be difficult or impossible to obtain in the immediate aftermath of a suicide.

4 Often it will be important to request and conduct interviews with closely affected people by going through an intermediary such as a relative, professional counsellor or support organisation.

(b) identification is clearly in the public interest.

Reporting methods and locations

5. The method and location of a suicide should not be described in detail (e.g., a particular drug or cliff) unless the public interest in doing so clearly outweighs the risk, if any, of causing further suicides. This applies especially to methods or locations which may not be well known by people contemplating suicide.

Responsibility and balance

6. Reports should not sensationalise, glamorise or trivialise suicides. They should not inappropriately stigmatise suicides or people involved in them. But this does not preclude responsible description or discussion of the impacts, even if they are severely adverse, on people, organisations or communities. Where appropriate, underlying causes such as mental illness should be mentioned.

Sensitivity and moderation

7. Reports of suicide should not be given undue prominence, especially by unnecessarily explicit headlines or images. Great care should be taken to avoid causing unnecessary harm or hurt to people who have attempted suicide or to relatives and other people who have been affected by a suicide or attempted suicide. This requires special sensitivity and moderation in both gathering and reporting news[5].

Sources of assistance

8. Published material relating to suicide should be accompanied by information about appropriate 24-hour crisis support services or other sources of assistance with these problems[6]. The degree of specificity may vary according to the nature of the report and the surrounding circumstances.[7]

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5 It may be preferable to use words such as "died by suicide" or "took his life" rather than a term such as "committed suicide" which can imply commission of a crime.

6 Mindframe publishes a range of resources for media professionals on the reporting of suicide. The SANE Media Centre provides media with guidance about reporting mental illness and suicide. When deciding what sources of assistance should be mentioned in a report, advice could also be sought directly from organisations providing services to people with problems relating to suicide or mental illness, such as Suicide Call Back Service, SANE Australia, Lifeline, or beyondblue. Services providing assistance to young people include Kids Helpline, ReachOut.com, and headspace.

7 Australian Press Council, *Specific Standards on Coverage of Suicide*, July 2014, http://www.presscouncil.org.au/uploads/52321/ufiles/SPECIFIC_STANDARDS_SUICIDE_-_July_2014.pdf (accessed 6 March 2018).

Appendix 2

Tabled documents, answers to questions on notice and additional information

Additional information

Received during the 45th Parliament

1. WA Primary Health Alliance – Correction of evidence taken at public hearing 3 May 2017 from Ms Learne Durrington (received 29 May 2017).
2. Australian Criminal Intelligence Commission - Correction of evidence taken at public hearing on 24 March 2017 (received 11 April 2017).
3. Australian Criminal Intelligence Commission - National Wastewater Drug Monitoring Program, Report 1, 1 March 2017 (received 11 April 2017).
4. Policia Judiciaria, Police Action in Drug Use Situations - Committee delegation to Portugal, 24 to 30 September 2017
5. Policia Judiciaria, Drug data 1998-2013, Committee delegation to Portugal, 24 to 30 September 2017
6. Policia Judiciaria, Fighting drug trafficking in Portugal, Annual Report 2016, Committee delegation to Portugal, 24 to 30 September 2017
7. Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias/General-Directorate for Intervention on Addictive Behaviours and Dependencies, Ministry of Health, Portugal (SICAD), Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances, Committee delegation to Portugal, 24 to 30 September 2017
8. Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias/General-Directorate for Intervention on Addictive Behaviours and Dependencies, Ministry of Health, Portugal (SICAD), New Psychoactive Substances: Portuguese legal framework for the prevention and protection against advertisement and commerce of new psychoactive substances, Committee delegation to Portugal, 24 to 30 September 2017
9. Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias/General-Directorate for Intervention on Addictive Behaviours and Dependencies, Ministry of Health, Portugal (SICAD), Promote the reduction of the consumption of psychoactive substances and prevent addictive behaviours and decrease dependencies, Committee delegation to Portugal, 24 to 30 September 2017

10. Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias/General-Directorate for Intervention on Addictive Behaviours and Dependencies, Ministry of Health, Portugal (SICAD), Interventions on Addictive Behaviours and Dependenies, Committee delegation to Portugal, 24 to 30 September 2017