

FAIR TREATMENT

WHY WE NEED TO CHANGE OUR APPROACH
TO PEOPLE WHO NEED TREATMENT

By Kristen Smyth and Susanne Porter,
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**FAIR
TREATMENT**
THE REFORM ON DRUGS



Uniting

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INTRODUCTION

People with problematic drug use don't set out to become dependent on drugs, let alone destroy their lives and the lives of people around them. Often through circumstance, misfortune or bad luck they find themselves in a position where they are vulnerable or on the wrong side of the law. Sometimes they seek treatment, often they are incarcerated and too often they are left to find solutions for themselves, leading to chaos and death.

As a society we have been told these people are responsible for their own demise, their circumstances often being cast through the lens of a sinner or at best aberrant choices. We seek comfort in the distinction that these people bring their misfortune upon themselves and regardless of the cost effectiveness or otherwise of maintaining a 'war on drugs', the payoff is that society does not need to address this 'other group' that has let itself and the rest of us down. This is an issue of othering. Of making ourselves feel better by pointing a finger. When we talk throughout this document of the we, it means all of us.

And it's an economics issue. The reality is that people with a drug problem are less likely to be employable, less likely to be in a stable relationship or maintain a healthy lifestyle and more likely to be involved with the criminal justice system, homeless or experience ill-health. Comorbidity including anxiety, depression and other disorders is common but the ensuing impact on welfare, health and law enforcement has rarely been enough to persuade policy makers that this highly stigmatised and inefficient model of engagement needs changing.

Not so long ago we stigmatised cancer patients and they would delay attending emergency departments until their conditions were insufferable. Before them tuberculosis was the same. Health presentations have a history of moving from shame and stigma through to solutions and success stories. Mental health is just the latest to experience this shift.

Stigma, chronic illness and a burden on the tax payer are good reasons enough for reform and there are recommendations here that call for needs-based population planning, smarter use of additional funding and a Fair Treatment summit that can demonstrate leadership. But above all this there is one more thing that must change. Our expectations.

Problematic drug use can be fixed. We must get used to saying this. It is possible to get well, and lives will get better. This discussion paper examines how we got to this point and makes practical recommendations that will shift the way we talk about drugs and the treatment response we need to embrace in order to save lives.

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KEY FAIR TREATMENT CAMPAIGN MESSAGES

- 1** Australia needs to treat people fairly with compassion and decency and end the stigma and prejudice and poor funding that sees nearly 200,000 people miss out on treatment each year.
- 2** More than one in three hospitalisations to NSW hospitals is alcohol or other drug related. This is a huge burden on the existing health system. It is also a tragic and unnecessary cost that means other health needs aren't being met.
- 3** NSW spends nearly \$200 million a year on a plan it doesn't believe will solve the problem. If it was serious about drugs and drug treatment it would be spending a proportionate sum to the burden of disease.
- 4** NSW led the way in the Southern Hemisphere with the first supervised injecting centre in 2001. It was an innovator in needle exchange during the 1980s that led to a significant reduction in intravenous drug health issues. It has runs on the board in this space.
- 5** Treatment providers need better governance and substantial workforce development to make sure they are given the best resources to do their job.
- 6** The treatment sector needs a policy framework that encourages clinicians to work in this space.
- 7** All of us need to learn about where our ideas, policies and perspectives on illicit drugs started.

WHERE ARE WE AT TODAY?

Drug treatment, like the rest of healthcare, should be interested in the effectiveness of its provision. But Australia has a culture of episodic treatment provision across the health system that pays little or no regard to ensuring long term quality outcomes – with occasional exception of outcomes payments. We have seen in diabetes and other chronic disease management, the difficulty in creating funding models that wrap outcomes into the model of engagement. This should not dissuade us from seeking to ensure people receive effective treatment.

WHY IS THIS?

Years of stigma, prejudice and poor policy should tell us one thing. As a society we don't like drugs and we don't like the people who have developed a dependency with drugs and we absolutely don't respond favourably to the chaos they cause. At home, at work, in the streets, often in the health system.

So we fund drug treatment with a burden on our health system of more than 33% with less than \$200 million in NSW, a disproportionate percentage little more than 7% of our total health expenditure.

THIS SUGGESTS WE DON'T HAVE A LOT OF FAITH IN SOLVING THIS ISSUE

As such, the system does not allow the follow up with patients to find out about their quality of life. This allows people to buy into this rhetoric and say it's too hard. We can blame the patients, suggest they're unreliable.

WHAT WE DON'T SAY IS WE DON'T REALLY WANT TO KNOW

So before we look at what we do, let's remind ourselves about what we don't do.

- We don't talk enough about getting people well. This creates a vacuum in which policy makers and funders assess us by our 'activity' - and they insist on rigorous accountability - so treatment managers spend more time pouring over spread sheets ticking all the activity micro-management than actually looking after patients.
- When providers are asked if they use clinicians to do long term follow-ups with patients, to check on their progress or see if there are any adjustments they can make to a person's daily regime, managers say they can't have clinicians phoning patients that are no longer part of the system - this is three, six and nine months after they've finished a counselling programme - they point to the funding requirements and insist that those clinicians are paid to see

new patients - often returning patients. And when things get really bad, those patients end up in hospitals, where ambulances, clinicians and dollars could all be directed elsewhere.

- We don't fund enough studies, to see what happens to people. There have been three treatment outcomes studies conducted in Australia. The first was the Australian Treatment Outcomes Study (ATOS), which recruited 825 heroin users upon entry to maintenance therapies (methadone or buprenorphine), residential rehabilitation, and detoxification in Sydney, Melbourne and Adelaide. The second, the Methamphetamines Treatment Evaluation Study (MATES), looked at 360 methamphetamine or amphetamine users from Sydney and Brisbane¹ and the third (and final) study has been the Patient Pathways study, conducted by Turning Point in 2014. The paper described treatment pathways and outcomes for nearly 800 clients accessing publicly funded alcohol and other drug treatment services across WA and Victoria. Just three studies on this critical issue.
- Australia doesn't always get it right even when there's extra money. As a nation we've had one moment of significant additional Commonwealth funding in the last few decades (see below) and that money has been diluted through a process of duplication, micro-management and often unnecessary programmes that replicate existing provision. And in the policy and funding vacuum, private providers have arrived, making ambitious promises and offering false hope in return for multiple thousands of dollars that are patchy at best where anyone can claim to be a counsellor or therapist with little or no accreditation.
- We don't have consistent governance. In 2014 Turning Point delivered its final report, for the Commonwealth's Department of Health that showed how to develop a quality framework for alcohol and drug services funded by the Federal Government to ensure effective and consistent delivery across Australia. The recommendations were signed off by the peak bodies. The paper mapped current practices related to quality assurance and standards across existing funded providers, and involved extensive national consultation with government agencies, peak bodies and more than 120 providers of alcohol and drug treatment, harm reduction and prevention services across Australia. The project highlighted enormous variability in quality standards and the capacity to deliver evidence-based practice across providers. Workforces simply didn't have the capabilities, resources and support needed to deliver evidence-based services.

TREATMENT SOLUTIONS

So, given where we are today and knowing what we don't do, here's a snapshot of what we do do, in regard to treatment, expectations and funding.

In the NSW Budget 2016-17, the NSW Government increased funding to \$75 million over four years to tackle drug misuse in the community². Total investment for 2016-17 was \$197 million for all drug and alcohol services. This new money announcement included:

- **\$24 million** to help more young people
- **\$16 million** for youth detox and treatment services
- **\$8 million** for early intervention innovation fund
- **\$15 million** to expand substance use in pregnancy services
- **\$8 million** to increase residential rehabilitation for women and parents with dependent children
- **\$1.5 million** to boost support for families and carers
- **\$26.5 million** over four years to help more people into treatment
- **\$12 million** for community treatment and aftercare
- **\$14.5 million** to help people with severe substance dependence

The 2016-17 Budget papers noted that one in three people presenting to NSW hospitals have a drug and alcohol problem in need of intervention³. Of the total annual expenditure of \$25 billion funding for drug treatment this represents little more than 7% of the total expenditure for hospital presentations which accounts for more than 33%. Compared to the annual investment of less than \$200 million, NSW Government announced funding of \$2.1 billion for mental health services, \$100 million for palliative care and \$8 billion for capital works investment over four years in the 2018 Budget⁴.

In 2015, the Commonwealth Government led by then Prime Minister Malcolm Turnbull unveiled the National Ice Taskforce report with an announcement of an additional \$300 million over four years to improve treatment, aftercare, education, prevention, support and community engagement to tackle crystal meth. This investment, effectively doubling the total amount put into drug treatment by the Commonwealth, was a significant shift away from focusing on policing borders and streets, a recognition that demand not just supply, needed to be addressed.

However, funding was distributed through the 31 Primary Health Networks. A decision that was criticised at the time given the ‘incredibly patchy’ coverage of the newly formed PHNs. Indeed, the New Horizons report criticised a similar idea with an earlier iteration of PHNs – Medicare Locals – describing responses from both purchasers and providers [as] not enthusiastic about the possibility that Medicare Locals become the third-party purchaser of Commonwealth

AOD treatment. A number of reasons were given. Experiences with Medicare Localsto date have been highly variable and Medicare Locals’ commitment to AOD (as a priority area amongst the many other competing primary care needs) is perceived as generally low⁵.

Dr Lynne Magor-Blatch, executive officer of the Australian Therapeutic Communities Association voiced the concern at the PHN decision when she observed that:

‘How are these resources going to flow through the PHNs when many would not even have the relationships with the community organisations that are doing alcohol and other drug work?’⁶.

Over the following years, funding decisions failed to follow any clarity around how dollars should be allocated, leading to much duplication and unnecessary micro-level bureaucracy.

HOW DID WE GET HERE?

The first prohibition-style drug laws in Australia were passed by the Queensland government and specifically prohibited the sale of smokable opium to Aboriginal people under the Sale and Use of Poisons Act 1891⁷. This was followed by the South Australian government banning all opium smoking, swiftly followed by New South Wales, Queensland and Victoria⁸. It is widely accepted today that these laws were specifically designed to keep Chinese migrants out of Australia as these laws were carefully worded to apply to opium in smokable form only—not opium as it was taken by the European population⁹. Debates at the time strongly support this assertion, in the state Victorian parliament a Mr Gaunson argued, “I am pointing out to the Labor Party what a terrible injustice they are doing to themselves by trying to prolong the existence of the Chinese ... it would be considered a devilish good job to let them all smoke opium until they were wiped out of existence.”¹⁰

In 1910, the newly formed Commonwealth government banned opium imports and made it an offence to be in possession of a prohibited import such as opium ‘without reasonable excuse’¹¹. The consequences of this blanket ban on drug possession were immediate and the consequences are recognisable in today’s blanket ban on drugs. In the first year of opium prohibition, 188 smugglers were arrested, and £2863 worth of illegal opium was seized¹². With the increased risk the price of the product soared. A tin of opium, which before prohibition cost just over £1, was by 1910 fetching in excess of £5, meaning that smugglers now stood to make huge sums of money. Such sums introduced drug corruption to the nation, with newspapers reporting the increasing suspension of customs officers. In an effort to boost profits, smugglers adulterated opium, initially with molasses and flour. In a single step, the Commonwealth government had established an underground drug market characterised by massive profit, corruption and impure product. The Controller-General of Customs reported in 1908 that, “while we have lost the duty, opium is still imported pretty freely”¹³.

In 1926, the League of Nations enacted the Geneva Convention on Opium and Other Drugs 1925. This convention made cannabis a restricted substance for the first time and included a blanket ban on

heroin. This was a problem for Australia, as heroin was used extensively in medical procedures, and so refused to eliminate medical heroin use due to “the permanent place which this drug has obtained in Australian medical practice”¹⁴. Over the next ten years, public global pressure, through the World Health Organisation (WHO) and the new United Nations grew, and the negative attention became a growing public relations issue for Australia’s politicians. In 1953, against the advice of the Royal Australian College of Physicians and the Royal College of Obstetricians and Gynaecologists, the government placed a ban on heroin in the Poisons (Heroin) Act 1953. It is worth noting that in the year before the ban, Australians were the highest consumers of medical heroin in the world, consuming around 5 kilograms per million people¹⁵, and yet there was not one recorded heroin death in Australia for the year.

In order to justify this ban, given the lack of evidence of both widespread addiction and any deaths from medical heroin use, parliamentarians resorted to alarmist rhetoric, the sort of language that is still prevalent in many parts of society today. During the debate, the member for Banambra argued, “Of all the addiction drugs that lead to the damnation of mankind, heroin is the most dangerous. This sinful, wicked chemical can contribute towards wholesale national rot and demoralisation.”. And another debater suggesting that “Heroin addicts... exhibited pronounced psychopathic tendencies ... most of them were weak, unhappy persons; and many were homosexuals”¹⁶.

“THIS SINFUL, WICKED CHEMICAL CAN CONTRIBUTE TOWARDS WHOLESALE NATIONAL ROT AND DEMORALISATION”

Ironically, illicit drug use in Australia was virtually unknown before this period but, post criminalisation, was well entrenched by the mid-1970s. There are a number of well-documented reasons for this, the shifting of youth society towards the counter-culture, with its focus on altered consciousness and anti-Vietnam war protests; American servicemen in the Kings Cross district introducing

heroin from South East Asia, providing traffickers access to Australian markets. In the meantime, in the USA, Nixon was being voted into office on a platform of ‘Law and Order’, one of his main policies being a global ‘War on Drugs’. Nixon’s administration promised sweeping powers for police and customs officials. However, John Ehrlichman, Nixon’s domestic policy adviser, was to admit in 1994, “The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I’m saying? We knew we couldn’t make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.”¹⁷

The Australian response was mixed, but just as they supported Nixon’s foreign policy, Australian politicians, like Queensland Premier Johannes Bjelke-Petersen and NSW Premier Robert Askin, supported Nixon’s War on Drugs and called for a crackdown on Australian youth culture¹⁸. In 1971, the Senate Committee on Drug Trafficking described the popular image of the typical drug user as, “a young, long-haired person, adopting an exaggerated style of dress, careless in his habit and probably a university student”¹⁹.

During the mid-1970s, the disappearance of Griffith-based Liberal candidate and anti-marijuana campaigner, Donald MacKay, resulted in intense media scrutiny of alleged Mafia controlled marijuana cultivation in Australia and, by the end of 1977, drug enforcement efforts had produced a marijuana ‘drought’ reflected by a sudden drop in availability, and a subsequent, and substantial, price rise²⁰. With the resources of law enforcement agencies fixed on and forcing the marijuana trade further underground, opportunistic importers ensured that supplies of heroin increased markedly.

As the heroin market expanded, its dimensions attracted financially interested elements within organised crime. By

the late 1970s, criminal syndicates were making regular runs between Thailand and Australia. In 1980, a kilogram of heroin purchased in Bangkok for \$2000 was worth \$250,000 once adulterated and smuggled into Australia²¹. Despite large scale seizures becoming commonplace throughout the 1980s, police made little impact on the expanding trade. The illegal trade inadvertently started with the banning of opium imports in the beginning of the 1900s had begun to reach full maturation.

And then, in the mid 1980s, something happened that changed the story.

When the Australian Prime Minister, Bob Hawke, announced that his daughter was a heroin addict a new dawn arrived for Australian drug policy - what is now called 'harm minimisation'. This has set the tone for most of Australia's drug policies since 1985 and is defined in three main areas: supply reduction strategies (disrupting the production and supply of drugs), demand reduction strategies (preventing the uptake of harmful drug use), and harm reduction strategies (reducing the specific harms that drugs pose to individuals or communities). Symbolically, Hawke moved the purview of problematic drug use from

the Justice department to the Health department.

However, Australian drug laws entirely retain their criminal justice orientation, with possession of any illicit drug (with the exception of cannabis in South Australia since 1986, and similar limited possession in the ACT and Northern Territory - there are fines) carried increasingly steep criminal penalties from this time. This confusion of attempting to support the health of people with problematic drug use and yet criminalising any and all engagement with illicit drugs has been ever heightened through successive governments.

WHO'S IT HURTING MOST?

According to the 2016 National Drug Strategy Household Survey (NDSHS), around 2.9 million people in Australia aged 14 and over were estimated to have used illicit drugs in the previous 12 months, and 8 million were estimated to have done so in their lifetime²². Of these, any can be arrested and have their lives devastated by a criminal record, however a relatively small proportion develop a problem with drugs. Such people come from all demographics; they are as diverse in their drug consumption as they are in their backgrounds. And treating these groups require personalised treatment plans; managed by excellently trained, well supported, passionate and interconnected AOD professionals.

SINGLE PARENTS

Single parents (predominantly mothers) with drug problems are highly susceptible to mental health problems, are younger, have more children, have greater economic problems, have a history of homelessness, and have fewer social supports - the greater the number of adversities, the less likely they are able to be caring for their children²³.

By criminalising drug use instead of helping people with drug problems, single parents are less likely to ask for help earlier in their use, less likely to access AOD services where they are unable to stay with their children, less likely to complete treatment programs that keep them from their children, and significantly more likely to be adversely impacted by a criminal record for drug use²⁴. AOD professionals will need to be able to address issues particular to women with children; shame, guilt, victimisation, and domestic violence.

REGIONAL AND RURAL COMMUNITIES

People with drug problems in rural and regional NSW present with more complex clinical needs, including greater polydrug use than urban participants, nearly double the rates of needle and syringe sharing for regional participants (31%) and

rural participants (29%) than for urban participants (16%), and more commonly reporting having 'additional drugs of concern' (49.4% compared to 32.9%)²⁵. People with drug problems in rural and regional NSW are also significantly more likely to be living with dependent children, to be unemployed and to be experiencing greater psychological problems than those in urban locals²⁶.

As a recent NSW Legislative Council inquiry on provision of drug treatment found, there is a chronic shortage of detoxification and rehabilitation services in regional and rural areas²⁷. The need for more services is clear when the waiting list for residential rehabilitation can extend to four months. There are also long travel distances to access treatment - for example, the nearest rehabilitation service in Broken Hill is well over 300 kilometres and residential services for adults are at least a two-hour drive from Dubbo²⁸. This is exacerbated by poor public transport in rural areas.

Other barriers to treatment in rural and regional areas include limited access to primary health services, a limited range of treatment options and concerns about confidentiality, lack of anonymity and stigma²⁹. Distance and isolation also impact on the costs of service delivery such as providing outreach. These differences mean that rural and remote communities require specific and geographically accessible treatment options.

CHILDREN OF ADDICTION

An estimated 20,000 children across Australia were victims of substantiated alcohol related child abuse or neglect in 2006-2007³⁰. Over 78,000 children aged 12 years or less live in a household containing at least one daily cannabis user and over 27,000 children live in a household with an adult who uses methamphetamine at least monthly and reports doing so in their own home³¹. By criminalising problematic AOD use, many families will not admit to use or seek help, these children are unable to

be supported by services until late-stage addiction presents and other services become involved (such as within the justice or domestic violence domains).

HOMELESSNESS

Around 43% of homeless people experience problematic AOD use, 66% of whom developed problematic use after becoming homeless³². The criminality of drug use is a funnel for homeless people into the justice system. 1 in 4 prison entrants were homeless in the 4 weeks before entering prison³³.

PRISONS

New South Wales currently houses the largest number of prisoners in Australia, accounting for 32 per cent of the national prisoner population (42,102 inmates)³⁴ at a cost of \$110,000 each inmate each year³⁵.

73% of these inmates reported that at least one of their current criminal offences was related to their use of alcohol and/or other drugs (around 30,700 inmates, or \$3.377 billion annual cost) with 79% of inmates reporting a drug problem history³⁶. Two-thirds (67%) of prison entrants reported illicit drug use in the 12 months prior to prison entry. Non-Indigenous entrants were more likely than Indigenous entrants to have used illicit drugs in the 12 months prior to prison (69% and 60%, respectively). As in the general population, recent illicit drug use was more common among younger entrants, with over three-quarters (76%) of those aged 18-24 having taken illicit drugs in the last 12 months, compared with 53% of those aged 45 and over³⁷.

CRIMINAL JUSTICE

Portugal picked up on this demographic as requiring help with drug use early on and in doing so, reversed the upward trend of problematic drug use in their country. This is an opportunity to gain treatment access to this demographic early in their problematic drug use, often in the drink driving and misdemeanour

stage of use. By criminalising drug use this group is missed at a critical stage, treatment models for problematic AOD use are much more successful if applied at this stage. Australia spends \$1.9bn a year in attempting to control drugs, of which \$1.3bn is spent on law enforcement to address supply with no cost benefit analysis done. This has left only around \$700m a year to be spent on treatment across Commonwealth, State and Territory budgets.

LGBTIQ

There are significantly higher rates of illicit drug use among LGBTIQ people compared to heterosexual people³⁹. However, frequency does not indicate problematic AOD use. A 2013 study of same sex attracted people aged 18 to 25 in Sydney, found that levels of addiction amongst the LGBTIQ population is at around 10%³⁹. The criminalisation of drugs reinforces negative stereotypes around gay culture.

YOUNG PEOPLE

Around a quarter of young people in NSW have used illicit drugs⁴⁰. Of these, most are engaged in the risk-taking experimentation of youth and therefore not at risk of developing the health issues associated with AOD addiction – so, the highest risk for most young people is to be arrested – once in the justice system, drug use amongst young people skyrockets, with around 65% using illicit drugs at least weekly⁴¹. Therefore, keeping young people out of the justice system for their drug use would be a high priority for any sensible policy. Young people who received an alcohol and other drug treatment service were 30 times as likely as the Australian population to be under youth justice supervision. Young Indigenous Australians were 14 times as likely as their non-Indigenous counterparts to

receive both services⁴². Young people who expressed a high level of concern about alcohol and drugs also reported particular levels of concern in coping with stress (67.4%), bullying and emotional abuse (65.2%), school or study problems (63.1%) and suicide (62.1%)⁴³. These numbers show that a whole-of-service approach is critical for young peoples' recovery from problematic drug use.

CO-MORBID AOD AND MENTAL HEALTH

Individuals experiencing AOD harm are at risk of a range of comorbid conditions including infectious and non-communicable diseases. Mental illnesses are a particularly prevalent comorbidity among AOD clients⁴⁴. For many with issues of comorbidity, entering the criminal justice system through drug use is exceptionally damaging. The appropriate management of long-term multi-morbid disorders is a key challenge for health systems internationally. It is increasingly apparent that multi-morbidities are the norm for people with chronic health problems, particularly the most socio-economically disadvantaged⁴⁵.

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES

Research is limited regarding CALD communities and drug problems. However, the research available indicates that although there are a smaller percentage of those within the CALD communities with problematic drug use, those with the problem experience far greater risk of harms associated with their use than other demographics. This is due to a number of factors, including migration stress (with feelings of dislocation, isolation and grief), greater levels of internalised shame and 'loss

of face' within CALD communities, and lower levels of overall health literacy⁴⁶.

Despite this situation, CALD communities are significantly under-represented in the AOD treatment system, with research in Victoria showing that less than 5% of closed treatment episodes in 2013 – 14 applied to clients born overseas⁴⁷ – given the population born overseas is 26%, this is an exceedingly low percentage. Those within the CALD population considered most at risk include asylum seeker and refugee populations (particularly young people), people who inject drugs and women in need of pre- and post-natal support⁴⁸. AOD workers within the CALD communities need particular appreciation of family and community structures, an understanding of stigma triggers within different ethnic groups and training in migrant stressors.

ABORIGINAL AND TORRES STRAIT ISLANDER (ATSI) AUSTRALIANS

Aboriginal and Torres Strait Islander Australians have higher rates of tobacco and other drug use compared to the non-Indigenous population. Alcohol and other drug use by Aboriginal and Torres Strait Islander Australians contribute to compromised physical and psychosocial health status and ongoing socio-economic disadvantage and needs to be understood in the context of a history of dispossession, denial of culture, and conflict⁴⁹. Severe alcohol and illicit drug problems are common in dispossessed indigenous populations⁵⁰. Indigenous Australians are vastly over-represented among prison inmate populations, where increasing numbers of illicit drug users are being seen. Aboriginal and Torres Strait Islander people make up 20 per cent of the prison population in Australia.

ALTERNATIVES TO AUSTRALIA'S MODEL?

So we've seen what we're doing in Australia. What do they do elsewhere? Adaptation is essential for effective drug policy in order to maximise the potential for more efficient, effective, just and humane responses to drug problems. Yet, as shown throughout history, opportunities for evidence-based reforms are often constrained by international, political and community pressure for tough, punitive responses.

PORTUGAL

As with other Western countries, Portugal enacted laws regarding which drugs were illicit during the International Opium Convention in the 1920s. The next mention of drugs in their drug laws was in 1963, with the recognition of the term 'drug

addiction' in a mental health law, although no services were set up to help deal with addiction at this time⁵¹. In the 1970s, while Portugal was still under an authoritarian government, drug addiction became increasingly visible in society – as it was in many Western countries at the time, including Australia, and Portugal chose the same route as the rest of the Western world, to treat addiction as a crime with possession punished accordingly – with imprisonment and fines. Stopping the phenomenon from spreading was seen as imperative to keeping Portuguese young people from 'physical and moral degradation'⁵². By 2000, Portugal was spending over 100 million Euro per year on policing their own war on drugs⁵³.

On 30 November 2000, Portugal undertook what many perceived to

be a radical new experiment, when it decriminalised by law the acquisition, possession and use of all illicit drugs. In so doing it opened the frontiers to a new approach: treating drug use as a health and social issue, not a crime. Indeed, decriminalisation explicitly separates the drug user from the criminal justice system, stating as a basic principle that a drug addict should be treated as a patient, not a criminal. Opponents of the reform suggested that Portugal would become a 'drug paradise', a haven for tourists. As Paulo Portas, the leader of the Populist Party, famously said "we promise sun, beaches and any drug you like"⁵⁴. Supporters of decriminalisation countered, that Portuguese society not only deserved but also, needed drug policy reform. As the Portuguese government saw it, the futility of drug

prohibition gave rise to courage and the will to experiment. Dr Manuel Cardoso, a key architect of Portugal's 2001 reformed drug policy explained that the aim of the new policy was "to introduce humane, evidence-based policy by treating drug use as a health and social issue rather than a criminal one."⁵⁵ Under this law, the use and possession for use of drugs is no longer a criminal offense, but instead is prohibited as an administrative offense. There is no distinction made among different types of drugs, nor whether drug use is in private or in a public place. To deal with administrative offenses, the eighteen administrative districts in Portugal established administrative committees that dealt with drug users in that district. The administrative committees generally consist of three people, two people from the medical sector (physicians, psychologists, psychiatrists or social workers) and one person with a legal background.

Portugal's Prime Minister said at the launch of the new Drug Strategy "This national drug strategy is... intended to be based on knowledge and not on prejudice, on principles and not on slogans, on pragmatism and not on dogma. However, despite being rooted in knowledge, this national strategy is still a political strategy, in the most noble sense of the word, involving choices made for the common good."⁵⁶ Then drug tsar, Vitalino Canas, agreed, saying "The wars have their victims and the drug users are victims of the traffickers."⁵⁷

Since reforming its drug policy, Portugal has seen:

- **Drug related overdose deaths drop** to 0.35 per 100,000 people (Australia's overdose death rate is more than twenty times higher than that, a figure that is rising every year).
- The **number of people arrested** and sent to criminal courts for drug offences has **declined** by more than 60 per cent.
- Taking into consideration health and non-health related costs, the social cost of drugs **decreased by 12%** in the five years following the NSFAD's approval and by a rather significant **18% in the eleven-year period following its approval**⁵⁸.
- Drug-related public **expenditure is estimated to have dropped** to around 0.05% of gross domestic product (GDP) since 2001⁵⁹.
- In 1999, Portugal had the highest rate of drug-related Aids in the European Union, 1600 new cases annually; since then, **HIV diagnoses attributed to injections have fallen by more than 90 per cent** to 30 new cases.

It is critically important to note that Portugal did not merely decriminalise

drugs. They enacted a system-wide, comprehensive overhaul of the entire social structure around drug use; from school education about drug use, to a funded health system and an entirely reordered legal systems for drug users.

The Portugal model is not perfect, but it demonstrates the principle of treating drugs as a health issue, with respect, honesty and compassion. Critics argue that what it fails to achieve is earlier intervention, providing a world-leading response at the acute and pointy end, but still needing to do more with the underlying causes and conditions to people choosing a life of drugs and destruction in the first place. That requires a level of holistic care inclusive of the social determinants of health that might be considered by every health policy thinker as the holy grail.

CANADA

Until the mid-1980s, Canadian drug policies and programs closely resembled those of Australia. Unlike Canada, however, the Australian response to the AIDS threat was rapid and pragmatic, quickly, national and state advisory committees on AIDS and drug use were set up early and these introduced public health and needle exchange programs⁶⁰. Over the next 15 years, Canada's rates of new HIV infection grew to the highest in the Western world, with up to 10% of cities infected. Conversely, Australia has a some of the lowest levels of HIV infection in drug users⁶¹.

On April 13, 2017, the Government of Canada introduced proposed legislation to legalize and regulate marijuana in Canada which will take effect in October this year. Marijuana has been the most commonly used illegal drug in Canada and while recreational use has been illegal, marijuana has continued to be used for medical purposes with the support of a healthcare practitioner. Marijuana is the most commonly used illicit drug in Canada, with 10.6% of Canadians reporting past-year use in 2012 and Canadian youth have had the highest rate of past-year marijuana use in 2009-2010 (28%), compared to students in other developed countries.

Critics of Prime Minister Trudeau point to the fact that the legalisation of marijuana is a populist policy, not backed up with sensible health measures. The intended revenue raised by newly legalised providers will be provided to the police in order to fund their efforts to prosecute illegal providers however there seems to be little if any recognition of the need to upskill workers and accommodate significant increase in initial usage of marijuana with other substances. Indeed, Canada is steeling itself for the law change as patent after patent is being filled for every kind of cannabinoid concoction of food and beverage derivatives.

USA

The US enforces one of the most extreme forms of total drug prohibition in the Western world. The result has been: extremely high levels of drug use, despite some decreases in sections of the population; escalation of costs; extremely high prevalence of HIV especially among drug users, and rapid prison expansion. In 1980, the federal budget for drug control was approximately US\$1 billion, and state and local budgets were 2-3 times that. By 1997, the federal drug control budget reached \$16 billion, two-thirds of it for law enforcement agencies; state and local funding also increased to at least that level⁶². The United States has spent \$1 trillion on the war on drugs since 1971, and federal spending on drug control in the US is currently estimated at \$15 billion annually⁶³. Of this figure, roughly 50% is spent on domestic law enforcement. The federal government has prioritised spending and grants for drug task forces and widespread drug interdiction efforts that often target low-level drug dealing⁶⁴. Despite this, a World Health Organisation survey showed the US remains high on the world-wide list for illicit drug use and estimates annual drug revenues in the Americas at \$150 billion⁶⁵. In 2013, approximately 24.6 million Americans, or 9.4% of the population, had used an illicit drug in the previous month - an increase from 8.3% in 2002⁶⁶. In 2017, around 70,500 Americans died of overdoses, as many as were killed in the Vietnam, Afghanistan and Iraq Wars combined. Since the beginning of the opioid epidemic in the 1990s, more than 700,000 Americans have died of drug overdoses⁶⁸.

"THE UNITED STATES HAS SPENT \$1 TRILLION ON THE WAR ON DRUGS SINCE 1971"

The so-called 'War on Drugs' began as a war on anti-war and African American organisations. This war has run its course, with American casualties in the hundreds of thousands and no end in sight.

More recently, nine states and Washington DC have moved to legalise cannabis through ballots and legislation - Washington, Colorado, California, Alaska, Maine, Massachusetts, Oregon, Nevada and Vermont. The Drug Policy Alliance reports that:

- Marijuana arrests **are down**.
- **Arrests for marijuana** in all legal marijuana states and Washington, D.C. **have plummeted, saving states hundreds of millions of dollars** and sparing thousands of people from being branded with lifelong criminal records.
- The **total number** of low-level marijuana court filings in Washington **fell by 98 percent** between 2011 and 2015.
- The total number of marijuana-related

court filings in Colorado declined by 81 percent between 2012 and 2015, and **marijuana possession charges dropped by 88 percent**.

- In Washington, D.C., marijuana **arrests decreased 76 percent** from 2013 to 2016, with possession arrests falling by 98.6 percent.
- In Oregon, the number of marijuana **arrests declined by 96 percent** from 2013 to 2016.
- In Alaska, the number of marijuana arrests for possession and **sales/manufacturing declined by 93 percent** from 2013 to 2015⁶⁹.

What this focuses on is the arrest rates, which, as one might expect have decreased. The health benefits remain unclear and this will be a contestable area of research for the next frontier. One thing is clear – focusing on arrest rates isn't doing anything to improve treatment.

UK

Total law enforcement expenditure costs UK governments 16 billion pounds annually⁷⁰. Despite this, the number of adults using illicit drugs in England and Wales in 2014 increased by approximately 230,000 to 2.7 million⁷¹. Lifetime illicit drug use is increasing, with the proportion of Britons who had ever taken an illegal drug increasing from 27% in 2008 to 31% in 2015⁷². There are still about 2,000 drug-related deaths in the UK annually⁷³.

Physicians in the United Kingdom are permitted by law to prescribe any drug except opium for their patients. The government's statutory Advisory Council on the Misuse of Drugs stated in 1988 that AIDS is a greater threat to public health than drug misuse and recommended that drug services modify their policies to contact and change the behaviour of the maximum number of drug users even when they are still actively using drugs. The Mersey Model of harm reduction includes prescribing drugs, syringe exchange, explicit education and a strong police role. The Mersey Model has been followed successfully in most parts of the United Kingdom, which has a national average of only 1% HIV infection in injection drug users. The police policy of 'cautioning' for small amounts for personal use has now been extended to all drugs and is practiced throughout the country⁷⁴.

“WE NEED TO ADMIT THAT WE ABANDONED WHOLE GENERATIONS TO THE SCOURGE OF DRUG ADDICTION”

UK political leaders across the political divide came together in September 2018 to admit that the British 'war on drugs' has failed the people of Britain. Lord Falconer wrote, "I am sorry for supporting the war on drugs. We need to accept there are alternatives to policies that have failed so many working class communities. We need to admit that we abandoned whole generations to the scourge of drug addiction. We need to confront our political failures and listen to those police chiefs pushing for saner policies. Above all, we need to take back control of drug supply from the most violent gangsters. And it needs to be done sooner rather than later."⁷⁵

SWITZERLAND

In order to avoid the mistakes of what has become the infamous Needle Park, the Swiss government agreed in 1992 to take over some responsibility for drug issues from the cities. In January 1994, the Swiss government began a multi-year, multi-city scientific trial to provide drugs to long-term dependent users to assess the effects on their health, social integration and behaviour. In 1997, the heroin maintenance experiment was declared a success: crime dropped by 60%, unemployment by 50%, and significant public funds were saved due to a reduction in the costs of criminal procedures, imprisonment and disease treatment. As a result, the Swiss Government extended the heroin trial.

Across Europe, an innovative harm reduction approach (that is being practiced in Switzerland, the Netherlands and Germany) involves toleration by authorities of facilities known as 'injection rooms', 'health rooms', 'contact centres' or similar terms. In 1987, syringes became available in pharmacies and, in 1991 a nationwide syringe exchange and availability program that includes dispensing machines was initiated. This program now includes syringe exchange in all prisons and heroin distribution in one prison. Methadone treatment programs also became increasingly available during this period. These comprehensive approaches have made Switzerland

an outstanding example of the cost-effectiveness of pragmatic approaches to drugs⁷⁶.

THE NETHERLANDS

In 1976, the Netherlands adopted a policy of selective enforcement of its cannabis laws. The prosecutors and police are instructed to not prosecute minor offenders, and to tolerate a retail supply of cannabis through cafes. The laws prohibiting the possession and use (and supply and cultivation) of cannabis are not actually repealed, but they are not enforced - selectively - by government policy.

The main objective of drug policy in the Netherlands is to reduce the risks that drug abuse poses for the users themselves, their immediate environment and society as a whole. Although the risks to society are considered, the government has tried to ensure that drug users are not caused more harm by prosecution and imprisonment than by the use of drugs.

In a number of Dutch cities there is undisturbed sale of marijuana in coffee shops, where the use of alcohol and hard drugs is not allowed. The authorities monitor the coffee shops and youth centres where marijuana trade occurs to ensure that large quantities are not sold, no sale of other drugs, no advertisements, no encouragement to use and no sale to minors. Dutch drug laws have not been followed by an increase in the use of cannabis products. In fact, by keeping cannabis dealing away from the hard drug market and by honestly addressing the myths associated with its use, it appears to have become less attractive to young people.

The Netherlands is one of the birthplaces of harm reduction; agencies began methadone prescribing programs in the 1970s, expanding and liberalizing these in the 1980s to deal with hepatitis, HIV, drug-related crime and other harms ('low-threshold programs'). In addition to drug rooms and 'coffee shops', Rotterdam has also informally adopted a tolerance area known as the 'apartment dealer' arrangement. Following this policy, police and prosecutors refrain from arresting and prosecuting dealers living in apartments providing they do not cause problems to their neighbours⁷⁷.

HOW DO WE FIX THIS?

Writing this paper involved spending months looking at policy papers, reports, talking to sector leaders, listening to personal stories from treatment providers and patients, family members and leaders in the field and one thing, above all else is clear.

PEOPLE WITH DRUG PROBLEMS AREN'T WELCOME IN THIS COUNTRY'S HEALTH SYSTEM.

Decades of prejudice going back to racist policies aimed at Chinese opium and counterculture marijuana have institutionalised a public and policy

response to drugs and people with drug problems that is this. We don't like you.

And the impact is horrific. Drugs cost lives. Indeed, it costs more than \$24 billion in direct and indirect costs including premature death, absenteeism and lower employment.

But it doesn't have to go on like this. Portugal has initiated the start of an inversion of the idea that you can arrest your way out of a drug crisis. To do this they have appropriated considerably more resources to treatment, in fact they have flipped the amount they spend on addressing supply, with the amount they now spend on addressing demand.

Closer to home, the Drug and Alcohol Service Planning Model (DASPM) developed between 2010 and 2013 has provided us with illustration of nationally consistent, evidence-based planning for alcohol and other drug services in Australia.

Patient Pathways, the last patient outcomes study recommended optimal treatment pathways that remain relevant – looking at intake and assessment, inpatient withdrawal, counselling and residential rehabilitation and care and recovery co-ordination, with links into mental health and employment services for severely dependent clients with multiple complex needs, or brief psychosocial interventions for lower severity clients without additional life complexities.

And there has been an excellent governance and workforce accreditation

paper, forged on the back of some work commissioned by the Commonwealth Department of Health, that formed the basis of Turning Point's National Capability Plan⁷⁸ – which recommends a model of pre-requirements that should be in place in order for organisations to receive funding and raises the threshold of workforce upskilling and service delivery.

SO THE SOLUTIONS ARE AT HAND

But one thing needs to change before all else. Just look at the most recent example of additional funding being spent in a once-in-a-generation policy window – the 2015 National Ice Taskforce response. Malcolm Turnbull put \$300 million new money to fund treatment and early intervention into Ice and associated illegal drug use. But that money has been diluted through a process of duplication, micro-management and often unnecessary programmes that replicate existing provision.

SO WE HAVE TO BE HONEST ABOUT DRUGS

We don't like them. We don't like the drugs and we don't like the people who take them. We don't have a great deal of love for the people who try and treat

the people who struggle with drugs and we are particularly dishonest about what we are doing in this issue when we talk to the public.

THAT IS WHY WE NEED A FAIR TREATMENT PEOPLE'S SUMMIT

WE NEED TO CLEAR THE AIR

Yes we need more money. Yes we need better standards across the board, in governance, in reporting, in talking about the issue and yes our workforce need to be supported and encouraged, they need to be nurtured and they need to be trained. That's how they get to be respected. That's how we attract the best and brightest.

But above all we need to change the conversation. When there is no debate there is no opinion. Just a vacuum. The Fair Treatment campaign commissioned this paper in order to ask what are we trying to achieve, as a treatment sector, with a fledgling health care model for the overwhelming demand for fair treatment, for solutions that might work, for a response to the poverty of hope and overwhelming drive of desperation. That's what drugs does to a person. It takes away their human.

IN CONCLUSION

This paper has specifically talked about the recognition that we need to be honest about what we're trying to achieve in drug treatment. About the funding, about the ambition, about the acknowledgement that if we were being serious about this we'd do it properly. And there is considerable work being done across the sector to look for solutions.

And so, to the importance of a Fair Treatment People's Summit. A unique opportunity to come together and rethink our approach to drug treatment. A chance to look at what works and what doesn't. A chance to reflect with genuine honesty about what we are trying to achieve. A landmark moment where we can change the way we provide treatment and save lives.

PRIORITIES FOR REFORM

1. IMPROVE THE SIZE AND FOCUS OF INVESTMENT.

The Commonwealth, State and Territory governments should fund alcohol and other drug treatment like other health services: based on needs-based population planning. The Drug and Alcohol Services Planning Model (DASPM) can be used to target effective treatment in those areas and cohorts that need it.

2. CALL FOR A PEOPLE'S TREATMENT SUMMIT TO LOOK AT HOW TO ESTABLISH FAIR TREATMENT FOR ALL (INCLUDE IN THE TERMS OF REFERENCE THE CONSIDERATION OF AN AGENCY, SUCH AS AN AOD COMMISSION TO PROVIDE OVERSIGHT AND LEADERSHIP).

The summit should include terms of reference that address the need for system reform, ways to address stigma and discrimination, improve accountability of governments, policy makers and service providers, and oversee service improvement strategies that include workforce capacity, monitoring and recording outcomes.

3. INVEST IN SERVICE AND WORKFORCE CAPABILITY.

The Commonwealth, State and Territory governments should look to create and contribute to an Alcohol and Other Drug Treatment Sector Capability Fund. This can address immediate needs, prior to the full implementation of the DASPM, by investing in evidence-based service improvement and evaluation, the expansion of an adequately trained and credentialed workforce, and capital works to improve the physical infrastructure of services.

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