Report on Consultations held with Australian organisations, services and individuals

Reporter: Margaret HAMILTON, Australia

INTRODUCTION

Consultations were held predominantly with those engaged in prevention, treatment and other services responding to drug use by individuals. Given the limitations of resources this allowed for the widest coverage of people and organisations actively engaged in illicit drug related activity. Where possible this was supplemented by email contact with other groups and individuals and reading submissions, reports or watching visual/graphic presentations submitted by organisations who responded to direct requests or to the generic invitation to make contact.

The report cannot list all specific people/or organisations who commented or provided submissions. Resources available did not allow for feedback and confirmation with the original source nor full referencing of all quotes and inclusions. Some could be made available if necessary. This report attempts to pull together the experience of one member of the CSTF through discussions, travel and presentations, forums and the like together with written submissions and ideas[1].

It follows the general framing of the report from CSTF on the Global Survey using the following headings:

[1] Apologies to anyone who I have not named who wished to be named and apologies to anyone I have named who hoped to remain anonymous. I have endeavoured to stick to my commitment to only acknowledge those who specifically contacted me and who asked or agreed to be identified.

[2] From here on in this report all Australian Aboriginal and Torres Strait Islander peoples will be referred to collectively as Aboriginal people.

[3] These additional specific groups (in italics) have been added here since there are some important specific issues related to them.

PART 1: SUMMARY OF ACTIVITIES UNDERTAKEN

Region or Thematic area: OCEANIA (Australian component)

Name of the organizer/s, leader/s of the region/thematic area: Margaret HAMILTON with support from various NGO network organisations and the Australian Drug Foundation.

I. FORMAT OF THE CONSULTATIONS

Taking account of the limited available resources, geographic distance between interested organisations, services and individuals and the limited support available to conduct these consultations an initial effort was made via email to notify a number of organisations, services and individuals about UNGASS 2016 and the opportunity to contribute through the CSTF.

These contacts were told about the opportunity to participate in:

1. The Global Survey of Civil Society/NGO's (see former CSTF Report)
2. A planned series of presentations with opportunities to engage in discussion in face to face situations
3. An open invitation to send emails contributing ideas, debates, position statements, documents, experience and case studies.

i. Who was contacted/participated?

See Appendix 1 for details of those (where available) who attended events held /consultation meetings and/or responded electronically.

Note: While there was a diversity of views on some topics, most were consistent. Where there were significant differences this will be noted in the section on issues raised as far as possible.

An attempt was made to notify as many services and organisations who have been involved in drug related policy and who might have an interest in contributing to representation of NGO's / Civil Society at UNGASS 2016 deliberations as possible about the opportunities to contribute. This included email through networks, peak bodies and personal contacts to:

- services involved in treatment and rehabilitation work in the illicit drug area; predominantly those with direct services to individuals and families who have already identified as having a problem with drugs
- organisations and services with a specific interest in prevention in relation to illicit drug use/problems; those interested in the prevention of any drug use as well as those focussed on prevention of drug related harm among those who are or who have used drugs,
- a small number of services who work with consumers/people who use drugs
- some who work at broader or generic community levels including a small number of people/service provision of in the following:
    - teaching/education and training services
    - regulation and implementation of drug laws at local level including some police.
- Services for people and groups including:
    - Australian Aboriginal and Torres Strait Islander peoples especially
    - Services directed at those with acute and/or chronic health conditions linked to drug use including HIV, Hepatitis B and C.
    - GLBTI community members
    - Parents and family members of people who use drugs
    - Legal Aid services and a brief consultation with legal groups examining alternatives to availability of some current drugs for medicinal purposes
    - Some secular and religious groups known to have an interest in drug policy but who were not readily identified among those otherwise consulted.

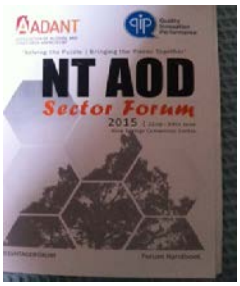
Most were contacted through network organisations using email lists and peak bodies membership lists in the alcohol and drug arena or through direct contact and involvement in meetings and conferences. Some were contacted through related networks involved in health promotion, education, local community services or interest group forums in Australia.

Reminders were sent out about the global survey and specific meetings/presentations and face to face consultations via network organisations.

Contacts made:

Global Survey - Although I don't know how many responses were completed from Australia I believe that many made some attempt to participate and the feedback about responses suggested that there was a good response from Australia.

Consultation – in person. Participants in meetings/attending presentations with opportunity for follow up engagement in discussion **and/or email: Total approximately 690[4].** Some of these involved the CSTF member presenting background information about UNGASS, the International Drug Conventions and the UN processes with an invitation to engage in discussion; others were more informal discussion groups or individual consultations and occasional follow up by telephone or email.








Example photos from consultation forums: (L to R)

- Northern Territory – June 2015, programme ADANT Forum Alice Springs (inc. CSTF presentation/consultation)
- Discussion group – December 7th 2015, Fitzroy, Victoria, YDHF following presentation re CSTF role/ UNGASS
- Hobart, Tasmania – Peak body [ATDC] meeting – presentation by CSTF member (Hamilton), Oct. 2015
- A. Prof Ted Wilkes and Prof. Dennis Gray, Alice Springs, June 2015
- Group attending / follow up discussion – Hobart, Tas. , 28 Oct. 2015
- Land in AS, NT 2015 X 2 photos
- A Prof. Ted Wilkes, Noongar Elder from Western Australia, commenting on UNGASS

[4] See Appendix 1 for full lists of those who attended in the following States/Territories: Victoria, NSW, Queensland, Tasmania, South Australia, and Western Australia. Estimates of numbers who participated from the Northern Territory (June 2015) and a second forum held in Victoria in December 2015 have been added as estimates as full lists are not available.

Email responses: Direct responses were received by email, post, or other means from further 37 people/services/organisations. These included a mix of notes, DVD's, messages, lists of issues, some case examples, photos or statements related to specific drug policies, programmes or practices. In some cases it was in the form of reference to or specific reports sent in response to a call for issues, ideas and case examples. Where this was done and used these have been referenced as far as possible.

ii. Reporting:

Due to time and resources constraints it was not meaningful or possible to present a detailed preliminary report on electronic consultations separate to the other forms of consultation since a mix of these were done over the whole of the period from May – December 2015.

A report on distribution of the global survey in Australia was provided in early September (see: Previous report/Appendix 2) and a brief preliminary summary of issues raised was provided to the CSTF Executive in early November (see: Previous report / Appendix 3).

A draft report (not for quoting or distribution at that time) was provided to the CSTF Executive in early January 2016.

This FINAL REPORT represents all the combined feedback received as part of the various forms of consultations throughout 2015.

Part 2: CONSOLIDATED SUMMARY OF THE RESPONSES IN PHASE 1 AND 2:

Using the UNGASS thematic agenda topics as far as possible the following represents the main issues raised, points made and opinions/experience of those who participated in the Australian aspect of the Oceania regional consultations.

I. Comments received about the consultation process/opportunity (includes aspects of 'lessons learned'):

- "Appreciated the opportunity to have input as it also included information about how drug policy is developed and the role of the UN/CND and the ways that NGO's (Civil society) could have input to these processes" (SA consultation, November 2015).
- A good reminder to always check that service consumer voice is heard. (SHARC, AGM, Victoria December 2015)
- People who use drugs [PWUD] (including those who inject [PWID]) have considerable knowledge of current conditions re availability of drugs, how they are being used and potential trouble/harm associated with their use and they can be a source of early warning of specific harms. "Retention of the ongoing surveys of drug users (IDRS and EDRS in Australia) has value as it is systematic and has been established for some time allowing trends over time to be monitored" (Participant at NDARC Drug Trends Forum, October 2015).
- "Additional effort is needed to include PWUD/PWID in consultation forums and advisory groups regarding policy at all levels". (Email received October, 2015)
- Need to enhance the chance for civil society/NGO's to be heard at every level. "There used to be greater opportunity in our own country to have our experience heard (eg: at ANCD forums held prior to each meeting of the ANCD) but this has ceased and ANACAD that is now the national advisory body does not hold such forums and it is hard to know what they are doing and who they get advice from…." (Individual following NSW consultation, Nov., 2015).
- Ensure that bodies that include a range and large number of diverse NGO's have capacity to be consulted and to address the issues that are commonly raised by service provider organisations in this field. "The de-funding of the national peak body (ADCA) means that there is no readily identified go-to body available in Australia" (Comment from an individual; email. August, 2015).
- "I found the opportunity to engage inspiring" (Dec. 2015)

NGO Peak bodies: One example of the goals of such bodies [ACT, Australia, 2015] whose mission is to represent and support the alcohol, tobacco and other drug sector and community in their jurisdiction:

- *"ATODA's vision is an ACT community with the lowest possible levels of alcohol, tobacco and other drug (ATOD) related harm, as a result of the ATOD and related sectors evidence-informed prevention, treatment and harm reduction policies and services.*
- *ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, education, information and resources. ATODA is an evidence informed organisation.*
- *The ways we work, and the outcomes we strive to achieve, reflect our commitment to the values of population health, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.*

Re: the consultation process and engaging civil society/NGO's - This feedback was consistent with the finding from the global survey: *Reduce barriers and increase civil society access to events* and *Support inclusion and communication amongst NGOs and member states.*

II. Comments on the preamble

i. Who to involve in the development and implementation of drug policies:

Overall comments support a broad engagement of community members, including key institutions and service delivery organisations alongside government instrumentalities, in drug policy considerations.

- There is value in having a mix of people with backgrounds and experience in scientific research, service delivery (prevention, treatment, rehabilitation, and related services directed toward individuals), use of drugs (PWUD), use of services (consumers) and those close to them including families; along with services involved in law enforcement at local level, all engaged in dialogue about drug policies that affect all of society.
- No one sector element can respond adequately to drug use and all need to find a way to communicate for effective responses.
- Australia has now had a thirty year history of bringing together a mix of people in development of responses to illicit drugs. This has proven to be essential at many levels including local neighbourhood, national and international level.
- Most recently this has been articulated in a National report from the Ice Taskforce: "We need to enable communities to play their part. Communities also need help to take action. [Intro.]. Community engagement: Collaborative strategies that engage a range of stakeholders are critical to addressing challenging social problems […..] in Australian communities. This is particularly important when the solution require sustained behavioural change. P. 93/94

One submission to the Australian Ice Taskforce might usefully be applied at many levels: *"Design of interventions targeting illicit drug use among […..rural] residents will require strong community consultation so as to engage and empower [….] communities. It is important to recognise that [specific] communities have diverse characteristics and interventions will need to be localised rather than follow a one-size-fits all approach".* Commonwealth of Australia, 2015, Department of the Prime Minister and Cabinet, Final Report of the National Ice Taskforce. P.93

- The particular strength of health and law enforcement jointly planning responses to drug use at all levels has been apparent for some time in Australia. Comments from consultations include:

  "….. Facilitating cooperation between local treatment services working alongside local police is necessary to effectively manage 'drug hot spots'".

  "Joint planning to prevent harm for drug users and reduction in drug related crime is a constructive response to illicit drug use".

  "There is value in the sharing of information (health and police) that is not specific to individuals but rather works to develop information about patterns of drug use and potential and real harm and in developing joint plans for responding to decrease harm for all of the community. While this has been valued, its implementation has been patchy; especially in more recent times".

This need for cooperation is affirmed by the Australian National Ice Taskforce:

"*Effective responses require coordination between health, law enforcement, education and other sectors to plan, fund and implement the types of activities [needed to respond …. to 'Ice*'] p.94.

This reflects the comments received at CSTF consultations conducted across Australia.

ii. The broader UN context of the Drug related Conventions:

People, services and bodies involved in the monitoring and enactment of the breadth of UN interests need to be consulted since much of what passes as drug policy and responses to illicit drugs is inconsistent with other UN expectations; especially in the area of human rights. There is a need to ensure that the various UN drug policies that intersect with human rights, the rights of the child, rights to health, housing and beyond are appropriately aligned and where there appears to be discrepancy, processes need to be put in place to review apparent contradictions.

> *A rights based approach to drug control and prevention would situate human rights and health at the centre of …..drug policy. ……. It must be remembered that drug control is not the final aim, but a proposed method of achieving the highest attainable standard of health for all*. (pp. 9) M Marin, School of Population & Global Health, University of Melbourne

One statement made at a forum: …"*human rights is not only about criminal justice. Drug policy must be aligned with the other objectives of the UN system".*

Another said: *"We should have the other rights groups here in this forum and that should happen at CND and UNGASS too; groups like Human Rights and Rights of the Child and First Nations Peoples rights watchdogs …. "*

This feedback was consistent with the findings of the Global Survey: *Meaningfully include other UN agencies in the UNGASS*

iii. The importance of information, data and evidence; especially as it relates to effectiveness of responses including prevention, treatment and also to law enforcement:

Data and research must underpin drug policies and also guide expenditure. This requires consistent collection/conduct and then adoption of best practice wherever possible across time and with social and cultural adaption to context. A number of people and organisations made comments about the vital importance of sound data and the utilisation of evidence in knowing:

- what the current status of drug availability, use and drug related trouble/harm is,
- selection of responses including for prevention and for treatment; and suggesting:
- that much more work is needed in evaluating the effectiveness of regulation and law enforcement efforts at every level; especially if the breadth, level and nature of expenditure in this domain is to be justified.

Some specific comments included:

- The need for sound data collection and collation; such that information derived from experience and evaluation(s) is available and reflects the context of the person/ community from whom it was collected: those impacted by illicit drug use.
- A need to acknowledge 'best practice' based on evidence of effectiveness and then urge adoption of these policies and practices; noting the potential for unanticipated negative consequences of some common actions; that then need modification or even cancellation.

PART 3: SPECIFIC UNGASS 2016 AGENDA ITEMS:

III. DRUGS AND HEALTH

i. The need for evidence-based or evidence-informed drug prevention

The importance of prevention – was repeatedly raised and the need for comprehensive, evidence informed programmes that are culturally specific to each community recommended

- Many suggest that there is insufficient focus on prevention and that the expenditure on demand reduction measures has not been proportional to that expended on supply reduction and law enforcement.
- . Prevention incorporates policies and programmes from primary prevention (usually the prevention of the initiation of/use of illicit drugs), secondary prevention (or early identification and early intervention once drug use has been initiated) and tertiary prevention (the treatment of established problematic drug use). There is considerable confusion about these different levels and definitions of prevention. This will not be pursued here. However, most people in Australia identify a mix of supply and demand reduction strategies as contributing to prevention while noting that harm reduction strategies can also be seen as preventing further health and other harmful impacts on the lives of people who use drugs.
- Information and education – Information provision is necessary but not a sufficient preventative response. Information should be tailored to suit the community of interest and should be done in conjunction with other measures as provision of information alone can be counterproductive; increasing alarm and concern and inappropriately producing impotence in the face of apparent overwhelming problems. It needs to be part of a coordinated, integrated programme of activity that engages a community and includes supply reduction measures, other demand reduction measures; including provision of early health interventions, and treatment for dependence.
- Pathways to resilience – don't just focus on problems and what's missing or dysfunctional – also identify what might be a resource for a community and/or for an individual in facing drug use and responding. Example: At the individual or family level there are examples of useful early screening instruments that can help to identify those at risk and those who appear to be resilient. Some of these are quite specific to particular community groups e.g. Australian Indigenous risk impact screen and brief intervention project: screening instrument (2011)[5]
- Some approach the issue of resilience as the need to restore diminishing cultural resilience and further this with extended advice on the nature of information and exposure of youth to drugs; noting that the WHO, 2001 statement suggests that "young people have a right to grow up in a society where they are protected from exposure to [….] drugs"; [Dalgarno Institute and Drug Free Australia] with an emphasis on development and strengthening of "cultural resilience" through delivery of appropriate information and messages. These groups draw attention to the need for primary prevention (not only focus on harm reduction or harm minimisation).
- Suggesting that the local social, cultural, economic and cultural context is important in approaching prevention, the comments from a recent Australian government report are consistent with many of the opinions expressed during consultation meetings[6]: (See following)

[5] http://www.aodknowledgecentre.net.au/aodkc/key-resources/health-promotion-resources?lid=27091

[6]Commonwealth of Australia, 2015, Department of the Prime Minister and Cabinet, Final Report of the National Ice Taskforce. pp.104 Part C. Chapter 8: Support families, communities and frontline workers.

In discussing the benefits of multi-level, community-based interventions, the Ice Taskforce suggest that "communities need information and advice to inform their responses. Many local prevention efforts focus predominantly on law enforcement. While this is an important part of targeting supply and preventing harm, such strategies alone may not be effective. Community prevention efforts—particularly in vulnerable communities—need to include comprehensive responses at the local level. Such approaches attempt not only to influence individual behaviour but also incorporate participation of the general community and its institutions to address the environmental and social factors that contribute to alcohol and other drug problems. (National Ice Taskforce. 2015) See footnote #6.

Other comments on prevention include reference to '**upstream**' prevention (sometimes included in discussion of **primary prevention**).

- "There is a role for primary prevention in this field. Eg: National governments could initiate strategies similar to the Australian Federal Government's *National Primary Prevention Framework of Violence* and consider equivalent implementation to change attitudes and the culture of alcohol and drug use". (Email feedback: City of Melbourne, December 2015)
- An **example of a useful guide**: Australian Drug Foundation, June 2014, *Preventing alcohol and drug problems in your community. A practical guide to planning programs and campaign* that includes the following summary[7]:
    - "Grassroots community prevention programs can have a significant impact on reducing alcohol and drug (AOD) problems. These programs are more likely to reduce harm when coupled with advocacy for legislative change.
    - There is now a body of evidence demonstrating best practice in community prevention, which should be considered when planning prevention initiatives.
    - Community activities are best focused on primary or 'upstream' prevention where programs aim to protect people from developing an AOD-related problem.
    - It's important for communities to work together on prevention programs rather than individuals trying to develop their own approaches that don't leverage related initiatives.
    - When identifying and communicating AOD problems, credible data and research needs to be used rather than relying on people's perceptions or media reports.
    - Consulting with stakeholders and the target audience early in the planning stages can have a huge impact on a prevention program's success.
    - Setting realistic objectives and writing down a program plan can help ensure everyone is on the same page, objectives are more likely to be achieved and the program can be evaluated, which is important when trying to gain further funding".

Preventing harm:

Others commented on the need to focus on "preventing harm"; suggesting that even for those people who use drugs there are important preventative measures to reduce the harm associated with this use such as the provision of safe injecting equipment for those who inject their drugs. Clearly this aspect of prevention is specific to the target group and should be conducted accordingly; though recognising that this target group will not necessarily readily self-identify and so a broader strategy is needed to be effective; including peer based approaches.

[7] http://www.druginfo.adf.org.au/attachments/1507_PreventionResearch_EngagingCommunities_FINAL_web.pdf

- For some, the inclusion of harm minimisation materials in educational packages for school children is seen as inappropriate; such as the health and psychology teacher of Year 8 students who comments against this in providing feedback to the Dalgarno Institute working with Drug Free Australia in production of materials including a DVD: *'Prevention!! Time for Cultural Shift'*[8].
- To others, the inclusion of harm minimisation materials is seen as vital; noting, for example: "Kids these days are exposed to all sorts of drugs whether we like it or not. Isn't it better to warn them of the specific dangers and possible things that can go wrong before this happens?" (Discussion: Alice Springs, June 2015). The matter of how prevention of harm is understood can divide opinion; though this is sometimes a problem of definitions and lack of mutual understandings in discussion.

ii. The widespread adoption and availability of harm reduction

Harm reduction has been the third pillar of the Australian Drug Strategy for over twenty years; together with supply reduction and demand reduction. This 3 pillar approach has been a generally accepted and utilised conceptual framework for the development of a comprehensive approach to drugs; including both legal psychoactive substances and those that are illegal. [Australia - National Drug Strategy 2010–2015; currently being reviewed and updated].

> *Australia is fortunate to have a comprehensive evidence-based public health approach to preventing drug-related harm. This approach was initiated in the mid-1980s and continues to this day.* (CREIDU Submission, Nov. 2015)

Where respondents spoke of international efforts, it was often urging greater effort in the adoption of harm reduction measures across the globe.

A number of responses during consultation forums assumed that harm reduction will remain a core component of Australia's approach to drugs, with their suggestions generally seeking to further extend the already existing harm reduction measures.

Some organisations are eager to see harm reduction more vigorously pursued in the future: Eg: Harm Reduction Australia[9] who have a goal "To educate the public, decision makers and the media about the efficacy and legitimacy of harm reduction and human rights-based policies and programs for redressing some of the potentially harmful consequences of drug use"

Key components of a harm reduction approach include:

- Blood Borne Virus (BBV) prevention,
- Access to drug treatment and
- Diversion of offenders from the criminal justice system; especially in the case of minor drug-related offences.

Other suggested measures include:

- Provision of naloxone
- Pill testing/checking

[8] Dalgarno Institute, "Prevention!! Time for Cultural Shift!" 2015.

[9] http://www.harmreductionaustralia.org.au/about-us/

BBV prevention and reduction:

- "The cornerstone of BBV prevention activities is the implementation of large-scale NSPs [needle and syringe programmes] across the country. NSPs significantly mitigated the HIV epidemic amongst people who inject drugs (PWID) in Australia, to the extent that only 30–40 cases of HIV per year are transmitted via injecting drug use. Further, although HCV prevalence has remained fairly steady at around 50-70% of PWID since the introduction of NSPs in Australia, the incidence of HCV appears to be declining among PWID". (CREIDU Submission, Nov. 2015)

Evidence from mathematical modelling studies suggests that by averting infections, NSPs have saved the Australian healthcare system up to $220 million in the period 2000–2010 and up to $950 million in future costs." (CREIDU Submission, Nov. 2015)

In submissions regarding sub-populations of high risk, especially those who are incarcerated, the prevention of BBV's was also highlighted – calling for an extension of NSP programmes to these facilities. This would reduce spread of BBV's among this population. Importantly, it would also help reduce BBV's in the overall population.

- "There is …. strong evidence that needle and syringe programs (NSPs) in prison can reduce the spread of BBV infection, yet even where these programs are available in the community, they are usually not available in prisons. There is no evidence that NSPs increase drug use in prison and no documented evidence of syringes dispensed through such programs being used as a weapon. (Submission: Kinner, S Nov. 2015. Ref's to evidence available)

Drug Treatment as harm reduction:

Drug treatment as a means of reducing demand and reducing harm associated with drugs is a core element of the Australian response to drugs.

- In the case of dependence on opiates, and consistent with international evidence, "the mainstay of Australia's public health approach to treatment for opioid dependence is opiate substitution therapy (OST). Methadone and buprenorphine are both available as OST medications in Australia, reflecting evidence that these medications are effective in reducing drug related harms". (CREIDU Submission, Nov. 2015)

From 3 different forums that included drug treatment providers and public health policy people:

- "Unless we provide drug treatment in prisons we are destined to continue the revolving door for those who are convicted of drug related offences; more drugs and more crime".
- "Ensuring adequate and intense follow up in the transition from any form of incarceration is essential to avoid overdose deaths".
- "For some, staying off drugs is much harder than giving up drugs and so to successfully reduce harm, there needs to be sound and sometimes intense and extended, assertive follow up to treatment".

Diversion for minor drug-related offences

"There is compelling evidence that incarceration of people who use drugs (PWUD) is criminogenic and that diversion into treatment is both more effective and cheaper than incarceration, yet in most countries the 'war on drugs' persists". (S Kinner 2015 submission. Evidence available on request).

A number of diversion programmes have been introduced in Australian States and Territories since the late 1990's. This has been driven by a desire to understand drug dependence as a health rather than criminal justice issue, concern regarding increasing numbers of people in youth detention centres and adult prisons and recognition that these responses are not the most effective in reducing drug use and should only be a response of last resort for the majority of drug offenders.

There is a range of specific conceptual responses to how diversion programmes might best be implemented including:

- justice reinvestment programmes that encourage a shift in the way in which resources currently used in criminal justice to arrest, convict and detain people might be better used to offer alternative responses specific to drug use and treatment needs.
- Diversion from the usual criminal justice pathways to information and education programmes and/or treatment and rehabilitation/reintegration programmes with or without a criminal penalty in some cases.
- Alternatives to usual conviction/sentencing procedures such as therapeutic jurisprudence (TJ), with a range of implementation approaches evolving across Australia (and elsewhere) including (but not only) drug courts that can allow for alternative sentencing provisions with intense monitoring and follow up. (See below section on drugs and crime for more detailed comments).

Overall there appears to be general agreement that for minor drug related offences, diversion from the criminal justice system is an appropriate response.

Provision of naloxone

Following persistent calls for the provision of take-home naloxone, some Australian jurisdictions have begun to implement a programme that includes training of peers; drug users and those close to them, alongside the provision of this opiate reversal drug for emergency administration. These interventions are currently being evaluated.

"….consistent with WHO guidelines that highlight the life-saving potential of these programs, particularly in resource-poor settings. Naloxone is a particularly safe drug, with no known misuse potential, ….. Expanding access to take-home naloxone to at-risk opioid consumers and their peers and family members should be a priority. Recent developments in the UK, USA and Australia will allow for easier access, including over-the-counter access through pharmacies and other services that should be monitored closely and implemented widely if evaluation proves positive". (CREIDU Submission, Nov. 2015)

- Another submission drew attention to the particular needs and vulnerability of people leaving prisons and the advantages of provision of take-away naloxone for this population.

Pill testing:

Although this suggestion remains controversial, there are increasing calls for its introduction**.** A number of people in forums raised the suggestion, especially in the context of a small number of drug related deaths apparently associated with use of drugs consumed at public events.

Eg: Unharm - http://www.unharm.org/drug_checking_petition :

We've teamed up with Melbourne mother Adriana Buccianti on a campaign for drug checking services (aka 'pill testing'). Adriana's son Daniel died at a music festival in 2012 after taking a drug that wasn't what he thought it was. Adriana says 'To me that just makes sense. If people don't know what they are taking, they are at much greater risk of dying. I believe drug checking services are a step we need to take.

One other example forwarded following a consultation forum:

> *'The Yarra Drug and Health Forum fully supports the introduction of scientific testing of 'pills' consumed at raves, dance parties and music festivals. It is clear that whilst the majority of people attending these events and using drugs do so for enjoyment and do not experience harmful side effects, it is also apparent that from time to time some do suffer the adverse consequences of consuming uncontrolled and unregulated drugs.*
>
> *The Yarra Drug and Health Forum believes international literature clearly indicates that comprehensive testing at these events can provide party goers with accurate information about drugs to enable them to make informed decisions about their choice of drug. Many people who receive advice about the contents of their pill dispose of them once they are aware that it does not meet their expectations and may be deleterious to their health.*
>
> *…….The Yarra Drug and Health Forum believes that the benefits of taking a harm reduction approach and ensuring that the environment in which party drugs are consumed is safer far outweigh concerns about pill testing as 'sending the wrong message'. It is time for all parties to agree on sending the right message; "we care for you and want to save your life".'*

- Another: "It's important that pills and powders seized are tested to identify their contents; people, especially the young, have a false sense of purchasing recreational drugs when in fact they are purchasing poison [since they often prove to have no psychoactive drug in them but] contain detergents, bleach, powder etc. This ….provides a strong argument for pill testing at events. (Senior Policy Officer, [Major metro capital city. Australia])

iii. Funding concerns for treatment, prevention, and other services for people who use drugs

This was the dominant theme of almost all consultations held in Australia throughout 2015; a year of significant uncertainty following earlier change(s) of government(s) and between a one and three year funding cycle coming to an end with no information about possible continuation until quite late in the year for most.

Some of the uncertainty relates to mixed funding sources for many Australian services in this area; with both national and state funding essential to maintain most of them. A very small additional supplement is occasionally available from limited charitable funds.

Following are a number of quotes from people at forums or in email responses as indicative of frustration:

> "Overall surety of funding makes a huge difference to our ability to stay positive, to recruit and most importantly, retain staff; to make it worth training staff in best ways to practice and ultimately to the effective delivery of services".
>
> "It's sometimes as though we are expected to just be dedicated, semi-volunteers providing services; not the professionals delivering evidence-based interventions that we have been trained for".
>
> "As a manager of a service, I find it hard to think about matters of international drug policy given the immediate concerns of maintaining a service to a very needy population that seem to be getting harder to treat".
>
> "The lack of clarify about funding is destroying us".
>
> "There is certainly not enough funding for good, ongoing prevention but we just don't have a chance to think about that when we are unable to meet the needs of those who come to our front door wanting help to treat their drug dependence".

"It is clear that our clients are at the bottom of the pile. It's hard to know how much the stigma of drug use is impacting on our funding. The community is calling out for a response to the current 'Ice' crisis but they seem to just want the drug to "be gone" and don't understand the importance of providing treatment and other responses. It currently seems that only the police get an increase and we don't even know if we can continue next year; just even continue our basic service!"

"It is so hard to get funding for prevention when it takes a long time to develop good prevention programmes and even longer to ensure that they can be and are delivered in a consistent manner to allow for realistic and valid evaluations. This always hampers any advocacy to government for adequate, ongoing funding".

"Why do we always have to have 'innovative' funding proposals? We actually know some of the best treatments that are available and if we could just offer them consistently and know that those delivering them were properly trained, monitored and supervised; we could do so much more and better. The interest, and now it seems the expectation, of funding sources that any proposal has to be 'novel' or 'innovative' means that we can't fund the things we know work. This is ultimately frustrating and wastes money".

"Stop-start funding and only funding pilot projects is really difficult as it means that we can't keep our trained staff and even when a pilot works well it's still extremely hard to get it re-funded".

Beyond this series of concerns were some that offered constructive suggestions:

"Every time there is an increase in resources for supply reduction measures and policing, ensure that there is an equivalent percentage increase in funding for prevention and treatment; where the evidence of effectiveness is usually greater".

"Work to match treatment funding to treatment needs; such as using monitoring data about use of various drugs, the likely needs for best-available evidence based treatment and the nature and amount of specific interventions (both preventative and treatment, recovery and re-integration services) that are needed".

iv. Universally available evidence-based and culturally-appropriate drug dependence treatment

(Commentary on this has been incorporated elsewhere).

Generally there was an expectation that this was a very high priority and that the guidelines now available from a mix of international sources (including UNODC, WHO, UNAIDS), international research literature and national guidelines were to be followed there would need to be a significant upscaling in the amount and quality of treatment available throughout the world.

- It will not be possible to meet any of the global targets associated with drugs without significant increases in drug dependency treatment.
- There is recognition of the need for comprehensive, evidence informed programmes that are culturally specific to each community.
- In providing drug treatment it is important to recognise the co-occurring conditions associated with drug use and drug dependency; as both antecedents and consequences. These include, importantly, mental health concerns and social problems such as homelessness. Without addressing these issues, drug treatment success will be limited.
- While recognising the value of evidence based treatment, it is necessary to acknowledge and respect the importance of choice.

v. The need for a health response to drug use

Other relevant commentary on this has been incorporated elsewhere. An example of the sentiment most often expressed in consultation forums:

- "The primary comment that I would like to offer UNGASS is that the overwhelming body of research into drug treatment suggests that health based treatments for people who use drugs (PWUD) are more likely to reduce harm than punitive law enforcement measures. De-stigmatisation of PWUD and a deeper understanding of the experience of PWUD could go a long way to reducing harm" (M Marin, School of Population and Global Health, University of Melbourne, Nov. 2015)

Previous experience with a national body that has often represented PWUD with great knowledge and integrity in Australia is the Australian Injecting & Illicit Drug Users League (AIVL). Their experience can make a difference to the way in which a programme is delivered as well as alerting others to new and complex changes in the patterns of drug use or emerging harm associated with drug use.

One of the clearest arenas where a health response struggles for recognition; yet where it should prevail, is in responding to people who use drugs and find themselves in health or other trouble as a result. This is demonstrated in the following submission that is quoted here in detail as an example of concern about the lack of a global focus on the health response to drug use; in a context where the health of the community is significantly threatened by the manner of responding to people who use drugs.

"Structural and legislative barriers to health and wellbeing.

Key reasons for the limited scale-up of effective harm reduction measures are modifiable structural and legislative factors. These barriers contribute strongly to the maintenance of high rates of health and social harms among people who inject drugs (PWID). The prevalence and severity of drug-related harms varies regionally and between countries, with increased harms invariably associated with punitive legislative frameworks that impede legitimate harm reduction activities and contribute directly to risk practices, marginalisation and stigma.

The ongoing criminalisation of drug use and normative behaviours for people who are drug dependent, such as the possession of small drug quantities for personal use or the possession of paraphernalia, has resulted in a gross over-representation of drug-related offenders in prison and enormous harms to individuals and costs to communities.

The interpretation of 'social supply' (where an individual purchases drugs to supply to their direct social networks) as a drug dealing/trafficking offence has also resulted in the conviction of many drug users for serious drug offences.

Direct health costs can be attributed to the criminalisation of the possession of drug paraphernalia; in the case of injecting drug use, contributing directly to the sharing of injecting equipment and BBV transmission27 and overdose and mortality related to the physical space in which injecting occurs and hurried injecting to minimise time in possession.

Ultimately, there is a global imperative to reform international and domestic drug laws to reduce the harms associated with drug use; such reforms can comfortably exist under current UN drug control conventions.

Beyond legislative barriers for the prevention of drug-related harms, many structural gaps regarding harm and demand reduction service systems exist globally*. In many parts of the world very few resources are available for harm reduction, drug dependence treatment services and the treatment of HIV and other*

BBVs. This, combined with often excessively restrictive treatment eligibility criteria for drug users and treatment protocols that lack evidence of effectiveness or breach individual human rights, contributes to the ongoing enormous and preventable burden of disease associated with drug use globally. It is crucial that the research and experience regarding the implementation and effectiveness of high-coverage drug harm reduction and treatment services, accumulated over several decades, be translated into regions where the coverage of such services is limited.

Finally, the lack of equivalence of drug dependence treatment and harm reduction measures for drug users who are incarcerated continues to breach fundamental human rights and international conventions. The worldwide undersupply of treatment and harm reduction services in prison should provide further impetus to law reform that avoids the routine incarceration of people for offences related to their personal use of drugs". (CREIDU Submission, Nov. 2015 References supplied/available)

vi. The need to address stigma, discrimination, and reintegration for drug user health and well-being
(Also covered to some extent above and also see below: women and children section)

This topic was mainly raised and discussed with reference to:

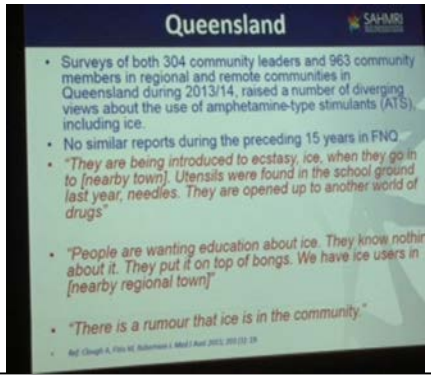
- Australian Indigenous peoples – our Aboriginal and Torres Strait Islander peoples,
- prisoners and
- people who use drugs (PWUD); especially those who inject drugs (PWID).

Australian Indigenous peoples – Aboriginal and Torres Strait Islander peoples

- There is general concern for the significant overrepresentation of Aboriginal people in the AOD (alcohol and other drug) records of health and other troubles in Australia. These statistics will not be listed here but are readily available.
- Historically the dominant concern has been on use of alcohol and cannabis.
- However there is growing concern about a rise in injecting drug use within Aboriginal communities, including in more remote areas of Australia. For example see Queensland slide. [10]

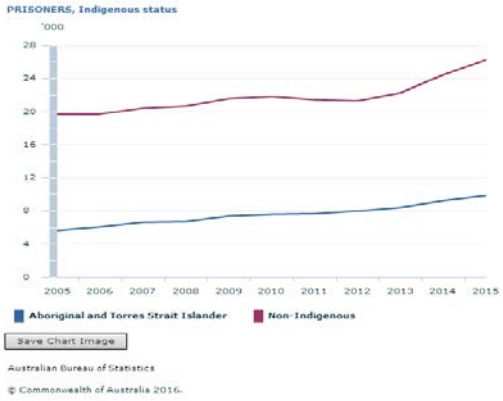
[10] Ward, James Keynote Address: Injecting Drug Use Among Aboriginal and/or Torres Strait Islander (Aboriginal) People Is A Critical And Emerging Issue, APSAAD Scientific Conference, Perth, Nov. 2015, SAHMRI [*Infectious Diseases Research Aboriginal Health, South Australian Health and Medical Research Institute, Adelaide, South Australia, Australia*

- Great concern was expressed about the over-representation of Aboriginal people in prisons[11]. See following rates in text box below for 2009[12] and graph for current data on numbers of Indigenous and non-Indigenous people in prison in Australia, 2015[13]:



This includes evidence of a higher proportions of HIV incidence due to injecting drug use among Aboriginal Australians compared to non-Indigenous Australians.

The age-standardised imprisonment rate was 1891 Indigenous prisoners per 100 000 Indigenous adults (Australian Bureau of Statistics, 2010). This compares with an age-standardised imprisonment rate of 136 per 100 000 non-Indigenous adults (Australian Bureau of Statistics, 2009). Imprisonment among Indigenous prisoners was 14 times higher than the rate for non-Indigenous prisoners (ABS, 2010)



[11] See for example: Australian National Council on Drugs, NIDAC Committee (2009, Revised 2013) Bridges and Barriers; Addressing Indigenous Incarceration and Health. Canberra

[12] Rodas, A Bode, A and Dolan, K. 2012, **Supply, demand and harm reduction strategies in Australian Prisons – an update.** National Drug and Alcohol Research Centre University of New South Wales. November 2011

[13] Australian Bureau of Statistics data http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2015~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20prisoner%20characteristics~7

At 30 June 2015:
There were 9,885 prisoners in Australian prisons who identified as Aboriginal and Torres Strait Islander, a 7% increase (620 prisoners) from 30 June 2014 (9,265 prisoners). The number of non-Indigenous prisoners also increased by 7% (1,758 prisoners).

- Aboriginal and Torres Strait Islander prisoners accounted for just over a Quarter (27%) of the total Australian prisoner population. The total Aboriginal and Torres Strait Islander population aged 18 years and over in 2015 was approximately 2% of the Australian population in aged 18 years and over.

- Aboriginal peoples in Australia are diverse such that 'one size will not fit all'. This diversity is seen in different cultural histories and practices. There are also differences between those in different locations (rural, remote, regional and those that live in major metropolitan centres or move between these locations).
- This diversity is also seen in Aboriginal communities' responses to harm minimisation: (as expressed in presentation: James Ward from SAHMRI; who also explored issues for similar global indigenous populations).
    - Within Aboriginal Communities, harm minimisation is a contested approach and significant tensions exist around strategies to address drug use.
    - Programmes such as NSP and OST may be supported outright, completely rejected or supported if delivered in a location separate from other Aboriginal services.
    - Partnerships are critical; [and care is needed to avoid]-contraction of services
    - Understated issue – often over policed, Aboriginal people [are] profiled resulting in increased risk of contact with criminal justice and other risks associated with injecting[14]
- Pathways to resilience need to be recognised and might not always be the same as the pathways for other folk.
- Milestone screening can be most useful to assist in early identification of people who might need additional support; including children.
- The confluence of drugs and violence has a profound impact on Aboriginal people.
- The co-occurrence of various deficits and difficulties including mental health problems together with drug use/dependence is a significant factor that must be considered in any assessment and response system.
- For Aboriginal people, in particular, there is a need to address issues of access to housing, employment and other factors that can be antecedents to drug use as well as in rehabilitation and transition programmes.
- There is value in accessing indigenous specific guidelines, manuals, screening instruments and the like. There is a range of these available internationally that are culturally specific, including some developed specifically for aboriginal peoples.

[14] Ward, James *Ibid*

- There is a need to dispel myths about evidence-based interventions not being effective and/or appropriate for aboriginal people. See for example: an Australian report specifically on treatment for Aboriginal and Torres Strait Islander peoples.[15] This apparent myth is more likely to be associated with a lack of access to evidence-based interventions than beliefs about such interventions.

***Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*.** (NIDAC, 2014)

This paper was developed by the National Indigenous Drug and Alcohol Committee (NIDAC) in response to the misperception that effective alcohol and other drug (AOD) treatment is not available for Aboriginal and Torres Strait Islander peoples. The paper aims to reduce these misperceptions by outlining:

- who can benefit from receiving treatment
- what treatment is known to work
- key principles that should guide the application of treatment
- what constitutes effective treatment for Aboriginal and Torres Strait Islander people.

The paper focuses upon interventions that are evidence-based and directly related to addressing AOD use.

- Other guidelines are also available: eg: A handbook[16] that provides everyday practical information for working in the field of alcohol and other drugs (AOD) with a focus on Aboriginal and Torres Strait Islander clients; based on the clinical and cultural experiences of the authors who have worked in a range of settings from large urban environments through to small remote communities. It contains information on AOD work, including:

  - clinical treatment
  - prevention
  - early intervention
  - harm reduction.

- Access to services, especially for those in more remote locations, is an issue (This includes access to harm reduction services such as safe injecting equipment; a service that could save lives).
- There is a particular need to recognise the importance of family in developing responses to Aboriginal peoples.

Example: 2015 CAAPS Alcohol and Other Drug Services, *An evidence based approach to providing AOD treatment to Aboriginal people and their families:* "In line with recommendations regarding delivery of AOD rehabilitation for Aboriginal people, the program is family focused and the model is implemented in a way that accounts for this focus".

- Telling of stories is an important cultural practice and represents a cornerstone of appropriate practice with aboriginal peoples. "We must allow for the telling of stories among our people; this is how we …. learn …connect …. And this is how we recover" (A. Prof Ted Wilkes, a Noongar Elder from WA. Alice Springs, June 2015)

[15] National Indigenous Drug and Alcohol Committee (NIDAC) 2014 *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*. Canberra (published by the ANCD) http://www.atoda.org.au/wp-content/uploads/AOD-Treatment-report.pdf

[16] Lee K, Freeburn B, Ella S, Miller W, Perry J, Conigrave K (2012) Handbook for Aboriginal alcohol and drug work (2012) http://www.aodknowledgecentre.net.au/aodkc/key-resources/health-promotion-resources?lid=23503

- Service accreditation standards must include culturally sensitive and culturally secure standards if they are to be regarded as adequate. One case example of such standards has been developed by WANADA in Australia: The Standard for Culturally Secure Practice (Alcohol and Other Drug Sector) and this is now a registered International Standard that can be used to independently audit AOD.

Standard on culturally secure practice (alcohol and other drug sector).
The Standard is supported by a separate Interpretive Guide that provides examples of the way in which the criteria contained in the Standard might be applied in practice. To achieve certification against the Standard, agencies will need to meet 80% of criteria labelled as 'essential' under each Performance Expectation, which represent the minimum level of activity required to demonstrate cultural security in agency practice. The essential criteria relate to policies and procedures that would be in place, how an agency identifies the cultural and service delivery needs of its target community and what agency management, staff and consumers would know. **WANADA** (2012)

The Culturally Secure Aboriginal Recruitment and Retention Guide: "Cultural security within the workplace is where an organisation actively demonstrates a commitment to creating a fair and respectful environment that meets the cultural needs and obligations for all workers. ….. Cultural security in the health services area is about ensuring that the delivery is such that no one person is afforded a less favourable outcome simply because she or he holds a different cultural outlook". WANADA website (www.wanada.org.au).

Prisoners

Australian adult prisoner numbers continue to rise.

- The number of prisoners in adult corrective services custody increased by 7% from 33,789 prisoners at 30 June, 2014 to 36,134 at 30 June, 2015.
- The national imprisonment rate was 196 prisoners per 100,000 adult population; a 6% increase from 186 prisoners per 100,000 adult population in 2014.
- Unsentenced prisoners increased by 21 per cent: The number in adult corrective services custody increased from 8,213 prisoners at 30 June, 2014 to 9,898 at 30 June, 2015.
- Sentenced prisoners increased by 3% from 25,513 to 26,163 prisoners[17].

The most common responses during consultations regarding prisons and the treatment of prisoners were:

- Concern about increasing rates of incarceration in Australia.
- The number and proportion of convictions for drug related offences among prisoners and the use of prison sentences as a response to drug related crime (even when many of these was for relatively short periods such as 3 months).

[17] Australian Bureau of Statistics. 2015
http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2015

- The lack of equivalence in access to health and other services for incarcerated peoples such that they face additional risks; inconsistent with human rights.

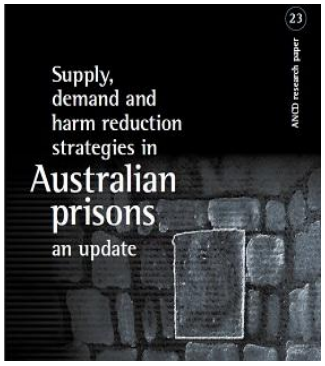
Example: "The United Nations Mandela Rules enshrine the 'principle of equivalence' (Rule 24.1) whereby people in prison should not be deprived of health services available in the corresponding community. Despite this, in many countries evidence-based responses to drug-related harm that are available in the community are not available in prison. There is compelling evidence that medication-assisted treatment (MAT) for opioid dependence is associated with reduced injecting drug use, reduced BBV infection, reduced mortality and reduced recidivism after release from custody, yet in many countries MAT is either not available in prison, or is available for only a subset of those in need". (Kinner, S submission, Nov. 2015).

- The difficulty of getting evidence-based treatment for drug dependence in prisons.
- The inadequacy of follow up following release from prison; recognising that this is a high risk event for many drug users.
- The high rates of blood-borne virus infections among prisoners and the potential for spread.
- The lack of access to clean injecting equipment in prison.
- High rates of Aboriginal people compared to non-Indigenous Australians in prison (see above)

In an effort to capture some of these issues, two services suggested the following report as their statement on these issues:

Rodas, A Bode, A and Dolan, K. **Supply, demand and harm reduction strategies in Australian Prisons – an update.** National Drug and Alcohol Research Centre University of New South Wales

A report prepared for the Australian National Council on Drugs, November 2011 (Pub: 2012)



This report highlights:

- the operation of Australia's prisons need far greater levels of accountability and transparency, as well as a much stronger commitment to providing effective programs and treatment for people with drug and alcohol problems issues if we are to see any real reductions in reoffending rates.
- Australia's prisons currently have a major focus on reducing the supply of drugs with programs that are rarely evaluated and in the end fail to stop the availability or use of drugs in prisons; mostly the use of drug detection dogs and urinalysis.

- Some evidence has suggested that urinalysis might provide a perverse incentive for prisoners to switch from smoking cannabis to injecting heroin. The rationale is that the same penalty applies to inmates with positive urine samples, whether for cannabis or morphine (a marker for heroin), although cannabis use is detectable for up to five weeks while heroin use is only detectable for up to two day. Differential sanctions with less severe penalties for cannabis use than for injecting drugs as used in one State could reduce this practice.
- Demand reduction strategies aim to reduce the demand for illicit drugs and include detoxification, methadone treatment, inmate programs and counselling, and drug-free units.
- A ten-year follow-up study of New South Wales inmates in methadone treatment found a 20 per cent reduction in re-incarceration and a decrease in mortality for those who left prison on methadone and remained on it after release (Larney, Toson, Burns and Dolan, 2012).
- In 2009, harm reduction strategies across Australian prisons included: harm reduction education; blood-borne virus testing and hepatitis vaccinations; condom and dental dams; and disinfectant (refer to Table 4 for coverage and evaluation data).
- Australia's prison population has leapt by 30% since 2002 – 2009 (date of last assessment)
- Further investigation (ANCD) has also discovered that total government expenditure on prisons & correction services has climbed dramatically from $1.5 billion in 2004 to $2.8 billion in 2008.
- It is difficult to get details on prison based drug and alcohol programs and given the expenditure of public monies this is concerning.
- There is a need for regular, transparent and independent reviews of every prison to determine the breadth and level of services available to address drug and alcohol problems and reduce reoffending. Such reports also need to provide information on outcomes, performance, effectiveness and the impact of the programs being implemented.
- The report also highlights that despite growing evidence of needle sharing in prisons, and the continued effectiveness of community based needle and syringe programs in the community, that not one prison in Australia has as yet introduced or even trialled a prison based needle and syringe program.

Further commentary in submissions included:

- Drug and alcohol use [is] a significant issue in Australian prisons. Prisoners [in this study] were over five times more likely than the general population to have a substance use disorder[18].
- Recent estimates indicate that 26% of all prisoners, and 64% of prisoners with a history of injecting drug use, have HCV.3 (Note: Taken from CREIDU Submission[19], Nov. 2015.).
- Risky drug use in prisoners often occurs in the context of entrenched disadvantage and complex physical and mental health needs; coordinated, continued and community-based care is pivotal to addressing the myriad drivers of risky drug use in this population. (Kinner, S submission, Nov 2015)

The priority for attention to those in prison was a focus:

- Reducing drug-related harm in people who cycle through prisons is important for human rights, public health, public safety and the public purse. In many countries, evidence-based responses are often not implemented or not implemented to scale, and the societal costs of inaction are both profound and avoidable. (Kinner, S submission, Nov 2015)

[18] Dolan K, Rodas A, Bode A. Int J Prison Health. 2015;11(1):30-8. Included in submission from forum participant.

[19] See Appendix 4 - at the end of this report as it includes considerably more detail about the global situation of PWID and blood borne viruses and the need to specifically address this.

People who use drugs (PWUD); especially people who inject their drugs (PWID)

There is general concern in much of the community of interest in the wellbeing of people who use drugs and, in particular, among those who work alongside people who use drugs about the extent and implications of stigma and discrimination.

Even in Australia with a National Strategy that avows concern for the health and well-being of drug users, stigma and discrimination remain. This is evidenced in the most recent survey carried out by a peak body working to represent the experience of people who use drugs[20]:

> "It is evident ….. that stigma and discrimination appear to be having negative effects upon a sector of society that is already marginalised and vulnerable, and in many instances pushing people into suicidal states ……. themes of alienation, disempowerment, frustration, suicidal ideation, betrayal, fear, and shame are all significantly represented [in responses]"

- The overall aim of this survey was to "reduce stigma and discrimination, improve access to services – particularly healthcare services – and reduce social exclusion among people who inject drugs (PWID), those with hepatitis C, HIV, and/or other blood borne viruses (BBVs), and those on opioid substitution therapy (OST)".
- From that report: People who inject drugs in particular can be very vulnerable to adopting the negative stereotypes that society inflicts upon them. This can frequently mean that people stop recognising when they are experiencing stigma and discrimination, it becomes 'normalised' and almost expected or considered as legitimate or 'deserved' behaviour. Examples of comments received and reported in that report:
    - "I felt powerless and as though I deserved to be in pain." - Male, 46-59, Regional, SA
    - "(I feel) like I don't matter to society at all, like I'm useless and worthless... I am still very upset." - Female, 36-45, Metropolitan, Vic.
    - "Victimised, helpless, compromised, disillusioned, and bloody terrified of ever having to place myself in the care of that particular hospital especially ever again." - Male, 36-45, Metropolitan, ACT
- The data from this survey suggests people seen as drug users, former drug users, or having a BBV are more likely to be treated poorly (often in regard to their healthcare), sometimes denied treatment altogether or provided a level of treatment far below the quality that other members of society would consider appropriate.
- Other studies have noted the significantly increased risk of suicide among people who use drugs compared to the general population: eg: The Australian Treatment Outcome Study[21] found that in the case of long-term heroin users nearly half had previously attempted suicide, compared with a little over 3% amongst the general Australian population. Additionally, amongst heroin users, one in ten reported current suicidal ideation and one in twenty had an actual suicide plan; this latter being seven times higher than the general population.

[20] Australian Injecting and Illicit Drug Users League (AIVL) 2015, We Live With it Almost Every Day of Our Lives - An AIVL Report into Experiences of Stigma & Discrimination, Canberra, Australia. http://www.aivl.org.au/wp-content/uploads/20151008_Report-Web.pdf

[21] NDARC. Darke, S. & Teesson, M. Managing drug users' high suicide risk: new NDARC resource assists co-ordinated approach (2015). Available at https://ndarc.med.unsw.edu.au/news/managing-drug-users%E2%80%99-high-suicide-risk-new-ndarc-resourceassists-co-ordinated-approach.

The AIVL Survey follows earlier research on the experience of discrimination and stigma. These reports[22] are readily available[23]; providing useful contextual information about the history, sources, contexts and implications of discrimination against PWUD. They suggest that:

- *"stigma and discrimination associated with people who inject drugs are both institutionalised and pervasive" and*
- *negative attitudes persist and are even seen as positive by some sectors of the community falsely believing that this can act as a deterrent "despite the wealth of research evidence highlighting the extremely harmful effects of stigma and discrimination on people who inject drugs and the lack of evidence to support discrimination as an effective deterrent to illicit drug use."*

In the 2011 report, AIVL aimed to define responsibility for action to reduce stigma and discrimination as something that needs to be shared by the entire community. The report outlined 3 levels for action (with only a selection of recommendations from those directed at the international level included here) across 4 topic areas: Legislation and policy, Community education, Peer empowerment and Professional societies and workforce development. Examples of specific recommendations in the first two of these:

Legislation and policy:

- *that the CND and the UNODC be called on to ensure that all international drug control laws and policies are consistent with accepted international standards in relation to human rights and the right to health for all*
- *that UN agencies be encouraged to review all relevant UN policies and programs to ensure they actively support and implement the principles of the meaningful involvement of people who use drugs*
- *that the International Network of People Who Use Drugs (INPUD) and regional drug user networks work together to highlight the impacts of illegality and criminalisation and of stigma and discrimination on the health and human rights of people who use drugs, with a view to encouraging legislative and policy reform to redress these impacts*
- *that AIVL work with the (INPUD) in its efforts to encourage the meaningful representation of people who use drugs on all relevant UN bodies—such as the Technical Advisory Group for the Global Commission on HIV and the Law—dealing with questions of legal and policy significance to our community.*

Community education: *That AIVL [be supported to] work with the INPUD:*

- *at [all levels], to take advantage of relevant international forums and events to raise awareness of stigma and discrimination associated with people who inject drugs*
- *to develop for the World Health Organization, UNAIDS and other global agencies a media guide on how to refer to people who inject drugs in their communiqués and other online and print-based publications*
- *and Harm Reduction International to develop an international media awareness and awards program that celebrates appropriate media behaviour. Award recipients could be announced at the International Conference on the Reduction of Drug Related Harm or another suitable international forum*
- *[to ensure] that media complaints units around the world take a firmer stance on the stigmatisation in the media of people who use drugs*

[22] Australian Injecting and Illicit Drug Users League (AIVL) 2011, 'Why wouldn't I discriminate against all of them?', A report on stigma and discrimination towards the injecting drug user community, Canberra, Australia

[23] http://www.aivl.org.au/wp-content/uploads/images/AIVL%20IDU%20Stigma%20%26%20Discrimination%20Report%20Nov%202011.pdf

- *and other international drug user organisations work together to more effectively use current media—such as Facebook, Twitter, current affairs programs and newspaper articles—to give a more balanced account of drug-related matters.*

Overall these sentiments were reflected by various people who work with and represent people who use drugs across Australia during the consultations.

Eg: Display Stand: WASUA (WA Substance Users Association)- discussion held with members Nov. 2015 during an annual conference, Perth. WA.

- One submission points out that: "the WHO has set elimination targets for HIV by 2030 and is in the process of setting elimination targets for hepatitis C and hepatitis B, by 2030.
- Key to meeting these elimination targets is the provision of improved antiviral treatments for all three diseases and the implementation of the highly effective hepatitis B vaccine.
- However, without changes in legislation on drug use to reduce stigma, discrimination and criminalisation associated with drug use, key populations who need to access treatment and care, namely PWID, will not access health services at the levels required to both benefit their personal health and reduce disease transmission.
- Importantly, the elimination models suggest that treatment alone will not be sufficient to meet the 2030 targets; treatment must be combined with high-quality harm reduction if the ambitious – but nonetheless achievable – targets of HIV, hepatitis B and hepatitis C elimination are to be achieved". (CREIDU Submission, Nov. 2015)
- Repeating here from above: "The primary comment that I would like to offer UNGASS is that the overwhelming body of research into drug treatment suggests that health based treatments for people who use drugs (PWUD) are more likely to reduce harm than punitive law enforcement measures. De-stigmatisation of PWUD and a deeper understanding of the experience of PWUD could go a long way to reducing harm". (M Marin, School of Population and Global Health, University of Melbourne Nov. 2015)

vii. Access to controlled medicines

At almost every consultation forum held across Australia there was strong and unanimous support for the need to ensure the availability of narcotic drugs for medical and scientific purposes and to ensure access to these medicines for all peoples across the globe.

Many people recognised that Australians are in a relatively privileged position with access to medications such as opiates for pain relief, palliative care and for the treatment of opiate dependence and other conditions; noting that there are many across the globe who do not have access to these medications. They call on all UN instrumentalities to do all that is necessary to ensure that others have access to these medicines and to set frameworks and targets that ensure that this is done.

Some organisations within Australia planned to provide further detailed feedback through other members of the CSTF and so this section is not detailed further in this report. Overall summary comment from one:

> "Access to essential medicines (for pain relief, palliation + treatment options eg: for opiate dependence) – is a necessity for human rights and dignity reasons. We must ensure that these medications are available and accessible to all peoples". (Conversation with small group of NGO in NSW, Nov. 2015)

This is likely to require greater cooperation and international efforts in many areas to increase capacity for assessment, administration and distribution of controlled substances and needs all instruments of the UN to be actively involved; especially the INCB, WHO, UNODC and UNDP.

IV. DRUGS AND CRIME:

Due to the mix of participants in consultation forums, there was generally less specific input on drugs and crime related issues, compared to health topics. However, a dominant message was the need to achieve balance in spending between regulation, law enforcement and interdiction on the one hand and the availability of prevention and treatment responses for individuals on the other; suggesting that these need to go hand in hand to be effective.

Matters relating to proportionality in responses to drugs and fairness are mentioned in the sections above as they impact on health.

One submission expressed a sentiment that was voiced by a number of others:

> "Although most people who use drugs (PWUD) do not commit crime, PWUD are at increased risk of contact with the criminal justice system and of incarceration. Some dependent users commit acquisitive crimes to fund their drug use; a small minority engage in violent crimes linked to illicit drug markets or driven by the disinhibiting effects of some substances. However, the most significant driver of incarceration of PWUD is not crime but drug policies that criminalise possession and 'social supply' of drugs". (Kinner, S)

i. Concerns about the unequal enforcement of policies and sentencing

Concern was expressed regarding disproportionate responses to users of different drugs in different locations and situational contexts. One submission specifically called for strong wording on the proportionality of sentencing. Another argued for recognition of the principle of proportionality to be applied systematically to the drug conventions and developed a comprehensive paper about the principle. It included:

> "A rights based drug control strategy should employ the principle of proportionality. The legal principle of proportionality is applied in both domestic and international contexts. Its application manifests in differing ways in the varied contexts in which it is used. Generally, the principle of proportionality refers to a state's responsibility to act in a rational and reasonable manner in striving to reach its objectives, without unjustifiably impinging on the rights of individuals or states"… To pass the proportionality test a government must:
>
> - … "be shown to be employing legitimate measures to achieving its aim;
> - the measures used must be necessary for achieving its aim and,
> - the measures applied must be proportionate to said aim".[24]

[24] Emily Crawford, *Proportionality,* Series Proportionality (trans, 2011), quoted by M.Marin((op.cit).

Others raised questions about the fairness of police actions in arresting and prosecuting some people in the context of drug use; suggesting that this was often overly intrusive or selectively adopted as a means of targeting certain individuals. A call for consistency was common in discussions.

Overall there appears to be general agreement that for minor drug related offences, diversion from the criminal justice system is most appropriate.

Alternatives to usual conviction/sentencing procedures such as therapeutic jurisprudence (TJ), with a range of implementation approaches have evolved across Australia (and elsewhere) including (but not only) drug courts that can allowing for alternative sentencing provisions with intense monitoring and follow up.

One response from a Court Diversion Officer, working in Community Corrections in one Australian jurisdiction Department of Justice[25] following a consultation forum:

> "I'm interested in promoting the role of therapeutic jurisprudence (TJ) as a problem-solving approach to addressing the issues that underlie offending behaviour and illicit drug use. Drug courts adopt a collaborative approach using teamwork between the judicial officer, prosecution, defence and treatment services to manage high end drug-addicted offenders in the community instead of in prison. Offenders are highly accountable through intensive case management and counselling, regular drug testing and court reviews. Judicial oversight gives 'teeth' to compliance measures and encourages constructive engagement with treatment interventions.... they offer excellent value for public money".

In the case of juveniles, one set of submissions included an emphasis on the importance of Article 33 of the Convention on the Rights of the Child making protection against drugs "unquestionably a human rights issue," and included an article that also drew attention to Article 37: Protection for children deprived of liberty noting that : "Article 37 in the Convention on the Rights of the Child is underpinned by more detailed international legislation on juvenile justice in the Beijing Rules and the Riyadh Guidelines suggesting that the basic premise is that even though a child can be a perpetrator all efforts shall be made to divert him/her away from institutional sentences, and if this is not possible the sentence shall be for the shortest possible time and in a child/youth facility. This applies for drug crimes as well as for other crimes"[26]

Some ambivalence and difference of opinions regarding Drug Courts remains in Australia. While there has been some effort to evaluate these and individual courts have generally been evaluated as significantly more successful in promoting reduction or cessation of drug use and crime, they are not widely available and governments have been slow to further develop them.

The Drug Court of Victoria targets a particular cohort of individuals who have entrenched criminal behaviour related to substance misuse that has developed often over a number of years. A high proportion exhibit a number of vulnerabilities and have records which include multiple terms of imprisonment. This is a cohort who impose a high burden on society and front line services. **It remains the state's interest to minimise the continuing involvement of this cohort with the justice sector, and indeed other front line services.**

[25] Ms. Liz Moore, Court Mandated Diversion, Community Corrections, Tasmania.

[26] Drug Free Australia submission contained video film & a number of articles including: Dahlgren, S and Stere, R; The right of children to be protected from Narcotic drugs & psychotropic substances. A human right/international law perspective, May 2010 pp.20

It is worth differentiating those who are involved with minor drug related offences and those who are, at least in principle, the focus of the Victorian Drug Court[27]:

The conclusions in the evaluation of this particular drug court suggest that:

> "The DCV continues to deliver positive outcomes for the community and participants, as evidenced by improvements in health and wellbeing for the participants, and a reduction in recidivism by those who complete the program. ……..(a small sample possible to follow up) suggest that a reduction in reoffending has occurred…., and backs up the stakeholder feedback on the efficacy of the program. Case studies of individual participants also illustrate the significant impact on their lives that the DTO and participating in the drug court has had".

While there is very strong endorsement for those who are involved in this specific drug court, it is worth noting that the majority of people who are tried for drug related crime cannot access such an intense service as it is not available. It is suggested that instead of funding specific drug courts that are geographically determined, it is necessary that all courts find ways of better managing people accused of and convicted of drug related offences. Specific evaluations appear to be positive for those who can access drug courts, but access and availability remain an issue. "Literature indicates that drug courts remain more effective at addressing the revolving door of drug related offending than the use of traditional criminal justice approaches in isolation." (Vic. DCV Evaluation). However these are only helpful if available and accessible.

In this context another submission suggested that drug courts are not necessarily the most effective way of delivering diversion programmes: "On paper, drug courts seem like a smart, progressive way to help people kick their dependence. But a recent report suggests otherwise". Forwarded in a submission from a youth drug treatment service.[28]

ii. The harms of trafficking and its associated violence and exploitation

The links between drugs and crime, especially concern about violence, is recognised; though the responses to this link varied. Some suggest changes in laws and regulation toward de-criminalising some drug offences and others suggest changes in policing practices.

Various groups consulted identified the common and interchangeable elements of illicit international trade in illicit drugs, human trafficking and illegal arms, expressing concern about the ready cross over of these trades and the inherent corruption and graft associated with this as a part of the concern about international security. There is thus an understanding of why this needs to be a topic of concern for UNGASS.

Noteworthy is the absence of information, knowledge and understanding of our Australia's own activity in the international arena when consulting with ground level direct service providers. This is more pronounced than in previous times when there was more active engagement of the 'interested community' in drug policy issues and when communication and administrative structures were more closely aligned and partnerships across regulation, law enforcement and health were more apparent; in the experience of this writer.

[27] Evaluation of the Drug Court of Victoria FINAL REPORT Magistrates' Court of Victoria 18 December 2014 [KPMG – Government commissioned report]

[28] Taken from submission citing: https://www.opensocietyfoundations.org/voices/well-intentioned-deeply-flawed-approach-addiction-treatment

iii. An evaluation of whether the current system is cost-effective and making society safer

Generally there is a strong call from Australian participants in the consultations for much greater transparency in funding of all programmes; requiring the equivalent levels of evidence and proof of effectiveness for any drug related activity to receive funding.

See also above re Preamble discussion and the need for data collection, collation, analysis and distribution of findings relating to the evidence of effectiveness for the majority of programmes funded in the name of drug supply reduction and prevention of drug related crime.

An extensive programme of evaluation research including economic evaluation and modelling has been carried out by the Drug Policy Modelling Program at the National Drug & Alcohol Research Centre, University of NSW and includes a number of studies such as the cost-benefit of different options in response to drugs, relative expenditure on different drug responses in Australia and beyond[29].

A number of programmes that might best be seen as demand reduction have been evaluated but far fewer of those related to supply reduction have similar research based evaluations; yet these continue to be funded, often much more readily than those with sound track records and positive evaluations that are related to demand reduction including some prevention and treatment responses.

Even on cost effectiveness bases, treatment, diversion programmes and other measures have been shown to be successful. Examples include the evaluation of one Drug Court that suggests: "The DCV also offers a cost effective sentencing alternative, being considerably cheaper than an equivalent term of imprisonment, and in line with other therapeutic justice programs"[30] and the cost savings of provision of injecting equipment in Australia that shows that this is a most cost-effective measure[31].

iv. Allowing for greater policy experimentation by member states

During the Australian consultations there was acknowledgement that the interpretation of the Drug Conventions was quite variable across the globe and that there is some value in allowing for cultural adaptation in application of the treaties and experimentation in the interests of furthering knowledge and experience. Further comment is included below re the Conventions.

[29] See for listing of publications and other information https://dpmp.unsw.edu.au/content/about-us

[30] Evaluation of the Drug Court of Victoria FINAL REPORT Magistrates' Court of Victoria 18 December 2014 [KPMG – Government commissioned report]

[31] National Centre in HIV Epidemiology & Clinical Research (2009) Return on Investment 2: Evaluating the cost Effectiveness of Needle and Syringe Programs in Australia. Sydney: UNSW & Comm. Dept. or Health & Ageing

V. DRUGS AND HUMAN RIGHTS, YOUTH, WOMEN, CHILDREN AND COMMUNITIES & CROSS CUTTING ISSUES

A mix of statements made are included here emphasising:

- Importance of family engagement in addressing drug use in the community and also in responding to those who are using drugs.
- No child should have to experience an environment where illicit drugs and/or excessive alcohol are being used.
- High priority of housing and preventing homelessness; since this is an antecedent to increased risk of uptake of illicit drugs as well as ongoing/escalation of use & housing is also a vital issue to address in treatment/rehabilitation for those who seek/supported/forced in to treatment.
- First nations peoples (including consideration of farmers of raw product) need culturally appropriate responses
- Gendered roles and impacts on aspects of drug policy must be considered.

i. The elimination of the death penalty for drug offences

There was strong, persistent attention to this issue; especially in light of two Australian citizens having been executed in another country following convictions related to drug offences early in the year. Participants were unanimously insistent that this is an inappropriate response to drug related offences and the summarised position on this is:

- The death penalty – should be abandoned; especially as it relates to drug related crime.

ii. Human rights violations

Comments of support for the priority being given to human rights conventions were common among submissions. .E.g.: “The human rights conventions should be privileged over the international drug conventions that actually breach the rights of PWUD. The drug conventions seem to target supply of drugs, neglecting the importance of reducing demand”. (Victoria, Dec 2015 M Marin, Email. School of Population and Global Health, University of Melbourne)

This same submission was most concerned about the ongoing use of CCDU’s in a number of countries, quoting “According to article 12 of the International Convention on Economic Social and Cultural Rights (ICESCR); all people have the right to the highest attainable standard of health.[32] and “The criminalisation and detention of PWUDs has deleterious consequences on individuals and has not been shown to reduce the harm associated with drugs.”[33]

[32] Social and Cultural Rights International Covenant on Economic, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 3, 1976.,

[33] Singleton, N & Strang, J 'What Would an Evidence Based Drug Policy Be Like?' (2014) 349 *BMJ (Clinical Research Ed.)* g7493.

iii. Drug-related issues which affect *babies & their mothers,* youth, women, *families*[34] and communities

A number of people involved in development and delivery of services to young people attended consultations. These included people from prevention oriented services and others from early intervention and treatment services. Of particular note was the interest from those involved with children in their very early years from birth – and a specific interest in the mothers of infants and their babies and the early lives of children as a prime time for support and prevention programmes.

a) Drug-related issues which affect *babies and their mothers*

There was the interest in the impact of a mothers alcohol and drug use on their babies in utero. E.g: "I would like to bring your attention to the issue of Foetal Alcohol Spectrum Disorder and the fact that, [taking rates from other similar countries/USA] we have a [high] incidence of FASD of around over 10,000 children a year prenatally exposed to alcohol" This comment helps to draw attention to the risks of exposure to a range of other psychoactive drugs. (Russell Family Fetal Alcohol Disorders Association www.rffada.org).

Linked to this, one submission[35] included a paper written from an international law perspective:

Drawing attention to the 1989 Convention on the Rights of the Child (CRC) noting "Article 33 making protection against drugs ….unquestionably a human rights issue". Further stating that "Protecting children from illicit use/production/trafficking of drugs is not an option for States Parties to the CRC. It is an obligation. Since CRC is more or less universally ratified the obligation is universal".

While most can readily agree to the priority of protecting children, some of the ways that this is enacted were the subject of comments during consultations. The child protection sector and the drug treatment sector are not always well coordinated and different primacy of concern can undermine necessary partnerships in responding. This is an arena where there is some professional and ethical tension in risk assessment and appropriate responses, as found in a recent report of research regarding child protection issues and drug use[36] (forwarded as a submission) set the scene for some subsequent discussion with others about these tensions.

> Those consulted regarding the mix of child protection and drug use generally agreed with the current Australian approach to policy and practice "that can be characterised as **taking a clinical approach to managing AOD use during pregnancy, which emphasises the health of newborns, rather than the enforcement of the laws in relation to substance use**". Taplin et al 2015

As one senior medical addictions specialist said: "It's necessary to start a conversation with the women that 'drug use' does not automatically mean 'bad parenting'"[37].

[34] These additional specific groups (in italics) have been added here since there are some important specific issues related to them.

[35] Drug Free Australia submission citing: Dahlgren, S and Stere, R; The right of children to be protected from Narcotic drugs & psychotropic substances. A human right/international law perspective, May 2010 pp.20

[36] Taplin, S Richmond, G McArthur M (2015) Identifying alcohol and other drug use during pregnancy: outcomes for women, their partners and their children, Australian National Council on Drugs, ANCD Research report #30

[37] Dr Yvonne Bonomo, Women's Alcohol & Drug Service, Royal Women's Hospital, Melbourne.

- There is agreement that parental substance use can affect children developmentally from the point of conception, after birth and across the lifespan. This makes pregnancy an opportune time to address maternal alcohol and other drug use.

> "One of the strongest messages from research is the need for a coordinated service response in addressing parental substance misuse in a child protection context. The service response should be multidisciplinary, comprehensive and collaborative in scope, use coordinated and evidence-based strategies that incorporate support, and include comprehensive health and social services that are responsive to women's and children's needs". Taplin, et al 2015

Taplin et al, 2015 found: "Early engagement of pregnant substance-using women by antenatal and support services was seen as a critical factor for better outcomes for unborn children, their mothers and families. Early child protection involvement allows more time to support women to address their risk factors". However, stigma is in part responsible for drug using pregnant women presenting late to ante-natal services with a fear of child protection involvement. ….. "Stakeholders expressed concern about the impact on mothers and families of the removal of babies at birth and the resulting distress, which may manifest in increased AOD use". These researchers/authors further suggest:

> "Screening for risk but assessing for need" …. When dealing with drug using mothers with regard to them and their unborn babies and infants. …."Simply put, screening for AOD risk in isolation from service provision appears to be of limited benefit". Taplin, et al 2015

All who were involved in the discussion of the Taplin report strongly agreed that women experiencing "multifaceted disadvantage require strong inter-sectoral partnerships, and responsive programs, to provide the intensive sustained support that is required, beginning in early pregnancy.

However there was also agreement with the opinion that had been expressed by key stakeholders in this study (Taplin et al) that the consequences of prenatal reporting to child protection services [can be][38]:

- disengagement from, or avoidance of, health services by pregnant women;
- later presentations at antenatal care;
- increased marginalisation; through to
- increased involvement with the child protection system.

This report points out that Australian legislation and policies around prenatal reporting have been focused on the early identification of risk in pregnancy, and the provision of appropriate services and supports. However, there is some concern about "emerging indications of a weakening of this supportive focus in some Australian jurisdictions and a leaning towards adopting the more punitive responses currently evident in [other countries/states], where the rights of the foetus can be deemed superior to that of the mother, and the state's assumed authority to protect the foetus overrules the interests of the mother".

As this report concludes:

> "What is clear, is that the rights and needs of both pregnant women and their foetuses are critically important, and ethical and legal positions need to be considered in addition to their health needs".

[38] A lack of available data meant that these opinions could not be evaluated.

b) **Drug-related issues which affect youth**

Other youth specific issues that were raised are covered elsewhere in this report eg: re prevention and also re diversion programmes where the commentary on adult incarceration is even more relevant to youth.

c) **Drug-related issues which affect women**

Currently in Australia there is heightened focus on violence against women and children. Not surprisingly, discussions about this in forums noted the impact of drugs and the relevance of drug policy in our communities since violence is seen to be exacerbated and influenced in many cases by the presence of drugs, drug use and drug dependence as well as the way in which women's roles are perceived and enacted in some communities; making them vulnerable to risks associated with drugs.

- In this context one submission focussed on the specific responses to reducing family violence, suggesting that "The issue of drugs in society warrants the same attention and courage to achieve change" and coordinated international action could enhance this further.

The CITY OF MELBOURNE provided the following links as examples of the resources available that "showcase the activities at all levels of governments to change outcomes for women, children and families. . Also attached is the link to City of Melbourne's We Need to Talk - Prevention of Violence Against Women Strategy 2013 - 2016.

http://www.ourwatch.org.au/What-We-Do-(1)/National-Primary-Prevention-Framework (Federal Government)

https://www.vichealth.vic.gov.au/our-work/preventing-violence-against-women (State Government)

https://www.melbourne.vic.gov.au/CommunityServices/CommunitySafety/Pages/PreventingViolenceAgainstWomen.aspx (Local Government - City of Melbourne)

…. [Especially valuable] is the ….commitment at all levels of government. The landscape for this work touches every sector: justice, education, health, enforcement etc. The research compiled, the data available, the training being provided, the support from high profile individuals who share one voice on this issue has been extraordinary".

- Universal access to family planning was seen as crucial.
- Others called for women's, babies' and infants' interests to be included on the international drug policy agenda; suggesting that more effort to protect women and babies is needed along with greater resourcing of treatment for women who use drugs and who are pregnant and/or who are mothers. (eg: Social Worker Women's Alcohol & Drug Service, Royal Women's Hospital, Melbourne).
- Women are also seen to have special needs in treatment (here: just one example [39])

Supporting pregnant women who use alcohol or other drugs: a guide for primary health care professionals (2014) – a guide for primary health care professionals who work with pregnant women. It outlines best practice for supporting pregnant women who use alcohol or other drugs including:

- using screening tools
- providing early access to treatment
- providing brief intervention
- responding to domestic violence
- providing comprehensive care
- addressing barriers to care.

[39] National Drug and Alcohol Research Centre, University of NSW, Supporting pregnant women who use alcohol or other drugs: a guide for primary health care professionals (2014)

One of the State peak bodies has produced an evidence-based resource[40] to raise the profile of women in AOD treatment, suggesting that organisation level engagement with interventions that serve the needs of women have far-reaching benefits including: improving gender responsiveness, addressing issues related to family violence for both victims and perpetrators, raising awareness regarding the needs of children and introducing concepts around positive parenting and family inclusive practice.

This resource provides structural solutions, such as building sustainable community partnerships, professional development and worker self-care that are essential in supporting improved work practices with women.

- Treatment access can be a difficult problem for women with children seeking help to change their drug use as there are very few treatment services that can manage children; especially in provision of appropriate residential treatment.

d) **Drug-related issues which affect *families and communities***

As there were submissions and discussion that related specifically to the role and opportunity for family engagement, this is included under this heading. Discussion of the place and role of families and communities often occurs together. A focus on families has been emphasised throughout all sections of this report.

During consultations, services for families was highlighted in areas including prevention, community involvement and in responding to individual drug users seeking help as well as recognition of the needs of families affected by the drug use of a member. Families should be specifically addressed in any consideration of drug policy and programme development and also in funding of services and governance arrangements.

"The needs of family members and friends must be addressed … there was evidence that many family members of [drug] users, particularly where such use is heavy or dependent, are at loss to know how to handle the situation. The impact on a family ….can be profound, particularly in cases where the adverse effects …are severe and the family member is reluctant to seek treatment. ….[can include] family breakdown, financial strain and loss of assets, families providing round-the-clock support to loved ones who are agitated and awake during periods of intoxication, and fear of aggression and violence. …. In short, family sensitive and responsive practice should be seen as central to AOD treatment". Parliament of Victoria Law Reform, Drugs and Crime Prevention Committee Inquiry (2014).See full reference following.

[40] Network of Alcohol and other Drugs Agencies (NADA). NADA Practice Resource for Working with Women Engaged in Alcohol and Other Drug Treatment. Sydney: NADA; 2015

In the context of prevention particularly, the following extract from a recent report about the apparent increase in the availability and use of methamphetamine in one state[41] provides one reason to include explicit consideration of the role of families in primary prevention.

The Interplay between Risk, Protective and Developmental Factors

Modern approaches to prevention strategies focus on a number of issues and factors that are not specifically focussed on drug use per se but may be related to the reasons why some people may (or may not) use drugs.

….include: "social determinants of health; risk and protective factors through the life span; developmental milestones, transitions and trajectories; and systems approaches to drug prevention. (Loxley et al. 2004, p.3). Drawing from the work of a number of researchers, the Committee has noted the importance of a 'developmental pathways' model in informing the development of drug policy and strategies. This approach to drug prevention also does not necessarily concentrate on drug use per se."

This same report goes on to detail the ways in which families are impacted by drug use, the rationale for including them and ways of including them in responding. The foreword of this Inquiry in Victoria, Australia emphasised the impact on families. "It was clear that people from across the state felt that methamphetamine was having a damaging effect on sections of their community and that extra support was required in the areas of health, law enforcement, education and particularly family support. In short, the Committee believes there needs to be a response to a drug problem that is having a significant impact on the social fabric of local communities. pp. xiv.

This same report went on to emphasise the importance of engaging communities in responding to drugs; recognising that the use of methamphetamine [particularly] "can clearly have repercussions that spread beyond the individual involved. It is important therefore that harms experienced by third parties and society collectively are taken into consideration during the development of strategies to address methamphetamine.

> "In short, an all-of-community multi-layered response by government, the community and private sectors, including user groups, families and family support groups, individuals and organisations is needed to combat this problem". …Providing one example of a community response (Mildura's Project Ice) and noting that a community focus is most appropriate since:

- Many actions can only be taken at local level
- Local effort can harness local community resources;
- Each community is different and responses will need to be tailored accordingly[42].

[41] Parliament Of Victoria Law Reform, Drugs And Crime Prevention Committee Inquiry Into The Supply And Use Of Methamphetamines, Particularly Ice, In Victoria Final Report Volume 1 Of 2 September 2014

[42] Parliament Of Victoria Law Reform, Drugs And Crime Prevention Committee Inquiry (2014) Ibid. Page xviii

In a more recently released national report, forwarded for this author's consideration, the first major recommendation for responding to methamphetamine in Australia is to "**Support families, communities and frontline workers**"[43]

> "Our first priority must be supporting families, workers and communities to better respond to people affected by ice: **Families**, frontline workers and communities are struggling to respond to the growing number of dependent ice users around the country. Our immediate priority must be to support those Australians who are most affected by ice use. Families need advice on how to help their relatives who are struggling as a consequence of their ice use. Frontline workers need guidance on how to engage with ice users, and those in crisis, in particular where aggressive behaviour or violence is present.
>
> We need to enable communities to play their part: **Communities** also need help to take action. Communities are key to sending strong messages against ice use, supporting users who want to get off the drug, and working with police and other services to keep local communities safe from ice".

e) **Drug-related issues which affect other marginalised populations**

Information on these populations is included in the section above: The need to address stigma, discrimination, and reintegration for drug user health and well-being etc.

VI. NEW CHALLENGES, THREATS AND REALITIES IN ADDRESSING THE WORLD DRUG PROBLEM

Most information relating to these issues is found above in other sections.

One challenge identified in at least three consultations forums is the need to achieve balance in spending between regulation, law enforcement and interdiction on the one hand and the availability of prevention and treatment responses for individuals on the other. These need to go hand in hand to be effective. This need for 'balance' was a feature of the report of the National Ice Taskforce (see below); suggesting that some 're-balancing' is necessary.

An issue that has not otherwise been covered: One submission suggested there is a need for "something about prescription drugs: harms even when taken as prescribed (especially dependency and withdrawal), prescribing controls, illicit use of pharmaceuticals". This is not a new challenge but remains a concern. "There is a need for evidence based or evidence informed prescribing practices and guidelines for pharmaceuticals". Manager, Reconnexion, a service of EACH, Vic.

i. New psychoactive substances (NPS)

It is recognised that NPS should be considered in relation to a range of substances that are likely to continue to increase in the market place both internationally and within Australia in coming years; "there is likely to always be a 'new psychoactive substance' requiring specific attention". Comment in forum. Sydney, Nov. 2015.

A number of participants are aware of experiments in other countries such as New Zealand and said that they were encouraged by these efforts to explore new ways of responding to new psychoactive substances; suggesting that innovative responses will be needed in to the future.

[43] Commonwealth of Australia, Department of the Prime Minister and Cabinet, Final Report of the National Ice Taskforce. 2015

Other comments, especially related to the current concern about crystal meth-amphetamine ('Ice') included:

- Amphetamine type stimulants /substances (ATS) need to be addressed specifically.
- Australia has seen an upsurge in the availability, use and harm associated with the use of crystal methamphetamine in particular in recent years.
- This substance is a significant preoccupation in the media, among communities and hence also governments in Australia. A number of enquiries, task force investigations and other efforts were running throughout 2015 – all evoking a range of responses from civil society groups. Some of these groups forwarded submissions/evidence that they had sent to those enquiries on to this CSTF member.

There is great concern about a disproportionate uptake of these substances by Aboriginal and Torres Strait Islanders. One documented example of the presence of ATS and risks to a particular population[44]:

In Queensland (Australian state): No previous reports of 'ICE' in previous 15 years in far North Q'sland, but a survey of 304 leaders & 963 community members in regional and remote in Q'sland during 2013/14, raised a number of comments about the use of (ATS):

"They are being introduced to ecstasy, ice, when they go in to [nearby town]. Utensils were found in the school ground last year, needles. They are opened up to another world of drugs"

"People are wanting education about ice. They know nothing about it. They put it on top of bongs. We have ice users in [nearby regional town]"

Further, from an organisation who work closely with and represent people who use drugs, reporting on the results of their survey of Aboriginal people: the most common concerns could be grouped in to 3 key themes; with implications especially for youth:

- "Recognising drug use and local contexts where they are seeing increasing levels of injecting drug use in a context where young people have little support; observing young people smoking 'ice' [crystal methamphetamine] and also being exposed to risks of overdose on opiate medications. They suggest that opportunistic and poly drug use is driven by availability within communities and that for many Aboriginal people who inject drugs [PWID] polydrug use, including the use of non-injectable drugs is (now) the norm.
- They draw attention to the need for better knowledge, information and support including advise to explore the use of peer networks and related interventions as a promising response and
- pointing out needs for improved health services; especially a need for access to health promotion, NSP's and allowing input in to programme planning; with a note too about the need for attention to confidentiality to facilitate access the likelihood of service uptake".[45]

[44] Ref: Clough A, Fitts M, Robertson J. Med J Aust 2015; 203 (1): 19.

[45] http://www.nuaa.org.au/wpcontent/uploads/2014/09/Rise-Project-Report.pdf

Some findings of the National Ice Taskforce[46] report will be noted here as these are conclusions drawn from many submissions to that body; their taking of evidence and opinion from a mix of government(s) within Australia and civil society/NGO groups. From the Executive Summary:

- "Law enforcement agencies have responded strongly to disrupt the supply of the drug
- The quantity of ice seized at the Australian border has increased dramatically in recent years

But ….. Despite the efforts of law enforcement agencies, the market for ice remains strong. Ice is still easy to get and its price remains stable. The lack of any discernible market response to the efforts by Australian law enforcement agencies to prevent the supply of ice is greatly concerning. In most markets—legal or not—the significant shock to supply caused by a large seizure of product, should at the very least push up prices, particularly when demand is so strong. It is remarkable that despite very large seizures there has been no increase in the street price of the drug".

"The market's resiliency [associated with unique aspects of the drug and thus its market] must shape our response." The report points out that "it is manufactured from chemicals, not produced from plants, and can be mass produced in industrial scale labs offshore … and it is both imported and locally manufactured in significant quantities; …. it is easily concealed and trafficked. It also ….. offers …the promise of euphoria, confidence and enhanced sexual pleasure at a relatively cheap price. The effects can be achieved through smoking it (making its use appear safer and more socially acceptable [than alternatives]… concluding that these features "have created a perfect opportunity for organised crime—a growing demand for a highly attractive and addictive substance, which can be sold at a high price in Australia".

The report goes on to identify the various elements necessary for a comprehensive response: Families and Communities engagement (see above), increasing treatment provision along with prevention efforts as well as recommending that:

> "Efforts to disrupt supply must be more coordinated and targeted; …..including identifying a "need for greater cooperation with international efforts with timely exchange of intelligence especially" and …. highlight "the critical need for better data, more research and regular nationally consistent reporting".

Since this report was only released in December, 2015 it has not been possible to gauge and then include civil society responses to it. However many of the points made were repeated in the CSTF consultations.

ii. Diverse views on the Conventions and on recent decriminalisation and regulation trends

[Note: Responses to these 2 topics have been combined]

Consultations suggest that within Australia, consistent with the report from the Global Survey reported on earlier, members of civil society hold a range of views on the current Conventions. These diverse views represent a spectrum from an interest in exploring reinterpretation or revision of the Conventions, including the possibility of incorporation of two of the major problematic psychoactive substances not currently included at all under the conventions (tobacco/nicotine and alcohol), to some who suggest retention/preservation of the Conventions. There were many more urging the former, revise and/or reinterpret, than the latter: preservation.

- Few spoke specifically in favour of the current Conventions and the drug classifications within them but most people assumed that they are not readily overturned at this time.

[46] Commonwealth of Australia, Department of the Prime Minister and Cabinet, Final Report of the National Ice Taskforce. 2015

- A small and relatively quiet minority suggested abandonment of the current Conventions and classifications completely and suggested that all effort to regulate these products be dropped.
- A larger number of people called for support of regulation of some of the currently illicit and thus unregulated substances; to allow for their regulated availability.
- Some who attended consultations called for a more open approach to a range of substances including some drugs currently listed as illegal under the Conventions and other possible psychoactive substances that are not particularly well known or popular but suggested that they might be of medicinal interest in the future[47]
- In the context of considering the legal status of various substances, including newer psychoactive drugs, some respondents drew attention to the unequal attention to specific substances according to whether they were legal or illegal in our jurisdiction; comparing the responses to tobacco (heavily regulated and heavily taxed), alcohol (inadequately regulated) and those drugs currently banned in compliance with the current conventions.

Example: "The division between which psychoactive drugs are legal and which are illegal is arbitrary. There are no pharmacological, epidemiological, public health, human rights or any other grounds for classifying alcohol and tobacco as legal and other drugs as illegal. This division arose from a series of historical accidents.

The crux of the problem of illicit drugs is untested drugs in an unregulated market. Ultimately this produces a black market that is generally much more of a problem than the drugs themselves. This is associated with deaths, crime, corruption and mass violence. A black market for many currently illicit drugs is likely to continue indefinitely.

The drug policy of the future has to be consistent with the economics of the market while also being politically acceptable. Increasing the regulation of currently illicit drugs might enable improved regulation of our biggest drug problem [currently not included in the drug conventions] – alcohol".

Dr Alex Wodak. Email submission. October 2015.

Other organisations offer specific statements regarding the Conventions and/or regulation. Examples of the spectrum of comments include:

Drug Free Australia's Position Statement Against Illicit Drug Legalisation, Regulation and Decriminalisation: We support a balanced and humane illicit drug policy that aims at primary prevention and recovery-based treatment and rehabilitation. This can **never** be achieved if illicit drugs are condoned through their legalisation. Legalisation equates to 'regulation' in the illicit drug context. There is a maxim that remains constant - 'availability, accessibility and permissibility will increase consumption'[48]

'Unharm' on the other hand is eager to see drug law reform pursued more vigorously in the future: "promoting a new vision for a world where drug use is as positive, ethical and safe as it can be. This involves challenging the prohibition of drug and criminalisation of drug use and promoting an ethics of wellbeing that recognises that drug use can be part of a flourishing life."[49] http://www.unharm.org

[47] Verbal and written submission following consultation. Melbourne, September 2015 from PRISM (Psychedelic Research In Science & Medicine), "a NGO that aims to facilitate research into the medical utility of 'controlled drugs' such as MDMA, Ayahuasca, Psilocybin and LSD"

[48] http://www.drugfree.org.au/index.php/general/about-dfa

[49] Unharm Director Will Tregoning (2015 at National Drug & Alcohol Research Centre (NDARC)/DPMP forum)

VII. DRUGS AND (ALTERNATIVE) DEVELOPMENT

On prompting, many who attended discussions were interested in and supportive of recognising the issues for peoples where drug cultivation and, to a lesser extent, production occurs but this was not a top of mind issue in Australia.

Some commentary was prompted by the concurrent discussion in Australia of the potential pharmaceutical use of cannabinoids and the complexity of issues associated with sourcing the raw materials and manufacture of such a medicinal product; however, this was more in the arena of curiosity than substantive discussion at this time.

LESSONS LEARNED

See Section one of this report.