

The impact of harm minimisation programs on families

- 4.1 From the evidence taken by the committee in the course of its inquiry it has become quite evident that there is no universally agreed definition of harm minimisation. It clearly means different things to different people.
- 4.2 The greatest point of difference in illicit drug policy is between those who see minimising harm as a means of achieving the illicit drug user being drug free and those who see continued use as acceptable. The term harm minimisation has been captured by those who consider themselves to be the policy elite, who want so-called reform of drug laws, such as calling for cannabis to be treated like other legal drugs and therefore legalised and taxed and treated like any other commodity. The committee considers this to be a pro-drug stance. These people also share the view of the international movement funded by George Soros to change international treaties outlawing some drugs.
- 4.3 Harm minimisation is referred to in the national policy on drugs, the National Drug Strategy (NDS), which was developed into the framework for Commonwealth, state and territory government responses to drug issues.¹ The committee has several concerns about the prominence of the harm minimisation philosophy and the approach of some of its proponents in Australia, which are examined in this chapter:
- In general, the debate on ‘harm minimisation’ is shrouded in ill-defined terms which mean different things to different people;

1 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004).

- The strategy contains similarly ill-defined terms which leave room for confusion and mixed messages about its goals, particularly in relation to how illicit drug use is addressed;
- The committee finds the lack of written policy explicitly relating to illicit drugs unacceptable;
- The strategy's lack of focus leaves room for misinterpretation of the federal government's zero tolerance approach by drug industry elites, as well as state bureaucracies, thereby giving mixed messages to the community about the acceptability of illicit drug use;
- The interpretation of the term 'harm minimisation' by the drug policy elites that illicit drug use is morally neutral is completely at odds with the government's stated policy of zero tolerance which has harm prevention as its aim, and forms an illogical basis to a national drug policy framework; and
- The safety of children is compromised by treatment and child protection approaches for drug-using parents.

4.4 This chapter demonstrates that 'harm minimisation' means different things to different people. The range of possible interpretations leaves room for the Australian Government's approach to illicit drug use, as stated by the Prime Minister and discussed throughout this report, to be distorted. The position was recently restated by the Prime Minister in Parliament:

This government will never give up in the fight against drugs. We will never adopt a harm minimisation strategy; we will always maintain a zero tolerance approach.²

4.5 The committee considers that the ultimate goal of a national illicit drugs strategy should be harm prevention — that is, to prevent people becoming drug users and to enable individuals who break the law and use illicit drugs to become and remain drug free for the benefit of themselves, their families and the nation.

2 Hon John Howard MP, Prime Minister of Australia, *House of Representatives Debates*, transcript, 16 August 2007, p 52.

Defining harm minimisation

- 4.6 Harm minimisation is sometimes viewed as having commenced in the early 1980s in response to the emerging AIDS epidemic amongst intravenous drug users.³ The usage of the term also coincided with the public disclosure of the heroin problem of the then Prime Minister's daughter.⁴ The term also emerged from 'public health' policies in a range of areas that shifted the focus from the health of individuals to the general health of the population as a whole.⁵ In particular, needles and syringes were controversially supplied to injecting drug users in order to decrease the rates of contraction of HIV/AIDS and other blood borne viruses. There was also a recognition of the need for individuals to change behaviour with the launching of the 'grim reaper' campaign.⁶
- 4.7 Harm minimisation, with its public health roots, emphasised 'expert' knowledge and 'evidence-based policy' to the exclusion of ordinary people's experiences and opinions.⁷ Drug policy in Australia was thereby captured by influential drug industry elites.
- 4.8 An example of how the term was captured was an early definition of harm minimisation as applied to drug policy set out by a Canadian academic from the University of Toronto in 1995:
- A policy or program directed towards decreasing adverse health, social and economic consequences of drug use even though the user continues to use psychoactive drugs at the present time.⁸
- 4.9 There are a number of difficulties in defining harm minimisation, including what is meant by the terms 'harm' (such as health, economic, personal, third party 'opportunity' costs) and also the term 'minimisation'

3 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 13.

4 Fitzgerald J and Swards T, Australian National Council on Drugs, *Drug policy: The Australian approach* (2002), p 11.

5 Zajdow G, 'A critical sociological perspective on harm minimisation' in Mendes P and Rowe J, *Zero tolerance and beyond: the politics of illicit drugs in Australia* (2004), Pearson Education Australia, p 73.

6 Winn M, 'The Grim Reaper: Australia's first mass media AIDS education campaign' in World Health Organisation, *AIDS prevention through health promotion: Facing difficult issues* (1991), pp 33-34.

7 Zajdow G, 'A critical sociological perspective on harm minimisation' in Mendes P and Rowe J, *Zero tolerance and beyond: the politics of illicit drugs in Australia* (2004), Pearson Education Australia, p 80.

8 Single E, 'Defining harm reduction', *Drug and Alcohol Review*, vol 14, pp 287-90.

(reducing harm as much as possible, or a reduction of harm in the context of competition for resources, or making drug-related harm less visible).⁹

Harm minimisation and the National Drug Strategy

- 4.10 National drug policy is developed by the National Ministerial Council on Drug Strategy. The council was established in 1985, at the time of the disclosure of the Prime Minister's daughter's heroin use. The council was established by the Special Minister's Conference on Drugs and is supported by a secretariat in the Commonwealth Department of Health and Ageing.¹⁰ The council comprises Commonwealth, state and territory ministers responsible for health and law enforcement.¹¹ The Commonwealth is also represented by the Minister for Education and Training. Council decisions are reached on the basis of consensus with dissensions and abstentions on specific items being noted.¹²
- 4.11 The council is one of 33 ministerial councils that operate under a framework developed by the Council of Australian Governments (COAG)—the peak intergovernmental decision-making body in the Australian federation.¹³ In recent years, COAG has discussed illicit drug policies on two occasions. On both occasions the National Ministerial Council on Drug Strategy was charged with reporting to COAG on the implementation of national strategy initiatives:
- November 1997 — Heads of Government agreed to join in a National Illicit Drug Strategy, which would 'make a balanced attack on both demand and supply and on minimising the harm drugs cause'. The Commonwealth's intention to establish an Australian National Council on Drugs was also announced.¹⁴

9 Parliament of Victoria Drug and Crime Prevention Committee, *Harm minimisation: Principles and policy frameworks* (undated), Occasional paper no 1, pp 3–4.

10 Council of Australian Governments, *Commonwealth-State Ministerial Councils: a Compendium* (2006), p 36.

11 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 23.

12 Council of Australian Governments, *Commonwealth-State Ministerial Councils: a Compendium* (2006), p 35.

13 Council of Australian Governments, *Commonwealth-State Ministerial Councils: a Compendium* (2006), pp 16–88.

14 Council of Australian Governments, *Council of Australian Governments Communique 7 November 1997*.

- April 1999 — Heads of Government agreed to work together to make a new investment in prevention, early intervention, education and the diversion of drug users to counselling and treatment. They agreed to a major shift in the practice of law enforcement and treatment and a clear message about the unacceptability of illicit drug use. The measures proposed increase the availability of information about the dangers of drug use and the impact of police action.¹⁵
- 4.12 The term ‘harm minimisation’ has been used in reference to both licit and illicit drug policy in NDS documents since the early years of the Hawke Government in 1985.¹⁶ The meaning of harm minimisation in the NDS documents has changed over time. When the initial strategy was launched, the then health minister Neil Blewett claimed:
- The National Campaign has as its aim to ‘minimise the harmful effects of drugs on Australian society’. Its ambition is thus moderate and circumscribed. No utopian claims to eliminate drugs, or drug abuse, or remove entirely the harmful effects of drugs, merely to ‘minimise’ the effects of the abuse of drugs on a society permeated by drugs.¹⁷
- 4.13 The current national policy framework is comprised of a number of documents that support prevention and treatment approaches practised by government and non-government agencies. The overarching policy statement for both licit and illicit drugs is the current NDS, covering the period 2004–2009.
- 4.14 The NDS lists a number of objectives that claim to ‘contribute to reducing drug use and supply, and preventing and minimising harm caused by licit drugs, illicit drugs and other substances’:
- prevent the uptake of harmful drug use;
 - reduce the supply and use of illicit drugs in the community;
 - reduce the risks to the community of criminal drug offences and other drug related crime, violence and antisocial behaviour;
 - reduce risk behaviours associated with drug use;
 - reduce drug-related harm for individuals, families and communities;

15 Council of Australian Governments, *Council of Australian Governments Communique 9 April 1999 (Special Meeting)*.

16 Success Works Pty Ltd, *Evaluation of the National Drug Strategic Framework 1998-99 – 2003-04* (2003), p 17.

17 Ministerial Council on Drug Strategy, *No quick fix: An evaluation of the national campaign against drug abuse* (1992), p 20.

- reduce the personal and social disruption, loss of life and poor quality of life, loss of productivity and other economic costs associated with harmful drug use;
- increase access to a greater range of high-quality prevention and treatment services;
- increase community understanding of drug-related harm;
- promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems;
- strengthen existing partnerships and build new partnerships to reduce drug related harm;
- develop and strengthen links with other related strategies; and
- develop mechanisms for the cooperative development, transfer and use of research among interested parties.¹⁸

4.15 As discussed later in this report, it is important to note that some drug policy elites do not believe that all illicit drug use is harmful, despite the accumulating scientific evidence on how drug use affects the brain and physical development.

4.16 According to the NDS, 'harm minimisation' encompasses:

- supply reduction strategies to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances;
- demand reduction strategies to prevent the uptake of harmful drug use, including abstinence-oriented strategies and treatment to reduce drug use; and
- harm reduction strategies to reduce drug-related harm to individuals and communities.¹⁹

4.17 The strategy also makes the following remarks about harm minimisation:

Harm minimisation does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies.²⁰

4.18 This is a much stronger statement on harm minimisation showing movement from the soft on drugs approach to a tougher approach.

18 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 5.

19 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 2.

20 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 2.

4.19 There is open disagreement in the community about the meaning of harm minimisation and other terms, and the relative priority that should be placed on different strategies to reduce illicit drug use and make individuals drug free. In discussing the language underpinning the drug policy framework, the confusion was observed by Melbourne University academics Professor John Fitzgerald and Tanya Swards:

The policy community, like any community, shares a common language. Our policy framework establishes the policy community's common language. Without a consensus about the meaning of key terms, the community can lose coherence, purpose and effectiveness.²¹

4.20 The committee considers that although the language in the NDS has changed direction since 1985 and can be interpreted to support the current Commonwealth Government policy of tough on drugs, many of the 'objectives' of the NDS, as well as the description of the 'harm minimisation' principle are poorly defined and open to misinterpretation. Conflicting views on the meanings of key terms such as 'harm reduction' (discussed below), leave the strategy open to distortion by members of the drug industry and 'policy experts'. Further, the committee considers it of utmost importance to recognise the various agendas of sections of the drug industry, who have a vested interest in forcing their views on drug policy at a national level.

Drug industry elites' involvement in policy development

4.21 The committee considers that the involvement of the 'drug industry elites' in the development of national illicit drug policy is undermining the implementation of the Commonwealth's stated 'zero tolerance' approach to illicit drugs. The committee believes the Commonwealth needs to wrest back control of illicit drug policy development from the states and territories and the drug industry elites.

4.22 Many of the key national illicit drug policy documents are developed by the drug industry elite:

21 Fitzgerald J and Swards T, Australian National Council on Drugs, *Drug policy: The Australian approach* (2002), p viii.

- the National Drug Strategy 2004–2009 was developed by a joint working group of senior bureaucrats on the Intergovernmental Committee on Drugs and the Australian National Council on Drugs;²²
- the development of the National Cannabis Strategy 2006–2009 was managed by the National Drug and Alcohol Research Centre (Director— Richard Mattick) and a project management group comprised of senior bureaucrats on the Intergovernmental Committee on Drugs, members of the Australian National Council on Drugs (see below) and representatives from the health, education and law enforcement sectors;²³ and
- the national amphetamine-type stimulants strategy currently in development will be undertaken by the National Drug Research Institute (Director — Professor Steve Allsop).²⁴

4.23 As stated in chapter one, the drug industry elites, comprising a range of peak drug bodies, academics and service providers, receive considerable government support to promote, evaluate and deliver drug education and treatment policies and services. In 2005–06, selected peak non-government agencies heavily involved in promoting, researching or developing harm minimisation responses to illicit drugs received significant funding from the Australian and state and territory governments:

- Australian National Council on Drugs — \$1.1 million.²⁵ Was established to provide independent advice to the Prime Minister, Australian Government Ministers and Ministers on the Ministerial Council on Drug Strategy on national drug strategies, policies, programmes and emerging issues. Key people on the council include Dr John Herron (Chair), Commissioner Mick Keelty (Deputy Chair), Associate Professor Robert Ali, Professor Margaret Hamilton and Garth Popple (Executive Members);²⁶
- Alcohol and other Drugs Council of Australia — \$0.9 million.²⁷ Publicly supports ‘harm minimisation’ and maintains a register of harm

22 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p ii.

23 Ministerial Council on Drug Strategy, *National Cannabis Strategy 2006–2009* (2006), p 3.

24 Register of Australian Drug and Alcohol Research, ‘Development of the National Amphetamine-Type Strategy - 2007–2009’, viewed on 7 August 2007 at <http://www.radar.org.au/viewproject.aspx?projectid=860&index=127&ongoing=yes>.

25 Australian National Council on Drugs, *Annual Report 2005–2006* (2006), p 64.

26 Australian National Council on Drugs, ‘About ANCD’, viewed on 23 August 2007 at <http://www.ancd.org.au/about/members/index.htm>.

27 Alcohol and other Drugs Council of Australia, *Annual Report 2005–2006* (2006), p 40.

minimisation supporters on its website. Key people on the council include Professor Robin Room (President) and Professor Wayne Hall (Vice President);²⁸ and

- Australian Drug Foundation — \$1.9 million.²⁹ Focuses on alcohol use by people under 30, but also provides education resources on cannabis and other illicit drugs. The foundation describes itself as having a ‘prevention agenda’ delivered on a platform of harm minimisation. The CEO of the foundation is Bill Stronach.³⁰

4.24 Comments by Mr Stronach that caused the committee great concern were:

‘We’ve focused as [the then Alcohol and Drug Foundation Victoria] quite clearly strategically on the media. We’ve employed journalists, not to churn out press releases but to get in there as subversives and work with their colleagues in the mainstream press. And that’s been done through developing, very slowly and very gently a level of trust, a level of credibility. More importantly, the ability to respond, because the press want instant answers and they want instant responses. So we’ve got 24-hour availability of those journalists and what we’re finding now is that in the last eight months over 50 per cent of the mainstream printed and radio and television reporting on alcohol and drug issues has now been generated by the Foundation, or has been filtered through it.

It’s a wonderful opportunity when the press ring up, as they invariably do, with some sensational story, asking for comment, for us to talk, often for an hour, and try and turn that around and get the reporting perhaps presented a different way. Because we know that the nature of reporting that we’ve seen in the past has been sensational, it’s been inaccurate, often dangerously inaccurate, and it’s not always but by and large, focused on those drugs which are illicit and their usage within Australia, and the harm caused by them is miniscule compared to the legal drugs.

So we’re having a significant impact there I believe and I think that’s an exciting project. So the thrust of the organisation is to move via the media the public perception which we hope will

28 Alcohol and other Drugs Council of Australia, ‘About ADCA’, viewed on 23 August 2007 at <http://www.adca.org.au/whoweare/index.htm>.

29 Australian Drug Foundation, *Audited financial statements 2006* (2006), p 8.

30 Australian Drug Foundation, ‘About us: Our principles’, viewed on 23 August 2007 at <http://www.adf.org.au/browse.asp?ContainerID=principles>.

move towards legislative change in those areas that we would see as desirable.’³¹

4.25 Significant funding is also given to the dominant drug research institutions established under the NDS to examine drug policy approaches within the harm minimisation framework:

- National Drug and Alcohol Research Centre — spent \$3.6 million in research funds in 2005 on a range of information, evaluation and best practice information activities;³²
- National Drug Research Institute — received \$1.7 million in core funding from the Commonwealth in 2005 to undertake a range of licit and illicit drug research projects;³³ and
- National Centre for Education and Training on Addiction — received \$0.5 million in funding from the Commonwealth in 2005 to undertake a range of research projects on workforce and prevention initiatives.³⁴

4.26 The committee is concerned that the entrenched position of members of the drug industry elite in the policy community is a barrier to the open discussion of an addiction prevention policy for this country. Drug Free Australia considered that various harm minimisation studies by Australia’s leading drug policy researchers are substantially flawed:

Of greatest concern is that these demonstrable errors and irregularities have consistently been in favour of the harm minimisation and/or drug law reform interventions being evaluated and corrections of these errors and irregularities consistently to their detriment.

... almost all government-funded Australian ‘evidence-based’ research in the last 15 years has been adduced to the support of a single ideology, that of harm reduction and its drug normalisation substrates, to the exclusion of research comparing the effectiveness of abstinence-based strategies in relation to these harm reduction/minimisation strategies.³⁵

4.27 High quality research is important in informing policy development. Undertaking most of the research within a soft harm minimisation framework limits the opportunity to examine alternative policies and

31 International Drug Conference, Washington, 1992, exhibit 14.4.

32 National Drug and Alcohol Research Institute, *Annual Report 2005* (2006), pp 35–36.

33 National Drug Research Institute, *Annual Report 2005* (2006), p 40.

34 National Centre for Education and Training on Addiction, *Annual Report 2005–2006* (2006), p 7.

35 Drug Free Australia, submission 167, p 2.

reinforces the soft harm minimisation approach as the dominant policy paradigm.

4.28 Changing this dominant policy paradigm is likely to encounter significant resistance by some of those involved in soft harm minimisation treatment approaches, who have a vested interest in supporting harm minimisation approaches that do not necessarily lead to the cessation of drug use. The committee was told that the soft harm minimisation workforce was likely to cost around \$500 million annually.³⁶

4.29 A further barrier to examining alternative policies is the support by prominent members of the drug policy elite for decriminalisation and legalisation of some illicit drugs.³⁷ In a written submission to the committee, Dr Alex Wodak, president of the Australian Drug Law Reform Foundation, stated that:

Taxed and regulated provision of cannabis could:

- broaden the base and lower the rate of general taxation revenue;
- generate a new revenue stream for government enabling generous funding for the prevention and treatment of alcohol and drug problems;
- enable mandatory warning labels to be required for all cannabis packages e.g. 'Medical authorities warn that smoking cannabis may cause severe mental health problems including schizophrenia';
- ensure that the concentration of the most active constituent of cannabis (THC) remains within a narrow band;
- enable mandatory help seeking labels to be required on all cannabis packages e.g. 'If you want to stop smoking cannabis now, ring 24 x 7 the national cannabis help line (02) 6277 4382';
- enable proof-of-age cards to be required thereby dramatically reducing sales of cannabis to persons under the age of, say, 18 years of age; and
- reduce cannabis sales to other vulnerable groups, e.g. pregnant women.³⁸

... the least-worst option for cannabis is to control demand and supply by taxation and regulation, introduce strict proof of age measures for all sales, ban all cannabis advertising and donations from the cannabis industry to political parties and mandate that all

36 Reece S, transcript, 3 April 2007, p 27.

37 Mullins G, submission 124, p 19; Coalition Against Drugs (WA), submission 150, p 1.

38 Australian Drug Law Reform Foundation, submission 39, p 6.

cannabis packaging must include government health warnings and information about availability of help.³⁹

- 4.30 As discussed in chapter eight, these views are irresponsible given the emerging evidence of links between cannabis use and mental illness and the progression from cannabis use to other drugs including ice. The committee believes that accepting Dr Wodak's proposal to decriminalise and legalise cannabis is irresponsible and contrary to contemporary recognition of the significant damage to the community and should be rejected.
- 4.31 The mixing of this legalisation/decriminalisation debate within the harm minimisation framework also contributes to the mixed messages that illicit drug use is tolerated by the community and blurs the message that illicit drug use has significant negative effects on drug users and their families.
- 4.32 It is concerning to see the interlinkages between a number of publicly funded organisations.

Harm reduction or harm minimisation – cause for confusion?

- 4.33 The term 'harm minimisation' is sometimes used interchangeably with 'harm reduction', and in the past, they were in fact synonymous.⁴⁰ Under the NDS, harm reduction is defined in terms which are unacceptably vague, as:
- ...strategies that are designed to reduce the impacts of drug-related harm on individuals and communities. Governments do not condone illegal risk behaviours such as injecting drug use, they acknowledge that these behaviours occur and that they have a responsibility to develop and implement public health and law enforcement measures designed to reduce the harm that such behaviours can cause.⁴¹
- 4.34 The NDS definition is so broad as to be meaningless in practical terms: it fails to provide a focus or boundary to the concept, and significantly, can cover **both** licit and illicit drugs and allows for whole of population
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39 Australian Drug Law Reform Foundation, submission 39, p 26.

40 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 13.

41 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 22.

interventions as well as those targeted at individuals. As a result, it can be used to refer to both a philosophical approach and specific types of programs or interventions.

4.35 There does, however, appear to be some broad agreement that harm reduction refers to policies and programs that are aimed at reducing the harms from drugs, but not drug use per se. A useful distinction is drawn between ‘use reduction’ interventions and harm reduction interventions, emphasising the focus on reducing harms rather than use within the harm reduction approach.

4.36 The NDS notes that the key features and principles of harm reduction include:

- that the primary goal is reducing harm rather than drug use per se;
- that it is built on evidence-based analysis (strategies need to demonstrate, on balance of probabilities, a net reduction in harm);
- that there is acceptance that drugs are a part of society and will never be eliminated;
- that harm reduction should provide a comprehensive public health framework;
- that priority is placed on immediate (and achievable) goals; and
- that pragmatism and humanistic values underpin harm reduction.⁴²

4.37 The acceptance of illicit drug use within the harm minimisation framework is unacceptable. The New South Wales Government highlights such an attitude by announcing in its state plan its target to ‘hold the proportion of people using illicit drugs below 15 per cent’.⁴³ It is similarly unacceptable that this view of ‘success’ is shared by some drug treatment service providers:

One Australian family support service redefines the concept of ‘success’ and utilises harm reduction in its work with families. ‘Our definition of success does not incorporate drug-free status as a definite and primary outcome. Instead we find that the by-product of having support, collective wisdom and coping skills is that the drug user is often healthier and moving more positively and quickly through his or her ‘Stages of Changes’.⁴⁴

42 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia’s Integrated Framework 2004–2009* (2004), p 22.

43 NSW Government, *State Plan: A new direction for NSW* (2006), p 7.

44 Australian Injecting and Illicit Drug Users League, submission 94, p 6.

4.38 Further, the Australasian Society of HIV Medicine considered that:

A harm minimisation approach, as it is applied to drug use, considers the actual harms associated with the use of a particular drug (as well as, but not exclusively of the drug itself), and how these harms can be minimised or reduced. It recognises that drugs are, and will continue to be, a part of our society and that prohibition has historically been a counterproductive policy.⁴⁵

4.39 This approach was also referred to by Youth Substance Abuse Service, who considered that:

While the National Drug Strategy 2004-2009 reinforces non-use as a desirable option it retains a level of pragmatism and recognises legal and illegal drug use and misuse will occur, despite the best efforts of all who seek to address illicit alcohol and drug use in the community.⁴⁶

4.40 The committee condemns these views and believes that they highlight the intrinsic ambiguity of the harm minimisation approach. Of further concern to the committee were comments by Professor Margaret Hamilton, a deputy chair of the Australian National Council on Drugs (ANCD), that the harm minimisation approach accepts that:

- psychoactive substances are and will continue to be part of our society;
- their eradication is impossible; and
- the continuation of attempts to eradicate them may result in maximising net harms for society.⁴⁷

4.41 Other elements of harm minimisation cited by Professor Hamilton were that 'harm minimisation assumes that an acceptance of abstinence is irrelevant',⁴⁸ and that it was a value-neutral term that avoided moralistic arguments about whether drug use is inherently 'bad' or 'good', noting that:

From the perspective of harm minimisation, drug use is neither good nor bad ... This morally neutral stance has made it possible

45 Australasian Society of HIV Medicine, submission 140, p 7.

46 Youth Substance Abuse Service, submission 87, p 4.

47 Hamilton M and Rumbold G, 'The case for harm minimisation' in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 134.

48 Hamilton M and Rumbold G, 'The case for harm minimisation' in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 133.

to begin to move away from a punitive and condemnatory approach toward a more humane framework.⁴⁹

- 4.42 Professor Hamilton has also questioned the Prime Minister's policy stance of zero tolerance, stating that:

Debate about [the application of harm minimisation] to the education area and to young people has continued. This has included the articulation by the Prime Minister John Howard of an apparently inconsistent policy stance of zero tolerance in the drug area and a subsequent explanation that this referred to a policy approach in the school context.⁵⁰

- 4.43 The committee considers taking a morally neutral stance to illicit drug use is entirely at odds with the Prime Minister's stated policy of zero tolerance. Further, it is dismissive of the damage to families and deflects responsibility for that damage away from the drug taker. The committee totally rejects Professor Hamilton's views.

- 4.44 The committee was pleased that many organisations reject these views. Organisations such as Teen Challenge NSW, Toughlove, Drug Free Australia, Australian Drug Treatment and Rehabilitation Programme, and Family Drug Support made it clear to the committee that illicit drug use should not be accepted as a normal part of society's function and that the ultimate goal of harm minimisation was abstinence.

- 4.45 Tony Trimingham, founder of Family Drug Support, told the committee about what the goal of drug treatment should be:

CHAIR—You are saying that the aim for you is this: you can use all sorts of methods, but the aim at the end of the day is to have that person drug free.

Mr Trimingham—That is the goal that every family would have.

CHAIR—That is the goal, but not everyone agrees to it.

Mr Trimingham—Not everybody achieves it.

CHAIR—No, not 'achieves'—that still remains the goal for you.

Mr Trimingham—Absolutely. We would never want—

CHAIR—It is not what everybody agrees on, but I am delighted that you do.

49 Hamilton M and Rumbold G, 'The case for harm minimisation' in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 137.

50 Hamilton M and Rumbold G, 'The case for harm minimisation' in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 139.

Mr Trimingham—As far as I am concerned it is the end result.

CHAIR—That is what I mean. The term ‘harm minimisation’ is being used by different people with different spins.

Mr Trimingham—Yes.⁵¹

Mixed messages from harm minimisation

- 4.46 Given the difficulties in defining harm minimisation, inquiry participants referred to a range of definitions in their response to the inquiry terms of reference. Many submissions referred to the definition of harm minimisation as articulated in the NDS.⁵² Other participants referred to harm minimisation as encompassing the sorts of interventions that would meet the strategy’s definition of ‘harm reduction’, such as needle and syringe programs.⁵³
- 4.47 It is clear that by continuing to adopt a national drug policy framework that promotes soft harm minimisation as a central theme, members of the community get mixed messages about whether using illicit drugs is wrong. Several submissions expressed the view that the adoption of harm minimisation as a central part of drug policy had resulted in an ‘acceptance’ of drug use by the community, highlighting their own experiences in contacts with counsellors and drug treatment service providers (box 4.1).
- 4.48 A former drug addict told the committee that:
- As the harm minimisation mentality has infiltrated our national psyche drug use has become not only accepted but expected. At a societal level, we have been conned into believing that:
- drug use is normal teen behaviour
 - drugs can be taken safely
 - that drug users have the right to ‘choose to use’

51 Trimingham T, Family Drug Support, transcript, 8 August 2007, pp 12–13.

52 See for example Hepatitis Australia, submission 54, p 1; National Centre in HIV Social Research, submission 61, p 1; Western Australian Government Drug and Alcohol Office, submission 82, p 3; Drug and Alcohol Multicultural Education Centre, submission 90, p 4; Australian Drug Foundation, submission 118, p 11; Hepatitis C Council of NSW, submission 129, p 5; National Drug and Alcohol Research Centre, submission 147, p 4; Australian Injecting and Illicit Drug Users League, submission 94, p 5.

53 See for example Catholic Women’s League of Australia, submission 30, p 10; Morrissey J, submission 12, p 3; Lopez J, submission 24, p 2; Name withheld, submission 55, p 2; Name withheld, submission 77, p 2; Festival of Light Australia, submission 85, p 5; Name withheld, submission 108, p 2; Australian Association of Social Workers, submission 121, p 6.

- that their impacts on the broader community are minimal and manageable
 - that drugs are not necessarily addictive and if users do become addicted it is because of their own flaws or the flaws of their parents; and
 - that drug use does not cause mental illness, it only exacerbates an underlying condition.⁵⁴
- 4.49 Many submissions to the inquiry from drug treatment agencies supported the adoption of a harm minimisation approach to treating illicit drug use.⁵⁵ Submissions from individuals also supported this approach.⁵⁶
- 4.50 Holyoake, a drug treatment provider operating across several jurisdictions noted that:

Generally the harm minimisation framework has a positive impact on family relationships. When working with people who have substance use issues within a harm minimisation framework it is important to meet the person where they are at and sometimes, at that point, their priority may not be abstinence. Utilising the harm minimisation perspective means that often the person with substance use difficulties may be able to implement less harmful patterns of use or reduced use. Over the long term this often results in the person changing their goals, from reduced use, to cessation of use.⁵⁷

54 Hidden R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 6.

55 Western Australian Network of Alcohol and Other Drug Agencies, submission 138, p 4; Family Drug Help, submission 76, p 8; Glastonbury Child and Family Services, submission 74, p 8; Barnardos Australia, submission 69, p 2; National Centre in HIV Social Research, submission 61, p 1; Hepatitis Australia, submission 54, p 1; The List, submission 49, p 7; Family Drug Support, submission 15, p 4; Manly Drug Education and Counselling Centre, submission 25, p 3.

56 See for example McIntyre, R, submission 81, p 5; Miller, T, submission 78, p 3; Name withheld, submission 77, p 2; Name withheld, submission 70, p 2; Name withheld, submission 68, p 2; Sutherland P and J, submission 66, p 1; Lawrence L and J, submission 57, p 1; Name withheld, submission 55, p 1; Damen P, submission 53, p 2; Hersee P, submission 48, p 3; Ravesi-Pasche A, submission 47, p 1; Cleere M, submission 44, p 2; Ryan P and W, submission 43, p 3; Lines S, submission 41, p 3; Westaway J, submission 40, p 2; Ennik M, submission 13, p 1; Stevens M, submission 23, p 2; Name withheld, submission 29, p 1; Perry J, submission 5, p 2; Clementson G, submission 9, p 1.

57 Holyoake, submission 117, p 5.

Box 4.1 Personal experiences with harm minimisation and drug education

Several families told their own stories to the committee about their experiences with drug education and treatment providers and how the emphasis was not on getting off drugs, but 'minimising harm':

Rachel is 17 years old. She was referred to a local youth service by her student counsellor and they have involved her in a program with other girls displaying risk taking behaviour. In this program there is a focus on harm minimisation and safe drug use was discussed with the girls. Rachel's parents were aware of the drug use and told their daughter that if she did not stop she would have to leave their home. One night Rachel was picked up by the police and was under the influence. Her parents asked her to leave. The youth service had attempted to involve the parents in counselling some months ago at Rachel's initiation. However the parents are adamant that they will not go to a service that encourages their daughter to use drugs and that if their daughter seriously wants to be part of the family she must stop her drug use. Rachel does not believe that she has an addiction and she believes that she is well in control of her drug use. She reports that the information given by the youth service was new and has helped her be aware of unsafe practices but she had been using prior to this information and would have continued anyway. Rachel does not intend to stop using drugs and says that it does not affect her life in any way.

Source Centrelink, submission 128, pp 5–6.

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*Another woman whose family attends church regularly has told us about her son who had been given 'drug education' at school which was completely counterproductive. The drug education consisted of being told, at age 14, to 'do a project on drugs' - with no further instructions. Her son and his friends decided to research glue sniffing by trying it themselves. They were apprehended by a teacher, and suspended from school for two weeks. The mother said she felt helpless — she and her son were given no advice, and no assistance by school counsellors or anyone else.*

Source Festival of Light Australia, submission 85, p 4.

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When Andrew was 15 years of age, I was aware that there was a marijuana smoking problem. I felt that there was no support for me. I went to drug and alcohol counselling that was close to the high school. They told me not to worry; that Andrew was only experimenting, and that they knew of lots of worse cases. I became aware that he was smoking marijuana on the night of his year 10 formal. I was rung up at 2.00 am and told that the police had my son, and that they had him for possession. I had to ring up a neighbour to go up and get him. A couple of days later, we had to go up to the police station for the talk by the sergeant, and, as we went in to the talk, one of the police officers said, 'Andrew, you were silly. I smoke marijuana. You should have been more careful.'

Source McMenamin H, transcript, 30 May 2007, p 1.

- 4.51 The harm minimisation framework was also supported by Family Drug Support, who had provided information and support to almost 30,000 families in 2006:

Harm minimisation is accepted in all areas of human life — bushfires, swimming pools, electricity and of course road safety — all have built in harm minimisation strategies that are acceptable and logical. For some reason when it comes to drugs some people lose their sense of logic, pragmatism and compassion.

Accepting harm minimisation does incorporate abstinence as an acceptable goal and does not condone or support drug use. Although sometimes the policy is misrepresented by those who don't like it.

We should be proud of Australia's successful harm minimisation leadership and families would like to see more services available that help keep people alive.⁵⁸

- 4.52 These sentiments were also expressed by a volunteer with Family Drug Support:

The simple and clear message from families is that despite moral, ethical, political and spiritual disagreements, harm minimisation/reduction SAVE LIVES.

I can safely say that no families want their loved ones to take drugs and universally would like them to stop. However, through devastating and heart wrenching experiences, and over an extended period of chaos, families have had to accept the following hard realities of dependent drug use:

- there simply is no logic as to why their loved ones make up the relatively small percentage of people who go on to dependent use;
- things are simply unfair;
- it may take many attempts over a number of years (for some decades) to achieve success (whether that is abstinence or reduction etc);
- set backs are an ever present reality; and
- each person reacts positively to different approaches and no one solution fits all.

Despite all this, many families still choose to stay connected through their love and commitment to their drug dependent loved one. They recognise and remain hopeful that their loved one will

58 Family Drug Support, submission 15, p 4.

change for the positive. In the meantime, harm minimisation provide various pragmatic alternative [sic] that can keep them alive until they reach their moment of change. You CANNOT RECOVER FROM DEATH.⁵⁹

4.53 An individual with a partner and son using illicit drugs supported the harm minimisation approach:

The emphasis on zero tolerance that appears to have infiltrated the drug discussion is distressing and disturbing as it negates the pain and silent suffering that individuals and their families experience dealing with these problems. It ignores the facts that harm minimisation saves lives and provides us with a realistic foundation for addressing an overwhelming and often complex problem. The harm minimisation model avoids blame and judgement and provides a compassionate approach that allows us to continue to see the worth of human life within a broken physical exterior.⁶⁰

4.54 Hon Ann Bressington MLC, a member of the South Australian Legislative Council and founder of an effective drug treatment service, told the committee about how harm minimisation had failed the community:

I think the most disturbing thing for me in the 11 years that I have been involved in this is the way that the message of harm minimisation has been manipulated. I do not think that anybody could argue that to reduce the harm, reduce the supply and reduce the demand are not noble objectives for any drug policy. However, we have seen that reducing the harm does not actually mean that. On the ground at the grassroots level it actually means minimising the harm, which is making it appear to be less than it is.

... There are many hidden harms to drug use, to the way that our drug policy is implemented and the conflict that exists between the harm minimisation approach and the Tough on Drugs strategy. I believe that there is a way to bring these together to meet in the middle; that it cannot be all harm minimisation or all abstinence. However, I do believe harm minimisation needs to be reeled in.⁶¹

4.55 The mixed messages that the harm minimisation framework gives to the community were highlighted by Toughlove NSW:

59 Chang T, submission 28, pp 5–6. Emphasis in original.

60 Ravesi-Pasche A, submission 47, p 4.

61 Bressington A, transcript, 23 May 2007, p 2.

Needle exchange programs provide health benefits, but what is the real message being conveyed? That it is okay to use illegal substances? That it is okay to harm or kill yourself? That it is okay to continue treating the closest people to you like the scum of the earth? That it is okay to steal, rob and mug?

A serious contradiction is in existence where, on the one hand, the federal government operates a Tough on Drugs policy, which Toughlove parents wholeheartedly support, and on the other the government spends thousands of dollars on introducing harm minimisation programs in our education system. What message is this giving to our young people? How can harm minimisation possibly be promoted when, at the same time, these drugs are illegal? Our messages are seriously mixed. Such programs are simply enabling, educating and helping our young people to get onto the drugs bandwagon. The cycle and impression that drug taking is cool must be broken.⁶²

- 4.56 A retired magistrate also highlighted how the terminology used normalised drug taking:

Harm minimisation programs whilst educating young people in aspects of drug use, tend to 'normalise' the taking of such substances. In my view, this has not proven to be as effective as it might have been.⁶³

- 4.57 A former drug user, Ryan Hidden, told the committee about his attitude to harm minimisation and his perception about the contradictions in the policy approach:

While I tell most people that I am a recovered drug user and I survived my addiction, to my friends and people who I trust, I tell them I survived harm minimisation, because it literally threatened to destroy my life and my family's life through the messages that it can implant into that structure and the way it threatened to tear us apart, literally. It was almost like that was its objective; it did not want me to escape my addiction, it wanted me to stay stuck there.⁶⁴

62 Smith L, Toughlove NSW, transcript, 3 April 2007, p 3.

63 Hanrahan J, submission 14, p 1.

64 Hidden R, transcript, 23 May 2007, pp 4-5.

Taking account of the 'hidden harm' on children

- 4.58 The harm minimisation approach can involve the health and welfare of drug users being balanced against others, including other family members such as children and potentially, unborn children. The committee has concerns that a harm minimisation approach to familial drug use can privilege the rights and needs of drug users over children in their care.
- 4.59 While harm minimisation measures may be effective at alleviating short-term risk, they may ultimately mean prolonged exposure to parental drug use for children. This includes exposure to drug equipment and paraphernalia, domestic violence and abuse, a lower standard of living and exposure to people associated with the drug culture and lifestyle that puts children at risk.⁶⁵
- 4.60 A 2003 report from the United Kingdom, *Hidden harm*, examined the extent of damage parental drug use caused to children, highlighting the negative effects of illicit drug use during pregnancy and child social and emotional development.⁶⁶ The committee received evidence from a range of inquiry participants about treatment approaches to pregnant women who are using illicit drugs, the neglect and abuse that children suffer when their parents use illicit drugs, and the intervention of child protection agencies.⁶⁷ As mentioned in the previous chapter, illicit drug use by parents is a significant contributory factor in the child protection caseload for all states and territories.⁶⁸
- 4.61 Some inquiry participants felt that harm minimisation had been positive for children in the care of drug users. Sydney Women's Counselling Centre, for example, said that harm minimisation provided some 'containment' for users, reducing the severity of drug-related chaotic and destructive behaviours in the family environment. The centre said that harm minimisation provided the time and opportunity to engage users and their families in treatments that led to recovery, and that through pharmacotherapy programs, families had a better chance of staying

65 See chapter three.

66 Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), pp 10–17.

67 Newman M, Grandparents Assisting Grandkids Support, Gold Coast Region, transcript, 7 March 2007, p 8; Name withheld, submission 86, p 2; Wanslea Family Services, submission 97, p 2; Marymead Child and Family Centre, submission 107, p 1; The Royal Women's Hospital, submission 142, p 7; South Australian Government, submission 153, p 7; Name withheld, submission 155, p 2; Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 28.

68 See chapter three.

intact.⁶⁹ Once again, however, the emphasis is on the adult drug user not the vulnerable child.

4.62 The Victorian Alcohol and Drug Association (VAADA) told the committee that harm minimisation programs improved the safety of children, including unborn children, helped drug users remain within family and friendship networks, and reduced health care costs for families. It noted, however, a potential conflict between the interests of drug users and those of their children, which was inadequately addressed by harm minimisation as it was practiced in the drug treatment sector:

Several service providers consulted by VAADA describe a particular problem for families of illicit drug users arising from a conflict between harm minimisation programs and child protection agencies. While harm minimisation programs focus on preventing harms to drug users, child protection agencies focus on preventing harms to children.⁷⁰

4.63 While supporting the principle of harm minimisation, Glastonbury Child and Family Services noted that there were some disadvantages of the current harm minimisation policies for child protection workers:

- Many children can stay in parental care for too long and at the time of removal can be significantly damaged both emotionally and behaviourally. Placements are then not always successful due to the level of trauma the child has experienced and sadly children are often 'lost' within the system, without realistic hope of recovery.
- There is inconsistency between professionals around what constitutes harm minimisation. Different workers within the child protection continuum can vary in their expectations around illicit drug use, with some expecting zero tolerance and others being more flexible. It can be confusing for both the professional and client when they are unclear of what the expectations are.
- There is also inconsistency within the community around what is satisfactory around harm minimisation. Many practitioners are unable to tolerate any form of illicit drug use and can be quite judgmental in working with families with these issues. It leads to mistrust, lower take up of the support system and potential lack of safety for children.
- Increasingly child protection is expecting the community to manage significant risk issues and monitor parents' involved with illicit substances. Many staff report feeling ill-equipped to

69 Sydney Women's Counselling Centre, submission 36, p 3.

70 Victorian Alcohol and Drug Association, submission 100, p 12.

understand the impact of substances on parents and their capacity to make changes.⁷¹

- 4.64 No-one could argue that it is not desirable to reduce harm, whenever and however feasible, to children rendered vulnerable by familial illicit drug use. However, the committee has concerns about how children are taken into account in reckonings of ‘net harm’, given that they are often not able to articulate or draw attention to what is happening in their family. The recent ANCD report *Drug use in the family: Impacts and implications for children* made the damning observation that within the standard diagnostic nomenclature that assesses a person’s drug use, impacts on dependent children do not even exist:

The terms ‘substance abuse and dependence’ and ‘harmful and hazardous use’ are commonly employed to classify the severity of an individual’s substance use. Such diagnoses, however, refer to the effects experienced by the individual using the substance, not the effects of an individual’s substance use on others. For example, ‘harmful and hazardous use’ of a particular substance such as alcohol defines harm in relation to increased risk for adverse health outcomes for the drinker. Such levels of use may or may not necessarily map onto adverse child outcomes.⁷²

- 4.65 Given the potential invisibility of dependent children within such a treatment culture, harm inflicted on children will continue to be, as the UK report described — ‘hidden’.
- 4.66 Approaches that could function as alternatives to harm minimisation in child protection, or better emphasise the rights and safety of dependent children, were explored in chapter three.

An alternative approach to illicit drug policy

- 4.67 The committee is attracted to the alternative approach developed in Sweden, particularly the overall aim of achieving a drug-free society. Despite historical and cultural differences, the committee believes that several practical aspects of the Swedish model for prevention and treatment can be implemented in Australia, through a high principled commitment to a drug-free individuals policy. These are explored in later chapters.

71 Glastonbury Child and Family Services, submission 74, p 8.

72 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 2.

4.68 Many inquiry participants nominated the Swedish approach to illicit drugs as a model for Australia (box 4.2).⁷³ A key feature of the Swedish approach is the overall goal of achieving a drug-free society.

Box 4.2 The Swedish approach to illicit drug policy

The Swedish drug control policy is guided by the vision and the ultimate goal of achieving a drug-free society.

The overriding aim of the Swedish approach to drug policy is to prevent abuse, strengthening the determination and ability of the individual to refrain from drugs.

Following the proclamation of a drug-free society, the focus of Swedish drug policy was increasingly on the abuser. Laws commit adult abusers of alcohol or drugs to coercive care.

A compulsory care order in Sweden can only be issued if certain legal conditions are met:

- that the person is in need of care/treatment as a result of ongoing abuse of alcohol, narcotics and volatile solvents; and
- the necessary care cannot be provided.

The *Swedish Anti Drug Policy (2004–2007)* involves no tolerance of drug abuse. Drug-related crime should always lead to prosecution and criminal sanctions, and drug-free treatment is seen as a priority measure in response to addiction.

There is wide consensus about the overall goal of drug policy — a drug-free society — and its objectives:

- to reduce the recruitment of young people to drug abuse;
- to enable drug users to stop their drug abuse; and
- to reduce the availability of illicit drugs.

Swedish police target drug users as well as drug dealers, even if the infringements are small, because they want to stop early experimenters from progressing along the ‘crime ladder’ from minor nuisances to theft, property damage and acts of violence.

There is joint drug training for police, social workers, psychologists and counsellors so that they share a common language and common strategy for dealing with drugs.

Source United Nations Office on Drugs and Crime, Sweden’s successful drug policy: A review of the evidence (2007), pp 9–21; Eva Brannmark, Swedish Police Board, ‘Law Enforcement – The Swedish Model’, Presentation at Drug Free Australia Conference, Adelaide, 27–29 April 2007.

73 Morrissey J, submission 12, p 3; Endeavour Forum, submission 22, p 1; Lopez J, submission 24, p 1; Catholic Women’s League of Australia, submission 35, p 12; Drug Advisory Council of Australia, submission 37, p 1; Drug Free Australia, submission 42, p 2; Australian Family Association, submission 59, p 1; Australian Family Association SA Branch, submission 72, p 1; Festival of Light Australia, submission 85, p 11; Coalition Against Drugs (WA), submission 124, p 7; Catholic Women’s League of Australia, submission 171, p 2; Bressington A, transcript, 23 May 2007, p 3.

- 4.69 A volunteer with a family support organisation considered that other countries' approaches offered a better solution than the approach adopted in Australia:

The best argument against harm minimisation policies has been provided by Sweden. There, drug use and dependence is a fraction of that of their European Union neighbours, even neighbouring Denmark. This has been in spite of Sweden's proximity to Russia and Eastern Europe, from which the spreading effects of drug-related crime have afflicted the rest of area. This can only have resulted from Sweden's holistic approach to illicit drugs, which punishes possession, use and dealing, and mandates both detox treatment and maintenance of a drug-free state, under pain of prison. Sweden's policy is to achieve a drug-free society, rather than one which accepts and compromises with the problem. National statistics show a steep climb towards achieving this goal, interrupted only by a flat spot during the mid-1990s when funding for programs was cut.

Australia's preference for harm minimisation reflects not only a fuzzy optimism, but a belief that it can all be done on the cheap - with a dollop of good intentions.⁷⁴

- 4.70 The Coalition Against Drugs (WA) told the committee that:

Sweden now has a restrictive policy on drugs. The overriding aim of Swedish drug policy is a drug-free society. This aim for a drug-free society is to be seen as a vision reflecting society's attitude to narcotic drugs. The aim conveys the message that drugs will never be permitted to become an integral part of society, and that drug abuse must remain an unacceptable behaviour, a marginal phenomenon. This overriding aim, then, indicates the direction of a restrictive drug policy.⁷⁵

- 4.71 Professor Hulse supported the committee's view that harm minimisation should never be the final objective of illicit drug policy:

Harm minimisation should be, if anything, a stepping stone to stabilise someone to move them towards abstinence. Getting people out of the narcotic network should be the final objective. I am yet to meet a heroin dependent person who says, 'I love being where I am. I love doing these things. I love ripping off people. I love having to do tricks for men down the road.' They love heroin.

74 Morrissey J, submission 12, p 3.

75 Coalition Against Drugs (WA), submission 124, p 7.

It is an issue of breaking that nexus. Harm minimisation is very fine. Harm minimisation for those people who relapse is a necessary component, but it should be focused at then trying to shift them along that process back to where they are not using.⁷⁶

- 4.72 Under the current NDS framework there is no clear policy document that applies to illicit drugs only. While the Prime Minister launched the National Illicit Drug Strategy ‘Tough on Drugs’ in 1997, in its current form it is no more than a collection of programs funded by the Commonwealth, states and territories.
- 4.73 The Department of Health and Ageing notes that the National Illicit Drug Strategy ‘demonstrates the Australian Government’s leadership in the fight against illicit drugs and strengthens its commitment to combat illicit drug use through a sharper focus to reducing the supply of drugs and on reducing demand’.⁷⁷ Programs included under the National Illicit Drug Strategy banner include:
- the Illicit Drug Diversion Initiative;
 - the Non-Government Organisation Treatment Grants Programme;
 - the Community Partnerships Initiative; and
 - identification, promotion and dissemination of good practice in treatment of illicit drug dependence.⁷⁸
- 4.74 The absence of a single national policy document that refers to illicit drugs with the objective of harm prevention and drug-free individuals is a key weakness of the current approach to national illicit drug policy.
- 4.75 Another weakness is the attempt to develop national policy at Ministerial Council level — where the consensus approach to decision-making leads to nebulous policy designed to accommodate competing interests.
- 4.76 Under the previous NDS document (covering the period 1998-99 to 2002-03), a National Action Plan on Illicit Drugs 2001 to 2002-03 was developed to ‘provide a nationally agreed direction for addressing illicit

76 Hulse G, transcript, 21 March 2007, p 4.

77 Department of Health and Ageing, ‘Illicit Drugs: National Illicit Drug Strategy’, viewed on 7 August 2007 at <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publth-strateg-drugs-illicit-index.htm>.

78 Department of Health and Ageing, ‘Illicit Drugs: National Illicit Drug Strategy’, viewed on 7 August 2007 at <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publth-strateg-drugs-illicit-index.htm>.

drug issues.’⁷⁹ This plan did not have an overarching objective, and was primarily concerned with ‘preventing the uptake of illicit drug use and reducing harm associated with use.’⁸⁰

- 4.77 The committee considers that an explicit national illicit drug policy document should be developed that has as its key objective the prevention of illicit drug use — preventing harm from commencing and preventing the continuation of any harm. A zero tolerance policy does not mean that the committee fails to recognise that some people will relapse, but that these people are consistently encouraged by the treatment sector and the broader Australian community to become and remain drug free.
- 4.78 The policy should be developed at a Heads of Government level, by the Council of Australian Governments, rather than being determined at Ministerial Council level.

Recommendation 8

- 4.79 **The Commonwealth Government develop and bring to the Council of Australian Governments a national illicit drug policy that:**
- **replaces the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free; and**
 - **only provide funding to treatment and support organisations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants.**

Harm minimisation programs

- 4.80 Programs that are generally referred to under the harm reduction framework in an illicit drug context include:

79 Ministerial Council on Drug Strategy, *National Action Plan on Illicit Drugs 2001 to 2002-03* (2001), p 1.

80 Ministerial Council on Drug Strategy, *National Action Plan on Illicit Drugs 2001 to 2002-03* (2001), p 1.

- methadone and buprenorphine maintenance programs – which aim to replace an illegal, short-acting, expensive opioid (heroin), which is usually injected, with a legal, longer-lasting, inexpensive opioid (methadone or buprenorphine), which is taken orally;
- needle and syringe programs — which aim to reduce the spread of infectious diseases, particularly HIV, through various services such as provision of clean injecting equipment, education and information and counselling and testing services;
- supervised injecting facilities — legally sanctioned and supervised facilities designed to reduce the health and public order problems associated with illegal injecting drug use which enable the consumption of pre-obtained illicit drugs;
- non-injecting routes of administration — which has the goal of reducing initiation into injecting drug use and promoting transition away from injecting for those already doing so;
- overdose prevention interventions — reducing the risk of an overdose and improving the likelihood of a positive medical response to an overdose; and
- other programs— such as pill testing kits, ‘rave-safe’ interventions and tolerance zones.⁸¹

4.81 The committee received considerable comment from families and organisations about how specific harm minimisation programs (sometimes referred to as harm reduction programs), such as methadone maintenance, safe injecting rooms and needle and syringe programs impacted on families.

Community and family support for harm minimisation programs

4.82 The committee believes that harm minimisation approaches can result in significant damage to families — especially the children of drug users — where drug treatment interventions do not protect children. Lorraine Rowe, a foster carer with 24 years experience, gave the committee an insight into the reality of how children are damaged by their parents’ illicit drug use:

There are hundreds of thousands of kids going through this across our country every day and they are not getting just the basic

81 Ritter A and Cameron J, Turning Point Alcohol and Drug Centre, *A systematic review of harm reduction* (2005), pp 14–47.

necessities. The parents are not emotionally available for them. If they are so focused on getting the drugs to manage through their day they are not able to be there when the kids need them—they are not feeding them, they are not clothing them, they are just not picking them up when they fall and skin their knees and all those things are important for all of us to learn how to trust people.

If you are getting rejected—whether it is just going from one home to another, no matter how loving that home may be for that short period of time—all the time you are not going to trust anybody. You are going to learn that we as adults are not reliable to little kids; we are unpredictable, that from one day to the next that bed is not going to be there or available for them. And so then you have teenagers who have no respect for society or for anybody because why should they respect us? We have never been there when they were little, we did not put a bandaid on their knees, we did not kiss them goodnight, we were not there to give them food.⁸²

4.83 The committee examined the impact on children of parental illicit drug use in more detail in chapter three and made several strong recommendations about how child safety can be strengthened to break the intergenerational cycle of illicit drug use and better protect children.

4.84 Some inquiry participants took the view that harm minimisation programs do not necessarily address drug use. The mother of a daughter with a drug addiction considered that:

Harm minimisation programs ... do not address the real problem. They cater to the symptoms and in essence hide, or mask the situation, and in fact make it easier for addicts to continue with their habit. In a sense it is one of the enabling factors that encourages substance abuse. ... There is one way only to deal with addiction, and that is for the addict to abstain totally from the use of all substances - illicit drugs, alcohol where that is the problem, and the prescription medication. In turn, this can only be achieved by addicts undertaking recognised rehabilitation and counselling programs.⁸³

4.85 Professor Hulse told the committee that harm minimisation programs should be a stepping stone to abstinence:

82 Rowe L, transcript, 15 August 2007, p 3.

83 Fairclough R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, pp 21–22.

You always need an exit. ... We should have facilities where people who are currently dependent attend where they have options provided to them and they are told, 'These are the options that are available to you in terms of maintenance treatments. This would be the first one to go on to. This would be the next one.' That range of services gives them some alternative other than continuing to inject. If, while they are there, as a person who uses three or four times a day, they self-administer, that is just the nature of the beast. But to focus on simply having an environment where people come and inject is not the goal. The goal is to use that as an opportunity to then look at where you are going to shift those people.⁸⁴

- 4.86 Teen Challenge NSW argued that harm minimisation does not deal with the issue but only medicates a symptom:

We believe that if we can address the issue and tackle the problem at the original cause, things such as family breakdown, abandonment, self esteem/image and teaching the skills necessary to deal with disappointment and move on in life, we stand a real chance of seeing a positive future for the young person, rather than a future of monitored substance abuse.⁸⁵

- 4.87 A former parole officer considered that:

Harm minimisation undermines families because children are able to access government needle exchanges which hastens the induction to addiction by supplying needles and syringes for free, and education in their use, thus effectively subsidising the addiction of these children. All of this can happen without the knowledge or support of parents.⁸⁶

- 4.88 Further, harm minimisation programs were seen by the Catholic Women's League of Australia to be of minimal benefit to families:

Reducing the harmful consequences of drug use, by giving drugs to addicts, making sure they have clean needles and by teaching people how to use drugs 'safely' does little to reduce the suffering of spouse, children and parents. Harm reduction does not avoid deterioration of brain function and nothing to correct the addict's behavioural problems. To help the addict it is imperative to stop

84 Hulse G, transcript, 21 March 2007, p 5.

85 Teen Challenge NSW, submission 139, p 2.

86 Lopez J, submission 24, p 2.

all drug use as Australia can no longer endure the haemorrhage of young lives lost to drugs.⁸⁷

4.89 The following sections examine selected harm minimisation programs in more detail.

Pharmacotherapy

4.90 Pharmaceutical drugs have been used in the treatment of opioid dependency in Australia for several decades. There are a number of different drugs and approaches that are used (box 4.3).

Box 4.3 Pharmacotherapy treatment for opioid dependency

Pharmacotherapy approaches to treating opioid dependence consist of two separate methods:

- Opioid Substitution (or maintenance) Treatment (OST) involves the substitution of an illegal, short-acting, expensive opioid (heroin), which is usually injected, with a legal, longer lasting, inexpensive opioid (methadone or buprenorphine), which is taken orally. The user remains an addict to methadone or buprenorphine.
- The second approach, detoxification, involves the use of opioid-antagonist medication (such as naltrexone) to bring about an opioid-free state in opioid users, while minimising withdrawal-related problems.

Whereas detoxification using naltrexone is typically a rapid-withdrawal technique, OST seeks to control a person's drug use on a long-term basis.

The Australian Government funds the cost of methadone for treatment of opioid dependence supplied as pharmaceutical benefits through clinics and pharmacies approved by State and Territory governments. Methadone typically comes as a liquid that is swallowed. A single daily dose of methadone will stop cravings for heroin for 24 hours or longer.

Buprenorphine is listed on the Pharmaceutical Benefits Scheme (PBS) for treatment of opioid dependence for supply through clinics and pharmacies approved by State and Territory governments. Buprenorphine comes in tablet form and is taken sublingually (dissolves under the tongue).

Naltrexone can be taken orally, but is also be administered through the insertion of an implant (typically into the abdomen). The implant overcomes the requirement to take a dose daily. It is listed on the PBS for 'use within a comprehensive treatment program for alcohol dependence with the goal of maintaining abstinence' — but not for treatment of opioid dependence.

Source O'Connor P, 'Methods of detoxification and their role in treating patients with opioid dependence', *Journal of the American Medical Association* (2005), vol 294 no 8, p. 962; Mattick R et al, *National evaluation of pharmacotherapies for opioid dependence: Report of results and recommendations* (2001), pp 1–4; Hulse G, *submission 16*, p 5.

87 Catholic Women's League of Australia, submission 171, p 5.

- 4.91 There were almost 39,000 people receiving pharmacotherapy treatment in June 2006.⁸⁸ Almost two-thirds received treatment from a private prescriber, with the remainder receiving treatment from a prescriber under a state or territory government program (28 per cent) or from a practitioner in a correctional facility (7 per cent).⁸⁹
- 4.92 Of clients receiving their pharmacotherapy doses from private prescribers, 89 per cent received their dose at a pharmacy with the remaining 11 per cent receiving their dose at a private clinic in 2006.⁹⁰ The use of private clinics to provide doses is more prevalent in New South Wales, where almost one-third of doses provided to clients in 2006 were dispensed.⁹¹
- 4.93 The Commonwealth makes a significant contribution to the cost of pharmacotherapy programs in Australia, providing Pharmaceutical Benefits Scheme (PBS) funding in 2005–06 of \$4.2 million for methadone and \$18.1 million for buprenorphine and a buprenorphine/naloxone product.⁹² The Commonwealth also funds a range of medical consultations under Medicare for around 25,000 people receiving treatment from a private prescriber. Unfortunately, the Department of Health and Ageing does not collect the data that would allow for an estimate of these costs.⁹³

Recommendation 9

- 4.94 **The Department of Health and Ageing conduct research to estimate the full cost of pharmacotherapy programs to the Commonwealth, including the cost of medical consultations covered by Medicare.**
- 4.95 While there is therefore no cost to clients for the methadone and buprenorphine, they can pay up to \$60 per week in dispensing fees.⁹⁴

88 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 43.

89 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 44.

90 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 45.

91 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 45.

92 Australian Government Department of Health and Ageing, submission 184, pp 1–2.

93 Australian Government Department of Health and Ageing, submission 184, p 2.

94 Bickle K, submission 186, p 1; Victorian Alcohol and Drug Association, submission 100, p 7; Winstock et al, 'The impact of community pharmacy dispensing fees on the introduction of buprenorphine – naloxone in Australia', *Drug and Alcohol Review (2007)*, no 26, p 413.

- 4.96 The general benefits of pharmacotherapy programs have been demonstrated in a number of Australian and international evaluations and include reduced illicit drug use, reduced medical comorbidity, decreases in the transmission of human immunodeficiency virus, reduced mortality and improved social functioning.⁹⁵
- 4.97 The committee received numerous submissions about pharmacotherapy programs from clinicians and treatment agencies, with participants raising issues such as the relative benefits of different types of treatment, their effectiveness, mortality and cost.⁹⁶
- 4.98 The committee was made aware of some of the difficulties in evaluating the effectiveness of pharmacotherapy programs, and disagreements about the use and safety of methadone, naltrexone implants and oral naltrexone.⁹⁷
- 4.99 Families and Friends for Drug Law Reform, which believes that drug prohibition laws are more the problem than the solution, outlined what it saw as the negative impact of methadone maintenance programs:

It should also be made clear that, like many therapeutic drugs, methadone may have unpleasant side effects. It is addictive. Like other opiates it is a 'drying' drug and can cause constipation and reduced saliva production. Long term effects can include tooth decay from reduced saliva and loss of libido. Methadone can be harmful for people with kidney and liver diseases. Further drawbacks associated with methadone arise from the restrictive, demeaning and alienating regime often prescribed for its

95 O'Connor P, 'Methods of detoxification and their role in treating patients with opioid dependence', *Journal of the American Medical Association* (2005), vol 294 no 8, p 962; Mattick R et al, *National evaluation of pharmacotherapies for opioid dependence: Report of results and recommendations* (2001), pp 1-4; Hulse G, submission 16, p 5.

96 Hulse G, submission 16, p 5; Perth Naltrexone Clinic, submission 27, p 7; Reece S, submission 33, pp 12-13; Australian Drug Law Reform Foundation, submission 39, p 8; Hepatitis Australia, submission 54, p 2; National Centre in HIV Social Research, submission 61, p 2; Queensland Alcohol and Drug Research and Education Centre, submission 98, pp 1-2; Alcohol and Drug Foundation ACT, submission 123, p 7; Association for Prevention and Harm Reduction Programs Australia, submission 130, p 9; Australian Psychological Society, submission 131, p 11; The Royal Women's Hospital, submission 142, p 3; Australian Drug Law Reform Foundation, submission 148, p 1; Hall W, submission 156, p 1; Drug Free Australia, submission 167, pp 4-6, Queensland Government, submission 173, pp 4-5.

97 Reece S, submission 33, pp 12-13; submission 154, p 2; Hall W, submission 156, p 1; Hulse G, submission 16, p 5; Australian Drug Law Reform Foundation, submission 148, p 1; Drug Free Australia, submission 167, pp 4-6.

dispensation. Moreover, it is not effective for some heroin dependents.⁹⁸

- 4.100 There can be considerable negative effects of methadone on a person's health, with prolonged use of methadone causing tooth decay and weight gain. Common side effects include:
- aching muscles and joints;
 - skin rashes and itching;
 - accelerated ageing;
 - loss of appetite, nausea and vomiting; and
 - abdominal cramps.⁹⁹
- 4.101 As a harm minimisation measure, methadone also has consequences for babies born to maternal drug users. These include significant health complications as the baby is born an addict and develops drug withdrawal, referred to as neonatal abstinence syndrome.
- 4.102 In addition, children growing up in households where parents are using methadone are exposed to significant risks, which have resulted in a number of deaths. Risks to children from a parent/s use of methadone were discussed in the previous chapter.
- 4.103 In its inquiry into substance abuse in Australian communities in 2003, the House of Representatives Standing Committee on Community Affairs made several recommendations relating to Methadone Maintenance Treatment (MMT) programs, including:
- establishing that the ultimate objective of MMT was to assist people to become abstinent from all opioids (including methadone);
 - that comprehensive support services must be provided to achieve this outcome; and that
 - research be undertaken to determine the extent of long-term use of methadone and its effect on the user, community and family roles.¹⁰⁰

98 Families and Friends for Drug Law Reform, submission 122, p 13; DrugInfo clearing house, 'Methadone', viewed on 19 July 2007 at <http://www.druginfo.adf.org.au/article.asp?ContentID=Methadone#advantages>.

99 DrugInfo clearing house, 'Methadone', viewed on 19 July 2007 at <http://www.druginfo.adf.org.au/article.asp?ContentID=Methadone#advantages>; Reece S, transcript, 3 April 2007, p 30.

100 Standing Committee on Family and Human Services, *Road to recovery: Report on the inquiry into drug abuse in Australian communities* (2003), pp 156–158.

- 4.104 It is disappointing that, four years later, the committee received serious criticisms of MMT programs including:
- access to methadone maintenance programs was difficult, particularly for women;¹⁰¹
 - there was an increase in the number of people undergoing pharmacotherapy, even though the number of people using heroin has declined due to the heroin drought — indicating that that it was likely that people were finding it difficult to ‘get off’ methadone;¹⁰² and
 - significant quantities of diverted methadone remained available in the community.¹⁰³
- 4.105 The committee noted that Sweden adopted an approach to methadone maintenance therapy that included stringent guidelines for entry to the program, six-month residential treatment and daily drug testing (box 4.4).
- 4.106 The committee is attracted to the Swedish model for MMT, and is disappointed that the recently revised National Pharmacotherapy Policy for People Dependent on Opioids has as its primary objective a qualified aim to ‘bring an end *or significantly reduce* an individual’s illicit opioid use’.¹⁰⁴

101 Royal Women’s Hospital, submission 142, p 3.

102 Reece S, submission 33, p 10.

103 Bressington A, transcript, 23 May 2007, p 12.

104 Intergovernmental Committee on Drugs, *National Pharmacotherapy Policy for People Dependent on Opioids* (2007), p 10. Emphasis added.

Box 4.4 The Swedish approach to methadone maintenance

Methadone treatment in Sweden is administered on a stricter basis than in Australia. The Swedish approach to methadone maintenance stipulates certain conditions that users must satisfy before they are accepted into the program:

- a history of at least four years of intravenous opiate use
- earlier attempts at drug-free treatment judged to be of negligible value to the patients
- at least 20 years of age
- opiates must be the dominant drug; and
- they must not be in prison when admitted to the program.

Social support from local government is a prerequisite and a referral from a medical specialist is required.

People undergoing treatment enter a six-month day care treatment where they get a personally tailored dose (the patient is not aware of the magnitude of the dose, but as a general rule doses are higher than in most programs around the world, which minimises risk of relapse) of methadone and undergo a training program during a full working day. Urine specimens are taken daily to confirm that doses are taken (which is taken in the premises) and that no illegal drugs have been used. After six months a person's contact with the clinic is gradually reduced and doses can be collected at a selected pharmacy, where urine specimen are also delivered to confirm that they remain drug free.

Source National Institute of Public Health – Sweden, 'Sweden: Drug situation 2002', Report to the EMCDDA by the Reitox National Focal Point (2004), pp 59-61; European Monitoring Centre for Drugs and Drug Addiction, 'Sweden: New development, trends and in-depth information on selected issues', 2005 National Report (2004 data) to the EMCDDA by the Reitox National Focal Point (2005), pp 26-27.

4.107 The Commonwealth needs to take a leadership approach with the implementation of MMT in Australia, particularly given the extent of its funding commitment through the PBS and consultation fees covered by Medicare. This should involve the Commonwealth specifying a range of outcomes in return for its funding of methadone and related medical services, and a reconsideration of the objectives in the national pharmacotherapy policy to emphasise that the goal of pharmacotherapy treatment is an ultimate cessation of illicit drug use.

Recommendation 10

4.108 The Commonwealth Government:

- **amend the National Pharmacotherapy Policy for People Dependent on Opioids to specify that the primary objective of pharmacotherapy treatment is to end an individual's opioid use; and**
- **renegotiate funding arrangements for methadone maintenance programs to require the states and territories to commit sufficient funding to provide comprehensive support services to meet the revised National Pharmacotherapy Policy for People Dependent on Opioids objective.**

4.109 The committee was particularly interested in the use of naltrexone, particularly the benefits of using naltrexone implants to treat opiate dependency. Naltrexone 'blocks' the effects of opiates and also has an anti-craving effect — eliminating the desire to use opiates.¹⁰⁵ Professor Hulse told the committee about the different expectations for treatment using naltrexone compared to methadone:

If you enter people onto methadone or buprenorphine and your expectation is that a proportion of those people will dabble—they are not heroin dependent; you may have arrested the heroin dependence, but they may relapse back into heroin dependence—and if that is your objective, all you need to do is provide a bit of methadone and perhaps a bit of counselling and hope that they will shift along and not go back to use. The difference with providing a program such as naltrexone—a sustained release program—is clearly that the objective is that they are not going to use.¹⁰⁶

4.110 Oral naltrexone, taken in tablet form, has been available in Australia for some time. A drawback of naltrexone in tablet form is that it relies heavily on compliance with the daily dosage, which people are often unable to meet unless they are strongly motivated and have family or other support. More recently, a naltrexone implant, lasting up to six months, has been

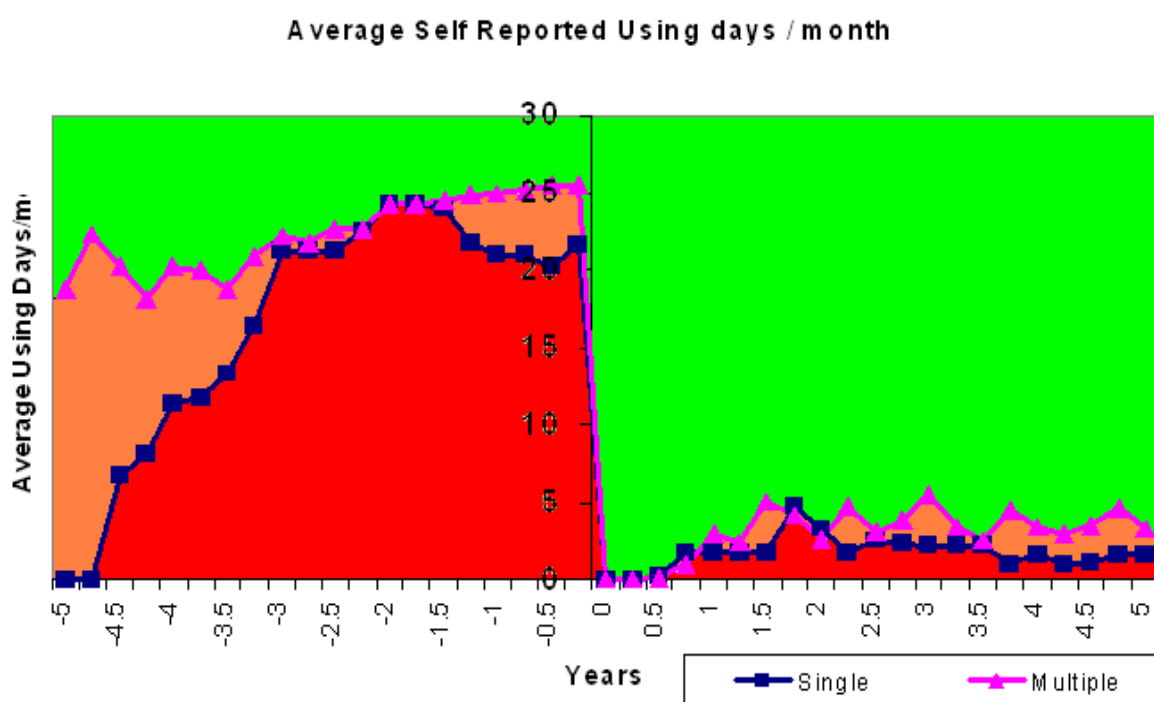
¹⁰⁵ Hulse G, transcript, 21 March 2007, p 16.

¹⁰⁶ Hulse G, transcript, 21 March 2007, p 6.

developed and is being used in Western Australia, where more than 4,500 people have received it.¹⁰⁷

- 4.111 Dr George O'Neil, who runs the Perth Naltrexone Clinic, provided the committee with some interim results on the effectiveness of naltrexone implants for a sample of clients treated. The results showed an impressive reduction in self-reported use of heroin in the five year period after the implants were administered compared to the five year period before treatment (figure 4.2). The centre of the graph shows the date of naltrexone treatment.

Figure 4.2 Average self-reported using days per month for the five year period before and after single and multiple naltrexone implants



Source Perth Naltrexone Clinic, submission 27, p 21.

- 4.112 The Australian Government Department of Health and Ageing noted that naltrexone implants may be an effective treatment to add to the options currently available, and subsequently achieve the highly desirable goal of abstinence from all opioids.¹⁰⁸ Various grants had been provided by the National Health and Medical Research Council (NHMRC) for clinical

107 Freemasons Western Australia, 'A man with a Mission - Dr. George O'Neil', viewed on 6 August 2007 at <http://www.gl-of-wa.org.au/subscribemb.asp>.

108 Department of Health and Ageing, submission 169, p 8.

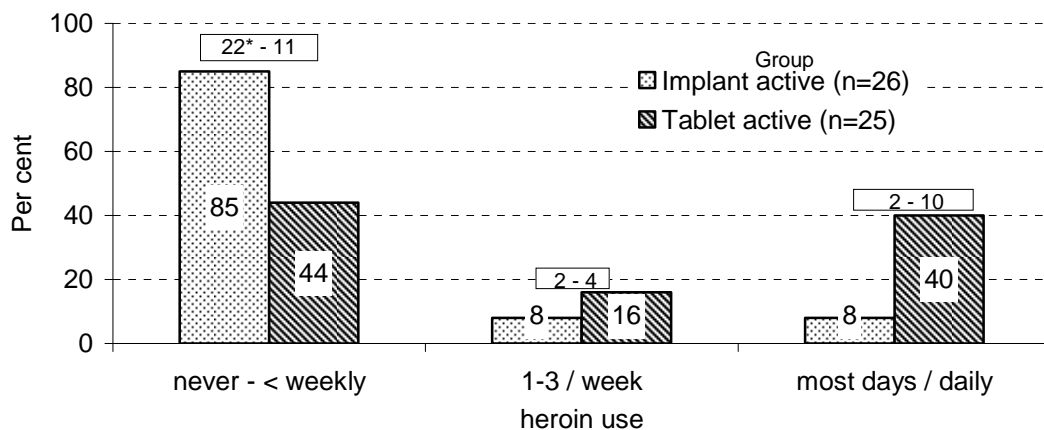
trials and studies associated with comparing the safety and efficacy of naltrexone implants.¹⁰⁹

4.113 Professor Hulse, who is conducting the trial at the University of Western Australia, provided the committee with some interim data from the NHMRC-sponsored randomised clinical trial that was comparing oral naltrexone with naltrexone implants (figure 4.3), noting that at four months after treatment commenced:

Fifty-six per cent of the oral naltrexone group—that is, the TGA registered treatment group—were using heroin in excess of either one to three times a week or more, whereas 16 per cent of the implant group were using one to three times.¹¹⁰

... At four months 2.4 per cent of urine tests from the active implant group showed opioid use compared to 14.7 per cent in the active oral group.¹¹¹

Figure 4.3 Heroin use by clinical trial participants after four months of naltrexone implant and oral treatment for heroin addiction



Note Results are from a randomised double blind placebo controlled clinical trial conducted at the University of Western Australia.

Source Hulse G, submission 16, p 3.

4.114 The committee believes that it is important to offer people a genuine choice about what pharmacotherapy program will work best for them. The committee believes that the time has come to include naltrexone implants on the PBS.

109 Department of Health and Ageing, submission 169, p 8; Hulse G, submission 16, p 2.

110 Hulse G, transcript, 21 March 2007, p 9.

111 Hulse G, submission 16, p 3.

- 4.115 The drug policy elites ostensibly oppose the broader introduction of naltrexone implants on the basis that they are yet to be proven safe and effective. They also question the evidence for the effectiveness of the implants because of the objectivity and credibility of those conducting research into naltrexone implants.¹¹²
- 4.116 Opposition to alternative pharmacotherapy approaches may also come from those with a financial interest in the prescribing of methadone. The committee heard that the operators of private methadone clinics in New South Wales received around \$3,016 per patient per year in dispensing fees.¹¹³
- 4.117 It is important that funding arrangements for naltrexone implant treatment, via the PBS or alternative mechanisms, should be put in place to ensure that naltrexone implants treatment programs are as accessible as other pharmacotherapies for heroin. This should be able to be done very quickly, unimpeded by the drug policy elites.

Recommendation 11

- 4.118 **The Commonwealth Government list naltrexone implants on the Pharmaceutical Benefits Scheme for the treatment of opioid dependence.**
- 4.119 Professor Hulse proposed additional research should be conducted to compare the effectiveness of naltrexone implant treatment compared to alternative pharmacotherapies including:
- a multi-centre trial of naltrexone implant compared with methadone or buprenorphine in the management of heroin-dependent persons;
 - a comparison of long-term mortality in opioid users treated with naltrexone implant, buprenorphine or methadone maintenance;
 - a follow-up of neonates and infants exposed to naltrexone; and
 - examining the impact of naltrexone implant, buprenorphine or methadone maintenance on the course of HCV/HBV/HIV infection.¹¹⁴

112 Wodak A, Australian Drug Law Reform Foundation, transcript, 3 April 2007, p 91; Hall W, submission 156, p 2.

113 Bickle K, submission 186, p 1.

114 Hulse G, submission 16, p 4.

- 4.120 The practical difficulties of conducting a multi-centre trial of naltrexone implants compared to methadone or buprenorphine were acknowledged by Professor Hulse:

We need a study which basically says that these people have been randomised to methadone, buprenorphine or naltrexone implant and looks at how they fare over the next six months. This probably needs to be a multisite study. That would be something that I would hope to run in Perth and in somewhere like St Vincent's Hospital in Melbourne, because then, if you can produce data at two sites which says that this is the outcome, you have a much stronger case.

I believe it is difficult to run a blind study when you are delivering methadone, buprenorphine and implant naltrexone. In the current study everything was blind. People did not know what treatment they were getting. But, if you are going to attempt to do that with a comparison between methadone, buprenorphine and implant naltrexone, what you would have to do is withdraw everyone to start off with. But you do not do that with methadone and buprenorphine. Furthermore, you would have to implant everyone. If you tell me that a long-term or even short-term opiate/heroin user, when you stick methadone or buprenorphine in the system, will not be able to tell you that they are on an opiate rather than naltrexone, I will tell you that you have not been talking to heroin users. You can go through all of this elaborate hoax of trying to blind all of this and you are going to give someone an opiate and they are going to say, 'Well, I know what treatment I'm on.' This is just fanciful. That is what we need to be running there.¹¹⁵

- 4.121 The committee supports the need for further research on the effectiveness of naltrexone implants compared to other pharmacotherapies. The committee believes that the Commonwealth, through the NHMRC or directly through the Department of Health and Ageing, should fund this research. The research also needs to be guided by an expert group that is open minded about different forms of treatment.

115 Hulse G, transcript, 21 March 2007, pp 11–12.

Recommendation 12

4.122 The Department of Health and Ageing:

- **provide funding for ongoing research into the relative effectiveness of pharmacotherapy programs including naltrexone implants and methadone; and**
- **form an advisory body comprised of independent research experts to advise on project methodology.**

Other harm minimisation programs

4.123 As noted earlier, there are a range of harm minimisation programs provided to drug users including needle and syringe programs (box 4.5), safe injecting rooms and overdose prevention initiatives.

4.124 Critics of the drug policy elite's definition of harm minimisation programs highlighted several issues relating to their effectiveness including:

- needle exchanges hasten the induction to addiction by supplying needles and syringes for free, and education in their use, thus effectively subsidising the addiction of children;¹¹⁶
- needles are now simply given away in ever-increasing numbers — six million a year in Victoria alone — needles are discarded rather than returned. Used syringes are employed as weapons to threaten people during robberies and home invasions;¹¹⁷
- evidence to support needle exchanges leading to an increase in the rate of needle sharing and that hepatitis C is spread among users of needle exchanges even when they refrain from sharing needles but share drug ampoules, water, cotton swabs, and other paraphernalia;¹¹⁸ and
- methodological errors in studies supporting needle and syringe exchange programs that overstate the effect of these programs on HIV and hepatitis C infection rates.¹¹⁹

116 Lopez J, submission 24, p 2.

117 Catholic Women's League of Australia, submission 35, p 10.

118 Festival of Light Australia, submission 85, p 8.

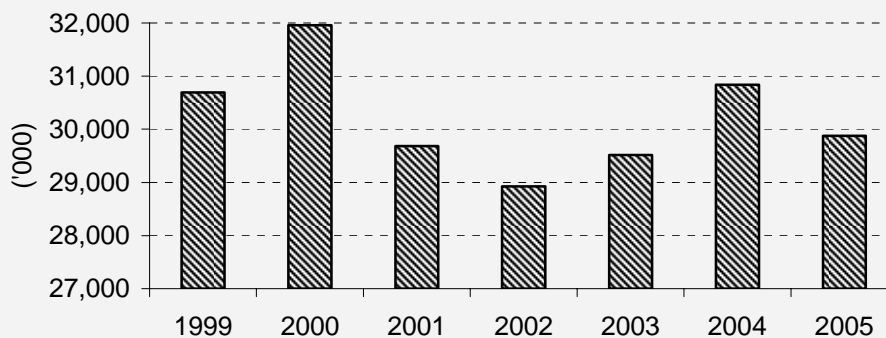
119 Drug Free Australia, submission 167, pp 17–18, see also Kerstin Kall, Chief Medical Officer Addiction Clinic, Linkoping University Hospital, Norway, 'Flawed Research into Needle & Syringe Programs', presentation to Drug Free Australia conference, 'Exposing the reality', Adelaide, 27-29 April 2007.

Box 4.5 Needle and syringe programs

Needle and syringe programs (NSPs) were introduced to Australia in 1986 due to concerns about the increasing HIV prevalence among injecting drug users. There are currently over 3,000 needle and syringe programs, of varying types, across Australia.

In 2005, almost 30,000 units of injecting equipment were distributed in Australia, with the majority distributed in NSW (29 per cent), Victoria (25 per cent) and Queensland.

Figure 4.4 Needle and syringe distribution (units of injecting equipment) ('000)



It was estimated that, in 2002-03, state and territory governments spent \$33.7 million on NSPs with the Commonwealth contributing \$4.6 million. The Commonwealth's current funding of supporting measures relating to NSPs totals \$48.1 million over the five year period to 30 June 2008 — \$44.5 million is provided to states and territories to increase education, counselling and referral services through NSPs and to diversify existing NSPs to increase accessibility through pharmacies and other outlets.

Needle and syringe programs currently operate in over forty countries including Belgium, Canada, Denmark, Finland, France, Germany, the Netherlands, New Zealand, Norway, Spain, Sweden, the United Kingdom, and the United States of America.

In the United States, there is a Congressional ban on the use of federal funds to operate NSPs.

Forty-three states and the District of Columbia have drug paraphernalia laws that penalise injecting drug users for needle and syringe possession. There are approximately 140 NSPs across the remaining states.

Source Dolan K et al, Needle and syringe programs: A review of the evidence (2005); Moore T, Turning Point Drug and Alcohol Centre, What is Australia's 'drug budget'? The policy mix of illicit drug-related government spending in Australia (2005), Christopher Pyne Blog, 13 June 2007, accessed 19 July 2007 at http://www.pyneonline.com.au/?id=blog&_action=showArticleDetails&articleID=1248&categoryID=416.

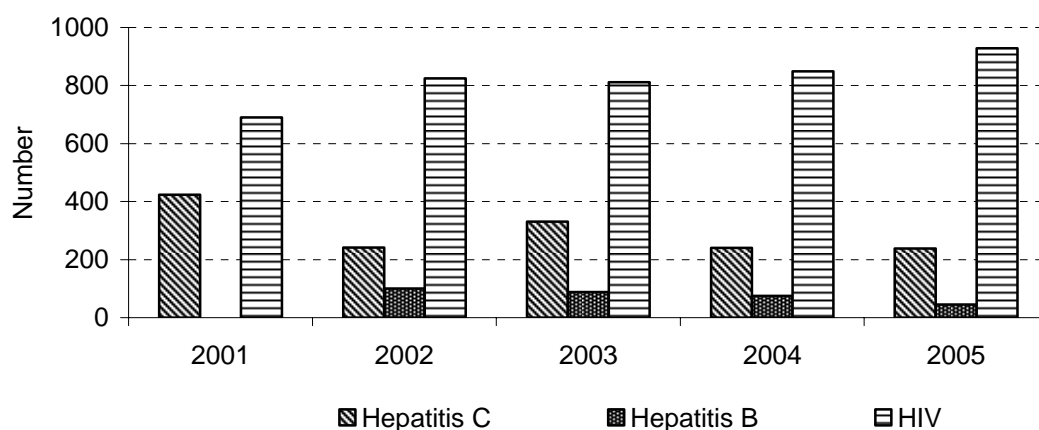
Discussion

4.125 The committee considers that it is important that drug users should be supported to get off drugs. Drug policy elites can give mixed messages to

the community about the acceptability of illicit drug use and perpetuate the myth that drug taking is an individual choice that the user may or may not perceive as destructive.

- 4.126 While the objective of needle and syringe exchange programs is to reduce the risk of infections, the number of new HIV diagnoses has increased steadily in recent years.¹²⁰ Possible explanations for rising infection rates given to the committee include that there is trivialised view of illicit drug taking,¹²¹ and an increasing incidence of risky behaviour (attributed partly to the rise in the consumption of ice).¹²²
- 4.127 Among injecting drug users, the number of newly acquired hepatitis B infections has declined in recent years with the number of newly acquired hepatitis C infections remaining relatively stable (figure 4.4).

Figure 4.4 Number of diagnoses of newly acquired HIV, hepatitis B and hepatitis C infection, 2001–2005



Note HIV infections refer to the general population. Hepatitis B and C refer to infections in injecting drug users only.

Source National Centre in HIV Epidemiology and Clinical Research, 2006 Annual Surveillance Report (2006), cat no PHE 78, pp 21, 62, 65.

- 4.128 Some inquiry participants expressed their support for the continuation or expansion of needle and syringe programs and safe injecting rooms.¹²³

120 National Centre in HIV Epidemiology and Clinical Research, 2006 Annual Surveillance Report (2006), cat no PHE 78, p 1.

121 Reece S, submission 33, p 2.

122 Australian Institute of Family Studies, submission 103, p 7; McLean T, 'Ice users 'in danger' of getting AIDS', *Canberra Times*, 19 July 2007, p 8.

123 The List, submission 49, p 5; Australian Injecting and Illicit Drug Users League, submission 85, p 8; Western Australian Substance Users Association, submission 113, p 2; South Australian Government, submission 153, p 12; Queensland Government, submission 173, p 5; Lines S,

4.129 While the key original intent of the safe injecting room at Kings Cross in Sydney was to reduce the morbidity and mortality associated with drug overdoses, the committee was concerned with reports that only 38 per cent of injections in the injecting room in 2006 were heroin injections. Substances such as cocaine and ice, highly destructive in the longer term but not presenting high risks of immediate overdose, are commonly injected, as is prescription morphine.¹²⁴

4.130 The Festival of Light said in its submission that:

The Commonwealth Government [should]... immediately cease all financial support for harm minimisation programs including needle exchanges, cannabis infringement notice schemes, and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence). ...The Commonwealth Government [should direct] ... the federal police to actively enforce the provisions of Section 307.10 of the Criminal Code against any person in the vicinity of the Sydney Medically Supervised Injecting Centre who is in possession of heroin, cocaine or any other 'border-controlled drug reasonably suspected of having been unlawfully imported' in order to send a clear message to all states and territories that the Commonwealth will not allow any such breaches of its commitment under the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol and the Convention on Psychotropic Substances of 1971.¹²⁵

4.131 Drug Free Australia submitted that:

Needle exchanges should be reviewed and practices completely overhauled in all [local government areas] that have adopted them in Australia. They need to be held more accountable. For example, in Sweden such measures are required to: (1) be endorsed by their local community and (2) demonstrate that they have directed clients to treatment services that lead to rehabilitation.

submission 41, p 3; Hepatitis Australia, submission 54, p 2; National Centre in HIV Social Research, submission 61, p 1; Name withheld, submission 77, p 3; Miller T, submission 78, p 3; Quon M, submission 8, p 7; Royal Australian College of Physicians, submission 119, p 15; Families and Friends for Drug Law Reform, submission 122, p 32; Hepatitis C Council of NSW, submission 129, p 9; Association for Prevention and Harm Reduction Programs Australia, submission 130, p 12; Australasian Society of HIV Medicine, submission 140, p 7; Ravesi-Pasche A, submission 47, p 5.

124 Drug Free Australia, *The case for closure: The King's Cross injecting room* (undated), p 3.

125 Festival of Light, submission 85, p 9.

The medically supervised injecting room at Kings Cross needs to be closed without delay. Apart from the fact that there is a possibility of it being replicated in other states and the fact that a large percentage of ice is being injected there, the reasons for its closure are well documented in the attached summary report and further explained in a research document on our website www.drugfree.org.au.¹²⁶

Recommendation 13

4.132 The Australian Government Department of Health and Ageing undertake a review of needle and syringe exchange programs to assess whether they are:

- **supported by the local communities in which they operate; and**
- **successful in directing drug users to appropriate treatment to enable them to be drug free individuals.**

126 Drug Free Australia, submission 42, p 10.

