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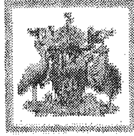

The Royal Australasian
College of Physicians

**The House of Representatives Standing Committee on Family and Human Services**

**Inquiry into the impact of illicit drug use on families**

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# Introduction

The RACP welcomes the opportunity to present a submission from Fellows to the *House of Representatives Standing Committee on Family and Human Services Inquiry into the impact of illicit drug use on families*. Information from the Fellows of the Australasian Chapter of Addiction Medicine was the primary source for this submission. Information from RACP policies on addiction, *Illicit Drugs Policy: Using Evidence to get Better Outcomes, Tobacco Policy: Using evidence to get better outcomes and Alcohol Policy: Using evidence to get better outcomes* was also included. These documents are available on the RACP web at: http://www.racp.edu.au/index.cfm?objectid=49F4AA63-2A57-5487-DB4AE18D11BD69CB.

The RACP comprises over 9,000 Fellows, including Fellows of the College itself (physicians and paediatricians), and Fellows of its Faculties of Public Health Medicine, Rehabilitation Medicine, Occupational Medicine and of its Chapters of Palliative Medicine, Addiction Medicine, Community Child Health and Sexual Health Medicine. The Joint Faculty of Intensive Care Medicine is part of the RACP and the Australian and New Zealand College of Anaesthetists. In addition, the RACP encompasses 28 Specialty Societies representing the spectrum of practice in Internal Medicine and Paediatrics across 23 sub-specialties.

The College has evolved to bring together different groups of physicians who share common ideals in medical practice. Physicians and paediatricians are medical experts to whom patients with complex and difficult or chronic diseases are referred. They emphasise the treatment of the whole individual within a social context. This requires not only a high level of medical expertise, but high cognitive competence and the ability to communicate exceptionally well with patients, other medical practitioners such as general practitioners, other health team members and medical trainees. These ideals have led the RACP to a unique position among the specialist medical colleges. Not only is the RACP the key professional training and education body for physicians in Australia and New Zealand, it has also emerged as a key informant and influence in health policy over a range of areas.

## Summary of this submission

1. The College would like to emphasis that the paramount objective of an inquiry into illicit drug related harms is to reduce death, disease, crime and corruption. The beneficiaries of this approach must be drug users, their families and the community. The College urges the inquiry to accept the evidence that continued heavy reliance on law enforcement to control illicit drugs is dependent on supply control, is expensive and of limited effectiveness, often producing serious unintended negative consequences.

2. The College firmly believes that illicit drug use is primarily a health and social issue.

3. The College would suggest an increase in the funding for health and social interventions to the current level of illicit drug law enforcement, fund interventions on the basis of evidence of effectiveness and safety and improving the return on substantial government investments.

4. The College has stated in all three of its addiction polices that illicit drugs are likely to be available in Australia for the foreseeable future, and that a realistic goal for policy is to regulate as a much of that market as possible.

5. The College recommends that the government expand and improve drug treatment to maximise the number of illicit drug users attracted, retained and benefited by effective, safe and cost effective drug treatment. This will require an expansion of capacity, broadening of options and enhancement of the quality and effectiveness of services provided. The College urges government to ensure drug treatment to be raised to reach the level of all other forms of health care.

6. The College believe that the central role played by rigorous, independent (of industry), scientific research in continuous quality improvement for health, social, educational and law enforcement interventions. Research in drug treatment is required to identify new and more effective interventions to attract drug users not previously attracted by conventional treatments as well as treatment refractory, severely – dependent drug users. Research should drive efforts to identify the least expensive, most effective and safest means of reducing drug-related harm.

7. The College urges the inquiry to honour the letter and spirit of all international drug policies (Single Convention, 2.5b).

8. The College would urge the inquiry to consider developing resources for families where they can readily access up to date and good quality services. Families require medical advice for example, on overdose problems. There needs to be support groups such as SMART groups as well as less philosophically driven groups to provide support where and when required.

9. The College would urge the inquiry to commit to strategies that protect family members from the consequences of other drug use such as the risk of HIV, HBC and HCV.

# 1. Background

Children of illicit substance users are at risk for multiple problems. The co-occurrence of parental substance abuse and child abuse has been reported in numerous studies.[1] Increased prevalence of psychological problems in the children and adolescents of substance using parents has been well documented. [2] [3] [4] [5] Further more these children are at increased risk of becoming drug users themselves. [6]Commonly abused substances include alcohol, marijuana, heroin, ecstasy amphetamines and inhalants. Foetal alcohol spectrum disorder provides a poignant example of the negative impact of prenatal exposure to commonly ingested teratogens. Women using illicit drugs are reported to be less likely to access pre- and postnatal care, avoid seeking help for parent-child problems, fear that their use will be exposed, which may lead to intervention by child protection authorities, perceive that nothing is wrong, or lack interest in parenting, may be isolated or marginalised from traditional health services and experience a lack of relevant services in rural regions and urban areas of poverty.[7]

The College through the Division of Paediatrics and Child Health is currently revising a policy on Child Protection. In summary, the policy has identified serious limitations of the current data available in Australia, which prevent any accurate estimate of the dimensions of the diverse problem of child abuse and neglect. It also discusses the fact that, without this baseline data, it is almost impossible to evaluate the efficacy of current interventions to prevent abuse and neglect. The lack of data also seriously hampers evaluation of current interventions after abuse and neglect is known to have occurred.[8]

Studies from both industrialised and developing countries show that many of the personality and behavioural characteristics of violent parents are related to poor social functioning and diminished capacity to cope with stress.[9] Parents with poor impulse control, low self-esteem, mental health problems, and substance abuse (alcohol and

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[1] Tomison AM *Child Maltreatment and Substance Abuse* National Child Protection Clearinghouse Discussion Paper Number 2 Spring 1996.

[2] Nunes EV, Weissman MM et al, Psychopathology in children of parents with opiate dependence and /or major depression. Journal of the American Academy of Child and Adolescent Psychiatry Nov 1998, 37:11 1142-1151

[3] Nunes EV, Weissman MM et al. Psychiatric Disorders and Impairment in the Children of Opiate Addicts: Prevalence and distribution by ethnicity. American Journal of Addiction 2000, 9:232-241.

[4] Wilens TE, Biederman J et al, Pilot study of behavioural and emotional disturbance in the high risk children of parents with opioid dependence. Journal of the American Academy of Child and Adolescent Psychiatry 1995, 34:779-785.

[5] Luthar SS, Cushing G et al, Multiple Jeopardy: Risk and protective factors among addicted mothers' offspring. Developmental Psychology 1998, 10:117-136

[6] Hops H, Duncan TE, Parent substance use as a predictor of adolescent use: A six year lagged analysis. Annals of Behavioural Medicine 1996, 18(3): 157-164.

7 Hegarty M, *Mind the Gap:* The National Illicit Drug Strategy (NIDS) Project to Improve Support for Children from Families where there are Mental Illness and Substance Abuse (MISA) Issues Literature Review A Partnership Between The Mental Health Co-ordinating Council (NSW) and The Department of Community Services (NSW) Sponsored by the Australian Government Department of Family and Community Services June 2004

[8] RACP, *Child Protection Policy*, Sydney: RACP 2007

[9] Sidebotham P, Golding J. Child Maltreatment in the 'Children of the Nineties': A Longitudinal Study of Parental Risk Factors. *Child Abuse & Neglect* 2001; 25: 1177–1200.

drugs) are more likely to use physical violence against their children and/or to neglect them.[10] Parents who use violence against their children may well have experienced violence as children.[11]

Research on the links between socio-economic conditions and violence against children suggest that efforts are needed to alter the underlying conditions that put extreme economic, social and emotional stress on families. Greater attention must be given to supporting families who live in communities characterised by high levels of unemployment, overcrowded housing and low levels of social cohesion.[12] Studies in Australia have shown that levels of alcohol related involvement in violence increase with age throughout adolescence and usually peak in the early twenties.[13]

The Australasian Chapter of Addiction Medicine considers alcohol and nicotine as addictive substances and, while not illegal, risky or high risk consumption of alcohol and smoking of tobacco do result in more harms especially to families than illicit drugs. The Royal College of Physicians (London) produced the first official report on cigarette smoking and health in 1962, [14] [15] and Fellows from RACP have taken lead roles in reducing harms from risky and high risk consumption of alcohol over the last 40 years.[16]

This submission will present the extent and nature of addictive substances followed by the harm these cause to families and communities.

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[10] Klevens J et al. Risk Factors and the Context of Men Who Physically Abuse in Bogota, Colombia. *Child Abuse & Neglect* 2000; 24: 323–332.

[11] Ertem IO et al. Intergenerational Continuity of Child Physical Abuse: How Good Is the Evidence? *Lancet*, 2000; 356 (9232): 814–819.

[12] United Nations World Report on Violence against Children Paulo Sérgio Pinheiro Independent Expert for the United Nations Secretary-General's Study on Violence against Children 2007 ISBN-10 92-95057-51-1

[13] Australian Institute of Criminology. Alcohol related Assault: Time and Place. *Trends and Issues in Crime and Criminal Justice*, No. 169. Canberra, Australian Institute of Criminology 2000.

[14] Royal College of Physicians. *Smoking and Health. Summary and Report of the Royal College of Physicians of London on Smoking in Relation to Cancer of the Lung and Other Diseases* New York Pittman Publishing Company, 1962.

[15] The Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists. *Tobacco Policy: Using evidence for better outcomes.* Sydney: RACP and RANZCP, 2005

[16] The Royal Australasian College of Physicians *Alcohol Policy: Using evidence for better outcomes* 2005 Sydney

## 2. Nature and extent of drugs and alcohol

### Deaths

In Australia in 1998, there were an estimated 19,019 deaths attributed to tobacco,[17] 64,782 deaths attributed to alcohol in 2001[18] and 1,023 deaths attributed to illicit drugs in 1998.[17] In 1996[19] it estimated that almost 4.9 per cent of the total burden of disease in Australia in 1996 was attributable to alcohol consumption, 10 per cent to tobacco smoking and 2 per cent to illicit drug use.

Deaths are not the only important measure of damage to health from drugs or other causes.

### Disease

While deaths are undeniably important, in Australia, in 1998, tobacco smoking accounted for 142,500 hospital bed-days in Australia, due to direct smoking or environmental smoking and 14,500 due to illicit drugs. [17] Findings from the NAIP indicate that almost 65,000 hospital bed days in the financial year 2000–01 were attributable to risky or high-risk alcohol consumption. Hospital bed-days are regarded as one of the best readily available proxies for disease (morbidity).

Disability Adjusted Life Years (DALYS) is a measure which attempts to combine the total impact on mortality and morbidity of a condition. In Australia in 2001, there were an estimated 10 per cent DALYS attributed to tobacco, 4.9 per cent DALYS attributed to alcohol and 1.8 per cent DALYS attributed to illicit drugs.

Illicit drugs only account for 15.6 per cent of drug-related hospital bed-days, and 1.8 per cent of drug-related DALYS.

### Economic cost

In Australia in 1998-1999 the total cost to the economy from psychoactive drugs was estimated to be $18.3 billion with $7.5 million attributed to tobacco, $5.5 million attributed to alcohol and $5.1 million attributed to illicit drugs. Thus of the all drug-related costs to the economy, 61.2 per cent were due to tobacco, 22 per cent to alcohol and only 17 per cent to illicit drugs.[20]

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[17] Ridolfo B, Stevenson C. The quantification of drug-caused mortality and morbidity in Australia, 1998. Drug Statistics Series No. 7. AIHW Cat. No. PHE 29. Canberra: AIHW. 2001

[18] Chikritzhs T, Catalano P, Stockwell T et al. 2003. Australian alcohol indicators, 1990–2001: patterns of alcohol use and related harms for Australian states and territories. Perth: National Drug Research Institute, Curtin University of Technology.

[19] Mathers C, Vos T, Stevenson C 1999. The burden of disease and injury in Australia. AIHW cat. no. PHE 17. Canberra: AIHW.

[20] Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australian 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002

**Table 1: Avoidable costs as a percentage of the total costs of drug abuse (at 2000 prices)**

| | 1988 Alcohol | 1988 Tobacco | 1988 Illicit Drugs | 1988 Total | 1992 Alcohol | 1992 Tobacco | 1992 Illicit Drugs | 1992 Total |
|---|---|---|---|---|---|---|---|---|
| **Tangible** | 85.4 | 46.1 | 30.2 | 57.2 | 87.6 | 44.9 | 28.6 | 55.3 |
| **Intangible** | 72.1 | 47.1 | 31.4 | 49.9 | 72.5 | 45.7 | 30.7 | 48.2 |
| **Total** | **82.6** | **46.6** | **30.6** | **54.3** | **84.3** | **45.3** | **29.3** | **52.7** |

Source: Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia, in 1998-9,* Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002[20]

The avoidable percentages differ markedly between the different drugs. It is estimated that 84.3 per cent of the total costs of alcohol were avoidable in 1992, while about 45 per cent of tobacco costs were avoidable. The estimated avoidable percentage for illicit drugs in 1992 was 29.3 per cent

**Social costs**

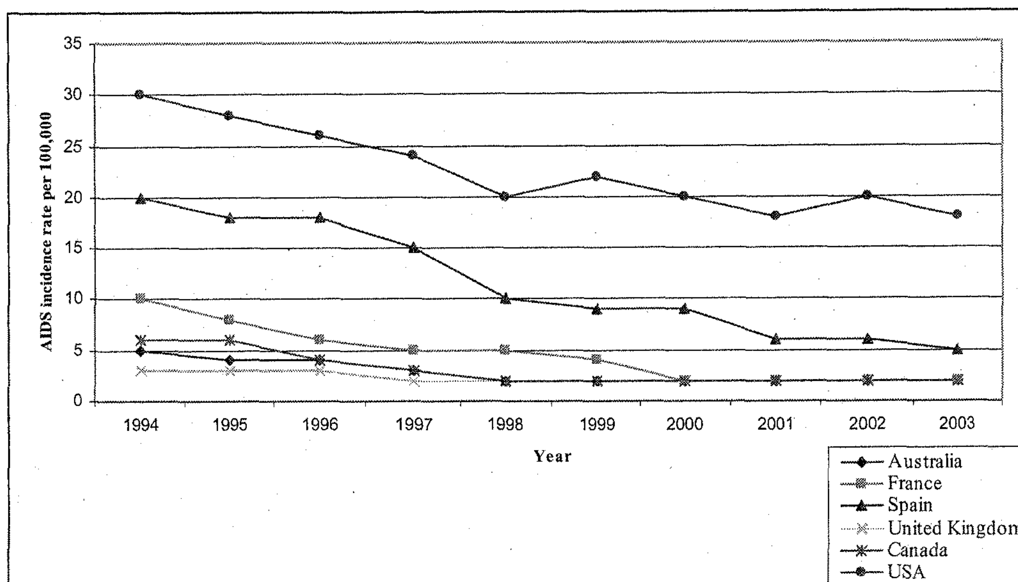
Social costs are much more difficult to quantify than health or economic costs. The social costs of illicit drugs may exceed those resulting from tobacco but are dwarfed by those due to alcohol. Alcohol also has a strong connection with violence: most serious assaults are caused by people who are intoxicated. Studies find that there are more assaults around large clusters of pubs and licensed premises.

**HIV/AIDS**

Figure 1 demonstrates that since 1994, countries, including Australia that have moved quickly to implement national policies based on behavioural prevention strategies managed to contain the spread of HIV/AIDS. Countries such as the US who adopted a 'tough on drugs' stance, ignoring the principles of harm minimisation has not been able to demonstrate good HIV outcomes. After 25 years, the per capita prevalence of HIV infections in the US is well over ten times those in Australia.[21]

[21] Annual Report, National Centre in HIV/AIDS Epidemiology and Clinical Research. 2006.

**Figure 1: AIDS incidence in selected industrialised countries by year**




Source: 2004 annual surveillance report. National Centre in HIV Epidemiology and Clinical Research

Table 2 illustrates the consumption or use of illicit drugs from a range of developing countries. When using this information to identify the harm caused to families and communities from illicit drugs the information does not explain the adverse consequences of consumption. In countries where there is evidence of an increase in the harm caused by illicit drugs there is also likelihood that people in these countries feel more able to self report their use.

**Table 2: Prevalence of illicit drug abuse as a percentage of the population aged 15-64 years from selected countries between 2000 and 2004**

| Countries | Opiates | Cannabis | Cocaine | Amphetamines | Ecstasy |
|---|---|---|---|---|---|
| Australia (2004) | 0.5 | 13.3 | 1.2 | 3.8 | 4.0 |
| New Zealand (2001) | 0.5 | 13.4 | 0.5 | 3.4 | 2.2 |
| USA (2000) | 0.6 | | | | |
| (2004) | | 12.6 | 2.8 | 1.5 | 1.0 |
| Canada (2000) | 0.4 | | | | |
| (2004) | | 16.8 | 2.3 | 0.8 | 1.1 |
| United Kingdom (2001) | 0.9 | | | | |
| England & Wales (2003/4) | | 10.8 | 2.4 | 1.5 | 2.0 |
| Scotland (2003) | | 7.9 | 1.4 | 1.4 | 1.7 |
| Sweden (2001) | 0.1 | 2.2 | | | |
| (2002) | | | | 0.2 | |
| (2003) | | | | | 0.4 |
| (2004) | | | 0.2 | | |

Source: Adapted from tables in 2006 World Drug Report pages 383-389 at:
http:/www.unodc.org/unodc/en/world_drug_report.html

# 3. Harms caused to families and communities

**Legal and policy framework**
Weak legal frameworks contribute both directly and indirectly to family violence against children. The laws condone, either explicitly or implicitly as a result of interpretation, some level of violence against children if it is inflicted by the child's own parents or guardians as a means of behavioural correction.

**Protective factors within the home**
Just as certain factors increase the likelihood of family violence against children, other factors can reduce its likelihood. Where research has been conducted, the focus is on identifying factors that mediate the impact of violence once it has occurred, for example those that might protect a victim from developing long-term mental disorders or that seem to be associated with breaking the cycle of violence. [22]

Factors that appear through common sense and research to facilitate resilience include higher levels of paternal care during childhood, [23] fewer associations with substance-abusing peers, or peers engaged in criminal activity, [23] a warm and supportive relationship with a non-offending parent, [24] and lower levels of violence-related stress. [24]

**Programs for schools**
Studies from Australia suggest the importance of comprehensive and whole of school approaches in reducing risk factors and increasing protective factors simultaneously preventing illicit drug use. Support from teachers, parents and other adults have been identified as important, as well as having supportive peers and belonging to supportive pro-social groups. Such a whole of school approach has also shown improvements in student mental health.[25] [26]

**Children and Adolescents of Illicit Drug Users**
Children and adolescents who have a substance using parent are more likely to have

1. Increased risks of drug use themselves (Hops 96).[27] Two and three generations of opiate addicts from one family are seen at methadone units in NSW.

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[22] United Nations World Report on Violence against Children Paulo Sérgio Pinheiro Independent Expert for the United Nations Secretary-General's Study on Violence against Children 2007 ISBN-10 92-95057-51-1

[23] Fergusson DM, Lynskey MT. Physical Punishment/Maltreatment during Childhood and Adjustment in Young Adulthood. *Child Abuse & Neglect* 1997; 21 (7): 617–630.

[24] Spaccarelli S, Kim S. Resilience Criteria and Factors Associated with Resilience in Sexually Abused Girls. *Child Abuse & Neglect* 1995; 19: 1171–1182.

[25] Bond L et al. The Gatehouse Project: Can a Multi-level School Intervention Affect Emotional Well-being and Health Risk Behaviours? *Journal of Epidemiology and Community Health*, 2004; 58: 997–1000.

[26] Stewart D et al. How Can We Build Resilience in Primary School Aged Children? *Asia-Pacific Journal of Public Health,* 2006; 16 (Suppl.): S37–S41. Queensland, Asia- Pacific Consortium for Public Health.

[27] Hops H, Duncan TE, Parent substance use as a predictor of adolescent use: A six year lagged analysis. Annals of Behavioural Medicine 1996, 18(3): 157-164.

2. Children and adolescents of illicit drug users come from families where there are poor family management practices, high family conflict, low family cohesion and high stress.
3. Internalising and externalising psychological behaviours, [28]
4. Psychiatric diagnoses.[29 30]Affective disorders and suicide attempts were more common amongst the group. [31 32]
5. Juvenile delinquency and to meet diagnosis of conduct disorder. [33 34 35 36]

The extent of the problems encountered by children and adolescents of illicit drug users in Australia is not clearly documented and deserves further study.

The **Teenlink** Health Service (in Western Sydney) for 8-16 year olds who have a parent on Methadone found in their review of patients from the first year that the majority lived in public housing and had parents who were unemployed. Compared with the population at large these children were more commonly had a parent in prison at some stage, or a parent die. Most strikingly, all of the children and adolescents had a parent on an illicit drug or in treatment for an illicit drug for the duration of their lives.[37] This is not the typical environment in which the majority of Australia's children grow and reflects the very high needs of the children and adolescents who have a substance using parent.

Consequences of the above are disengagement from mainstream education, risk of early school dropout, delinquency and drug use perpetuated in the next generation. There is a need for special services to support these children in their development and behaviour both from a diagnostic and management perspective.

Avenues for preventing and minimising the problems outlined above are possible. These include various parenting programs, baby health clinics and the availability of

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[28] Wilens TE, Biederman J et al, Pilot study of behavioural and emotional disturbance in the high risk children of parents with opioid dependence. Journal of the American Academy of Child and Adolescent Psychiatry 1995, 34:779-785.
[29] Luthar SS, Cushing G et al, Multiple Jeopardy: Risk and protective factors among addicted mothers' offspring. Developmental Psychology 1998, 10:117-136
[30] Nunes EV, Weissman MM et al, Psychopathology in children of parents with opiate dependence and /or major depression. Journal of the American Academy of Child and Adolescent Psychiatry Nov 1998, 37:11 1142-1151
[31] Nunes EV, Weissman MM et al. *Psychiatric Disorders and Impairment in the Children of Opiate* Addicts: Prevalence and distribution by ethnicity. American Journal of Addiction 2000, 9:232-241.
[32] Nunes EV, Weissman MM et al, Psychopathology in children of parents with opiate dependence and /or major depression. Journal of the American Academy of Child and Adolescent Psychiatry Nov 1998, 37:11 1142-1151
[33] Nunes EV, Weissman MM et al, Psychopathology in children of parents with opiate dependence and /or major depression. Journal of the American Academy of Child and Adolescent Psychiatry Nov 1998, 37:11 1142-1151
[34] Nunes EV, Weissman MM et al. Psychiatric Disorders and Impairment in the Children of Opiate Addicts: Prevalence and distribution by ethnicity. American Journal of Addiction 2000, 9:232-241.
[35] Loeber R, Development and risk factors of juvenile antisocial behaviour and delinquency, Clinical Psychological Review 1990, 10: 1-41.
[36] Ferguson DM, Lynskey MT, Conduct problems in childhood and psychosocial outcomes in young adulthood: a prospective study. Journal of emotional and behavioural disorders 1998. 6: 2-18
[37] Lampropoulos B, Zappia P, et al, Poster Presentation: Australian and New Zealand Adolescent Health Conference Nov 2006

services to untangle to difficulties encountered by the children, adolescents and their parents throughout the child's life course. This serves both the purpose of supporting the lives of the next generation as well as the drug users with their parenting which is often identified as a stress. The challenge is that the illicit substance using population does not access mainstream services readily therefore alternative means for access need to be made available. One possibility is to base the services at access points known to drug users such as methadone services. An example of such a service is the **Teenlink** program. [38]The other challenge is the chronicity of the drug use problems and hence the need for services to be available i.e. funded in the long term. Problems with the duration of funding have resulted in loss of valuable services for this vulnerable population.

**Treatment and management of women during pregnancy**
In Australia guidelines[39] published to improve the health outcomes for pregnant women who are drug dependent suggested that information about the effects of drugs during pregnancy should be available to all women of child bearing age prior to pregnancy occurring. This is particularly important in relation to licit drugs such as alcohol (where considerable damage may occur before the first missed period) and tobacco, for which the risks are well established.

**Reducing access to alcohol and illegal drugs**
There are a variety of interventions that can prevent violence: violence against children in the home and family setting can be reduced significantly by the implementation of laws, policies and programmes which strengthen and support families, and that address the underlying community and societal factors that allow violence to thrive.

Interventions which reduce access to alcohol or raise its price have been shown to reduce both levels of consumption and rates of youth violence within the community. Limiting access to alcohol, through controlling the number of alcohol outlets or raising prices, may help prevent child maltreatment.[40] Similar efforts to reduce alcohol-related violence against children, although these measures should be considered carefully, as they might prompt people who drink to switch to cheaper and less regulated home-brewed alternatives.[41]

There is also evidence that programmes which alter peer drinking habits and other social norms can reduce harmful alcohol consumption levels among young people, and thus may be useful in reducing alcohol-related violence. Modifying drinking establishments such as bars and clubs can be effective. For example, improving management and staff practice through training programmes, implementing codes of

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[38] Lampropoulos B, Zappia P, et al, Poster Presentation: Australian and New Zealand Adolescent Health Conference Nov 2006

[39] National Clinical Guidelines for the Management of Drug Dependency during Pregnancy, Delivery and the Early Development Years of the Newborn Cost shared funding project Intergovernmental Committee on Drugs 2006

[40] Markowitz S, Grossman M. Alcohol Regulation and Domestic Violence towards Children. *Contemporary Economic Policy*, 1998; 309–320.

[41] Room R et al. *Alcohol in Developing Societies: A Public Health Approach*. Helsinki, Finnish Foundation for Alcohol Studies/Geneva, World Health Organization. 2003

good practice, and strictly enforcing licensing legislation creates environments less conducive to violence.[42] [43] [44]

In wider night time environments, the presence of large numbers of intoxicated individuals at the end of the night increases the potential for violent confrontations. [45] Interventions such as provision of safe late-night transport, improvements to street lighting and use of closed circuit television have been shown to help reduce alcohol related violence around licensed premises. [45]

**Life skills-based education**
Aimed at enabling children to adopt self protective behaviours, life skills-based education can include a wide variety of topics. An example of some of these are education on how to avoid unwanted sexual intimacy; gaining practice and confidence in self expression; developing problem-solving and negotiating skills and conflict resolution by non-violent means facilitate and improve interaction between children and community authorities. Educational awareness and ability to access to these services empower children.[46] [47] [48]

**Injecting drug users and hepatitis C**
The impact of hepatitis C infected injecting drug users may have a severe impact on families. Of the estimated 210,000 Australians infected with hepatitis C, 126,000 - 168,000 acquire the infection via injecting drug use. In 2001, new infection rates per year have increased from 11,000 in 1997 to 16,000, predominantly among injecting drug users. 48 per cent to 62 per cent injecting drug users were reported to be are HCV RNA positive and form a reservoir of infectivity, infecting their families and the community at large. Only 20,000 (9.5 per cent) of infected IDUs underwent treatment with anti-viral agents and are presumably no longer infectious.

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[42] Mattern JL, Neighbors C. Social Norms Campaigns: Examining the Relationship between Changes in Perceived Norms and Changes in Drinking Levels. *Journal of Studies on Alcohol* 2004; 65: 489–493.
[43] Graham K et al. The Effect of the Safer Bars Programme on Physical Aggression in Bars: Results of a Randomised Controlled Trial. *Drug and Alcohol Review* 2004; 3: 31–41.
[44] Homel R et al. Making Licensed Venues Safer for Patrons: What Environmental Factors Should Be the Focus of Interventions? *Drug and Alcohol Review* 2004; 23: 19–29.
[45] Bellis MA et al. Violence in General Places of Entertainment. In: Pompidou Group (Ed). *Violence and Insecurity Related to the Consumption of Psychoactive Substances.* Strasbourg, Council of Europe 2004.
[46] WHO, UNICEF, World Bank, UNESCO and UNFPA. *Skills for Health.* WHO's Information Series on School Health, 2003 Document No. 9. Available at: http://www.who.int/school_youth_health/media/en/ sch_skills4health_03.pdf.
[47] Landgren K. The Protective Environment: Development Support for Child Protection. *Human Rights Quarterly*, 2005; 7: 215–248.
[48] Dahlberg L, Butchart A. State of the Science: Violence Prevention efforts in Developing and Developed Countries. *International Journal of Injury Control and Safety Promotion*, 2005; 12(2): 93–104.

## Social and economic costs to Aboriginal and Torres Strait Islander families and communities

*Tobacco*
Over half (50 per cent–57 per cent) of Aboriginal and Torres Strait Islander peoples aged between 18 and 54 years are current smokers, compared with 29 per cent or fewer of other Australians.[49]

*Alcohol*
Indigenous peoples are less likely than non-Indigenous people to have consumed alcohol in the last 12 months (71 per cent compared to 82 per cent)[50]; however, there is conflicting evidence about the relative levels of risky or high risk drinking among these population groups.

*Illicit substances*
Illicit substance use is estimated to be higher for Indigenous Australians,[51 52] with approximately one quarter of Indigenous peoples reporting having used illicit substances in the last 12 months. A comparable figure for non-Indigenous Australians was 15 per cent.[52]

*Social and economic harms to families and communities*
Aboriginal and Torres Strait Islander peoples who consume alcohol at risky levels, or who smoke tobacco, suffer considerable premature mortality. [53 54 55]

Life expectancy among Indigenous Western Australians was estimated to have the potential to rise 5.9 years (for males) and 3.4 years (for females) if tobacco smoking and unsafe alcohol use were eliminated together.[56] Little, however, is known about mortality resulting from other drug use, despite sporadic reports of deaths attributable to petrol sniffing[57 58 59] and a known association between suicidal ideation and

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[49] ABS. National Aboriginal and Torres Strait Islander Health Survey 2004–05. ABS cat. No. 4715.0. Canberra: ABS 2006

[50] AIHW *National drug strategy household survey: detailed findings.* Cat. No. PHE 66. Canberra: AIHW 2005. 2004

[51] Chikritzhs T, Brady M 2002 NATSISS: substance use. Presentation at the Centre of Aboriginal Economic Policy Research conference, the Australian National University, Canberra, 11–12 August 2005. 2005. www.anu.edu.au/caepr.

[52] Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed Findings.* AIHW cat. no. PHE 66. Canberra: AIHW (Drug Statistics Series No.16). 2005.

[53] Gray D. *A matter of life and death: contemporary Aboriginal mortality.* Canberra: Aboriginal Studies Press 1990.

[54] Measey MA, d'Espaignet ET, Cunningham J. *Adult morbidity and mortality due to tobacco smoking in the Northern Territory 1986–1995.* Darwin: Territory Health Services. 1998

[55] Unwin CE, Gracey MS, Thomson NJ. *The impact of tobacco smoking and alcohol consumption on Aboriginal mortality in Western Australia, 1989–1991.* Medical Journal of Australia 1995; 162:475–78.

[56] Arnold-Reed DE, D'Arcy C, Holman J, Codde J,Unwin E. *Effects of smoking and unsafe alcohol consumption on Aboriginal life expectancy.* Medical Journal of Australia 1998; 168:95.

[57] Brady M, Torzillo P. *Petrol sniffing down the track.* Medical Journal of Australia 1994; 160(21):176–7.

[58] Goodheart RS, Dunne JW *Petrol sniffer's encephalopathy.* Medical Journal of Australia 1994; 160:178–81.

substance use among Indigenous Australians (heroin,[60] alcohol, [61] cannabis, [62 63]). More information is available on comorbidities, particularly the chronic conditions arising from heavy alcohol and tobacco use, HIV, HBV and HCV infection rates among intravenous drug users,[64 65 66 60] and cognitive and mobility impairments experienced by chronic petrol sniffer.[67 68 69 70]

The potential harms associated with substance use are large, and are exacerbated by the risky behaviours (for example, needle sharing) that often accompany illicit drug use.

Criminal and violent behaviour, and subsequent incarceration, are similarly potential harms associated with substance use. Aboriginal and Torres Strait Islander peoples are incarcerated at a highly disproportionate rate compared with the rest of the Australian population, [71] and evidence suggests that drug-influenced criminal behaviour is a frequent pathway to incarceration. Stealing, break and entry, vandalism, gambling, drug dealing, sex work and violent crime (for example, assault) are regular consequences of intoxication, [72 73 74 75] with violent crime and property damage being the main offences committed by Indigenous male prisoners and detainees.[76 77]

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[59] South Australian Coroners Court 2002. *Finding of inquest: Kunmanara Ken, Kunmanara Hunt and Kunmanara Thompson.* Viewed 9 September 2005 <www.courts.sa.gov/courts/coroner/findings/findings_2002.

[60] Shoobridge J, Vincent N, Allsop S, Biven A. *Using rapid assessment methodology to examine injecting drug use in an Aboriginal community. National Council for Education and Training on Addiction/Aboriginal Drug and Alcohol Council.* 1998 Viewed November 2005, www.adac.org.au/resources/r_idu_lit_review.pdf

[61] Hunter E. *Resilience, vulnerability and alcohol in remote Aboriginal Australia.* Aboriginal Health Information Bulletin 1990; 14:16–24.

[62] Clough AR, Lee KSK, Cairney S, Maruff P, O'Reilly B, d'Abbs P et al.. *Changes in cannabis use and its consequences over three years in a remote Indigenous population in Northern Australia.* Addiction 2006; 101:696–705.

[63] Tatz C. *Aboriginal violence: a return to pessimism.* Australian Journal of Social Issues 1990; 25(4):245–60.

[64] Holly C. *Review of literature on injecting drug use within urban Indigenous communities.* Adelaide: Aboriginal Drug and Alcohol Council (SA) Inc. 2001. Viewed November 2005, <www.adac.org.au/resources/r_idu_lit_review.pdf

[65] Larson A. *What injectors say about drug use: preliminary findings from a survey of Indigenous injecting drug users.* IDU working paper no. 2. Brisbane: Australian Centre for International and Tropical Health and Nutrition, University of Queensland. 1996.

[66] Roberts C, Crofts N *Hitting up in the Top End: characteristics of needle exchange clients in Darwin.* Australian and New Zealand Journal of Public Health 2000; 24(1):82–5.

[67] Cairney S, Maruff P, Burns C, Currie B *The neurobehavioural consequences of petrol (gasoline) sniffing.* Neurosciences and Biobehavioral Reviews 2002; 26:81–89.

[68] Cairney S, Clough A, Maruff P, Collie A, Currie BJ, Currie J. *Saccade and cognitive function in chronic kava users.* Neuropsychopharmacology 2003; 28(2):389–96.

[69] Cairney S, Maruff P, Burns CB, Currie J, Currie BJ. *Neurological and cognitive impairment associated with leaded gasoline encephalopathy.* Drug and Alcohol Dependence 2004; 73:183–8.

[70] Cairney S, Maruff P, Burns CB, Currie J, Currie BJ. *Neurological and cognitive recovery following abstinence from petrol sniffing.* Neuropsychopharmacology 2005; 30:1019–27.

[71] ABS *Prisoners in Australia,* ABS cat. no. 4517.0. Canberra: ABS. 2005.

[72] Brady M *Children without ears: petrol sniffing in Australia.* Adelaide: Drug and Alcohol Services Council. 1985.

[73] Burns CB, d'Abbs P, Currie BJ P*atterns of petrol sniffing and other drug use in young men from an Australian Aboriginal community in Arnhem Land, Northern Territory.* Drug and Alcohol Review 1995; 14:159–69.

Around 60 per cent of both male and female Indigenous prisoners acknowledged that they had been under the influence of some form of substance at the time of their offence,[78 79] although few male Indigenous prisoners attributed committing the crime to their intoxication.

The influence of the familial environment is another critical factor in influencing substance use or abstinence, particularly for Indigenous Australians where connections to the immediate and extended family are strong and culturally expected. In communities where risky alcohol use and drug taking is problematic, or for individuals who are regular users, family instability is often commonplace, characterised by frequent conflict and episodes of domestic and other violence, parental absenteeism and home-based alcohol and drug use.[80 81 82 83]

The peer group is also greatly influential, as acknowledged by young Indigenous Australians involved in petrol sniffing[84 85] and intravenous drug use.[86] While the sway of the peer group is not unique to Aboriginal and Torres Strait Islander peoples, it may be more attractive for those whose home life and family circumstances are stressful.

Exposure to substances, their use by community members and the opportunity to use these substances influences use, but the effect of supply and demand is an area of

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[74] d'Abbs P, Hunter E, Reser J, Martin D *Alcohol misuse and violence: alcohol-related violence in Aboriginal and Torres Strait Islander communities: a literature review.* Canberra: Australian Government Publishing Service. 1994.
[75] Larson A *What injectors say about drug use: preliminary findings from a survey of Indigenous injecting drug users. IDU working paper no. 2.* Brisbane: Australian Centre for International and Tropical Health and Nutrition, University of Queensland. 1996.
[76] Australian Institute of Health and Welfare *Drug use among Aboriginal and Torres Strait Islander peoples: an assessment of data sources.* Drug statistics series no. 17. Cat. No. PHE 76. Canberra: AIHW. 2006.
[77] Putt J, Payne J, Milner L *Indigenous male offending and substance abuse.* Canberra: Australian Institute of Criminology. 2005.
[78] Johnson H *Key findings from the drug use careers of female offenders study.* Canberra: Australian Institute of Criminology. 2004.
[79] Putt J, Payne J, Milner L *Indigenous male offending and substance abuse.* Canberra: Australian Institute of Criminology. 2005.
[80] ANCD (Australian National Council on Drugs) Cape York Indigenous issues. 2002.Viewed 2 December 2005, www.ancd.org.au/publications/pdf/cape_york_report.pdf
[81] d'Abbs P, Hunter E, Reser J, Martin D *Alcohol misuse and violence: alcohol-related violence in Aboriginal and Torres Strait Islander communities: a literature review.* Canberra: Australian Government Publishing Service. 1994.
[82] Hunter E. *Out of sight, out of mind—Emergent patterns of self-harm among Aborigines of remote Australia.* Social Science and Medicine 1991; 33(6):655–9.
[83] Kelly AB, Kowalyszyn M *The association of alcohol and family problems in a remote Indigenous Australian community.* Addictive Behaviours 2003; 28:761–7.
[84] Brady M, Torzillo P *Petrol sniffing down the track.* Medical Journal of Australia 1994; 160(21):176–7.
[85] Burns CB, d'Abbs P, Currie BJ *Patterns of petrol sniffing and other drug use in young men from an Australian Aboriginal community in Arnhem Land, Northern Territory.* Drug and Alcohol Review 1995; 14:159–69.
[86] Shoobridge J, Vincent N, Allsop S, Biven A *Using rapid assessment methodology to examine injecting drug use in an Aboriginal community.* National Council for Education and Training on Addiction/Aboriginal Drug and Alcohol Council. 1998. Viewed November 2005, www.adac.org.au/resources/r_idu_lit_review.pdf

research requiring more attention. The Illicit Drug Reporting System uses 'key experts' to estimate the prevalence of drug use in Australian capital cities, and, by extrapolation, the supply of specific drugs. But, in non-urban settings, the collection of such information is more difficult, particularly for illegal or stigmatised drugs.[87]

**Families with members in prison for drug related offences**

Of the 1,925 persons in prison for drug-related offences at 30 June 2004, 1,558 (81 per cent) were imprisoned for dealing/trafficking drugs, 193 (10 per cent) for manufacturing/growing drugs and 174 (9 per cent) for possessing/using drugs. The proportion of people imprisoned with a drug-related most serious offence ranged between 9 per cent and 11 per cent over the period 1995 to 2004. In 2004, one in ten sentenced prisoners was imprisoned for drug-related offences.

**Drug induced psychoses and other mental disorders:**

Drug induced psychoses and other mental disorders attributed to illicit drugs are a considerable problem in Australia. The use and availability of psychostimulants, in particular amphetamine sulphate or hydrochloride ('speed') and methamphetamines ('meth', 'crystal meth', 'ice' and 'base') are increasing throughout Australia.[52] Population studies estimate that more than half a million Australians had used an illicit stimulant during the year 2000.[52]

Although amphetamine consumption may have levelled off in recent years, there is general agreement that it increased in Australia following the heroin shortage in 2000/01. Amphetamine-related problems such as psychoses and crime have continued to increase possibly due to increasing purity of street methamphetamine or the increasing use of more rapidly absorbed forms of methamphetamine.

Drug induced psychoses and other mental disorders attributed to the legal drug alcohol are also a considerable problem in Australia but have been excluded from this inquiry.

**The impact of harm minimisation programs on families**

*The history of harm minimisation in Australia*

All eight Australian governments adopted harm minimisation as the official national drug policy on 2 April 1985. Apart from the five Australian Labor Party governments in 1985, there was also a Bjelke-Petersen National government in Queensland, a Gray Liberal government in Tasmania and a Tuxworth Liberal-Country government in the Northern Territory. Harm minimisation continued to receive bi-partisan support at the Federal level for the next 14 years and is still Australia's official national drug policy.

Australia's national drug strategy has been reviewed by independent experts every few years since harm minimisation was adopted. On each occasion, the reviewers have recommended the retention of harm minimisation as Australia's national drug

[87] Clough AR, Cairney S, Maruff P, Parker R *Rising cannabis use in Indigenous communities.* Medical Journal of Australia 2002; 177(7):395–6.

policy and this recommendation has been accepted by the Ministerial Council on Drug Strategy (MCDS) – the nation's paramount drug policy making body. MCDS is made up of all nine health ministers, all eight police ministers and the Commonwealth Justice Minister. Harm minimisation has also been accepted since 1985 by every conservative led political party state and territory government. This has not been as apparent in recent years as conservative led political parties have been defeated in all states and territories for the last 21 consecutive elections.

*Support from the current Australian Liberal party*
The current government has provided $10 million a year to state and territory governments since 1999 to enhance their needle syringe programs. It has also generously supported and funded harm reduction in Asia to reduce the spread of HIV among injecting drug users in our region. Since 1996, Australia has continued to be one of the most vigorous defenders of harm reduction at UN forums in Vienna, Geneva and New York. The current government has also funded measures to divert selected drug using offenders from expensive and ineffective criminal justice punishments to less expensive and far more effective drug treatment. These are all harm reduction policies that the community should thoroughly commend.

*Harm minimisation in United States (US)*
In contrast to the situation in Australia, the government of the US has consistently rejected harm reduction. The US, with 14.7 new AIDS cases per 100,000 in 2003, has by far the highest rate of AIDS in the developed world. The US rate is now more than 12 times higher than in Australia which had 1.2 new AIDS cases per 100,000 in 2003. More than a third of new AIDS cases in the USA are injecting drug users. The US, with a population of 300 million, provides only 25 million sterile needles and syringes a year to reduce the spread of HIV while Australia, with a population of 20 million, provides 32 million sterile needles and syringes a year. Practical drug policies have kept HIV under control in Australia while gesture politics has increased HIV spread in the US.

A study commissioned by the Commonwealth Department of Health in Australia[88] estimated that by 2000 needle syringe programs cost Australia's governments $130 million but prevented 25,000 HIV and 21,000 hepatitis C infections and by 2010 will have prevented 4500 AIDS deaths and 90 deaths from hepatitis C. Needle syringe programs saved Australian governments at least $ 2.4 billion allowing for a 5 per cent annual discount for future benefits (as is conventional in government accounting). If this discount is not deducted, the savings were estimated to be as much as $ 7.7 billion. This major evaluation was based on a study of data from 103 cities around the world. Cities with needle syringe programs had an average annual 18.6 per cent decrease in HIV, compared with an average annual 8.1 per cent increase in HIV in cities without such programs.

[88] *Return on Investment in Needle and Syringe Programs in Australia*. Health Outcomes International Pty Ltd in Association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University for the Australian Government Department of Health and Ageing, October 2002

## 4. Ways to strengthen families and communities who are coping with a member(s) using illicit drugs.

1. Emphasise that the paramount objective of a modern drug policy for legal and illegal drugs is to reduce death, disease, crime and corruption (with reduction of drug consumption a potential means to achieve this end). The beneficiaries of drug policy should be the entire community including drug users and their families.

2. Accept the evidence that over reliance on law enforcement to control both illicit drugs supply and demand is expensive and ineffective and often produces serious unintended negative consequences.

3. Recognise that illicit drug use, like legal drug use, is primarily a health and social issue (with an important subsidiary role for law enforcement).

4. Increase funding for health and social interventions to the current level of illicit drug law enforcement, fund interventions on the basis of evidence of effectiveness and safety and improving the return on substantial government investment.

5. Accept that illicit drugs are likely to be available in most countries for the foreseeable future and that a realistic goal for policy is to minimise the harm from that use. To achieve this goal a balanced approach supply, demand and harm reduction strategies are required. Hence, as with legal drugs, criminal sanctions should continue to be applied against individuals who operate outside the law. Thus the production, sale, purchase, possession and consumption of unsanctioned quantities or unsanctioned types of mood altering drugs would continue to attract criminal sanctions. The threshold levels and magnitude of penalties for offences is likely to remain subject to continuing debate.

6. Expand and improve drug treatment to maximize the number of drug users attracted, retained and benefited by effective, safe and cost effective drug treatment. This will require expansion of capacity, broadening of options and enhancement of quality. Drug treatment should be raised to reach the level of other forms of health care.

7. Accept the central role played by rigorous, independent, scientific research in continuous quality improvement for health, social, educational and law enforcement interventions. Research in drug treatment is required to identify new and more effective interventions to attract drug users not previously attracted by conventional treatments as well as treatment-refractory, severely-dependent drug users. Research should drive efforts to identify the least expensive, most effective and safest means of reducing drug-related harm. This would include educational and other efforts to discourage drug initiation and continuing use, drug law enforcement and all forms of drug treatment.

8. Acknowledge that while the community of nations has long embraced a drug policy largely formulated in the 1961, 1971 and 1988 international drug treaties, monitored and implemented through a range of United Nations organizations, these require prohibition of nominated drugs where in the opinion of a party (i.e. country), prohibition provides 'the most appropriate means of protecting the public health and welfare' (Single Convention, 2.5 b). Countries adopting a modern drug policy would continue to honour the letter and spirit of all international drug policy commitments and treaty obligations.

9. The availability of services to support drug using parents with their children and adolescents at access points such as drug treatment services eg **Teenlink** Service.[89] This serves both the purpose of supporting the lives of the next generation as well as the drug users with their parenting which is often identified as a stress.

10. Further development of multiple access points for substance using families to come in contact with required services eg paediatric, drug treatment or family support services.

11. Support existing drug treatment services in incorporating a whole of family approach to their treatment. This could be achieved by implementing small programs such as the **Teenlink** service.

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[89] Lampropoulos B, Zappia P, et al, Poster Presentation: Australian and New Zealand Adolescent Health Conference Nov 2006