Submission to the Inquiry into the health impacts of alcohol and other drugs (AOD) 2024

Our background and expertise

We are a group of senior academics and practitioners from diverse backgrounds. Collectively we have expertise in alcohol and other drug (AOD) use, law, public health, sociology and human rights, in issues of injecting drug use, blood-borne viruses, stigma, discrimination and social policy, and have collectively authored many books, articles and reports on areas of direct relevance to this Inquiry and to the proposed Bill. Our affiliations and expertise are detailed below.

Kate Seear is Professor and Deputy Director of the Australian Research Centre in Sex, Health and Society at La Trobe University. She holds the prestigious Australian Research Council Future Fellowship, is a practising lawyer, founder and convenor of the Australian Drug Lawyers Network, leader of the Gender, Law and Drugs program at La Trobe University, and the author of five books and over 100 publications on alcohol and other drugs, law, gender, human rights, stigma, family and sexual violence, including *Law, drugs and the making of addiction: Just habits* (Routledge), which was the winner of the 2020 UK Socio-Legal Studies Association's history and theory book prize. Professor Seear is the corresponding author for this submission.

Renae Fomiatti is an Australian Research Council DECRA Senior Research Fellow at the Australian Research Centre in Sex, Health and Society at La Trobe University. Renae conducts qualitative research on the social and cultural dimensions of alcohol and other drug consumption and treatment, related phenomena such as blood-borne viruses and overdose, and contemporary experiences of health and gendered embodiment.

Emily Lenton is a Research Officer at the Australian Research Centre in Sex, Health and Society at La Trobe University. She has over twenty years of experience of working in research, health promotion and service delivery in the blood-borne viruses and AOD sectors.

kylie valentine is Professor and Director of the Social Policy Research Centre and the Centre for Social Research in Health at UNSW Sydney. She has expertise in policy-relevant research on the experiences and outcomes of marginalised groups, and policy interventions targeted at these groups, and is co-editor in chief (with Professor Kate Seear) of the journal *Contemporary Drug Problems*

Sean Mulcahy is a Research Officer at the Australian Research Centre in Sex, Health, and Society at La Trobe University. His research examines human rights law and its application to marginalised populations including people with blood-borne viruses, people who use drugs, and LGBTIQA+ people.

Gemma Nourse is a Research Associate at the Australian Research Centre in Sex, Health and Society at La Trobe University. Gemma conducts sociological research on the relationship between drugs, intoxication, medicine, health and stigma, with a particular interest in matters of gender.

Nyssa Ferguson is a Research Officer at the Department of Public Health at La Trobe University. Her research examines the social, political and gendered dimensions of alcohol and other drug consumption, harm reduction initiatives and related workforce issues.

Overall statement

Our recommendations are as follows:

Recommendation 1: When assessing the 'health impacts' of AOD, and/or the 'health, social and economic harms' (term of reference b) of AOD, the Committee should adopt a broad understanding of key concepts such as the 'impacts', and 'harms' that can be associated with AOD, including an expansive and critical approach to how impacts and harms might arise. This includes critical reflection on the role of law and policy in shaping such impacts and forms of harm.

Recommendation 2: When assessing the 'health impacts' and/or 'harms' of AOD, the Committee should remain cognisant of and open to the possibility that for many people who use AOD, there are few or no adverse harms, and/or that the effects of consumption are complex and variable. This includes maintaining an awareness of the pleasurable and beneficial aspects of consumption.

Recommendation 3: In the conduct of this Inquiry and in the production of its report, the Committee consider the important role of language, including the potential for language to generate, exacerbate and magnify harms, including AOD-related stigma. This may necessitate a move away from language that is often thought to be stigmatising including the use of terms such as 'substance abuse', 'substance misuse', 'recovery', 'addiction', 'addict', and 'substance use disorder'.

Recommendation 4: That this Inquiry recommend a comprehensive approach to sustainable AOD sector funding and system reform to 'deliver value for money' and reduce harms associated with AOD use.

Recommendation 5: That the government commit to ongoing funding of peak and peer organisations and recommend state and territories do the same including beyond the point of the conclusion of the next National hepatitis C Strategy and/or elimination.

Recommendation 6: That the government commit to funding culturally safe AOD services including for LGBTIQ+ populations.

Recommendation 7: That organisations employing living and lived experience workers within the AOD sector have clear processes in place for supporting this workforce or risk exacerbating harms they are seeking to address and that the governments provide resourcing if necessary to enable this work to be undertaken.

Recommendation 8: If approaches to AOD sector funding, policy, and/or law/regulation are to take 'best outcomes' into account, a set of principles regarding what constitutes 'best outcomes' should be developed in consultation with peer organisations and peak bodies, who are well placed to provide an evidence-based

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assessment of the strengths and weaknesses of the existing system and to identify potential areas for reform, informed by, and in collaboration with, key stakeholders and people who use AOD.

Recommendation 9: The Committee should give consideration to opportunities for moving towards a formalised (*de jure*) system for the decriminalisation of illicit drugs or legalisation.

Recommendation 10: That the Commonwealth work with the states and territories to implement comprehensive and consistent, nationwide reforms to a number of areas of policy and law that impact the health, economic and social outcomes of people who use AOD, including laws pertaining to secondary supply of needles and syringes for people who inject drugs.

Recommendation 11: That the Commonwealth implement a national law to govern the operation of workplace drug testing.

Recommendation 12: That the Commonwealth amend the Disability Discrimination Act to mandate that any discrimination in insurance must be justifiable and proportionate and that insureds be given access to the actuarial or statistical data upon which insurance decisions are based upon request.

Recommendation 13: That the Commonwealth take appropriate steps to end punitive responses to people who use drugs in public housing.

Recommendation 14: A national bill or charter of rights be introduced in line with the Australian Human Rights Commission's position paper, *A Human Rights Act for Australia.*

Recommendation 15: All parliamentarians, relevant parliamentary staffers, and relevant public servants receive training, provided by the Australian Human Rights Commission or another properly resourced and appropriate body. At a minimum, such training should cover the operation of parliamentary human rights scrutiny processes and the legal obligations of public authorities and public servants, including procedural and substantive obligations. If a national bill or charter of human rights is introduced, training should be extended to cover, at a minimum, the dimensions and operation of the bill/charter including any parliamentary human rights scrutiny processes and the legal obligations of public authorities, as well as public servants.

Recommendation 16: Wherever possible, and unless there is genuine urgency for a bill to be reviewed and brought before parliament, clear public timelines for rights scrutiny processes be established and reflected in standing orders so that legal advisors and other experts (such as peak and peer organisations, or other civil society organisations) have adequate time to review bills and provide advice, and so that relevant committees have more time to review and assess all relevant information when scrutinising bills for their human rights compatibility.

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Recommendation 17: Resourcing for key agencies and organisation to be increased to enable them to expand their advocacy on human rights issues including the provision of rigorous, detailed and quality input into rights processes (e.g. through parliamentary submissions). These organisations should include the Australian Human Rights Commission, community legal centres and legal aid organisations, and non-governmental organisations including national peak and peer organisations for people who use drugs.

Recommendation 18: That relevant Commonwealth Departments undertake a review of systems in light of the findings in the Inquest into the death of Veronica Nelson to ensure that systems do not produce cruel, inhuman or degrading treatment and AOD-related stigma of the kind documented in the Coroner's findings. This includes at a minimum measures to ensure equivalence of care in custodial settings through working with responsible state and territory departments/agencies.

Recommendation 19: That the Commonwealth support the states and territories to develop a comprehensive implementation plan for prison NSPs in order to reduce harms that can be associated with injecting drug use.

Recommendation 20: That capacity is built in human support and service agencies to ensure that people who use AOD and have additional support needs are provided with high quality, trauma-informed care.

We explain these issues in more detail in the sections that follow.

The framing of this Inquiry

We open our submission with some observations about the framing of the Inquiry itself including the language used in the terms of reference (and some associated materials). The Inquiry appears to be focused on the 'health impacts' of AOD, where 'impacts' are conceptualised in one, specific sense: as *necessarily adverse, taking the form of harms.* There are many reasons why it is important to be more circumspect here, and open to other possibilities regarding how AOD intersect with or shape health. In this section we explain some of the reasons why the nature of AOD-related issues, effects and harms should be approached carefully, and the implications of this both for the remainder of our submission and associated recommendations.

When assessing the impacts of AOD, a helpful starting point might be to reflect on how we understand the 'effects' and 'forms of harms' typically understood to be associated AOD consumption. Traditionally, the forms of harm that can be associated with AOD are thought to be effects of the pharmacological properties of the substances themselves. A number of scholars, including authors of this submission, have argued that the 'effects' of AOD are more complex than this, however, and not necessarily consistent, stable, predictable or singular, including singularly or inherently harmful or problematic.[1] Various factors and forces shape the forms of harm that can be associated with AOD,

[1] See, for example: Barratt, M. J., Seear, K. & Lancaster, K. (2017). A critical examination of the definition of 'psychoactive effect' in Australian drug legislation. *International Journal of Drug Policy, 40,* 16-25; Fraser, S., Moore, D. & Keane, H. (2014). *Habits: Remaking addiction.* Basingstoke: Palgrave Macmillan; Seear, K. & Moore, D. (eds.) (2014). Complexity: Researching alcohol and other drugs in a multiple world. (Conference Special Issue). *Contemporary Drug Problems, 41*(3), 293-484; Seear, K. (2013). What do we really know about doping 'effects'? An argument for doping effects as co-constituted 'phenomena'.

including whether they will generate any harms at all. Importantly, the kinds of factors that can shape the 'impacts' of drugs (or their 'effects' on people) include law, policy and practice itself.

We have more to say about this in the section on 'the role of sectors' below, but the key point is that harms are not inevitable or constant; as such we should not proceed on the basis of an assumption that AOD always 'work' in straightforwardly negative ways. Among other things, thinking about AOD as inherently 'problematic' can shape how we think about, research and describe them, foreclosing possible legal, policy and practice opportunities while making others seem essential or obvious. These dynamics can actually contribute to harms in a range of ways: a point that is also well-observed in the literature, including several studies written by authors of this submission.[2]

Relatedly, it is important that the Committee consider stigma in the conduct of this Inquiry. In a welcome development, the nature and function of AOD-related stigma has become an issue of increasing policy focus and attention in recent years.[3] Research suggests that AOD-related stigma arises from a wide range of sources, that it can be long lasting (including that it can last for a lifetime) and that it generates many adverse health, social and economic consequences.[4] There is growing recognition that when considering both how AOD work and whether to reform our approaches to them, we must also give detailed consideration to how laws, policies and practices can shape (i.e. produce, exacerbate or reduce) stigma. Importantly, public inquiries of this kind themselves have the potential to generate or ameliorate stigma, including how they conceptualise AOD and frame problems, through a process known as 'policy problematisation'.[5] Problematisation concerns how and why 'certain things (behaviour, phenomena, processes) become a problem' or become 'an object for thought'.[6] Taking up these ideas, Australian policy expert Carol Bacchi argues that policymakers do not simply identify and address pre-existing 'problems' but give shape to them, constituting problems as they go. This occurs in many ways, including through assumptions about what is (and is not) a 'problem' worthy of action, as well as *whether* such 'problems' can be solved, and *how* to solve them. As the lead author of this submission has explained elsewhere, drugs are:

> routinely depicted as self-evident 'problems' [naturally] generating a range of problems including

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Performance Enhancement and Health, 2(4), 201-209; Seear, K. (2013). Beyond the boundary: Drugs, the body and sport. *Contemporary Drug Problems, 40*(2); Fraser, S. & Moore, D. (2011). *The drug effect: Health, crime and society.* Melbourne: Cambridge University; Fraser, S. & valentine, k. (2008). *Substance and substitution: Methadone subjects in liberal societies.* Basingstoke: Palgrave; Demant, J. (2013). Affected in the nightclub: A case study of regular clubbers' conflictual practices in nightclubs. *International Journal of Drug Policy, 24*(3), 196-202; Hart, A. C. & Moore, D. (2014). Alcohol and alcohol effects: Constituting causality in alcohol epidemiology. *Contemporary Drug Problems, 41*(3), 393-416; Dwyer, R. & Moore, D. (2013). Enacting multiple methamphetamines: The ontological politics of public discourse and consumer accounts of a drug and its effects. *International Journal of Drug Policy, 24*(3), 203-211.

[2] Fraser et al. (2022). Exhausted practical sovereignty and lateral agency: Non-uptake of treatment for hepatitis C in the antiviral era. *International Journal of Drug Policy, 107,* 103771; Moore et al. (2024). Countering 'the moral science of biopolitics': Understanding hepatitis C treatment 'non-compliance' in the antiviral era. *Sociology of Health and Illness, 46*(3), 399-417.

[3] See, for example: Department of Health. (2017). *National Drug Strategy 2017-2026*. Commonwealth of Australia: Canberra.

[4] Lloyd, C. (2010). *Sinning and sinned against: The stigmatisation of problem drug users.* London: UK Drug Policy Commission (UKDPC); Lloyd, C. (2013). The stigmatisation of problem drug users: A narrative literature review. *Drugs: Education, Prevention, and Policy, 20*(2), 85-95; see also: Fraser, S., Pienaar, K., Dilkes-Frayne, E., Moore, D., Kokanovic, R., Treloar, C. & Dunlop, A. (2017). Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis. *International Journal of Drug Policy. 44*, 192-201; Hatzenbuehler, M. L., Phelan, J. C. & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813-821.

[5] Bacchi, C. (2009). *Analysing policy: What is the problem represented to be?* Sydney: Pearson.

[6] Foucault, M. (1988). The concern for truth (A. Sheridan, Translator). In L. D. Kritzman (Ed.), *Michel Foucault: Politics, philosophy, culture. Interviews and other writings, 1977– 1984*, pp. 255–267. Routledge.

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> criminal behaviour, illness, injury and death. The notion that drugs are inherently harmful is both commonplace and taken-for-granted in much policy.[7]

This way of thinking about AOD can produce or exacerbate problems, however, including by foreclosing ways of thinking, and by stigmatising people who consume AOD. This Inquiry represents an important opportunity to address (and ameliorate) stigma including through how the Committee approaches its mission, describes the issues at hand, frames problems and solutions and deploys language. Language has been repeatedly shown to have special significance in the AOD field and the capacity to contribute to stigma.[8]

We have previously given evidence about these matters to other parliamentary inquiries, including the Victorian Parliamentary Inquiry into drug law reform (in 2017) and the Victorian Inquiry into the use of cannabis (in 2021). Here we repeat for this Committee's benefits some of the background observations that our lead author made in her written submission and oral evidence to both of those inquiries. In particular: stigma can delay or impede people's willingness to seek help or heath care.[9] The law has come into increasing focus as a source of stigma.[10] In the 2008 *World Drug Report*, the United Nations Office on Drugs and Crime (UNODC) described stigma as one of the 'unintended consequences' of the international drug control system and its application.[11] In the 2016 *World Drug Report*,[12] it was noted that people who use drugs are often subject to stigmatisation and discrimination. Other international bodies have raised similar concerns. As the lead author of this submission as previously argued:

> The policy landscape is dominated by a concern with the problem of *what changes to drug law might do* rather than a concern for *what drug law presently does*, including the numerous and widely documented harms generated and/or exacerbated by existing approaches. In other words, policy and law reform debates often focus on the fear of a future without prohibition rather than seriously addressing the clear and present problems of failed prohibition. This is not to say that what happens into the future is unimportant. There is an urgent need to arrest the rising tide of overdose deaths. Nevertheless, debates about drug policy and law are frequently dominated by an acute sensitisation towards *what a new or imagined drug law might one day do* rather than a sensitisation towards or concern for *what drug law is already doing*. This article therefore invites reflection not only on what risks might follow a departure from the status quo, but *what risks might flow from steadfastly holding to it.*[13]

Taking all of this together, our first recommendations are therefore to encourage the Committee to engage with work that problematises the assumption that forms of harm are the product of AOD

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[7] Seear, K. (early online). Shifting solutions: tracking transformations of drugs, health and the 'human' through human rights processes in Australia, *Health Sociology Review*.
[8] See for example: https://adf.org.au/talking-about-drugs/power-words/
[9] Hatzenbuehler, M. L., Phelan, J. C. & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813-821; Link, B. G. & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385; Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry, 19*(2), 137-155.
[10] For a more detailed discussion, see: Seear, K., Lancaster, K. & Ritter, A. (2017). A new framework for evaluating the potential for drug law to produce stigma: Insights from an Australian study. *Journal of Law, Medicine and Ethics.* 45(4), 596-606.
[11] United Nations Office on Drugs and Crime, *World Drug Report 2008*, https://www.unodc.org/documents/wdr/WDR_2008/WDR_2008_eng_web.pdf.
[12] United Nations Office on Drugs and Crime, *World Drug Report 2016,* (United Nations publication, Sales No. E.16.XI.7). https://www.unodc.org/doc/wdr2016/WORLD_DRUG_REPORT_2016_web.pdf.
[13] Seear, K. (2020). Drug policy's past, present and future: Where should Australia head now? *Alternative Law Journal*, *45*(4), 254-260.

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themselves, and to ensure the forms of harm shaped by other forces including law, policy and practice, such as criminalisation, are not neglected or forgotten as part of the Committee's work. For these reasons, we recommend:

> **Recommendation 1: When assessing the 'health impacts' of AOD, and/or the 'health, social and economic harms' (term of reference b) of AOD, the Committee should adopt a broad understanding of key concepts such as the 'impacts', and 'harms' that can be associated with AOD, including an expansive and critical approach to how impacts and harms might arise. This includes critical reflection on the role of law and policy in shaping such impacts and forms of harm.**
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> **Recommendation 2: When assessing the 'health impacts' and/or 'harms' of AOD, the Committee should remain cognisant of and open to the possibility that for many people who use AOD, there are few or no adverse harms, and/or that the effects of consumption are complex and variable. This includes maintaining an awareness of the pleasurable and beneficial aspects of consumption.**
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> **Recommendation 3: In the conduct of this Inquiry and in the production of its report, the Committee consider the important role of language, including the potential for language to generate, exacerbate and magnify harms, including AOD-related stigma. This may necessitate a move away from language that is often thought to be stigmatising including the use of terms such as 'substance abuse', 'substance misuse', recovery', 'addiction', 'addict', and 'substance use disorder'.**

In the next sections we focus on some specific issues within our area of expertise.

Term of reference a – Services and funding

Term of reference a invites reflection on whether current services across the AOD sector are delivering equity for all Australians, value for money, and the best outcomes for individuals, their families, and society. The focus on the performance of the AOD sector in delivering equity and value for money ignores structural, long-standing issues that the sector itself has repeatedly identified, such as chronic underfunding; multiple and fragmented reforms at the state and national levels that affect operations; rigid commissioning systems and funding models; siloed workforces; and intersecting sectors and systems of care.[14] The Inquiry appears to be focused on the performance of the current sector, with no mention of how successive policy failures have limited the capacity of the sector to deliver equity and best outcomes. As we discuss below, 'best outcomes' is also a political and contested concept, and deserves close scrutiny by the Committee. Below, we canvass in greater detail some of these historic and long-standing issues and discuss factors that should inform policy formulations of 'best outcomes'.

Investment in the AOD sector

Over the last decade, the Australian AOD sector has produced multiple reports and reviews calling for urgent structural reform of the AOD treatment sector to address different and various funding systems,

[14] Victorian Alcohol and Drug Association (VAADA). (2024). *Care and complexity: Towards a re-designed Victorian AOD service system*. Melbourne. Retrieved from https://www.vaada.org.au/care-and-complexity-towards-a-re-designed-victorian-aod-service-system/.

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data and reporting systems, various philosophies, approaches and models of care and system rigidity that has impeded integrated models of care. Summarised in a recent Victorian report, 'multiple reviews have highlighted longstanding challenges regarding service delivery and client experience in Victoria, including difficulty accessing and navigating the system, a lack of continuity of care, and poor links to other systems (MH, health and family violence, housing)'.[15] We are concerned that the terms of reference focus on the performance of the current sector and ignore the well-documented history of under-funding, reform and fragmentation that contributes to these long-standing issues.

Sustainable, long-term funding structures and models are required to develop a more integrated and coordinated treatment system with the capacity to provide equitable, high quality AOD support and care. According to the 2020-21 pre-budget submission developed by 14 Australian AOD organisations, there is a crisis in 'unmet demand' caused by chronic underfunding that means an estimated 500,000 people have been turned away from treatment.[16] A recent report summarises the current challenges facing the AOD sector in Australia:

> The Victorian AOD treatment system, like those in other states and territories in Australia, cannot meet the community's current need for AOD treatment. Chronic underfunding sees demand for AOD treatment far exceeding capacity, with significant wait times. Past reforms, designed to improve demand pressures and make the AOD system more efficient and effective have not remediated demand and have contributed to other problems.[17]

This unmet demand leads to long delays in accessing treatment that exacerbate the social, health and political harms people who use drugs experience and increasing healthcare costs.

As much research has noted, chronic under-funding has been compounded by multiple reforms and changing funding structures. Many of these have been tied to episode of care models and activity units that encourage time-limited treatment episodes and 'gaming' of the system,[18] among other things. According to the pre-budget submission, insufficient funding also acts as a 'barrier to recruiting and retaining a specialist alcohol and other drugs treatment workforce'.[19] In the Victorian context, prior to the recommissioning and reform of Victorian AOD treatment services in 2013-14, a review of the effectiveness of alcohol and other drug prevention and treatment services was undertaken in 2011.[20] The VAGO report identified several problems related to funding and service delivery in the existing Victorian treatment system, which, since 1994-5, had been based on a payment model characterised by 'episodes of care'. The VAGO report argued that this system measured 'output over outcomes',

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[15] Victorian Alcohol and Drug Association [VAADA]. (2024). *Care and complexity: Towards a re-designed Victorian AOD service system*. Melbourne. Retrieved from https://www.vaada.org.au/care-and-complexity-towards-a-re-designed-victorian-aod-service-system/.

[16] *Reforming Australia's alcohol and other drugs treatment sector: 2021 Pre-budget submission.* Australia. Retrieved from: https://treasury.gov.au/sites/default/files/2020-09/115786_ST_VINCENTS_HEALTH_AUSTRALIA_-_SUBMISSION_1.pdf

[17] VAADA. (2024). *Care and complexity: Towards a re-designed Victorian AOD service system*. Melbourne. Retrieved from https://www.vaada.org.au/care-and-complexity-towards-a-re-designed-victorian-aod-service-system/.

[18] Moore, D. & Fraser, S. (2013). Producing the 'problem' of addiction in drug treatment. *Qualitative Health Research*, *23*(7), 916-923.

[19] *Reforming Australia's alcohol and other drugs treatment sector: 2021 pre-budget submission.* Australia. Retrieved from: https://treasury.gov.au/sites/default/files/2020-09/115786_ST_VINCENTS_HEALTH_AUSTRALIA_-_SUBMISSION_1.pdf

[20] Victorian Auditor-General's Office. (VAGO). *Managing drug and alcohol prevention services.* Retrieved from: https://www.audit.vic.gov.au/sites/default/files/20110302-AOD.pdf

allocated inadequate resources to 'complex clients' and encouraged the deliberate opening and closing of episodes to extend the length of treatment and boost the perceived level of service activity.

In response to the issues identified in the VAGO review (and in addition to a longstanding interest in sector reform), the state government instituted a reform of the treatment system and services in 2013-14, moving to an activity-based funding unit, which enables governments to more easily track where money is being spent. Although there has been little research evaluating the impacts and effects of the reform, the most recent Victorian review suggests that the most significant change—the development of a centralised intake and assessment service—is not working well because intake points and procedures are not transparent to the public or other care systems.[21] Service users are also required to travel further to distinct access points to access treatment and pre-existing relationships with local service providers and supports were disrupted.

In summary, successive reports and reviews highlighted here have pointed out that chronic underfunding and hastily implemented reforms have contributed to a rigid service system that has 'stifled innovation' and 'disempowered the workforce'.[22] These structural impediments produce a range of negative consequences for highly marginalised and stigmatised people seeking help. Therefore, we need a comprehensive approach to sustainable AOD sector funding and system reform to 'deliver value for money' and reduce harms associated with AOD use.

> **Recommendation 4: That this Inquiry recommend a comprehensive approach to sustainable AOD sector funding and system reform to 'deliver value for money' and reduce harms associated with AOD use.**

Peak and peer organisation funding

Australia was an early leader in its commitment to supporting harm reduction, funding the prevention of blood-borne viruses, HIV and hepatitis C, through establishing needle and syringe programs. The treatment landscape for these viruses has changed dramatically over the decades, and Australia has followed the World Health Organization's ambitions to eliminate these as public health priorities by 2030. The next (forthcoming) national hepatitis C strategy is touted to be the final one, based on the assumption that hepatitis C will no longer require a coordinated funded approach. Many peer-led organisations are the only organisations in reach to some people who consume drugs, funded to provide harm reduction as well as advocacy, care and access to life-saving medications, such as naloxone. We are concerned that redirecting or reducing funding from these services under the premise that we have reached 'elimination' targets or made significant advances on them would have significant implications for the funding of these essential services. As we suggest, there is a need for a broader approach and understanding of the harms associated with drugs, and argue for the government to take a major step toward a broader conceptualisation of harm reduction care that is not framed by the diseases associated with these practices, but people's quality of life, other social and systemic factors that shape health, human rights, and the need for a diverse and robust AOD service sector.

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[21] VAADA, 2024. *Care and complexity: Towards a re-designed Victorian AOD service system*, Melbourne. Retrieved from https://www.vaada.org.au/care-and-complexity-towards-a-re-designed-victorian-aod-service-system/.
[22] Victorian Alcohol and Drug Association [VAADA]. (2024). *Care and complexity: Towards a re-designed Victorian AOD service system.* Melbourne. Retrieved from https://www.vaada.org.au/care-and-complexity-towards-a-re-designed-victorian-aod-service-system/, p. 6.

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Recommendation 5: That the government commit to ongoing funding of peak and peer organisations and recommend state and territories do the same including beyond the point of the conclusion of the next National hepatitis C Strategy and/or elimination.

Improving equity

In addition to regional and rural communities, the AOD sector has not received significant investment or funding to develop gender and sexuality-specific services. It is now reported that LGBTIQ+ people consume AOD at almost twice the rate of others[23] and 'are more likely to misuse alcohol and other drugs […] compared to the general population'.[24] Research suggests that LGBTIQ+ people report more family dysfunction and have experienced more violent crime, sexual, physical and emotional abuse and accumulated trauma than heterosexual people, which may result in higher rates of AOD consumption.[25] Engagement with AOD treatment by LGBTIQ+ people is also understood to be 'often precluded [due to] insensitivity and misunderstanding' of gender and sexuality issues.[26] While there is a clear need to direct more support and develop targeted gender and sexuality-specific services, chronic underfunding has impeded the development of culturally safe AOD services.

Recommendation 6: That the government commit to funding culturally safe AOD services including for LGBTIQ+ populations.

Employment and workforce capacity

Employing people with lived and living experience in the AOD sector contributes to more effective services and better outcomes for people accessing services, their families, supporters and communities.[27] In response to recommendations outlined in the *Royal Commission into Victoria's Mental Health System*,[28] efforts to invest and expand a lived and living experience workforce in the AOD sector have been embedded into government workforce frameworks[29] and strategies.[30] Yet efforts to resource and support the needs of this unique and criminalised workforce remains underexplored. Existing research has documented that a high prevalence of lived and living experience workers in the AOD sector in Australia face stigma and discrimination.[31] Importantly, and as described in more detail in sections

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[23] Hill, A., Lyons, A., Jones, J., McGowan, I., Carman, M., Parsons, M., ... & Bourne, A. (2021). *Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia.* National report.
[24] Mullens, A. B., Fischer, J., Stewart, M., Kenny, K., Garvey, S. & Debattista, J. (2017). Comparison of government and non-government alcohol and other drug (AOD) treatment service delivery for the lesbian, gay, bisexual, and transgender (LGBT) community. *Substance Use & Misuse*, *52*(8), 1027-1038.
[25] Wishart, M., Davis, C., Pavlis, A. & Hallam, K. T. (2020). Increased mental health and psychosocial risks in LGBQ youth accessing Australian youth AOD services. *Journal of LGBT Youth*, *17*(3), 331-349.
[26] Mullens, A. B., Fischer, J., Stewart, M., Kenny, K., Garvey, S. & Debattista, J. (2017). Comparison of government and non-government alcohol and other drug (AOD) treatment service delivery for the lesbian, gay, bisexual, and transgender (LGBT) community. *Substance Use & Misuse*, *52*(8), 1027-1038.
[27] Victorian Government Department of Health. (2023). Workforce initiatives: lived and living experience workforces (LLEWs). Available from https://www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives (accessed 1st September 2023)
[28] Victoria, Royal Commission into Victoria's Mental Health System, *Final Report* (2021) ISBN 978-1-925789-64-5.
[29] Department of Public Health. (2023). Our workforce, our future: A capability framework for the mental health and wellbeing workforce report. Retrieved from https://www.health.vic.gov.au/our-workforce-our-future.
[30] Department of Public Health. (2021). Victoria's mental health and wellbeing workforce strategy 2021–2024 report. Retrieved from https://www.health.vic.gov.au/publications/mental-health-workforce-strategy.
[31] See, for example: Kostadinov, V., Skinner, N. & Duraisingam, V. (2023). Workers with lived and living experience: Characteristics and wellbeing in the Australian AOD Sector. *Contemporary Drug Problems*, *50*(4), 527-540; Kostadinov, V.,

below, the law plays a central role in producing (and consequently addressing) harms related to alcohol and other drugs. As such, the inherent risks associated with being employed to undertake this work in a context of prohibition (including routine exposure to criminalisation and stigma) must be mitigated to ensure the safety and security of employees. Organisations employing living and lived experience workers within the AOD sector must have clear processes in place for supporting this workforce or risk exacerbating harms they are seeking to address.

> **Recommendation 7: That organisations employing living and lived experience workers within the AOD sector must have clear processes in place for supporting this workforce or risk exacerbating harms they are seeking to address and the governments provide resourcing if necessary to enable this work to be undertaken.**

Best outcomes for whom?

The concept of 'best outcomes' and outcome monitoring in general should be approached carefully by the Committee: desired outcomes differ among people who use AOD, and between people who use AOD, their families and friends and 'society', in which stigmatised perceptions of use circulate.[32] Importantly, outcomes should be conceived broadly and not reduced solely to individual-level outcomes such as abstinence or recovery. Since the late 1980s, harm reduction has been the primary approach underpinning AOD policy and treatment in Australia. Although scholars have continued to analyse and debate the principles, values and regulatory effects of harm reduction, harm reduction policy and practice is supported by a significant body of sociological and epidemiological research as well as illicit drug policy analysis, which has highlighted the effectiveness of harm reduction interventions and practice in Australia. While 'new' concepts such as 'recovery' and 'trauma-informed practice' are frequently lauded in Australia for their capacity to transform drug treatment and produce 'best outcomes', their evidence base is less reliable and weaker than the decades long evidence for harm reduction.[33]

Relatedly, any consideration of 'best outcomes' should be developed in consultation with peer organisations and peak bodies, who are well placed to provide an evidence-based assessment of the strengths and weaknesses of the existing system and to identify potential areas for reform, informed by, and in collaboration with, key stakeholders and people who use AOD. While the AOD sector is well-placed to deliver significant health and social outcomes with a new funding model and multi-disciplinary collaboration and integration, improving AOD-related outcomes should also be considered in relation to strategies to minimise drug-related stigma, criminalisation and discrimination and social justice reforms that ensure the health, wellbeing and safety of people who use drugs, such as housing, a basic income and universal access to high-quality healthcare.

> **Recommendation 8: If approaches to AOD sector funding, policy, and/or law/regulation are to take 'best outcomes' into account, a set of principles regarding what constitutes 'best outcomes should be developed in consultation with peer organisations and peak bodies, who are well placed to provide an evidence-based**

Roche, A., McEntee, A., Duraisingam, V., Hodge, S. & Chapman, J. (2021). Strengths, challenges, and future directions for the non-government alcohol and other drugs workforce. *Journal of Substance Use, 26*(3), 261-267.
[32] Savic, M. & Fomiatti, R. (2016). Producing 'progress' through the implementation of outcome monitoring in alcohol and other drug treatment. *Contemporary Drug Problems*, *43*(2), 169-187.
[33] Fomiatti, R., Pienaar, K., Savic, M., Keane, H. & Treloar, C. (2023). Improving understandings of trauma and alcohol and other drug-related problems: A social research agenda. *International Journal of Drug Policy*, *121*, 104198.

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assessment of the strengths and weaknesses of the existing system and to identify potential areas for reform, informed by, and in collaboration with, key stakeholders and people who use AOD.

Term of reference c – The role of sectors

Term of reference c invites reflection on the role that numerous sectors including education, employment, justice, social services and housing can contribute to prevention, early intervention, recovery and reduction of alcohol and other drug-related harms in Australia. As we noted earlier in this submission, the various effects (including harms) that can be associated with AOD are shaped by a range of forces including structures and systems such as law and policy itself. Thus, in this section, we emphasise the way that these systems might be reformed.

Legal and justice issues

The law plays a central role in generating, magnifying, exacerbating (and thus ameliorating) AOD-related harms. It does so in several ways, including through laws that criminalise drug use, possession and supply, thus exposing people to criminalisation and stigma, incarceration and social exclusion. In this sense, criminal laws exacerbate social disadvantage and generate other social problems, such as the persistent effect of criminal records on employment, housing, welfare and so on.[34] This is a subject about which a great deal has been written, including by some of the authors of this submission. Members of our team have written extensively on the role that drug laws, policies and practices can play in producing the very problems they hope to address, including problems which are presumed to pre-exist law, policy and practice (and thus to arise naturally, principally or solely from drugs themselves). Some examples of issues that shape harms include:

- Laws that criminalise drug use, possession and supply;
- Diversion practices and policies, including policies that limit access to diversion (e.g. by age, or to a maximum number of diversions, or that require an admission of guilt as a precondition of access);
- Laws outside the criminal law which enable punitive measures and/or responses to drugs, such as laws that enable people to be evicted from public housing in the event of their association with drugs, thereby increasing the risk of homelessness, disconnection from communities and services and precarity more broadly;
- Underfunding of legal services, including community legal centres and legal aid organisations which provide vital supports to people in contact with the justice system, and who can help them navigate these systems, including by supporting them to access diversion, seek treatment if they are interested and/or eligible;
- Laws that criminalise 'peer distribution' or 'secondary supply' of needles and syringes, and thus increase both the risk of blood-borne virus transmission, and the risk of criminalisation. These

[34] See, for example: Seear, K. (2020). *Law, drugs and the making of addiction: Just habits.* Routledge: London; Seear, K. (2020). Drug policy's past, present and future: Where should Australia head now? *Alternative Law Journal*, 45(4): 254-260; Seear, K. (2020). Addressing alcohol and other drug stigma. Where to next? *Drug and Alcohol Review*, *39*, 109-113; Seear, K., Lancaster, K. & Ritter, A. (2017). A new framework for evaluating the potential for drug law to produce stigma: Insights from an Australian study. *Journal of Law, Medicine and Ethics,* 45(4), 596-606; Seear, K. & Fraser, S. (2014). Beyond criminal law: The multiple constitution of addiction in Australian legislation. *Addiction Research & Theory, 22*(5), 438-450; Seear, K. & Fraser, S. (2014). The addict as victim: Producing the 'problem' of addiction in Australian victims of crime compensation. *International Journal of Drug Policy, 25*(5), 826–835.

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laws have been amended in some states and territories based on the work of the lead author and others, but there should be a uniform national approach where peer distribution is legalised to be consistent with Australia's overarching policy or harm minimisation;
- The lack of laws to regulate workplace alcohol and other drug testing, which can have detrimental effects on people's employment;
- The lack of legal protections for people who use medicinal cannabis and can fall afoul of roadside drug testing and workplace drug testing regimes; and
- The lack of legal protections for people who use drugs or have a history of using drugs accessing insurance who may be discriminated against in a way that is not justifiable and proportionate and often do not have access to the actuarial or statistical data upon which any discrimination is based.[35]

Although there are important overlaps between the issues described in this section, human rights and prisons, we have separated those issues out in the sections to follow.

Recommendation 9: The Committee should give consideration to opportunities for moving towards a formalised (*de jure*) system for the decriminalisation of illicit drugs or legalisation.

Recommendation 10: That the Commonwealth work with the states and territories to implement comprehensive and consistent, nationwide reforms to a number of areas of policy and law that impact the health, economic and social outcomes of people who use AOD, including laws pertaining to secondary supply of needles and syringes for people who inject drugs.

Recommendation 11: That the Commonwealth implement a national law to govern the operation of workplace drug testing.

Recommendation 12: That the Commonwealth amend the Disability Discrimination Act to mandate that any discrimination in insurance must be justifiable and proportionate and that insureds be given access to the actuarial or statistical data upon which insurance decisions are based upon request.

Recommendation 13: That the Commonwealth take appropriate steps to end punitive responses to people who use drugs in public housing.

Human rights issues

Importantly, people who use AOD (and others involved in drug markets) are often subjected to human rights violations of various kinds. These should be properly understood as AOD-related harms in and of themselves given that people who use drugs have not forfeited their right to rights, but also because human rights violations can make people who use drugs vulnerable to other harms, including illness, injury and death. Additionally, human rights have the capacity to operate as a protective mechanism for people who use drugs (and others involved in drug markets) and thus can play an important role in harm reduction and general health and wellbeing. In this section of our submission, we examine some of the

[35] Mulcahy, S., Seear, K., Fraser, S., Farrugia, A., Kagan, D., Lenton, E., Elphick, L. & Holas, N. (2022). Insurance discrimination and hepatitis C: Recent developments and the need for reforms. *Insurance Law Journal, 32*(2), 92-105.

current challenges pertaining to human rights and drug law, policy and practice in Australia, based on these observations about the interdependence of health and rights.

There are growing calls around the world to better recognise the human rights of people who use drugs. The importance and value of human rights is recognised in Australia's *National Drug Strategy 2017-2026*, and in the associated *Fifth National Hepatitis C Strategy: 2018-2022*. For instance, the *National Drug Strategy* recognises the value of reducing the adverse social, economic and health consequences associated with AOD and avoiding policies and practices that 'unintentionally further marginalise or stigmatise people who are at higher risk of experiencing alcohol, tobacco and other drug related harm', and includes a goal to 'eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health'.[36]

A useful starting point for analysing Australia's performance on human rights issues is the inaugural Global Drug Policy Index, which assesses the drug policy performance of an initial thirty nations on a range of measures.[37] Each country receives scores out of 100 on a range of different measures, including human rights, and then an overall score out of 100. Australia's overall score was 65/100, and we ranked 5th out of the 30 countries analysed. Although Australia did well on some measures, we scored poorly on others, including:

- 59/100 – human rights violations
- 25/100 – equity of the impact of criminal justice responses
- 25/100 – imprisonment for non-violent drug offences
- 33/100 – decriminalisation
- 61/100 – harm reduction funding
- 33/100 – equity of access to harm reduction
- 44/100 – equity of access to controlled medicines for pain and suffering

Our performance on human rights is unsurprising. Australia lacks an overarching bill of rights that provides human rights protections across the nation, and this gap in the legal infrastructure arguably exposes people who use drugs to rights violations of various kinds. Australia's approach to the human rights of people who use drugs is also shaped by how drugs are conceptualised, and how key human rights mechanisms (such as parliamentary human rights scrutiny) are operationalised. To this end it is important to say a few words about the way that Australia's system of parliamentary human rights scrutiny (in operation in the Australian Capital Territory, Victoria, Queensland and the Commonwealth) works, and how this has approached questions at the intersection of AOD and human rights.

Two authors of this submission (Seear and Mulcahy) have undertaken extensive research on these issues. Their work draws on: 1) analyses of parliamentary human rights scrutiny processes pertaining to AOD legislation in the aforementioned four jurisdictions with scrutiny mechanisms; 2) in-depth, semi-structured interviews with key stakeholders involved in these parliamentary human rights scrutiny processes, including former and current members of parliament, their staff and others directly involved in scrutiny processes (including human rights advisors to scrutiny committees, scrutiny committee staff and parliamentary counsel); and 3) in-depth, semi-structured interviews with human rights experts from around the world. Their research has found, among other things, that:

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36 Department of Health. (2017). *National Drug Strategy 2017-2026*. Commonwealth of Australia: Canberra, 26.
37 For an overview, see: https://hri.global/publications/the-global-drug-policy-index/

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1. The rights of people who use drugs are frequently limited in parliamentary human rights scrutiny processes;

2. When proposed laws are scrutinised for their human rights compatibility, and assessments are undertaken to determine the proportionality of any rights limitations within the law, the nature, quality and extent of the justifications that are offered for limiting peoples' rights vary considerably;[38]

3. The explanations offered for rights limitations often rely on simplistic accounts of AOD problems and solutions. For instance, limitations of the rights of people who use AOD are often said to be justifiable simply on the basis that AOD are inherently 'unsafe', with often no attempt to explain how and why this is so beyond generalised claims about AOD harms. For instance, alcohol consumption is often simply treated as causing or 'fuelling' violence without considering the gendered nature of such violence or important differences on consumptive practices.[39] So, we argue, assessments of rights limitations often lack quality, rigour and nuance;

4. Assessments of rights compatibility rely heavily on how those undertaking assessments understand the issues that are adjudged to be central to the assessment, or whether they bring assumptions into the assessment (e.g. that AOD cause harms).[40] These assessments are often subjective and contestable but have important implications for people who use AOD. In other work, the lead author of this submission has argued that this is partly about assessing how assumptions about problems, AOD effects and harms (and thus solutions) shape how decision makers approach their work;[41]

5. People who use AOD may be limited in terms of their capacity to participate in political processes, including because of stigma, criminalisation and other factors that shape their ability to be involved in the processes that profoundly affect their lives.[42] There is a broad need to provide more opportunities for parliamentary scrutiny committees to hear evidence from affected communities, including through open inquiries, to improve how rights issues are conceptualised and determined, and to thus minimise the possibility of instantiating harms through the legal regulation of AOD.[43]

In previous work, including in a submission to the recent Parliamentary Joint Committee on Human Rights' inquiry into Australia's human rights framework, some authors of this submission called for

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[38] See: Mulcahy, S. & Seear, K. (in press). A culture of rights finding its feet: Parliamentary human rights scrutiny in the Australian Capital Territory. *The Journal of Legislative Studies*; Seear, K. (2020). *Law, drugs and the making of addiction: Just habits.* Routledge: London.
[39] Duncan, D., Moore, D., Keane, H. & Ekendahl, M. (2022). Obscuring gendered difference: The treatment of violence in Australian government alcohol policy. *Social Politics: International Studies in Gender, State and Society*, *29*(3), 1057-1079; Moore, D., Keane, H., Ekendahl, M. & Graham, K. (2022). Gendering practices in quantitative research on alcohol and violence: Comparing research from Australia, Canada and Sweden. *International Journal of Drug Policy*, *103*, 103669.
[40] Seear, K. & Mulcahy, S. (Early online). Forging new habits: Critical drugs scholarship as an otherwise to rights. *International Journal of Human Rights;* Seear, K. (2020). *Law, drugs and the making of addiction: Just habits.* Routledge: London.
[41] Seear, K. (Early online). Shifting solutions: Tracking transformations of drugs, health and the 'human' through human rights processes in Australia. *Health Sociology Review.*
[42] Seear, K. & Mulcahy, S. (In preparation). Troubling human rights in the matterphorical lawscape: A dopesick ontology.
[43] Mulcahy, S. & Seear, K. (In preparation). Mournful mothers and damaged damsels: Are we really listening to women during parliamentary human rights scrutiny?; Mulcahy. S. & Seear, K. (In preparation). Making and breaking 'bad' habits in drugs, law, and human rights scrutiny.

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Australia to introduce a national bill or charter of human rights.[44] This has the potential, we argue, to help advance the health and wellbeing of people who use drugs and to ameliorate some of the adverse effects we have discussed in this submission. It could also help protect rights in treatment settings, including where human rights are at risk, including rights to privacy and bodily autonomy. However, other measures are also needed to advance and strengthen rights. This includes issues we have identified in our previous research relating to structural issues with parliamentary human rights scrutiny, such as training of those involved in scrutiny work, timelines for legislative scrutiny, and the limited ability for 'outsider' input into this work.[45]

> **Recommendation 14: A national bill or charter of rights be introduced in line with the Australian Human Rights Commission's position paper, *A Human Rights Act for Australia***
>
> **Recommendation 15: All parliamentarians, relevant parliamentary staffers, and relevant public servants receive training, provided by the Australian Human Rights Commission or another properly resourced and appropriate body. At a minimum, such training should cover the operation of parliamentary human rights scrutiny processes and the legal obligations of public authorities and public servants, including procedural and substantive obligations. If a national bill or charter of human rights is introduced, training should be extended to cover, at a minimum, the dimensions and operation of the bill/charter including any parliamentary human rights scrutiny processes and the legal obligations of public authorities, as well as public servants.**
>
> **Recommendation 16: Wherever possible, and unless there is genuine urgency for a bill to be reviewed and brought before parliament, clear public timelines for rights scrutiny processes be established and reflected in standing orders so that legal advisors and other experts (such as peak and peer organisations, or other civil society organisations) have adequate time to review bills and provide advice, and so that relevant committees have more time to review and assess all relevant information when scrutinising bills for their human rights compatibility.**
>
> **Recommendation 17: Resourcing for key agencies and organisation to be increased to enable them to expand their advocacy on human rights issues including the provision of rigorous, detailed and quality input into rights processes (e.g. through parliamentary submissions). These organisations should include the Australian Human Rights Commission, community legal centres and legal aid organisations, and non-governmental organisations including national peak and peer organisations for people who use drugs.**

Importantly, a recent landmark Victorian coronial decision into the death in custody of Aboriginal woman Veronica Nelson found that drug-related stigma had contributed to her death and that stigma was a human rights issue.[46] The particular legal basis of this finding was that her treatment had been

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[44] Seear, K., Mulcahy, S., Farrugia, A., Moore, D., Fraser, S., Treloar, C., Lenton, E., Kagan, D., Nourse, G. and Zuluaga, A. (2023). *Submission to the Parliamentary Joint Committee on Human Rights Inquiry into Australia's Human Rights Framework.*
[45] Mulcahy, S. & Seear, K. (Forthcoming). A culture of rights finding its feet: Parliamentary human rights scrutiny in the Australian Capital Territory. *The Journal of Legislative Studies*; Mulcahy, S. & Seear, K. (2022). On tables, doors and listening spaces: Parliamentary human rights scrutiny processes and engagement of others. *Australian Journal of Human Rights, 28*(2-3).
[46] McGregor, S. (2023). *Inquest into the death of Veronica Nelson.* Coroner's Court of Victoria.

'cruel, inhuman and degrading' within the meaning of section 10 of the Victorian Charter for Human Rights and Responsibilities, a section modelled on Article 7 of the *International Convention on Civil and Political Rights* and thus of broader applicability (i.e. beyond Victoria, and the Charter jurisdictions, and beyond custodial settings). In the Inquest the Coroner found that stigma was pervasive in some aspects of the custodial system in Victoria and that in the context of Ms Nelson's treatment and death, had 'causally contributed to Veronica's passing'.[47] The Coroner also found it inherently stigmatising that prisoners 'are inhumanely not afforded the suite of pharmacotherapy that would otherwise be available to them in the community', such that they might be 'forced into voluntary withdrawal', and that 'prisoners who do access substitution therapy may be removed from the program for non-compliance'.[48]

The lead author has argued that this decision has far-reaching implications for a range of sectors in Australia including AOD treatment settings.[49] As she argues:

> [The Nelson case] is an important departure from logics that so often operate in drug law, policy and practice, including in settings as diverse as: opioid substitution therapy; voluntary and involuntary drug treatment; and in drug courts. In all of these settings (as well as others), shame, humiliation, and other kinds of cruelty are assumed not only to be lawful, but to be *necessary and productive*: a means of initiating change, abstinence or 'recovery', and of fixing apparently 'disordered' subjects (see, for example, Fomiatti, Moore and Fraser 2019; Sarmiento, Seear and Fraser 2019; Murphy 2011; Vrecko 2009; Fitzgerald 2008; Moore 2007), or for protecting others such as children (Flacks 2021). In this sense the decision also breaks with certain longstanding habits in law and legal thinking including those that 'naturalise' or normalise drug-related harms and drug-related suffering. The decision constitutes such suffering as neither deserved nor acceptable, natural nor inevitable, and instead positions it as preventable and cruel. In doing so, the Coroner's finding opens up the possibility that other practices pertaining to drugs, including in law, might be unlawful and in need of remedying.[50]

Seen this way the Nelson decision has implications for various sectors and settings, and necessitates a careful review of existing approaches to ensure they do not replicate the dynamics identified by the Coroner in that case. This includes, for instance, ensuring: equivalence of care in custodial settings in accordance with the Mandela Rules (discussed below) and the Bangkok Rules; and a review of practices in other settings including in approaches to withdrawal, the logics and standards of care in use.

> **Recommendation 18: That relevant Commonwealth Departments undertake a review of systems in light of the findings in the Inquest into the death of Veronica Nelson to ensure that systems do not produce cruel, inhuman or degrading treatment and AOD-related stigma of the kind documented in the Coroner's findings. This includes at a minimum, measures to ensure equivalence of care in custodial settings through working with responsible state and territory departments/agencies.**

In the next section we consider some additional issues at the intersection of health, prison settings and human rights.

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[47] Coroners Court of Victoria 2023: 235.
[48] Coroners Court of Victoria 2023: 179.
[49] Seear, K. (Forthcoming). Remembering Poccum: Stigma, suffering, torture and rupture after the death of Veronica Nelson. In: Flacks, S. and Seear, K. (eds.) *Judging Drugs*. Cambridge: Cambridge University Press.
[50] Seear, K. (Forthcoming). Remembering Poccum: Stigma, suffering, torture and rupture after the death of Veronica Nelson. In: Flacks, S. and Seear, K. (eds.) *Judging Drugs*. Cambridge: Cambridge University Press.

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Prison systems

The UNODC, WHO, UNAIDS and many others argue that a package of harm reduction supports should be made available to people who inject drugs. This is also noted in the aforementioned *National Hepatitis C Strategy 2018-2022*. Australia was an early adopter of harm reduction measures including needle and syringe programs (NSPs). At NSP sites, which can be fixed or mobile, sterile injecting equipment is freely distributed to people who inject drugs. This practice has long been recognised as an essential part of the strategy to minimise hepatitis C transmission because it helps to reduce needle sharing. Onward distribution of sterile needles and syringes by people who use drugs has also been a common practice in Australia and been instrumental in preventing transmission. This is a testament to people who inject drugs and peer-based drug user organisations and others in the response.

Importantly, several countries have extended NSPs into prisons. There are now more than 60 in place worldwide. Crucially, Australia still does not have a prison NSP. Prison NSPs are an extremely valuable harm reduction service, with many potential benefits including the prevention of AOD-related harms such as hepatitis C transmission, including reinfection. They are increasingly important in the context of Australia's ambition to be the first nation to eliminate hepatitis C, including because a relatively high number of prisoners live with hepatitis C, and because reinfection with the virus can take place in prison. Research shows that many people are treated in prison—with some research showing that in 2020, 37% of all hepatitis C treatments were delivered to people in prisons. The reinfection rate within prisons is 'high', meaning that prevention is also a missed opportunity within prisons.[51] As the lead author has elsewhere argued, the absence of prison NSPs also represents a major human rights violation, as supported by numerous international human rights principles and instruments. For instance, Principle 9 of the *United Nations Basic Principles for the Treatment of Prisoners*—which are often called 'the Mandela Rules'—states that: 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'. Some interpret this to mean that where countries offer NSPs outside prisons, there is a positive obligation to provide them within prisons. As well, principle 24 of the *World Health Organization Guidelines on HIV Infection and AIDS in Prisons* states that in countries where NSPs operate within the community: 'Considerations should be given to providing clean injecting equipment during detention and on release to prisoners who request this'. The Bangkok Rules for women prisoners are also relevant here.[52]

As we noted earlier, human rights are also explicitly mentioned as a guiding principle of the national hepatitis C strategy. The strategy states that 'People with hepatitis C have a right to participate fully in society, without experience of stigma or discrimination', and that they have the same rights as everyone else to comprehensive care and information. We are currently failing in this respect, however, with prisoners denied access to these vital services. Therefore we need a comprehensive implementation plan for prison NSPs in order to reduce harms that can be associated with injecting drug use.

> **Recommendation 19: That the Commonwealth support the states and territories to develop a comprehensive implementation plan for prison NSPs in order to reduce harms that can be associated with injecting drug use.**

Social services

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[51] Hajarizadeh, B., Carson, J. M., Byrne, M., Grebely, J., Cunningham, E., Amin, J., ... & Anlezark, J. (2024). Incidence of hepatitis C virus infection in the prison setting: The SToP-C study. *Journal of Viral Hepatitis*, *31*(1), 21-34.
[52] https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf

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Service systems are often poorly resourced to meet the needs of people who use AOD and have other support needs relating to health, housing, disability, employment, education, or material circumstances. People who use AOD can be excluded from services because of these resource constraints, including people who have experienced domestic and family violence.[53] Although it is quite usual for people to need support in multiple areas of their life, this can be cast as 'complex needs' or 'at risk'. In this way, resource gaps in services, and the systemic responses to AOD use, become wrongly attributed to the characteristics of the person needing support. 'Complex needs' are a product of service systems, not characteristics of people.[54] To address this, casework and other support in human support and service agencies need to have adequate capacity to support people who use AOD as part of their core business, and AOD use (including intoxication) must not be grounds for exclusion from a service, or used as a reason to refer on rather than accept a person as a client. In some cases, this will require investment in staff capacity and skills, and modification of built environments to ensure safety and trauma-informed care for all clients.[55]

Child protection and family support services are feared and avoided by many parents, especially mothers, who use AOD.[56] Many people have well-founded fears that responses from these services will be punitive and obtrusive, to the point of removal of children from their care. AOD use many be treated as grounds for identification of a child being at risk of harm and is included in risk assessment tools and procedures when the safety of children is investigated.[57] Although reducing rates of child removal is a policy priority, there are still many instances of separation of families in which parents are AOD users. This is because service systems cannot respond with care and support and is a significant example of the harm caused by the social organisation of AOD use. This harm is borne disproportionately by First Nations families and communities.

> **Recommendation 20: That capacity is built in human support and service agencies to ensure that people who use AOD and have additional support needs are provided with high quality, trauma-informed care.**

Education issues

Although our submission does not include a detailed discussion of AOD education, we do wish to bring to the Committee's attention the important work of Dr Adrian Farrugia, also based at La Trobe University, on the ways that drug education can both ameliorate and generate harms, including gendered harms.

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[53] valentine, k., Cripps, K., Flanagan, K., Habibis, D., Martin, C. & Blunden, H. (2020). *Inquiry into integrated housing support for vulnerable families*. https://www.ahuri.edu.au/research/final-reports/339
[54] valentine, k. (2015). Complex needs and wicked problems: how social disadvantage became multiple. *Social Policy and Society*, *15*(2), 237-249.
[55] Robinson, S., valentine, k., Marshall, A., Burton, J., Moore, T., Brebner, C., O'Donnell, M. & Smyth, C. (2022). *Connecting the dots: Understanding the domestic and family violence experiences of children and young people with disability within and across sectors.* Australia's National Research Organisation for Women's Safety Limited (ANROWS).
[56] valentine, k., Smyth, C. & Newland, J. (2019). 'Good enough' parenting: Negotiating standards and stigma *International Journal of Drug Policy*, *68*, 117-123.
[57] Henry, C., Liner-Jigamian, N., Carnochan, S., Taylor, S. & Austin, M. J. (2018). Parental substance use: How child welfare workers make the case for court intervention. *Children and Youth Services Review*, *93*, 69-78; Roscoe, J. N., Lery, B. & Chambers, J. E. (2018). Understanding child protection decisions involving parents with mental illness and substance abuse. *Child Abuse & Neglect*, *81*, 235-248.

We endorse Dr Farrugia's recommendations to critically examine the role of drug education in this context, including through work that looks at broader questions such as the effects of drug education.

Conclusion

We thank the Committee for the opportunity to make this submission and for their time and consideration and can be contacted via the corresponding author if any further details are required on our submission.

Yours sincerely,

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