Special Commission of Inquiry into the Drug ‘ice’
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Sydney, NSW, 2001
Via email: inquiry@iceinquiry.nsw.gov.au

7th May, 2019

Dear Professor Howard, SC

Thank-you for the opportunity to prepare a written submission for the Special Commission.

The Drug Policy Modelling Program (DPMP) is the leading drug policy research and practice program in Australia. Our mission is to improve government decision-making on drugs. We have been conducting research into drug policy, including amphetamine-type stimulants (ATS) policy, for the last 14 years. All the views expressed below are backed up by sound scientific evidence.

We commend the Commission for the broad scope, the sensible questions raised across the four issues papers, and the sense that ‘no stone will be left unturned’. This is extremely positive. It was also pleasing to see the revised terms of reference (TOR) for the Commission expand beyond crystal methamphetamine to all classes within the ATS group, although broadening to all classes of AOD would have been preferable.

By not considering alcohol and other drugs (AOD), the scope of the inquiry still severely limits the opportunities for reducing harms from drugs in NSW. We must stop focussing on single drugs, or drug classes, and focus on all currently illicit drugs, and those legal drugs used illicitly. There are three reasons why a focus solely on ATS (or crystal methamphetamine) is inappropriate and unhelpful:

1. it does not resemble or represent the ways in which NSW people use drugs, with high instances of polydrug use among people who use licit and illicit drugs (Australian Institute of Health and Welfare, 2017);
2. it does not consider harms which can be exacerbated in the context of polydrug use
3. it is supremely unhelpful for designing effective treatment, prevention, harm reduction and law enforcement responses. Treatment is not by drug type – it is based on the whole person, and their needs and initiatives. Similarly, prevention campaigns for young people that focus on a single drug or drug class are only bound to increase stigma (see our response to Issues Paper 3). Finally, law enforcement responses targeting one drug type often lead to a displacement effect onto the use or supply of other illicit drugs.

We would encourage the Commission to consider the application of all the work and options to all drug needs in order to build more effective drug policy responses.
In our response to the Inquiry we have chosen to focus on key issues that we think best reflect “options to strengthen NSW’s response to ATS as per the Inquiry terms of reference, and those issues with which we have direct experience and strong evidence-informed views.

Please find below our 26 recommendations that provide detailed feedback. We identify where these intersect with questions posed in the Issues Papers and have followed the order of the Issues Papers.

All the references referred to in our submission are available directly from us, should the Commission wish to have copies of the original research. We would be pleased to expand on any of the points raised in our submission.

Kind regards

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**Issues Paper 1: Use, prevalence and policy framework**

**Recommendation 1. Measures of harmful consumption should replace the focus on population prevalence of use (1.1.1; 1.1.2)**

Population prevalence measures of drug use have been the focus of most governments for many years (and this is reflected in questions 1.1.1 and 1.1.2 where the Commission is seeking better ways to measure prevalence). However, population prevalence of use is a meaningless measure of the success or otherwise of policies and actions against drug use. The problem with population prevalence of use is that it does not identify either patterns of consumption that may be of concern, nor the harms associated with use. For example, if population prevalence of the use of amphetamines is 5%, those people may have used once in the last year or every day. Clearly there are major differences between infrequent annual use and daily use – and significant differences in the policy implication (as can be seen for example in early DPMP work on the social cost per gram Moore, 2007). This is why measures of the quantity, frequency and/or intensity of use are vital to inform policy (Bewley-Taylor, 2017; Kilmer, Reuter, & Giommoni, 2015).

The harms that arise from drug use, such as ill health, criminal activity, and mortality, are much more meaningful measures for NSW drug policy and responses to ATS. Yes, these measures are more challenging to collect and collate, and they may be driven by factors outside the sphere of drug policy. For example, measures of drug law enforcement including the recorded number of drug arrests can be influenced by police resources as much as by drug policy initiatives (Hughes & James, 2012). Nevertheless, a move away from prevalence of use estimates is essential for NSW to have any sense of the size and scale of the problem.

**Recommendation 2. Wastewater analysis should be used with extreme caution (1.1.3)**

Wastewater analysis has significant limitations. The data from wastewater are metabolites – the metabolites in wastewater should not and cannot be used to say anything about population prevalence, or consumption patterns (whether harmful or not) (1.1.1). As such, wastewater analysis fails as a measure of harmful consumption.

The question of whether wastewater analysis can reliably identify geographic locations of ATS in NSW (1.1.3) depends entirely on how the data from the wastewater analyses are interpreted. If they are referred to as ‘metabolite presence’ (i.e. not converted into population prevalence with extremely dubious assumptions, such as the average quantity used), then they can be useful. But restraining the research community and the media from over-interpreting wastewater results seems extremely difficult (Lancaster, Ritter, valentine, & Rhodes, 2019).

Wastewater analysis may also provide some useful data about geography with reference to the presence of the metabolites of ATS, but only if they are measured over time or between places. It is only this comparator function (metabolites in region x changed xx% between year 1 and year 2; or metabolites in region x were A and in region y were B), that can be used meaningfully. (The absolute amount of metabolite is meaningless, it is only with reference to a comparison – either over time, or between places). And even then, we again caution that the presence of metabolites says nothing about harms, and hence is a meaningless measure for the NSW government. For more information see our analysis of wastewater analysis technology for drug policy (Lancaster et al., 2019).

If NSW is committed to measure the success of ATS policy initiatives, it must focus on measuring harms from ATS and cease using the NDSHS and wastewater data to measure success.
Recommendation 3. The accountability and transparency of government processes surrounding AOD both in NSW and at the national level should be improved (1.3.1, 1.3.2)

In relation to questions 1.3.1 and 1.3.2, the National Drug Strategy (NDS, 2017-2026) is governed by the Ministerial Drug and Alcohol Forum (MDAF) which reports directly to COAG. NSW has two ministers as members of the MDAF (health minister, and justice/enforcement minister). The MDAF meets up to three times a year (the last available communique was June 2018).

The National Drug Strategy requires MDAF to provide COAG with an annual report on the progress being made against the national alcohol and other drug policy frameworks, including the headline indicators of the NDS. There is no evidence of progress on this (the June 2018 MADF communique notes that “the NDSC had commenced work on the development of the National Drug Strategy Reporting Framework”).

Our previous research on AOD governance, examining what constitutes ‘good governance’ in Australian drug policy, found accountability and participation the two most important principles for good governance, followed by following the rule of law and transparency (Hughes, Lodge, & Ritter, 2010). We raised concerns at the time about the extent to which some principles were being met, and while we acknowledge and welcome the creation of the MDAF since publication of this work in 2010, raise further concerns now.

The National Drug Strategy Committee (NDSC) is clearly the workhorse for the MDAF (and hence any reporting on headline indicators) but there is no public domain information¹ available about the NDSC, its membership, or its meeting frequency. One can only conclude that there is a lack of accountability and transparency in the governance of the NDS and national alcohol and other drug policy more generally.

No body (including the Productivity Commission) has conducted an inquiry or review into the costs and benefits of the NDS (1.3.9) nor for prior iterations of the NDS. (See Lancaster and Ritter (2014) for a description of the evolution of national strategies since 1985). There have been evaluations conducted of previous national drug strategies (e.g. (Siggins Miller, 2009)) but the last two strategies were not evaluated and none of the past evaluations made reference to ‘costs and benefits’.

Recommendation 4. NSW should provide leadership on reconceptualising the three pillars of the NDS towards goals and actions (1.3.10)

With regard to the ‘three pillars’ of the NDS, there has been longstanding informal discussions within the drug policy scholarly community of the need for a reconceptualisation. For a description of drug policy goals and pillars in other countries, see Ritter, Hughes and Hull (2016). Reducing supply, reducing demand and reducing harm are the appropriate three goals (as well as the overarching harm minimisation, much misunderstood). But how and whether these goals then translate directly to pillars is more unclear. Our preference is to retain these as goals, and then the actions (or pillars) could be more precisely articulated as prevention, treatment, harm reduction, laws/regulation, law enforcement and social welfare. These six areas of action can be mutually reinforcing (or not depending on implementation) but they articulate to the goals (supply, demand and harm reduction) in various ways. For example, policing can contribute to demand reduction; treatment can contribute to supply reduction; social welfare can contribute to both demand and supply reduction. In this way, it is possible to disentangle the action (and agency responsible) from the original pillars notion. Goals and actions seem a more helpful approach than pillars.

¹ Searching websites 26/4/19
Recommendation 5. Expand current NSW decriminalisation approaches for the personal use and possession of all illicit drugs (2.1.1 – 2.1.9)

As noted by the Commission, NSW has a number of existing forms of decriminalisation. This includes *de facto* decriminalisation of use and possession of cannabis, through the police cannabis caution programs for first- and second-time offenders and a new *de jure* decriminalisation through the 2019 infringement scheme, for the use and possession of other drugs. The 2019 introduction of the infringement notice for use/possession of drugs other than cannabis in NSW is to be particularly applauded, as NSW has long remained one of only two states to not provide police diversion options for use/possession of drugs other than cannabis.

A wealth of evidence demonstrates the benefits of alternatives to arrest for use and possession offences. For example, our evaluations found drug diversion is a cost-effective response to use and possession that significantly reduces the number of people who are arrested and sent to court for this offence alone and thereby improves a number of outcomes for the individual and reduces substantially the costs borne by the state (Shanahan, Hughes, & McSweeney, 2017). Programs like drug diversion are not associated with an increase in drug use or offending (Hughes, Shanahan, Ritter, McDonald, & Gray-Weale, 2014c; Hughes, Stevens, Hulme, & Cassidy, in press-b). However, all Australian drug diversion schemes have strict eligibility requirements (Hughes & Ritter, 2008), which limit access to programs (Hughes et al., 2014c). Of note the NSW cannabis caution scheme applies only to people detected for a first or second offence, with no priors, and excludes anyone in possession of more than 15 grams of cannabis. The new infringement scheme, currently only applied in festival settings, is for people who possess 0.25 grams of MDMA (when in capsule form) or 0.75 grams (when in other form e.g. pills) or 1 gram of other substances other than cannabis (e.g. methamphetamine). (The model/design of the new infringement scheme (threshold quantities, fine amount $400.00) appears tailored to a particular setting, music festivals, and may not be the best model across NSW, see recommendation 6).

Both decriminalisation measures (cannabis caution scheme and the new infringement notice) are discretionary (police can choose whether to apply it or not). This is very problematic as it can lead to discrimination and variance in application across local area commands (NSW Auditor General, 2011).

There remain many people in NSW who use and possess drugs who continue to be policed and sent to court and/or are convicted for use and possession alone. For example, over the period 2002 to 2012, we calculated that only 31.5% all use/possess offenders in NSW received an administrative response (Belackova, Ritter, Shanahan, & Hughes, 2017). We have just completed the first national evaluation of the reach of all Australian drug diversion programs (that is what proportion of use/possess offenders are diverted away from the courts) (Hughes, Seear, Ritter, & Mazerolle, in press-a). It is currently in press (available end June 2019), but this shows that there are significant state differences in the proportion of use/possess offenders that are diverted from court and a real need to expand alternatives to arrest for use/possess offenders within NSW. We would be happy to share a copy of this report with the Commission as soon as it is available.

One of the most talked about drug decriminalisation systems is Portugal. Portugal decriminalised the use and possession of all illicit drugs in 2001, under the goal of treating all drug use as a health and social issue - not a criminal issue. At the same time, it expanded investment in drug treatment, harm

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2 Decriminalisation (removal of criminal penalties for the personal use and possession of illicit drugs) is either by law (*de jure*) or in practice (*de facto*).
reduction and social reintegration. Eighteen years post-reform the impacts have been clear: a reduced burden on the criminal justice system, reductions in problematic drug use, reductions in drug-related HIV and AIDS, reductions in drug-related deaths, increases in treatment access and reintegration services such as employment assistance and reduced social costs of responding to drugs (Gonçalves, 2015; Hughes & Stevens, 2010).

There is now a large body of research on the impacts of decriminalisation beyond the Portuguese experience with over 30 countries practising some form of decriminalisation (Eastwood et al, 2016). Hughes, Stevens, Hulme and Cassidy (in press-b) recently reviewed the evidence-base on alternatives to simple possession across nine different countries for the Irish government (including Australia, Czech Republic, Germany, Portugal and the USA) and found no evidence of significant increase in the prevalence of use after decriminalisation. Conversely decriminalisation of personal use and possession was associated with many positive consequences including reductions in drug-related harms, reduction in the burden on the criminal justice system and improved employment and economic outcomes (Hughes et al., in press-b).

**Recommendation 6. The Commission should explore decriminalisation models for NSW (2.1.12)**

Designing a fit-for-purpose decriminalisation model for NSW is not easy. The design considerations are complex and include the threshold quantities, the nature of sanctions (fines or other), whether a therapeutic response (ranging from education to treatment) is included and the eligibility criteria. The work by Hughes et al (in press-b) demonstrates that some models are associated with adverse consequences, such as net-widening, whereby more rather than less people end up in the criminal justice system. The risks of this occurring are shaped by design considerations such as the choice of model and eligibility criteria, particularly if threshold quantities are employed and are set too low, as well as broader contextual factors, such as the extent to which police support or oppose any reform. The model of decriminalisation being explored currently in festival settings (§400 fine) carries increased risks of net-widening and net-deepening, if people are unable to pay the fines (and are returned to the justice system as a result). Conversely, models employing referrals to health and social services may increase burdens on treatment systems, particularly if compulsory referral models are employed.

Based on the work of DPMP academics Ritter, Hughes and Shanahan (2018) we recommend the Commission explore the following three models of decriminalisation for implementation in NSW:

- **Model 1**: Removal of use/possess from criminal law irrespective of amount possessed (“no TQ model”)
- **Model 2**: Removal of use/possess from the criminal law up to a certain threshold amount (“TQ only model”)
- **Model 3**: Removal of criminal penalties for eligible people/offences up to a certain threshold amount (“eligibility model”)

The Special Commission asks whether decriminalisation is consistent with international conventions (2.1.7). The 1961 and 1971 Conventions require member states to prohibit but not criminalise possession. The 1988 Convention requires member states to make drug use a criminal offence but has long permitted the use of alternatives to conviction for minor offences. More notably, on 17 January 2019 the Chief Executives Board of the UN (representing 31 UN agencies including the United Nations Office on Drugs and Crime) adopted a new common position on decriminalisation. This calls on member states to promote alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use. This reflects the recognition that criminalisation increases stigma, reduces access to drug treatment and harm reduction services and that policing itself can also increase harmful drug use practices.
There is strong merit in expanding current NSW decriminalisation approaches for the use and possession of all illicit drugs. We are happy to assist in the design of any reform.

**Recommendation 7. Redesign drug trafficking thresholds in NSW to better reflect actual patterns of drug consumption and purchasing (2.2.2)**

Drug trafficking threshold quantities have been employed for over 20 years in every Australian state and determine a charge of “dealer” versus “user” based on a quantity of drug possessed (2.2.2). However, many current legal thresholds are not evidence-based and place many people who use drugs at risk of erroneous charge or conviction as a drug trafficker (Hughes, Ritter, Cowdrey, & Phillips, 2014a, 2014b). This is particularly so in New South Wales and in relation to current trafficable threshold quantities for MDMA which are amongst the lowest in Australia.

It is estimated that 57 percent of people who regularly use MDMA in NSW exceed the current trafficable threshold limit of 0.75 grams in their purchasing and/or use behaviour and 80 percent exceed current thresholds in a heavy session of drug consumption (such as at festival) (Hughes et al., 2014a, 2014b). Such behaviour is of concern, not only because of the number of people regularly using MDMA who exceed the thresholds, but also because binging (ie high quantity use) (Sindicich & Burns, 2012) and stockpiling (ie high-quantity purchases) are both common behaviours among regular MDMA users (Fowler, Kinner, & Krenske, 2007).

Drug trafficking thresholds in NSW, particularly for MDMA, should be redesigned in order to be consistent with typical patterns of drug consumption and purchasing. This could reduce the burden on the criminal justice system, reduce harm to people who use drugs and increase targeting of serious drug offenders. There is a precedent for such a move as the ACT Government undertook similar reforms in 2014 as part of the (Criminal Code (Controlled Drugs) Legislation Amendment Regulation 2014), based on research provided by DPMP (Hughes & Ritter, 2011).

**Recommendation 8. Reduce police use of drug detection dogs in NSW or amend methods of deployment to target suppliers, not people who use drugs (2.4.5)**

NSW was the first Australian state to introduce drug detection dogs as a street-level policing strategy with the stated aim of ‘targeting drug supply’ and ‘attacking the root causes of drugs in society’. Yet there has remained a long history of concern about their deployment with a new comprehensive analysis of the program finding that the program overwhelmingly detects young people for ‘use/possession’ alone (86.4% of incidents), with supply offences only detected in 4.8% of incidents (Agnew-Pauley & Hughes, 2019).

In this analysis (spanning data from June 2008 to June 2018) most detections by drug dogs in NSW were for cannabis (59.0%) or MDMA (18.1%), compared to 7.9% for methamphetamine (Agnew-Pauley & Hughes, 2019); this is in large part a consequence of where the drug detection dogs are deployed, as most detections are at public settings, particularly public transport (28.2%), licensed premises (27.5%) and outdoor/public places (27.6%), which are the settings where suppliers are least likely to be detected (Agnew-Pauley & Hughes, 2019).

In a review of the first two years of operation the NSW Ombudsman (2006) concluded that ‘there is little or no evidence to support claims that drug detection dog operations deter drug use, reduce drug-related crime, or increase perceptions of public safety’. Other research has shown that the presence of drug detection dogs at festivals has minimal deterrent effect on drug use and supply (Dunn & Degenhardt, 2009; Grigg, Barratt, & Lenton, 2018) and that it often leads to more risky drug
taking behaviour, such as purchasing drugs from inside the festival (Hughes, Moxham-Hall, Ritter, Weatherburn, & MacCoun, 2017; Measham, 2018), concealing drugs or hurriedly consuming drugs upon sighting the dogs to avoid detection (Dunn & Degenhardt, 2009; Grigg et al., 2018).

The evidence demonstrates that police use of drug detection dogs is ineffective and often counterproductive. There is thus merit in reconsidering the NSW Police drug detection dog policy, to curtail or reform the policy to ensure they are only used post obtaining a warrant and in situations where suppliers are likely to be detected. Expansion of police powers to deploy drug detection dogs in NSW is strongly opposed.
**Issues Paper 3: Health and community**

**Recommendation 9. Double investment in treatment (3.3.2)**

Service delivery models of care are not matched to population need (3.3.1) and current NSW government investment is inadequate with substantial unmet demand for treatment (3.3.2). Based on the Drug and Alcohol Service Planning Model (DASPM), we know that we need to double the treatment resources in order to meet demand (recalling that the model conservatively projects a 35% treatment rate overall for those who meet substance use disorders) (Ritter, Berends, Chalmers, Hull, Lancaster, & Gomez, 2014; Ritter, 2019).

The estimates generated by DASPM are modest and not overly ambitious. In work we completed for the Network of Alcohol and Other Drugs Agencies (NADA) on bed-based care (inclusive of inpatient, withdrawal and residential rehabilitation beds) (Mellor & Ritter, 2019), we predicted that between 2,078 beds and to 3,402 beds are required per annum to meet demand for AOD treatment in NSW. The vast majority of the beds predicted were for residential rehabilitation (83%), followed by withdrawal (14%) and inpatient withdrawal (3%). The vast majority of all needed treatment beds were for the treatment of alcohol dependence (between 51-58%) with the remainder for amphetamine, opioids, cannabis and benzodiazepines. Estimates for beds needed for amphetamine- specific treatment per annum in NSW is between 254 and 384 (11-18% of all treatment beds). This work did not consider the unmet demand for non-bed based services, including psycho-social counselling.

**Recommendation 10. Establish formalised agreement between funders on a coordinated planning approach for the provision of ATS treatment services in NSW (3.3.3)**

In terms of planning, the approaches currently being used in NSW are ill-coordinated, siloed and wasteful of planning resources. The key funders and planners for NSW ATS treatment (that is NSW Ministry of Health, the LHDs, the PHNs and Commonwealth (Aboriginal and Torres Strait Islander service funders) should come together and hold a planning roundtable (or series of seminars/roundtables) to agree on a coordinated joined up planning approach. The Drug and Alcohol Services Planning Model (DASPM, previously DACCP) is a possible tool that could be explored in one of these roundtables, and ways in which DASPM can be made fit-for-purpose for NSW could be explored (see also recommendation 24). A commitment from all funders to plan together not separately is essential, and it must move from talking to signed MOUs or other formalised agreements between funders.

**Recommendation 11. Invest in greater research of in-custody involuntary AOD programs (3.3.6, 3.3.7)**

The overwhelming majority of involuntary treatment systems in NSW are connected to the criminal justice system including court-mandated treatment, drug courts and the NSW Compulsory Drug Treatment Program. Evaluation and research on these programs have therefore tended to focus on recidivism with research demonstrating that those finishing drug courts and court-mandated treatment are less likely to reoffend (Alberti, King, Hales, & Swan, 2004Eardley, 2004 #105; Freeman, 2002; Wundersitz, 2007). In all instances research has shown that involuntary treatment programs best service a very limited population (e.g. high needs drug dependent offenders).

A recent review we conducted of involuntary treatment systems found very little research and evidence on the effectiveness of in-custody programs in reducing AOD use or dependence in the long-term (i.e. after the program has finished) (Vuong, Ritter, Hughes, Shanahan, & Barrett, 2019),
and even less evidence to support such systems outside of in-custody settings (see Recommendation 12 below). To reduce problematic AOD use, investment would be better spent in front end diversion and decriminalisation. Failing that, mandatory treatment responses should be treated with caution and there must be investment in research to understand how such programs impact on AOD use, especially where that is a significant aim or feature of the program.

Recommendation 12. Involuntary treatment models for problematic AOD use should only be expanded if there is compelling evidence on effectiveness and support from the medical community (3.3.6)

There is very little to no research on the effectiveness of non-custodial involuntary treatment models and programs that attempt to address problematic AOD use without adjacent criminal behaviour or extreme risk of harm (Vuong et al., 2019). In addition, such programs raise a number of complex motivational, moral and civil liberties concerns (Hall, Lucke, & Wales, 2010) and are unsupported by international bodies including the World Health Organisation and the UN Office on Drugs and Crime (United Nations Office on Drugs and Crime, 2017).

The NSW Involuntary Drug and Alcohol Treatment Program (IDAT) is the only non-custodial involuntary system in NSW (3.3.7). It is a short-term (28 days) program, seen as an option of last resort for people who are at extreme risk of harming themselves or others. We are currently evaluating this program for the NSW Ministry of Health, including a process evaluation, a cost assessment and an outcome evaluation. The first two reports have not been released by the Ministry, so we are unable to comment herein.

There are currently no involuntary treatment programs operating in Australia outside those like IDAT (aimed at reducing severe and immediate harm i.e. loss of life) and those in custodial settings. The most recent program of this type in Australia, (the NT Mandatory Alcohol program) was closed after a range of high-profile problems, ethical violations including “defacto discrimination against Aboriginal people” and non-compliance with domestic and international laws (Lander, Gray, & Wilkes, 2015). A formal program evaluation found high program costs and a lack of discernible outcomes for clients (PricewaterhouseCoopers Indigenous Consulting Pty Limited, 2017).

We advise that the government exercise extreme caution in any deliberation of mandatory models and only commit funds to those programs informed by evidence and supported by the broader medical community. Please see our recently released bulletin on mandatory treatment models for more information (Vuong et al., 2019).

Recommendation 13. Implement new and effective strategies to tackle stigma and discrimination (3.3.14 to 3.3.19)

Experiences of stigma and discrimination are rife in the everyday lives of people with AOD problems, including being judged, treated badly, looked down upon and excluded from or denied services, including healthcare services, specifically because of their AOD use (Lancaster, Seear, & Ritter, 2017).

As noted by Issues Paper 3, stigma can act as a help-seeking barrier for both people with AOD problems and their families (McCann & Lubman, 2018) and can have a significant negative impact on psychological and physiological health beyond that attributable to foregoing the treatment needed (Pascoe & Smart Richman, 2009). In answer to question 3.3.14 stigma and discrimination can make people feel worthless or hopeless, in turn triggering them to use alcohol or other drugs (Lancaster et al., 2017).
Stigma can be particularly pronounced for people who use illicit drugs, especially for people who inject drugs (Brener, 2017). Among people who use ATS, people who use methamphetamine are particularly vulnerable to stigma and discrimination, given extensive media portrayal of these people as dangerous and psychotic (Fredrickson, Gibson, Lancaster, & Nathan, 2019).

Recommendation 14. Reduce stigma and discrimination by ensuring consumer participation in policy, planning and service delivery (3.3.15, 3.3.16)

Including people with lived experience of AOD use in policy, planning and practice about their own health can challenge stigma, discrimination and uninformed opinions and is a key ethical consideration (Lancaster, Ritter & Stafford, 2013). Formal structures of inclusion is known as consumer participation and this can come in many different forms from consultation to partnership, delegation and control (Duckett & Willcox, 2011). Consumer participation provides opportunities to disrupt the routine dehumanisation faced by people who use drugs (Rance & Treloar, 2015). As noted by Ritter and colleagues (2016) engagement should reach beyond a ‘tick a box’ process and strive for meaningful partnership that views people who use drugs as key stakeholders.

There are a range of resources that have been developed in order to assist AOD services in best-practice consumer participation, including those by peak drug user organisations (Australian Injecting and Illicit Drug Users League, 2008) and guidelines issued by the NSW Ministry of Health (2015); and barriers to meaningful involvement have been continually documented (Australian Injecting and Illicit Drug Users League, 2008; Rance & Treloar, 2015; Treloar, Rance, Madden, & Liebelt, 2011). These resources could readily be used and applied beyond AOD services.

Recommendation 15. Implement targeted communications campaigns to specific at-risk groups rather than mass media campaigns (3.3.16)

A large body of international research shows that mass media campaigns have no effect on drug use behaviour and can compound stigma and marginalisation (Werb, Mills, Debeck, Kerr, Montaner, & Wood, 2011). These campaigns aim to create fear so as to deter drug use but can further separate and stigmatise people who use drugs (Lancaster et al., 2017). Extreme framing of methamphetamine use in Australia as an ‘epidemic’ and portrayal of people who use methamphetamine as dangerous and psychotic can prevent people from seeking help because it allows individuals to dissociate their drug use with problematic drug use where they do not identify themselves or experience within this ‘epidemic’ framing (Chalmers, Lancaster, & Hughes, 2016).

A study of two anti-methamphetamine campaigns *Faces of Meth* and *The Meth Project* found that people who used methamphetamine did not relate to the depictions of physical and behavioural change in the campaign, and that they had not had a deterrent effect (Marsh, Copes, & Linnemann, 2017). Other studies have found that some mass media campaigns have been associated with increased illicit drug use and intention to use illicit drugs where they increase the perception that drug use is widespread (Terry-McElrath, Emery, Szczypka, & Johnston, 2011; Werb et al., 2011).

In contrast, campaigns that target specific at-risk groups using community-based organisations have demonstrated at least some impact on health seeking and risk reduction behaviours, for example in HIV prevention, while avoiding stigma-related language (Vella, Wilkinson, Pedrana, & Stoove, 2014). In coordination with consumer groups, the NSW Government should explore and find the best communication approaches that will be credible among target sub-populations of people who use ATS in order to increase awareness of potential harms and treatment options to encourage help-
seeking. Any dedicated funds for future mass marketing campaigns in NSW targeting people who use ATS should be diverted into targeted communication campaign strategies.

**Recommendation 16. Conduct anti-stigma awareness training across all relevant workforces (3.3.17)**

Awareness training provides an opportunity to challenge stigma, the causes of stigma and it’s impacts, and can be conducted through a variety of different programs and interventions. A comprehensive literature review we conducted for the Queensland Mental Health Commission on strategies to address AOD stigma and discrimination found that it is more effective to provide information with skills-building rather than just information alone (Lancaster et al., 2017).

Many peer-based drug user organisations have already developed awareness programs that could be used or adapted, including AIVL’s online training module for health professionals (see here: [http://aivl.org.au/project/stigma-and-discrimination/](http://aivl.org.au/project/stigma-and-discrimination/)) and stigma and discrimination training developed by the NSW Users and Aids Association (NUAA) stigma and discrimination training (see here: [https://nuaa.org.au/wp-content/uploads/2017/01/stigma_training_pamphlet_print_2.pdf](https://nuaa.org.au/wp-content/uploads/2017/01/stigma_training_pamphlet_print_2.pdf)).

In Queensland, our work identified a range of decision makers, beyond the fields of health, welfare and the police who exercise power and discretion in relation to people experiencing problematic AOD use, including Department of Health and Corrections employees (Lancaster et al., 2017). So “enhanced professional development opportunities” such as anti-stigma awareness training should be expanded beyond those working directly with people who use ATS.

As per our advice to the Queensland Mental Health Commission, we recommend the Special Commission of Inquiry identify key workforces and then undertake a needs assessment of those workforces (Lancaster et al., 2017) before working with peer-based drug user organisations and consumers to devise appropriate anti-stigma training.

**Recommendation 17. Implement guidelines for government departmental and Ministerial communication about AOD issues (3.1.15, 3.3.18)**

While Issues Paper 3 recognises the role of media in creating and or perpetuating stigma against people who use ATS, it must be noted that many media organisations will quote verbatim from media releases from trusted sources like government ministers or departments. Where stigmatising language and imagery is used, this may be reproduced unchallenged. In regards to question 3.1.15, there is a significant opportunity for the NSW government to lead in terms of non-stigmatising language and improve on current practice by avoiding stigmatising terminology in their own materials to the press, such as describing methamphetamine use as a “scourge on our communities” (NSW Government, 2018).

The development of clear guidelines for all government department communications (press releases, online media, resources, reports etc) should ensure that no language or portrayals of people who use alcohol and other drugs which could be stigmatising occur. While we have no comment on media reporting standards (3.3.18) we note a range of recommendations in relation to media reporting of illicit drugs has been developed in previous research that could be drawn on (for example page 7 of Hughes, Spicer, Lancaster, Matthew-Simmons, & Dillon, 2010) as well as
guidelines that have already been developed by organisations including AOD Media Watch⁴ and the NUAA⁵.

**Recommendation 18. Pregnant women should be permitted to access the Medically Supervised Injecting Centre (MSIC) (3.5.3)**

Pregnant women should be permitted to access the MSIC. There are no grounds on which to refuse services to pregnant women, especially as they may be the most marginalised of our community. Distressing as the imagery may be, excluding pregnant women from accessing such services would potentially expose them and their unborn child to further harm including death, and is discrimination.

As the name suggests, the MSIC is fundamentally a medical service designed to save lives through decreasing overdose deaths, providing a gateway for treatment and counselling and reducing the spread of diseases like HIV and Hepatitis C (MSIC Evaluation Committee, 2003). Both in Australia and overseas, there is a large body of research evidence that demonstrate supervised injecting services achieve these aims (Belackova, Salmon, Day, Ritter, Shanahan, Hedrich, Kerr, & Jauncey, 2019; de Vel-Palumbo, Matthew-Simmons, Shanahan, & Ritter, 2013; Potier, Laprévote, Dubois-Arber, Cottencin, & Rolland, 2014). In Sydney alone, the MSIC successfully managed 4,376 drug overdoses without a single fatality in its first 11 years of operation (KPMG, 2010). Pregnant women should not be prevented from accessing these services and their associated benefits.

**Recommendation 19. NSW government should pilot an NSP prison scheme (3.5.6)**

A vast body of literature supports the extension of Needle-Syringe Programs (NSPs) in prisons in order to reduce the spread of blood borne viruses, notably Hepatitis C (Lazarus, Safreed-Harmon, Hetherington, Bromberg, Ocampo, Graf, Dichtl, Stover, & Wolff, 2018). NSPs are highly effective and cost effective at reducing hepatitis c transmission and in most settings are the primary mechanism for reducing blood borne viruses among PWID (Sweeney, Ward, Platt, Guinness, Hickman, Hope, Maher, Iversen, Hutchinson, Smith, Ayres, Hainey, & Vickerman, 2019).

Expansion of NSPs to prisons is supported by “principle of equivalence” in health care – that detainees should have same access to healthcare services, including needle exchanges, as everyone else, with all 5 of the new National Blood Borne Viruses and Sexually Transmitted Infection Strategies 2018-2022 released by the Commonwealth Department of Health last year, calling for NSPs in prison.

Prisoners are at high risk of contracting blood borne viruses while in prison due to high levels of drug dependence and blood-borne viruses (hepatitis c prevalence is between thirty to forty times higher than the general population) and engagement in risky behaviours such as injecting drug use (Butler & Simpson, 2017).

Despite prohibition, research demonstrates that in Australia about half of the people who inject drugs continue to inject in prison (Reekie, Levy, Richards, Wake, Siddall, Beasley, Kumar, & Butler, 2014). However, access to injecting equipment is severely restricted and results in the sharing of drug use equipment, contributing to the spread and higher prevalence of blood borne diseases in prison populations than the general population (Lazarus et al., 2018).

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⁵ https://nuaa.org.au/info-for-health-professionals/language-matters/?doing_wp_cron=1556848326.8480389118194580078125
According to Stoove and colleagues (2015) over 20 years of research on NSPs in prisons from 13 countries shows no increase in use or availability of drugs or instances of needles being used as a weapon (despite fears). Some research has indicated that the presence of in-prison NSPs make prison guards safer, as access to needles prevented detainees from hiding syringes, resulting in fewer injuries when conducting searches (Jacob & Stover, 2000) and have the potential to reduce violence associated with informal economies built up around supply and distribution of needles inside prison by prisoners (Treloar, McCredie, & Lloyd, 2016).

In any case, there are a variety of models available for the NSW government to pilot, including those that isolate the NSP away from prison staff, thereby eliminating risks (i.e. through the use of in-prison health centres as an MSIC) (Moore, 2011). In developing a pilot for NSW we draw the Commission’s attention to the work of the UNODC (United Nations Office on Drugs and Crime, 2014), and also the ACT Government who have commissioned a range of work in order to develop a NSP model in the ACT.

**Recommendation 20. NSW should pilot a pill testing scheme (3.5.7)**

NSW should proceed with a pilot of pill testing in order to provide harm reduction services to people who use ATS and to also monitor local ATS markets in real-time which may amplify harm-reduction beyond the site of the service. We note that ACT Health and ACT Police are committed to supporting pill-testing in their jurisdiction, and Qld Health is currently considering the evidence.

Pill testing (also known as drug checking) services invite members of the public to anonymously submit psychoactive drug samples for forensic analysis and then provide individualised feedback of results and counselling as appropriate. The rationale for the operation of these services is to educate people who decide to use currently illegal drugs about the content and purity of the products, so they can make a more informed decision about whether to use them or how to use them (Brunt, 2017). These services also monitor drug market changes and when particularly dangerous drug samples are identified, they can issue tailored public alerts and inform specific harm reduction interventions (Gine, Vilamala, Measham, Brunt, Bucheli, Paulos, Valente, Martins, Libois, Togel-Lins, Jones, Karden, & Barratt, 2017).

There is a strong evidence base on the effectiveness of pill-testing as a means of harm reduction. Recent evidence from a UK pill testing service operating at music festivals, The Loop, found that 20% of service users disposed of substances when the drug testing service revealed the substance to be other than what had been intended to be purchased (Measham, 2018). A further two-thirds of UK festival goers whose samples did not match their intended purchase disposed of further substances (Measham, 2018). Preliminary data from a recent pill-testing pilot at a music festival in Canberra found that 100% of the people (n=7) discarded their drugs when they were alerted to the presence of n-ethylpentylone (Pill Testing Australia, 2019) and the first evaluation at the same festival last year revealed that 35% of patrons who had their drug tested indicated that they would change their behaviour as a result (including 18% who indicated they would not consume the drug, and 12% who would consume less) (Makkai, Macleod, Vumbaca, Hill, Caldicott, Noffs, Tzanetis, & Hansen, 2018).

There are no reports across any of the services of increases in drug use as a result of pill testing services. All pill-testing services provide a brief intervention and harm reduction information alongside their feedback about the drug’s content (and purity in some cases). That is, the analysis result is only the beginning of the conversation with the service provider: it provides a ‘hook’ to attract an otherwise hidden population into the service (Hungerbuehler, Bucheli, & Schaub, 2011).
There are more than 31 pill testing services operating across over 20 countries (Barratt, Kowalski, Maier, & Ritter, 2018b) that all provide potential models for the NSW Government to draw from. DPMP conducted a global review of pill-testing services in 2017, including services at fixed sites in central locations (such as at transport hubs, or in community centres providing other healthcare check-ups and support services), pop-ups at festivals and music events, postal services, and in clubs (Barratt et al., 2018b). A key feature of each is the opportunity to provide accurate information from health professionals, including the message that ‘no drug is safe’.

Research indicates strong support for pill testing from consumers in Australia with a survey of festival goers in 2016 (Barratt, Bruno, Ezard, & Ritter, 2018a) finding 94% of patrons would use a service if it were available, and would be willing to wait up to an hour for the results (80%). This means that (if adequate funding is available) information about drug purity could be provided to Australians in addition to drug content. Multiple models should be trialled in NSW. For example, a festival-based or on-site pill-testing service could utilise the same equipment and staff as a weekday fixed-site service, while servicing different at-risk population – those who obtain drugs in advance and those who obtain drugs inside festival settings.
**Issues Paper 4: Data, research and funding**

**Recommendation 21. The NSW government should invest in research infrastructure (4.1.1 – 4.1.12)**

This submission would not have been possible without research. The systematic collection and analysis of data – qualitative and quantitative, investigator-driven research and commissioned research are all vital to allow NSW to respond with alacrity and success to ATS. However there is insufficient NSW government research investment. Notably, very little of the DPMP research we have cited here was funded by the NSW government.

While significantly more research investment is required by the NSW government, this should not solely be through commissioned research on specific topics. What is required is research infrastructure funding. For example, one of the reasons why the DPMP has been successful has been because of its past research infrastructure funding (in this instance from a philanthropy; now no longer funded). This enabled DPMP to conduct highly applied and relevant research independently from government.

**Recommendation 22. New research be commissioned on drug budget expenditure (4.2.2)**

There are no data on the current NSW whole-of-government investment in ATS. This is a significant research gap. We do know, however, that government funding is skewed towards law enforcement, rather than treatment and prevention despite this research being dated (2004/05 year) and being national (Ritter, McLeod, & Shanahan, 2013). There is little reason to suspect that the current NSW allocations differ from these, but this is an empirical question.

**Recommendation 23. The length of AOD treatment services funding contracts should be increased (to >3 years), especially where new services are established (4.2.1)**

To improve the coordination of resourcing and funding for responding to ATS between the Commonwealth and NSW Governments, longer contracts, specifically contracts of four to five years for AOD services should be considered. While this is only one small measure, longer contracts, which are better aligned between the two funders, would be a small improvement.

Short-term contracts provide a number of logistical hurdles for service providers including the administrative and financial burden of tendering and retendering for services and difficulties in program planning and retaining qualified staff (Ritter et al., 2014). As found in the New Horizons Report (Ritter et al., 2014) contracts of three years can be especially burdensome for new services and do not acknowledge the time and resources needed for program and policy establishment and routinisation.

Evidence from the Advisory Council on the Misuse of Drugs (UK) found that frequent re-procurement of services, particularly when systems function well is unnecessary and a major drain on resources, resulting in ‘churn in the system’ causing disruption and creating ‘risky transition points’ for service users; at its worst can have negative impacts on service users’ recovery outcomes (Advisory Council on the Misuse of Drugs, 2017). The Productivity Commission report into contribution of the not-for-profit (NFP) sector found that short-term and/or irregular funding is not conducive to establishing and maintaining long-term approaches and recommended that governments “align the length of the contract with the period required to achieve agreed outcomes” (Productivity Commission, 2010, p. xxiv).
Recommendation 24. Review and redevelop the DASPM (preferably under a national banner and by a research group located in a University) (4.2.15, 4.2.16)

One mechanism for improving the coordination and resourcing between the different levels of government is to introduce and use a shared planning tool. The Drug and Alcohol Services Planning Model (DASPM, previously DACCP) is one potential tool for increasing coordinated investment, timing of contracts, and improving planning. To our knowledge, there has not been engagement with DASPM by the NSW Government since their original investment in its development.

The DPMP has undertaken work commissioned by NADA to use DASPM for an analysis of the beds needed in NSW (for both residential rehabilitation and drug withdrawal. Report available). Other jurisdictions are actively pursuing the use and redevelopment of DASPM, under contract with DPMP (NT and Queensland). We need a redevelopment process for DASPM (not only because of errors and bugs in the original version, but also to reconsider the planning architecture and align it better with the needs of the planners). In theory this should be a national project, especially given the complex web of funding for AOD treatment (Chalmers, Ritter, Berends, & Lancaster, 2016). A research team is the most logical place to house such a redevelopment of DASPM. This is what has occurred for the MHCCP, now called the NMHSPF (https://nmhspf.org.au/about-the-nmhspf/) and is housed with the University of Queensland.

Recommendation 25. Refine outcomes measures in collaboration with people who use AOD (4.2.4)

Performance measures of services can be improved without changes to funding. There is still a persistent tendency in AOD program evaluations to focus on very basic quantitative indicators, weighted towards reduced AOD consumption and offending (Neale, Vitoratou, Finch, Lennon, Mitcheson, Panebianco, Rose, Strang, Wykes, & Marsden, 2016) – despite it being well-established that pathways to reduced harm involve considerably more than simply reducing or abstaining from substance use. In order to avoid such reductive measures, more meaningful pictures of treatment success should incorporate other aspects such as quality of life, reconnection with family and community, level of functioning in one’s career or job, and level of involvement with the legal system.

As per recommendation 14 clients should be involved in any process to determine outcomes measures. Acknowledging client ownership (client-centred approach) is the guiding principle for planning, delivery and evaluation of AOD treatment, which includes the development of outcome measures. Not involving clients in the design of outcome measures can limit both the usefulness of these measures and the impact they can have on clinical decision making and practice (Greenhalgh, Long, & Flynn, 2005).

Recommendation 26. Invest in research to empirically test different types of funding mechanisms in order to support delivery of more appropriate, efficient and effective AOD treatment services (4.2.5)

In addressing funding arrangements with NGOs (4.2.5) it is important to note that outcome-based funding models (i.e. payment by results) are generally not considered a viable option for the AOD sector (Advisory Council on the Misuse of Drugs, 2017; Productivity Commission, 2010; Ritter et al., 2014). It is worth noting that no other area of healthcare in Australia uses outcome-based funding (Ritter et al., 2014, p. 140).
There is an array of different funding mechanisms for AOD services, ranging from activity-based funding to competitive tendering (see Ritter, Hull, Berends, Chalmers, & Lancaster, 2016 for a summary of different mechanisms). What is missing is an evidence-base on these different funding mechanisms and how they may relate to the performance of services, and to client outcomes. We have been successful with an NHMRC to start to study this. The study, called Horizons, was established to examine the relationships between funding (amount and source), purchasing mechanisms (eg competitive tendering, block grants), staffing (number and qualifications) and their impact on client treatment outcomes in mainstream AOD treatment services. Data collection is being completed and we have survey data on funding and staffing from more than 200 AOD treatment sites in Australia.

We are now matching survey data to the AODTS-NMDS data focussed on the proxy outcome measures of treatment retention and reason for cessation. Results should become available mid-2020. It is hoped that NSW government will be able to draw on the results to better configure purchasing models. The study will not give a definitive answer to the question about best-practice funding mechanisms, but will certainly go some way to fill significant gaps in knowledge. We note that findings may not be applicable to specialist or targeted services, particularly Aboriginal and Torres Strait Islander services, and recommend further investment in research to ensure that funding mechanisms are appropriate.

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