PENINGTON INSTITUTE

Victorian Parliamentary Law Reform, Road and Community Safety Committee

Inquiry into Drug Law Reform

Submission – Penington Institute

March 2017

PENINGTON INSTITUTE

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About Penington Institute

Our mission

Penington Institute actively supports the adoption of approaches to drug use which promote safety and human dignity.

We address this complex issue with knowledge and compassion. Through our analysis, research, workforce education and public awareness activities, we help individuals and the wider community.

Our history

Launched in 2014, Penington Institute, a not for profit organisation, has grown out of the rich and vibrant work of one of its programs, Anex, and its 20 years' experience working with people and families directly affected by problematic drug use.

Penington Institute is inspired by and named in honour of Emeritus Professor David Penington AC, one of Australia's leading public intellectuals and health experts.

Our vision

Our vision is for communities that are safe, healthy and empowered to manage drug use.

Our understanding

Drug use trends, drug development and markets historically move faster than research and policy responses. With our outreach to the front line we are well-placed to know and understand the realities of how drugs are impacting communities – well before the published literature surfaces significant issues.

We combine our front-line knowledge and experience with our analysis of the evidence to help develop more practical research and policy, support services and public health campaigns. Our strong, diverse networks provide an excellent platform for building widespread support for effective initiatives.

Our activities:

We:

- Enhance awareness of the health, social and economic drivers of drug-related harm.
- Promote rational, integrated approaches to reduce the burden of death, disease and social problems related to problematic substance use.
- Build and share knowledge to empower individuals, families and the community to take charge of substance use issues.
- Better equip front-line workers to respond effectively to the needs of those with problematic drug use.

Our purpose is framed by our knowledge that we need to look at more effective, cost-efficient and compassionate ways to prevent and respond to problematic drug use in our community.

Introduction

Penington Institute is pleased to present its submission to the Victorian Parliamentary Law Reform, Road and Community Safety Committee's (the Committee) **Inquiry into Drug Law Reform** (the Inquiry). We greatly welcome this Inquiry: its unique terms of reference and historic timing present immense opportunity to improve outcomes for Victorians.

The Committee will hear many ideas for change. Some have been considered by similar reviews in the past. However, this Inquiry is qualitatively different: it is not just trying to solve specific problems (such as ice), but rather take a wide-ranging look at Victoria's drug laws and the people who interact with them. The Inquiry is therefore an opportunity to improve a system that is not performing optimally.

But driving a system to do more will not be enough if something different is needed.[1] Change is required.

A common interest

There is no doubt that psychoactive substances – which, by their nature, have the effect of modifying a person's state of mind – have enabled a perception that the behaviours and motivations of drug users are not shared with the general community's. Problematic drug use, though it affects a small minority of drug users, generates understandable public concern.

While we acknowledge drug laws and policies are highly politicised, it is not the case that we can act in the interests of either drug users *or* the general community: people who use drugs are part of our community, and acting in their interests protects, rather than jeopardises, the community at large.

In the past, the stigmatisation and criminalisation of drugs and drug users has proven a potent combination. It has slowed the pace of reform, while producing few tangible benefits.

The community's views are changing

However, community attitudes to drugs are in a state of transition. In 2013:

- most Australians supported some form of decriminalisation for all drugs;[2]
- only a quarter of people supported a prison sentence for heroin, with the proportion even smaller for other drugs;[3] and
- one quarter supported legalising cannabis – a figure we expect would now be higher in light of subsequent changes overseas.[4]

On the other hand, when asked how governments should allocate drug-related expenditure, most respondents said funding should go to law enforcement, followed by health and education.[5] It seems Australians are trying to navigate multiple conflicting narratives about drugs and the people who use them. The traditional poles of the drug debate are still present, but people are not firmly clustered around them.

[1] Mulgan and Leadbeater (2013), *Systems Innovation*, London: Nesta, p. 46. Available via: http://www.nesta.org.uk/publications/systems-innovation-discussion-paper.

[2] Australian Institute of Health and Welfare (2014), *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra: AIHW, p. 104.

[3] Ibid.

[4] Ibid.

[5] Ibid.

Our laws need to keep pace with these shifts – and with the evidence. As it inquires into these matters, the Parliament has a responsibility to equip the community to reconcile conflicts and reshape their own views.

Change is unavoidable

Overall, it fair to say that our drug laws have little impact on the majority of drug use (which produces few harms), while encouraging, generating and exacerbating the most unsafe forms of drug use.

If, ultimately, our laws should have the primary aim of minimising the adverse consequences associated with illicit, synthetic and prescription drugs, reform is needed.

Law reform[6] alone won't work

However, our laws are just one part of a complex system. In evaluating their performance, we must consider the factors that influence that performance: people, policies, organisations, funding, markets.[7]

Thus, positive law reforms alone cannot ensure better outcomes. Only an integrated, evidence-based system of supports – that is laws, policy and funding – can deliver this. Our recommendations reflect this reality.

Our submission

We have provided a summary of our findings, recommendations and law reform options* immediately following this introduction. The rest of the submission is structured as follows:

- Chapter 1 provides a brief overview of Victoria's drug-related laws, authorities and strategy.
- Chapters 2-4 consider whether our drug laws have reduced the supply, use and harms of drugs.
- Chapter 5 finds no reason to conclude that making our existing laws harsher will provide any benefit.
- Finally, Chapter 6 sets outs a range of reforms options for the Committee – based on evidence – with some likely to be less controversial, and others more so.

Penington Institute stands ready to expand further on any aspect of this submission as required.

[6] A note on the term 'law reform': We have considered law reform in two main senses. First, there is law reform where legislative change is, itself, the reform (such as decriminalisation). Second, there are changes to laws or regulations which authorise or give effect to a new initiative (such as dispensing naloxone free from frontline services). Law reform could be required at both the state and Commonwealth level.

[7] We understand the Committee intends to interpret 'procedures' (as referenced in the Terms of Reference) as "existing policies, operating guidelines and practice."
(Correspondence with the Committee Secretariat, March 2017.)

Findings and recommendations

Finding — Major changes to drug laws Current laws are not working to minimise drug harms. There is enough to suggest better solutions lie in the direction of decriminalisation and regulated supply – but the devil is in the detail. Victoria can no longer delay the full exploration of these options through a special commission.	**Law reform implication?**
Recommendation **1.** Ask the Victorian Law Reform Commission to develop a discussion paper that considers how regulation could be better deployed to increase safety in the supply and consumption of drugs. The Commission should develop a graduated model for all major illicit drugs, keeping all options on the table – ranging from 'no change' or increased restrictions, through to decriminalisation and regulated supply – while always being informed by the harms, risks and prevalence of each substance considered.	**Yes** (possible)

Finding — Supervised consumption Current laws do not allow supervised consumption, but the evidence is very clear it would help.	**Law reform implication?**
Recommendation **2.** That the Committee: **a.** recommend a supervised injecting facility be trialled in Richmond (perhaps by passage of the Private Member's Bill currently referred by the Parliament to the Committee for separate inquiry); and	**Yes**
b. should the facility be favourably evaluated and subsequently become permanent, develop options to trial supervised injectable heroin to people dependent on opioids who have not responded to other treatments.	**Yes**

Finding — Reducing overdose (targeted measures) There are a range of opportunities to save lives now, with minimal barriers or controversy.	**Law reform implication?**
Recommendation **3.** The Victorian Government should address regional overdose by: **a.** developing an evidence base for regional overdose prevention opportunities; and **b.** conducting an awareness-raising campaign. **4.** The Victorian Government should incentivise overdose prevention activities in Victorian Government funded services.	
5. The Victorian Government should ensure appropriate funding and access arrangements for naloxone, in order to unlock innovative models of overdose prevention, including free naloxone distribution from needle and syringe programs and other high-value service venues.	**Yes** Pharmacy dispensing regulations

6. The Victorian Government should regularly review and report on the impact of real-time prescription monitoring, including its use by practitioners and outcomes for people identified as at-risk. **7.** The Victorian Government should work with the Commonwealth to ensure people identified as at-risk through prescription monitoring have access to support, especially addiction and chronic pain specialists. **8.** The Victorian Government should ensure its medicinal cannabis advisory committee considers a broad range of potential public health benefits, including reductions in overdose, when advising on future access to medicinal cannabis for people who have chronic non-cancer pain.	**Yes** (possible)

Finding — Refreshing Victoria's needle and syringe program NSPs are serving the state well, but require refreshed leadership and resourcing from government.	**Law reform implication?**
Recommendation **9.** The Victorian Government should refresh the Victorian needle and syringe program (NSP) by updating its aims, service models, coverage and equipment provided. A refreshed strategy should also revisit the legislative underpinnings for NSP services to ensure they reflect current best practice.	**Yes** (NSP legislation)

Finding — Pharmacotherapy treatment in Victoria Pharmacotherapy is highly effective and cost-effective, but unaffordable for clients, creating access barriers and service fragmentation.	**Law reform implication?**
Recommendation **10.** The Victorian Government should establish a funding model to subsidise pharmacotherapy dispensing fees in Victoria. This will increase service coverage, access and quality in the pharmacotherapy system and be an enabling factor for other reforms (such as improving service integration and workforce resilience). Victoria could work with the Commonwealth on a national approach, but given perennial inaction on this issue, should be open to establishing a state-based system.	**Possible** Move ORT medicines to s85 in *National Health Act (Cwlth)*

Finding — Specialist alcohol and other drug treatment The specialist AOD treatment system has been underfunded for too long and must now work through a backlog of people with serious drug problems. Demand must be modelled, met and managed continuously into the future.	**Law reform implication?**
Recommendation **11.** The Victorian Government should work with the Commonwealth and all states and territories to undertake comprehensive service planning to ensure a robust and flexible specialist drug treatment system. However, governments should actively plan to reduce the burden on the treatment system over time by investing in effective harm prevention and early intervention – while always meeting contemporary demand for specialist services.	

Finding — Effective prevention and early intervention Harm prevention and early intervention can help take pressure of specialist treatment and law enforcement.	**Law reform implication?**
Recommendation **12.** The Victorian Government should develop a comprehensive strategy to invest in effective prevention and early intervention, thus relieving pressure on specialist drug treatment, the justice system and the community in general. The strategy must set realistic goals for people across the drug user spectrum, having the overarching aim of preventing progression to problematic use. Essential components include: • localised, GP-led models of early intervention; • developing effective diversion options for those most at risk of progressing to problematic drug use; and • online approaches to harm prevention and reduction advice.	

Finding — Transparency in performance Current Victorian and Commonwealth reporting on drug-related activities is inadequate and fragmented.	**Law reform implication?**
Recommendation **13.** The Victorian Government should report annually and in and integrated way on outputs, outcomes and expenditure in the enforcement of drug laws. This should include regular reporting that elucidates how individuals charged with drug or drug-related offences navigate health, treatment, police, courts and corrections systems. **14.** The Victorian Government should work with the Commonwealth and states and territories to: **a.** establish an outcomes-based national performance framework for the new National Drug Strategy; and **b.** commission a comprehensive evaluation of Australia's policy and expenditure with regard to illicit drugs and drug use – the first in Australia's history.	**Possible** (Legislate better reporting)

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Chapter 1: The current state – laws, strategy, expenditure

Key points

- The use, possession, cultivation and trafficking of most psychoactive substances is prohibited in Victoria, except in limited medical and scientific circumstances. Commonwealth law prohibits drug importation and exportation.
- Penalties for drug offences vary, but most are criminal in nature and can be severe.
- Victoria broadly follows a national approach to drugs, incorporating supply reduction, demand reduction and harm reduction.
- Like the rest of Australia, not all aspects of the strategy are resourced adequately.

Laws and authorities

Laws

While others will address Victoria's drug legislation in detail, it is worth stating, for clarity, that the *Drugs, Poisons and Controlled Substances Act 1981 (Vic)* (the Act) prohibits use, possession, cultivation, trafficking and conspiracy relating to illegal drugs. The substances deemed illegal are recorded in Schedule Eleven of the Act and are known as 'drugs of dependence'. Many substances are illegal, but the more prevalent ones in Victoria are cannabis, methamphetamine (including crystal methamphetamine or ice), 3,4-Methylenedioxy-methamphetamine (MDMA or ecstasy), cocaine and heroin. The penalties for these different offences vary significantly, from a caution to serious terms of imprisonment.[8]

The Act also sets out additional offences relating to the unauthorised manufacture, supply and administration of medicines and poisons deemed either 'Controlled Drugs' or 'Prohibited Substances' in the national Poisons Standard. These provisions are largely in place to protect medical and scientific practitioners who wish to possess or provide these substances for legitimate purposes.

Apart from the Poisons Standard, which is part of the *Therapeutic Goods Act 1989 (Cth)* and has been adopted by all states and territories, most other Commonwealth drug law that affects Victorians relates to the importation and exportations of drugs and their precursors. These offences are set out in the *Criminal Code Act 1995 (Cth)*, the *Criminal Code Regulations 2002 (Cth)*, and the *Customs Act 1901 (Cth)*.

We note that on 8 March 2017 the Victorian Government introduced the Drugs, Poisons and Controlled Substances Miscellaneous Amendment Bill 2017 (the Bill), which creates new offences prohibiting the production, sale, commercial supply and advertisement (but not possession or use) of substances that either have a psychoactive effect when consumed, or are represented as having such an effect.[9] This change aims to address some aspects of the market for 'novel psychoactive substances' (NPS), which have emerged as a serious, if not yet widely prevalent, public health problem around the world in the past decade. The real-world impact of the Bill (should it become law) is yet to be seen.

[8] Law Handbook (2015), "Victorian Drug Laws", http://www.lawhandbook.org.au/03_02_02_victorian_laws/, accessed 28 February 2017.

[9] Parliament of Victoria (2017), "Drugs, Poisons and Controlled Substances Miscellaneous Amendment Bill 2017: Explanatory Memorandum", 8 March 2017, p. 1.

Authorities

Various public authorities are empowered to give effect to Victoria's drug laws – most particularly Victoria Police, the Office of Public Prosecutions, Courts Victoria, Corrections Victoria and the Departments of Justice and Regulation (now including, as of recently, responsibility for youth justice) and Health and Human Services. The Therapeutic Goods Administration, a division of the Commonwealth Department of Health, administers the Poisons Standard. Australian Border Force and various Commonwealth law enforcement and criminal justice authorities enforce Commonwealth drug laws.

Victoria's approach to drugs

Victoria's approach to drugs largely reflects Australia's national strategy

Reflecting the shared responsibility for drugs, all Australian governments (including Victoria) are party to the National Drug Strategy (NDS), which provides a national approach to drug use – broadly defined as including substances that have a legal status of licit (such as alcohol and tobacco), illicit or pharmaceutical.

The NDS establishes 'harm minimisation' as its overall aim, which in turn comprises three supporting 'pillars': reducing the supply of drugs, reducing the demand for drugs and reducing the harm from drugs. As some drugs are prohibited and others are not, the NDS acknowledges governments give effect to harm minimisation in different ways and with different priorities, according to the nature, risks, consumption patterns and legal status of the substance. The strategy does not set out implementation arrangements and there is no funding attached to it: these details are up to individual governments.

There is no current version of the NDS; it has been expired for over a year. We understand a new version will be finalised soon,[10] although the draft that was circulated for consultation in 2015 was largely in line with the previous version. The NDS is developed and authorised through the Council of Australian Governments and managed by the Commonwealth.

Early versions of the Strategy were well-regarded internationally for their fairly quick recognition of both demand and harm reduction – approaches which, in combination with law enforcement, it was considered would create the potential for a balanced approach.[11]

The NDS is a useful starting point for thinking about key concepts in addressing problems associated with drugs. However, the three pillars framework is limited – the activities that sit under them are not all resourced adequately, nor does the evidence suggest they are equally meritorious or even complementary. Merely continuing to toil away under each pillar will not deliver substantively against the Strategy's objectives. Empirical experience with the NDS, which has grown alongside an increasingly compelling international evidence base, suggests many solutions to Australia's contemporary drug problems would necessitate carefully integrating the best aspects of the three pillars. We expand on these ideas throughout the submission.

Strategy and expenditure are not the same

It is important to note that there is a significant discrepancy between the broad range of activities set out in the NDS and the extent to which they are endorsed and resourced in practice. An oft-cited (and unfortunately unique) analysis produced by the National Drug and Alcohol Research Centre in 2013[12] found that, in 2009-10 financial year, Australian governments' expenditure on addressing drug issues significantly favoured supply reduction. Of a total of $1.7 billion:

[10] Commonwealth of Australia (2016), Proof Committee Hansard: Senate Community Affairs Legislation Committee, 19 October 2016, p. 95.

[11] Lancaster and Ritter (2014), "Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985–2010", *International Journal of Drug Policy*, 25 (1):81-87, p. 86.

[12] Ritter et al (2013), *Monograph No. 24: Government drug policy expenditure in Australia – 2009/10*, DPMP Monograph Series, Sydney: National Drug and Alcohol Research Centre.

- law enforcement—which contributes overwhelmingly to the supply reduction pillar—comprised 66 per cent of government expenditure;
- demand reduction was at 30 per cent (drug treatment being 21 per cent; prevention 9 per cent); and
- harm reduction represented 2 per cent.[13]

The intervening years have seen little change, although there has been recent investment at both the state and Commonwealth levels to grow expenditure on drug treatment, prevention and education.

There is no equivalent analysis to the NDARC study for Victoria only, but it would be fair to say the state's efforts broadly reflect the national split (NDARC notes the vast bulk of law enforcement expenditure occurs at the state level[14]). It should be noted that not all of Victoria Police's work in relation to drugs falls neatly into the supply reduction category: discretionary cautioning, diversion and community policing are all important in enhancing the interaction between drugs and criminal justice.

We expect the Victorian Government will provide a submission detailing its investment to address drug harms. In **Chapter 6** (Reform options), we have addressed the need for a coordinated, focused approach from governments in their efforts be transparent on drug-related expenditure. This is an essential and readily available reform that would enable ongoing assessment of the performance of Victoria's drug laws.

[13] The remaining 2 per cent of expenditure was classified as 'Other' and primarily related to data and research.

[14] Ritter et al (2013), *Government drug policy expenditure in Australia – 2009/10*, p. 25.

Chapter 2: Are drug laws working to minimise supply?

Key points

- Victoria's drug laws are not meaningfully reducing the availability of illicit drugs.
- Drug-related arrests and seizures have grown significantly, but are not making drugs scarce.
- Dependent and non-dependent consumers report that drugs are easy to obtain.
- Australian drug laws have enabled the growing availability of new synthetic drugs.

Supply reduction appears unable to reduce supply

Australia's efforts to reduce the supply of illicit drugs have not made any substantive or lasting progress against this goal – a fact now broadly acknowledged by experts, decision makers and law enforcement itself. The statement that Australia cannot arrest its way out of drug problems has become firmly embedded in the policy debate (even if subsequent government decisions do not always reflect that accepted wisdom).

Most recently, the National Ice Taskforce and all Australian governments (through the National Ice Action Strategy) acknowledged that the low price, high purity and wide availability of crystal methamphetamine in this country appears to have been unmoved by Australia's large investment in supply reduction measures.[15] These findings hold true across all major drug types.

The failure of supply reduction is not for want of trying. Supply reduction attracts significant investment – primarily directed through border protection and police forces and enforced all the way through the broader criminal justice system. The exact quantity of government funding expended for this purpose in Victoria is unknown, but would likely amounts to several billion dollars over the past decade.

Supply reduction outputs are going up

The drug laws in effect in Victoria have overseen a large growth in law enforcement outputs, including drug-related arrests and seizures. Between October 2011 and September 2016, recorded Victorian state drug offences increased 53.4 per cent to 30,368, driven primarily by increases in use, possession and trafficking arrests.[16] Victorian cultivation and manufacturing offences were fairly stable across the same period, growing only 16.7 per cent (perhaps reflecting the offshore origin of much of Australia's drug supply, making it primarily a Commonwealth responsibility).

Across the country, in the past decade, the number of national illicit drug seizures has increased 91.7 per cent and the weight of national illicit drugs seized has increased 263.1 per cent. Data from Illicit Drug Data Reports (produced annually by the Australian Criminal Intelligence Commission) shows steady growth in the number of seizures by both state and federal police forces over the past four reporting years. Victoria Police seizures grew 10 per cent between 2011-12 and 2013-14, and then jumped 26 per cent to 7562 in 2014-15. At the federal level, seizures grew 227 per cent over the four year period to 2669 in 2014-15. (Trend analysis of the weight of seizures is not possible because of heavy outliers in some years.)

[15] Commonwealth of Australia, Department of the Prime Minister and Cabinet (2015), *National Ice Action Strategy 2015*, Canberra, p. 18.

[16] Victorian Government, Crime Statistics Agency (2016), "Offences recorded by offence categories – October 2011 to September 2016" (Table 1).

Growing seizures suggest a growing market for drugs, rather than a shrinking one

Multiple Australian studies[17] suggest that increased seizures do not indicate authorities are intercepting a growing proportion of the drug supply. In fact the opposite: increased seizures merely suggest a growing market for drugs.

Most recently, in 2014, the Bureau of Crime Statistics and Research (a NSW Government agency) found that increases in seizures and supplier arrests had no effect on emergency department admissions relating to these drugs, or on arrests for use and possession, up to four months later. The authors concluded there was "little in our results that would support increased investment in supply control policy as a means of reducing drug consumption and drug-related harm."[18]

Drugs are not becoming scarcer

Other indicators appear to validate this finding. Effective supply reduction measures would be expected to make drugs more expensive, less pure and more difficult to access. However, the present configuration of laws has overseen, at best, no change to price, purity and availability and, at worst, a significant aggravation of these measures.

The annual median purity of methamphetamine seized in Victoria was fairly steady from 2005 to 2010, hovering between 10 and 20 per cent. From 2010 onward, however, purity skyrocketed – and now sits at around 80 per cent.[19] These trends have been observed nationwide. Heroin purity in Victoria has been extremely stable, at around 15 per cent, over the same period,[20] further validating the lack of relationship between law enforcement efforts and drug supply.

Law enforcement acknowledges these realities

The NSW Crime Commission's 2015-16 Annual Report offered the following candid assessment of the drug supply in Australia, which bears reproduction:[21]

> The illicit drug trade continues to be the main stream of income for organised crime groups operating in Australia. Drugs that are predominantly manufactured overseas including cocaine and amphetamine-type stimulants (ATS), continue to command high prices domestically when compared with their cost offshore. As a consequence, international crime groups have continued, and likely have increased, their efforts in importing prohibited drugs into Australia in the last 12 months.
>
> Organised crime is increasing and is at levels not seen previously in New South Wales. The growth of organised crime is almost entirely driven by the prohibited drugs market and the indicators relied upon for this conclusion include the following:
>
> > **Availability of drugs:** Methamphetamine ('ice') and cocaine supplies are still high; prices for both drugs are considerably lower than five years ago and the detection and seizures are increasing both in number and volume.

[17] Wan et al (2014), *Monograph Series No. 53: Supply-Side Reduction Policy and Drug-Related Harm*, Canberra: National Drug Law Enforcement Research Fund, p. 16.

Rumbold and Fry (1999), *The Heroin Market Place Project: Examining the short term impact of the Port Macquarie heroin seizure on the characteristics of the retail heroin market in Melbourne*, Melbourne: Turning Point Alcohol and Drug Centre.

Weatherburn and Lind (1997), "The impact of law enforcement activity on a heroin market", *Addiction*, 93(5): 557-569.

Wood et al (2003), "Impact of supply-side policies for control of illicit drugs in the face of the AIDS and overdose epidemics: Investigation of a massive heroin seizure", *Canadian Medical Association Journal*, 168(2): 165-169.

[18] Wan et al (2014), p.18.

[19] Australian Criminal Intelligence Commission (2016), *Illicit Drug Data Report 2014-15*, https://www.acic.gov.au/sites/g/files/net1491/f/2016/08/01-introduction-acic-iddr-2014-15.pdf?v=1470179289, p. 49, accessed 21 February 2017.

[20] Ibid, p. 82.

[21] NSW Crime Commission (2016), *Annual Report 2015-2016*, p. 18-22.

> **Australia is a supply driven market:** Offshore interests decide the volume of drugs that are imported into Australia and the domestic drug consumption market will consume whatever is available. When an over-supply occurs, the result is a reduction in the price of prohibited drugs, which is precisely what we are seeing at present. Commendable law enforcement efforts around the country have resulted in larger seizures and more arrests, but they have had little, if any, effect on the quantities of prohibited drugs available for consumption in Australia.

Following the report's publication, *The Daily Telegraph* quoted a "senior law enforcement insider" as saying, "We are not losing the war on drugs, we have lost it."[22]

The Australian Bureau of Statistics estimated Australians spent about $7.1 billion on drugs in 2010, of which $5.8 billion was profit that went to traffickers.[23] A separate analysis estimated tax avoidance associated with the Australian drug trade could amount to $20 billion.[24]

Victorians can easily obtain drugs

Measuring a black market is difficult. There are always limits to how certain we can be of its size and activities. However, analysis of several datasets indicates drugs remain easily accessible, and largely reflect the supply-side indicators explored above.

Drugs are easily obtainable for all users – both dependent and non-dependent. The Illicit Drug Reporting System (IDRS) is an annual survey of injecting drug users in Australia. In 2016, 41 per cent of respondents reported daily use and 17 per cent used 'weekly or more'.[25] Respondents indicated that both heroin and methamphetamine were 'very easy' to obtain.[26]

The Ecstasy and Related Drugs Reporting System (EDRS) reports details of ecstasy and related drug markets in Australia. Unlike the IDRS consumer group, in 2016 only 25 per cent of respondents reported a frequency of use that was 'weekly or more'.[27] 93 per cent of ecstasy-using respondents found it easy or very easy to obtain,[28] while 92 per cent of methamphetamine-using respondents found the crystalline form (ice) easy or very easy to obtain.[29]

Thus, balancing across the two data sets, it appears both dependent and non-dependent drug users find drugs easy to obtain.

New synthetic drugs

A range of new synthetic drugs – for example, synthetic cannabinoids, phenethylamines, synthetic cathinones, tryptamines, novel opioids and many others[30] – have become a feature of Australia's drug supply in recent years.

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[22] Morri (2017), *Organised crime in NSW at levels not seen previously as state loses war on drugs*, 20 Jan 2017, http://www.dailytelegraph.com.au/news/nsw/organised-crime-in-nsw-at-levels-not-seen-previously-as-state-loses-war-on-drugs/news-story/bb06ee988ad76a822cd7637c2060d60f, accessed 23 January 2017.

[23] Anex, "Profits dwarf drug responses", *Anex Bulletin*, 11(6): 1-7, http://www.anex.org.au/wp-content/uploads/2013/07/Anex-bulletin-vol11-ed-6.pdf.

[24] Jiggens (2013), *Estimating the size and value of Australia's market for illegal drugs and its potential for taxation under a regulated market*, http://www.ffdlr.org.au/forums/docs/howmanyconesb+w-3.pdf.

[25] National Drug and Alcohol Research Centre (2016), "Key findings from the 2016 IDRS: A survey of people who inject drugs", https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/IDRS%20October%202016_FINAL.pdf, accessed 29 November 2016, p. 2.

[26] Ibid, p. 2.

[27] National Drug and Alcohol Research Centre (2016), "The 2016 EDRS key findings: A survey of people who regularly use psychostimulant drugs", https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/EDRS%20October%202016_FINAL.pdf, accessed 29 November 2016, p. 1.

[28] Ibid, p. 2.

[29] Ibid, p. 4.

[30] National Drug and Alcohol Research Centre (2016), "New (and emerging) Psychoactive Substances (NPS)", https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20New%20Psychoactive%20Substances%20%28NPS%29.pdf , accessed 9 March 2017.

They are commonly referred to as novel psychoactive substances (NPS), a category perhaps best defined by its plurality: hundreds of new chemical formulations have been identified around the world (manufacturers continuously circumvent formulations that have already been made illegal). Many of the short and long term effects of NPS are unknown or unpredictable, and can be worse than traditional drugs.

The legal status of NPS varies in Australia and in Victoria. Victoria Police's Chief Commissioner, Graham Ashton, has acknowledged novel psychoactives as the next frontier of drug harms.[31] Despite new legislation in Victoria to criminalise their manufacture, distribution and sale, it is unclear whether law enforcement will be able to actually detect supply, except reactively.

NPS are commonly marketed as 'legal highs', pointing to at least part of their consumer appeal.[32] NPS are often sold to consumers either as having effects that mimic a traditional drug, or indeed as being that traditional drug when they are not.[33] In this sense, the existence of an NPS supply is a direct product of drug laws that ban traditional drugs.

Pharmaceutical supply

Victoria's laws with regard to the supply of pharmaceuticals are not intended to eliminate supply, but rather ensure only people who are prescribed psychoactive pharmaceuticals drugs actually consume them. Medical practitioners and pharmacists are obliged to support their patients to ensure they use the medicines prescribed to them as directed.[34] Two predominant classes of pharmaceuticals stand out as both the most commonly misused and the most concerning in their misuse: opioids and benzodiazepines.[35]

In 2014, almost 3 million people in Australia were prescribed at least one opioid under the PBS or Repatriation PBS (RPBS). The most common prescriptions were for paracetamol with codeine (more than 1.7 million patients), followed by oxycodone (around 1 million patients).[36] Utilisation is highest in older age groups. Since the end of 2009, there has been a general increase in prescriptions, from around 2.5 million per quarter to around 3.5 million per quarter. Defined daily doses (DDDs, as defined by the World Health Organization) have increased approximately 20-fold since 1987. However, utilisation of morphine decreased by more than 40 per cent between 2004 and 2014.[37]

With regard to benzodiazepines, overall prescribing has actually decreased since the 1990s.[38] However, certain benzodiazepine medications have increased significantly (especially alprazolam – Xanax). The literature generally agrees benzodiazepines are still significantly over-prescribed as a class of drugs in Australia, in light of limited evidence of long-term efficacy.[39]

Although data are limited, it seems the majority of people who misuse pharmaceuticals are not using drugs prescribed to them personally.[40] This indicates a robust resale market for diverted pharmaceuticals.

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[31] Silvester (2015), "The "Turbo" Ice Age", *The Age*, 1 October 2015, http://www.theage.com.au/victoria/the-turbo-ice-age-20150930-gjy2bj.html.

[32] A separate, smaller proportion of people – sometimes referred to as 'psychonauts' – intentionally seek out new drugs for the purpose of experimentation. The legal status of NPS is not this group's primary concern.

[33] Queensland Crime and Corruption Commission (2015), "New synthetic drugs — deceptive and dangerous", http://www.ccc.qld.gov.au/research-and-publications/publications/ccc/new-synthetic-drugs-deceptive-and-dangerous.pdf, accessed 9 March 2017, p. 1.

[34] Dobbin (2014), "Pharmaceutical drug misuse in Australia", *Australian Prescriber*, 37: 79-81.

[35] Ibid.

[36] Commonwealth of Australia, Department of Health (2015), Opioids Roundtable Outcomes Statement, http://www.pbs.gov.au/reviews/authority-required-files/opioids-roundtable-outcome-statement.pdf, accessed 13 March 2017, p. 3.

[37] Ibid, p. 3.

[38] Islam et al (2014), "Twenty-year trends in benzodiazepine dispensing in the Australian population", *Internal Medicine Journal*, 44(1):57-64 .

[39] Brett and Murnion (2015), "Management of benzodiazepine misuse and dependence", *Australian Prescriber*, 38(5): 152–155.

[40] Rigg et al (2012), "Patterns of prescription medication diversion among drug dealers", *Drugs: Education, Prevention and Policy*, 19(2): 144-155.

Chapter 3: Are drug laws working to minimise use?

Key points

- Drug use in Victoria is fairly common, stable, and seemingly unaffected by drug laws.
- There is a trend toward consuming more potent drugs (pharmaceutical opioids, crystal methamphetamine and novel psychoactives).

Illicit drug use: fairly common, stable and little affected by drug laws

Is drug use normalised?

In the past 20 years a large body of research has been dedicated to assessing whether drug use has been 'normalised' among young people, particularly in Western countries. Australian experts broadly accept that normalisation has occurred in Australia, especially among young people, although levels of normalisation vary across and within social groupings and sub-populations.[41]

Key aspects of normalisation among young people include the understanding that most people do not experience significant harm from drugs, that most people manage their use ensure to their responsibilities are not unduly affected,[42] and that most 'age out of it' eventually.[43] However, young people recognise that harm does occur, and that risks can and should be managed – even among the substances considered most addictive.[44]

Drug use in Victoria has been fairly stable across the past decade, despite easy access – suggesting that it is not drug laws that are keeping population use stable. This is indicated in other datasets. When asked why they choose not to use a particular illicit drug, Australians most often cite lack of interest (73.3 per cent) and health or addiction concerns (47.0 per cent). Legal reasons were cited by only 28.6 per cent of respondents.[45]

Below we provide a brief overview of data on drug use trends in Australia. It is important to note that changes in drug use have a complex relationship with changes in drug harms. We address trends in drug harms in Chapter 4.

Drug use data

The most recent published national data on drug use is from 2013, although the 2016 survey should be available in 2017. In 2013:

- The proportion of people in Australia having used any illicit drug in the last 12 months was much the same as the past decade, at around 1 in 7.
- About 15 per cent (2.9 million) had used an illicit drug in the 12 months before the survey, increasing from 2.7 million (14.7 per cent) in 2010.
- About 42 per cent of Australians 14 and over in Australia (8 million people) have ever used an illicit drug.

[41] Fitzgerald et al (2012), "Drug normalisation and Australian youth: group differences in the social accommodation of drug use", *Journal of Youth Studies*, 16(7): 901-915.

[42] NSW Bar Association Criminal Law Committee (2014), "Drug Law Reform Discussion Paper", http://www.nswbar.asn.au/docs/webdocs/Drugs_DP_final1.pdf, accessed 12 December 2016.

[43] Green (2015), "'I wonder what age you grow out of it?' Negotiation of recreational drug use and the transition to adulthood among an Australian ethnographic sample", *Drugs: Education, Prevention and Policy*, 23(3): 202-211.

[44] Ibid.

[45] NSW Bar Association Criminal Law Committee (2014).

- There was no change in recent use of most illicit drugs in 2013, and use of any illicit drug remained stable between 2010 and 2013.
- However, there was a significant change for a number of specific drugs.
    - The proportion who had misused a pharmaceutical rose from 4.2 per cent in 2010 to 4.7 per cent in 2013, while the use of ecstasy, GHB and heroin declined.
    - The proportion of methamphetamine users who prefer the crystalline form (ice) rose dramatically to 50 per cent, while the proportion using it more than weekly grew to 15.5 per cent (reflecting the growth in purity noted in Chapter 2).[46]
- Across Australia, people in the age group 20-29 were the most likely to have used an illicit drug in the previous 12 months (27 per cent of all people in that age group).

Victoria overwhelmingly follows these national trends. Along with NSW, Victoria has the lowest rate of recent use of illicit drugs (14.3 per cent), and of cannabis in particular (9.1 per cent).[47]

Pharmaceuticals – increases in misuse

It would appear that increases in the availability of both opioids and common benzodiazepines have coincided with an increase in their misuse. As noted above, recent pharmaceutical misuse rose significantly between 2010 and 2013 – a figure we expect to rise again in forthcoming data – and indeed has risen steadily since 2001.[48] In 2013, 11.4 per cent of people had misused pharmaceuticals in their lifetime.

Novel psychoactive substances (NPS)

As noted in Chapter 2, the supply of NPS is increasing, although their use is not yet common in Australia. In 2013, 1.2 per cent of people reported recent use of synthetic cannabis, with a further 0.4 per cent reporting recent use of another emerging psychoactive substance.[49] Although data is limited, emerging hallucinogens appear to be the most consumed sub-group of NPS apart from synthetic cannabinoids.[50]

[46] AIHW (2014), *National Drug Strategy Household Survey detailed report 2013*, p. 7.

[47] Ibid, p. 11.

[48] AIHW (2014), *National Drug Strategy Household Survey*, Illicit use of drugs chapter online tables, "Misuse of pharmaceuticals" (Table 6.2).

[49] AIHW (2014), *National Drug Strategy Household Survey detailed report 2013*, p. 7.

[50] Burns et al (2014), "The rise of new psychoactive substance use in Australia", *Drug Testing and Analysis*, 6(7-8): 856-849.

Chapter 4: Are drug laws working to minimise harm?

Key points

- Drug dependence is far less common than drug use.
- However, dependence is very harmful, accounting for most drug-related health, social and economic harms in Victoria.
    - There are growing harms associated with ice, non-medical pharmaceuticals and polydrug use.
    - Accidental overdose deaths are increasing at an alarming rate.
    - Emerging psychoactive drugs are not yet prevalent, but their use is concerning.
- Drug laws facilitate the most harmful effects of drugs, by generating an unregulated supply and discouraging help-seeking.
- Victoria's most effective harm reduction strategy, needle and syringe programs, work despite, rather than because of, Victoria's drug laws.
- Drug laws intensify the stigmatisation of drug users.

Drug harms: uncommon, but entrenched and growing

The Terms of Reference for this Inquiry elevate *minimising drug-related health, social and economic harm* as the Committee's primary interest in evaluating the performance of Victoria's drug laws (as distinct from deterring and reducing the use of drugs in general). The findings in this chapter, in particular, compel the finding that our current laws are failing.

While population level use of drugs is fairly stable, drug dependence and other harms persist at levels that are both concerning and reducible.

Drug use exists on a spectrum,[51] with some drug use particularly problematic. Most people never experience significant, serious or lasting harm from drug use, but rather manage their use to ensure their educational, employment and social commitments are not unduly affected.[52] Most people eventually 'age out of' drug use, although the pathways may not be linear.[53,54]

Harmful or 'problematic' drug use does not have an objective or settled meaning,[55] but would usually be defined by the presence of adverse consequences. It may include a wide range of any drug use leading to physical or psychological dependence, as well as to adverse consequences to personal or public safety, public order, relationships and/or personal commitments. The accumulation and interaction of multiple harms generates greater severity. We can use different measures to indicate the prevalence and incidence of these consequences.

This chapter does not exhaustively describe Victoria's contemporary drug harms, but rather highlights some of the most prevalent and problematic harms and their interaction with current laws.

[51] Commonwealth of Australia (2015), *Draft National Drug Strategy 2016-2025*, http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/73E3AD4C708D5726CA257ED0000506 25/$File/draftnds.pdf, accessed 28 November 2016, p. 6.

[52] NSW Bar Association Criminal Law Committee (2014).

[53] Green (2015).

[54] AIHW (2014), *National Drug Strategy Household Survey*, Illicit use of drugs chapter online tables, "Illicit use of drugs, people aged 14 years or older, 1995 to 2013 (per cent)" (Table 5.1).

[55] Seddon (2011), "What is a problem drug user?", *Addiction Research and Theory*, 19(4): 334-343.

Drug dependence

Dependence develops when a person adapts to repeated drug exposure and can only function normally in the presence of the drug. When the drug is withdrawn, physiological and psychological reactions occur – ranging from mild to life-threatening, depending on a range of factors including the substance and the severity of dependence.[56] Withdrawal often leads to further use and a deepening of the dependence. Drug tolerance often develops, requiring greater quantity and frequency of consumption to achieve the desired effect.[57]

As a proportion of overall use, drug dependence is consistent and low in Australia, with frequency of use (a reasonable proxy indicator of dependence) stable for cannabis, ecstasy and cocaine in the past decade.[58] Best estimates show an average of 13 per cent dependence across cannabis, cocaine, opioids and amphetamines.[59]

However, in 2013, between 15 and 25 per cent of recent users of methamphetamine used at least once a week – a frequency that is suggestive of dependence – with ice users most likely to have used frequently.[60] Again, as reflected in the IDRS survey, which surveys mostly people who inject drugs weekly or daily, drug laws are not reducing their opportunities for using drugs.[61]

Data on the delivery of alcohol and other drug treatment is an imperfect measure of population prevalence, because the treatment system itself does not service anywhere near the number of people who need it. However, over the 5-year period to 2014-15:

- the number of closed treatment episodes increased from 150,488 to 170,367 (a 13 per cent increase);
- alcohol continued to be the most common drug leading clients to seek treatment;
- among illicit drugs, cannabis was the most common principal drug of concern (24 per cent), followed by amphetamines (20 per cent) and heroin (6.1 per cent); and
- among illicit drugs, the main change was that amphetamines overtook heroin as the third most common drug of concern, increasing its share from 8.7 per cent to 20 per cent.[62]

Ice-related harms are growing

The growing harms of methamphetamine have been thoroughly ventilated through recent Victorian and national inquiries, but are worth reviewing here given significant community concern. The following harmful trends have been documented:

- a growth in riskier forms of consumption (injecting and smoking);[63]
- significant growth in ice-related ambulance call outs and overdose incidents;[64]
- serious mental health problems;[65,66]

[56] National Institute on Drug Abuse (2007), "Definition of dependence", https://www.drugabuse.gov/publications/teaching-packets/neurobiology-drug-addiction/section-iii-action-heroin-morphine/8-definition-dependence, accessed 12 January 2017.

[57] Commonwealth of Australia (2004), "Treatment options for heroin and other opioid dependence: A guide for frontline workers", http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/content/C8A49A8F08C2F7FBCA2575B4001353A9/$File/opioid_workers.pdf, accessed 12 January 2017, p.9.

Tolerance can also drop quickly for some drugs, raising the risk of overdose.

[58] NSW Bar Association Criminal Law Committee (2014).

[59] Ibid.

[60] AIHW (2014), *National Drug Strategy Household Survey*, Illicit use of drugs chapter online tables, "Frequency of meth/amphetamine(a) use, recent(b) users aged 14 years or older, 2007 to 2013 (per cent)" (Table 5.20).

[61] National Drug and Alcohol Research Centre (2016), "Key findings from the 2016 IDRS: A survey of people who inject drugs".

[62] AIHW (2016), *Alcohol and other drug treatment services in Australia 2014–15*, Drug statistics series no. 27, Cat. no. HSE 173, Canberra: AIHW, p. 6.

[63] Commonwealth of Australia (2015), Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Canberra.

[64] Turning Point (2017), "Ambo-AODstats", http://amboaodstats.org.au/VicState/, accessed 15 March 2017.

[65] Victorian Government (2016), *Victoria's Mental Health Services Annual Report 2015-16*, p. 43.

[66] Darke (2008), "Major physical and psychological harms of methamphetamine use", *Drug and Alcohol Review*, 27(3):253-62.

- family breakdown;[67]
- a growth in ice-related acquisitive and violent offending.[68,69]

In 2015, the Victorian Ombudsman found ice use reported by prisoners in Corrections Victoria rehabilitation programs had doubled from 20 per cent to 40 per cent in the last four years,[70] and that violent offences committed by drug users in this cohort have doubled in the last four years from 18.7 per cent to 36.7 per cent.[71]

Perhaps the most salient point to make is that there is little reason to assume that these harms have abated, particularly in light of the slow rollout of urgent new capacity for drug treatment. The 2016 National Drug Strategy Household Survey, which will be published by mid-late 2017, should help to illuminate these matters.

Accidental overdose is growing – driven by pharmaceuticals and polydrug use

Victoria is in the midst of a large and sustained increase in accidental deaths due to drug overdose (both licit and illicit).[72] Deaths have grown 36 per cent across the decade 2004 (210 deaths) to 2014 (284) – reflecting national trends. Across Australia, in 2014 there were more overdose deaths than deaths resulting from car accidents.[73]

Although 2014 is the most recent year for which we have complete data, there is no reason to suspect the trend has declined since that time[74] – amounting to well over 2500 accidental overdose deaths since 2004. Further, it has been estimated that for each drug-related death, there are 20 to 25 non-fatal overdoses,[75] many of which come with significant, ongoing costs to people's health and the health system.[76] Non-fatal overdose can cause serious harm, including brain damage, pulmonary oedema, pneumonia and heart attack.

While there is no Australian estimate of the economic cost of overdose, it almost certainly runs to the billions of dollars each year.[77] Overdose is also a problem around the world, with between 69,000 and 103,500 deaths in 2014 alone.[78]

The profile of overdose is changing and diversifying

Overdose is most likely to occur among people who are dependent on drugs.[79] However, though it is statistically less common, any person who uses illicit or synthetic drugs could experience overdose, especially because an unregulated supply produces variable quality, dosage and effects.

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[67] Commonwealth of Australia (2015), *Final Report of the National Ice Taskforce*, p. 164.

[68] Victorian Government, Crime Statistics Agency (2016), In brief: What drug types drove increases in drug use and possession offences in Victoria over the past decade?",https://www.crimestatistics.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2016/07/b1/e4c026718/08072016_Inbrief5_FINAL.pdf, accessed 10 November 2016.

[69] McKetin et al (2008), Hostility Among Methamphetamine Users Experiencing Psychotic Symptoms, *American Journal on Addictions*, 17(3):235-40.

Clinically significant hostility co-occurs with psychotic symptoms in around one-quarter of methamphetamine users who experience psychosis, and it is more common with severe psychotic symptoms that persist for longer than two days.

[70] Victorian Ombudsman (2015), *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, p. 36.

[71] Ibid.

[72] Penington Institute (2016), *Australian Annual Overdose Report*, p. 9, available via: http://www.penington.org.au/overdoseday/.

[73] Ibid.

[74] Coroners Court of Victoria (2016), *Coroners Prevention Unit Data Summary: Victorian overdose deaths, 2009-2015*, pp. 3-4.

[75] European Monitoring Centre for Drugs and Drug Addiction (2010), *Annual Report: The State of the Drugs Problem in Europe*, p. 85.

[76] Warner-Smith et al (2002), "Morbidity associated with non-fatal heroin overdose", *Addiction*, 97: 8, August 2002, 963–967.

[77] Inocencio et al (2013), "The economic burden of opioid-related poisoning in the United States", *Pain Medicine*, 14, 1534-1547.

[78] United Nations Office on Drugs and Crime, *World Drug Report 2016* (United Nations publication, Sales No. E.16.XI.7), p. 18.

Between one third (69,000) and one half (103,500) are estimated to have been overdoses. With extremely poor data on these issues across much of the world, these figures may significantly underestimate the size of the problem. Recognising these same issues, other countries are mobilising and acting on overdose – most notably, in recent times, the United States.

Although most demographics are affected by overdose, the data indicates middle aged Victorians (ages 30-60), especially men living in rural areas, are most at risk.[80] The rate of overdose deaths in regional Victoria has grown 57 per cent (compared with 36 per cent for the state as a whole), and the number of deaths has risen 64 per cent, since 2008.[81]

Prescription pharmaceuticals are now more commonly implicated in overdose deaths than any illicit drug (although overdoses involving multiple substances – 'polydrug overdose' – are common). Concomitant alcohol or benzodiazepine use, and recently depleted tolerance, are significant risk factors for overdose.[82]

Victoria does not collect data on Aboriginal and Torres Strait Islander status for overdose deaths. However, all jurisdictions that do are reporting a particularly heightened rate of accidental overdose in this population. Among these jurisdictions the Indigenous overdose rate increased 141 per cent between 2004 and 2014 (to 9.4 per 100,000), compared with 45 per cent growth (to 4.8 per 100,000) among non-Indigenous people in the same period.[83]

These newer trends are adding to, rather than replacing, existing overdose risks among city-based injecting opioid users, which remains a cohort of major concern.

New synthetic drug types are proving deadly

While accidental overdose deaths are currently dominated by prescription pharmaceuticals and heroin, a multitude of NPS – such as the NBOMe group[84] and W18[85] – are beginning to have a deadly impact in this country.[86]

It is particularly concerning that these substances are often sold to consumers as traditional drugs,[87] despite many new psychoactives being toxic at much lower doses.[88] This means these drugs have the potential for serious harm even at low levels of prevalence in the general population.

A recent spate of accidental drug deaths in Melbourne demonstrates this effect. Three people died in January 2017 after consuming capsules containing 25C-NBOMe, 4-FA and MDMA, which was falsely sold as containing only the latter.[89] With no means to verify the contents of drugs produced illegally, consumers are exposed to higher levels of harm[90] and clinicians are under-equipped to treat problems, especially in emergency

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[79] World Health Organization (2014), "Information sheet on opioid overdose", http://www.who.int/substance_abuse/information-sheet/en/, accessed 10 November 2016.

[80] Australians aged 40-49 are the most likely to die of a drug overdose. Second are 30-39 year olds. Third are 50-59 year olds. In 2014, people in their 30s, 40s and 50s accounted for 78 per cent of all overdose deaths.

[81] Penington Institute (2016), *Australian Annual Overdose Report*, p. 9.

Overall numbers are too small to make trend analysis in SA, Tasmania, the NT and the ACT.

[82] Darke et al (2000), *Monograph No. 46: Heroin overdose: prevalence, correlates, consequences and interventions*, Sydney: National Drug and Alcohol Research Centre.

[83] Penington Institute (2016), *Australian Annual Overdose Report*, p. 12.

[84] Kueppers et al (2015), "25I-NBOMe related death in Australia: A case report", *Forensic Science International*, 249: e15-e18.

[85] Mettler, K. (2016), "W-18: The new street drug that is 10,000 times more toxic than morphine", *The Sydney Morning Herald*, http://www.smh.com.au/national/health/w18-the-new-street-drug-that-is-10000-times-more-toxic-than-morphine-20160428-gohbaw.html

[86] news.com.au (2016), "Drug 'N-bomb' that caused GC overdoses was the same drug that killed backpacker Rye Hunt", *news.com.au*, 21 October 2016, http://www.news.com.au/national/queensland/crime/drug-nbomb-that-caused-gc-overdoses-was-the-same-drug-that-killed-backpacker-rye-hunt/news-story/be610a069b46c5b92d9a5d3e4879c32f.

[87] Queensland Crime and Corruption Commission (2015), p. 1.

[88] Kueppers et al (2015), e15.

[89] Cowie (2017), "Police defend decision not to warn public of new drug after Melbourne club deaths", *The Age*, http://www.theage.com.au/victoria/police-defend-decision-not-to-warn-public-of-new-drug-after-melbourne-club-deaths-20170206-gu6zf2.html.

[90] It should be acknowledged that the drug market appears to exert some level of quality control through the self-regulatory relationship between consumer and producer. If it did not, drug-related death rates would likely be far higher.

situations. In Australia, overdose responses are not strongly oriented toward new psychoactives, and there is a dearth of evidence on best practice approaches – even in clinical settings.[91]

As noted in Chapter 2, new legislation in Victoria may criminalise the manufacture, distribution and sale of all NPS, but with few detection mechanisms for these drugs, their harms are likely to persist. 25C-NBOMe, for example, was already illegal at both the federal and Victorian levels when it killed Victorians earlier this year.

Blood-borne virus transmission is stable, but too high

While HIV prevalence remains low in Australia,[92] including among injecting drug users,[93] hepatitis C virus (HCV) prevalence among people who inject drug remains high (approximately 50 per cent).[94] An estimated 55,500 Victorians are living with chronic HCV,[95] around one-third of whom have moderate to severe liver disease.[96]

The vast majority of new HCV cases are among injecting drugs users who share equipment.[97] Best estimates suggest that around one quarter of people who access needle and syringe programs (NSPs) have shared injecting equipment at least once in the past month – a proportion that has been essentially unchanged for many years.[98]

NSPs are helping to keep HIV rates among the lowest in the world and HCV rates steady. However, while NSPs operate legally in Victoria, they are only able to attract clients because an operational agreement with law enforcement ensures police do not enforce suspected drug use and possession offences in the vicinity of an NSP outlet.[99] In this sense, NSPs' success in minimising harm comes despite, rather than because of, Victoria's drug laws.

Drug laws intensify harmful stigma

People who use drugs face a stigma that is complex, pervasive and wide-ranging.[100] While stigma is a universal phenomenon that that exists across all cultures,[101] a more unique factor is that drug stigma combines with, and is intensified by, criminal prohibition. Addiction, in particular, is highly stigmatised in the community;[102] addiction stigma often becomes internalised by people who are dependent on drugs.[103] Families of people who use drugs also experience stigma.[104]

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[91] Alcohol and Drug Foundation (2013), *New and emerging drugs*, http://adf.org.au/wp-content/uploads/2017/02/ADF-PreventionResearch-Apr13.pdf, accessed 10 March 2017, p. 11.

[92] Kirby Institute (2016), *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report*, p. 54.

0.13 per cent of the population.

[93] Kirby Institute (2015), *Australian NSP Survey: 20 Year National Data Report 1995-2014*, p. ii; p. 194.

2.1 per cent, or 2.2 per cent in Victoria.

[94] Centre for Research Excellence into Injecting Drug Use (2015), "Updated policy brief: People who inject drugs can be successfully treated for hepatitis C (HCV), and treatment has the potential to reduce the community prevalence of HCV", accessed 23 November 2016, http://creidu.edu.au/policy_briefs_and_submissions/6-updated-policy-brief-people-who-inject-drugs-can-be-successfully-treated-for-hepatitis-c-hcv-and-treatment-has-the-potential-to-reduce-the-community-prevalence-of-hcv.

[95] Hepatitis Victoria (2017), "What is Hepatitis C?", https://www.hepvic.org.au/page/12/hepatitis-c-what-is, accessed 24 January 2017.

[96] Commonwealth of Australia (2014), *Fourth National Hepatitis C Strategy 2014-2017*.

The burden of liver disease caused by HCV – including liver cirrhosis, liver cancer, liver failure and the potential need for liver transplant – is continuing to rise. Australia-wide, chronic HCV was estimated to be the underlying cause of liver disease in 22 per cent of liver transplants in 2012.

[97] Ibid.

[98] Kirby Institute (2015), *Australian NSP Survey: National Data Report 2011-2015*, p. i.

[99] Victorian Government, Department of Human Services (2011), "Victorian Needle and Syringe Program Operating Policy and Guidelines", https://www2.health.vic.gov.au/Api/downloadmedia/%7B8C35CEA2-FDBA-476D-924F-0ED98DED2ED0%7D, accessed 13 January 2017.

[100] Room (2005),"Stigma, social inequality and alcohol and drug use", *Drug and Alcohol Review*, 24(2):143-55.

[101] Buchman and Reiner (2009), "Stigma and Addiction: Being and Becoming", *American Journal of Bioethics*, 9(9): 18-19.

[102] Ibid.

[103] Room (2005), p. 152.

[104] Commonwealth of Australia (2015), *Final Report of the National Ice Taskforce*, p. 164.

The effects of stigma are less-safe drug consumption,[105] a reduction in people seeking help[106] and, especially among Aboriginal and Torres Strait Islander people, shame.[107] Experiences of stigma and discrimination are frequently cited as problematic by drug users around the world.[108] By contrast, some of the most effective interventions for people who use drugs are those that actively seek to eliminate stigma from the service experience, such as in primary NSPs and evidence-based treatment.

It has been argued that, in limited circumstances, stigma can be beneficial for public health by creating and reinforcing a social deterrent not to take certain decisions or actions. The reduction in smoking rates in developed countries is the most commonly cited example in this case.[109]

However, stigmatising smoking appears to have mostly changed behaviour in relatively privileged population groups and, among those who continue to smoke heavily, this group is highly disadvantaged, suggesting stigma will only worsen health and economic inequalities over time.[110]

We address the question of how law reform may affect stigma in Chapter 6.

> "There's so much stigma about drug addiction … no one understands that it's not a choice. Like, it might be a choice at the start but you get stuck. I just found I got taken like a joke everywhere. It was actually embarrassing for me to go and seek help because I didn't know how people were going to react to me … They assumed or believed that I was just 'that junkie.'"
>
> *— Brooke, former ice user*
>
> *(Interview with Penington Institute)*

[105] Csete et al (2016), "Public health and international drug policy", *The Lancet Commissions*, 387(10026): 1427-1480.

[106] Ibid.

[107] Treloar C and Jackson LC et al (2016), "Multiple stigmas, shame and historical trauma compound the experience of Aboriginal Australians living with hepatitis C", *Health Sociology Review*, vol. 25, pp. 18-32.

[108] Drug Policy Alliance (2014), "Stigma and People Who Use Drugs", http://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Stigma_and_People_Who_Use_Drugs.pdf.

[109] Dean (2014), "Stigmatization and denormalization as public health policies: some Kantian thoughts", *Bioethics*, 28(8):414-9.

[110] Bell (2010), "Smoking, stigma and tobacco 'denormalization': Further reflections on the use of stigma as a public health tool", *Social Science and Medicine*, 70(6):795-9.

Chapter 5: Could we just make existing laws harsher?

Key points

- Increasing criminal penalties would be likely to exacerbate drug harms, cyclical reoffending and prison overcrowding. It may marginally reduce occasional drug use.
- More of the same will not deliver long hoped-for reductions in drug problems – and the problems themselves are becoming more diverse, complex and intractable.
- In the face of persistent poor outcomes, the justice system is itself developing alternatives to failed punitive responses, but these are not yet scaled up.
- Criminal penalties already amplify harmful stigma. Harsher penalties would make this worse.

The evidence (Chapters 2-4) clearly demonstrates drug supply use and harms have not been eliminated, and indeed it was unreasonable to expect the justice system to achieve this. In the present supply landscape, criminals are becoming more technologically sophisticated, deploying a range of cheap, effective, encrypted tools to organise and communicate.[111,112] Further, the ever-increasing diversity and potency of drug products is confounding the detection methods of law enforcement.[113] In short, enforcing drug laws has never been harder.

Nevertheless, the Committee may receive a range of suggestions for Victoria to double down on the punitive and criminal justice-led approaches of the past. It is worth highlighting the false promise of such regressive action: these are failed but well-funded approaches, falsely held out as 'tough', in contrast with effective but poorly funded health and harm reduction approaches.

This Chapter reviews outcomes for people who are found to have breached Victoria's drug laws, or who have committed drug-related crimes.[114] We find there is no reason to conclude that a renewed focus on criminal approaches – were it cost-effective – would yield the long hoped-for promises of drug law enforcement, and harmful stigma would be intensified.

Note: Given Australia's legal and political environment, we have put 'extreme' increases in criminal penalties for drug use and possession – such as those currently seen in the Philippines under President Rodrigo Duterte – out of scope. If the Committee is interested, Human Rights Watch offers a good summary of the alarming human rights abuses attendant with such an approach.[115]

Current laws are not improving offender outcomes

Most offenders use drugs, including inside prison

Approximately 65 per cent of offenders use drugs,[116] and around half of their charges are directly attributable to alcohol and/or drug use.[117]

[111] NSW Crime Commission (2016), *Annual Report 2015-2016*, p. 18-22.

[112] Olding (2014), "Young man's death highlights the tragic reality of online illegal drug stores", *Sydney Morning Herald*, 13 January 2014, http://www.smh.com.au/nsw/young-mans-death-highlights-the-tragic-reality-of-online-illegal-drug-stores-20140111-30nnp.html.

[113] Barratt et al (2017), "A critical examination of the definition of 'psychoactive effect' in Australian drug legislation", *International Journal of Drug Policy*, 40: 16-25.

[114] This question is somewhat difficult to track, because the individual experience of people who move through the justice system for drug-related offending is not transparent. We address this issue in Chapter 6 (Transparency).

[115] Human Rights Watch (2017), "License to Kill: Philippine Police Killings in Duterte's 'War on Drugs'", https://www.hrw.org/report/2017/03/01/license-kill/philippine-police-killings-dutertes-war-drugs, accessed 10 March 2017.

[116] AIHW (2015), "Prisoner health: Illicit drug use", http://www.aihw.gov.au/prisoner-health/illicit-drug-use/, accessed 10 March 2017. This figure is much higher, at 76 per cent, for prisoners aged 18-24.

A range of data suggests that drug use is a significant issue in Australian prisons. Drugs, though not as accessible as in the general community, can be obtained quite easily.

Although Victoria does not provide data to the Australian Institute of Health and Welfare's *Health of Australia's Prisoners* study, in 2015 10 per cent of prisoner dischargees surveyed reported using illicit drugs while in prison,[118] including 6 per cent injecting and 4 per cent needle sharing.[119] Given the nature and timing of this survey – when prisoners have just been released – the prevalence of prison drug use is likely to be far higher. In 2009, a NSW surveys put estimates of illicit drug use in prisons at around 40-45 per cent,[120] with 48.2 per cent of respondents saying it was quite easy or very easy to obtain drugs in prison.[121]

Overdose deaths do occur inside Victorian prisons, with recent cases relating to ice[122] and prescription drugs.[123]

Drugs, crime and disadvantage

There is a complex interplay between drugs, poor mental health, crime, socioeconomic exclusion and prison. People with significant disadvantage are far more likely to experience drug harms, have problematic drug use and have drug-related interactions with the criminal justice system. Problematic drug use is highly correlated with economic exclusion and social isolation.[124,125,126]

People convicted of a drug offence in Australia consistently report that their conviction is a barrier to finding work, even when there is no clear risk relationship between the job and their conviction and when they have discontinued using drugs.[127] This generates a high level of economic and social harm; it is a market distortion that prevents the free flow of labour and productive participation in the community.[128] Not surprisingly, these experiences contribute to escalating cycles of problematic drug use and related offending.[129]

Outcomes are serving neither the community nor drug users

Australian prisoners do report moderate improvements to physical and mental health after a spell of incarceration (with a vital exception being rates of hepatitis contraction while incarcerated).[130]

However, overall, offenders have some of the poorest social, health and economic outcomes of any group.[131] It is well acknowledged that Victoria's custodial system is not reducing drug use or drug-related offending. This was

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[117] Australian Institute of Criminology, "How much crime is drug or alcohol related? Self-reported attributions of police detainees", *Trends and issues in crime and criminal justice* (No. 439, May 2012), http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi439.pdf.

[118] AIHW (2015), *The health of Australia's prisoners 2015*, Cat. no. PHE 207, Canberra: AIHW, p. 102.

[119] Ibid, p. 103.

[120] NSW Health (2010), *2009 NSW Inmate Health Survey: Key Findings Report*, Sydney: Justice Health, http://www.justicehealth.nsw.gov.au/publications/2009-ihs-report.pdf.

[121] Ibid, p. 110.

[122] Coroners Court of Victoria (2016), "Finding – Inquest into the Death of Cain Douglas Ernest Hutchinson", Melbourne, http://www.coronerscourt.vic.gov.au/resources/198da224-d10a-48b6-bb50-499416eebb68/caindouglasernesthutchinson_278715.pdf.

[123] Herald Sun (2017), "Port Phillip Prison inmate dies in suspected drug overdose", *Herald Sun*, 22 February 2017, http://www.heraldsun.com.au/news/law-order/port-phillip-prison-inmate-dies-in-suspected-drug-overdose/news-story/30a142e70680660ff84a8c33c939f0c.

[124] Australian Medical Association (2007), "Social Determinants of Health and the Prevention of Health Inequities" https://ama.com.au/position-statement/social-determinants-health-and-prevention-health-inequities-2007, accessed 13 October 2016.

[125] NDARC (2004), *Social Determinants of Drug Use*, https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf.

[126] Scottish Drugs Forum (2007), "Drugs and poverty: A literature review", http://www.dldocs.stir.ac.uk/documents/drugpovertylitrev.pdf.

[127] Australian National Council on Drugs (August 2013), *ANCD Position Paper: Pre-employment criminal record checks*.

[128] Pager (2007), *Marked: Race, Crime, and Finding Work in an Era of Mass Incarceration*, University of Chicago Press.

[129] Stevenson (2011), *Working Paper: Drug Policy, Criminal Justice and Mass Imprisonment*,http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf.
Imprisonment for drug crime is problematic, with high economic and social costs and an increased likelihood of recidivism and additional criminal behaviour.

[130] AIHW (2015), *The health of Australia's prisoners 2015*.

subject to a wide-ranging investigation by the Victorian Ombudsman across 2014 and 2015, which found the state has a growing prison population and a worsening reoffending rate (44.1 per cent).[132] These problems have been compounded by ineffective, or non-existent, reintegration strategies for prisoners.[133]

Crucially, the disruptive nature of incarceration is itself a major contributor factor in reoffending[134]— a true vicious circle that even the best reintegration approaches will struggle to confound.

Nevertheless, the lack of AOD treatment, transitional and community-based supports for prisoners with drug use problems is concerning.[135] The Ombudsman noted similar service gaps exist for people with mental illness[136] – undoubtedly an overlapping cohort.

The justice system itself is unsatisfied with punitive responses

There are certainly opportunities to improve access to drug treatment and other services within prisons, especially for people who use drugs and who have committed serious crimes requiring a custodial sentence.[137]

However, increasingly, Victoria's justice system itself is developing alternatives for both drug use/possession and drug-related offending. The most effective and promising developments in Victoria in recent years are those that de-emphasise criminal and custodial responses in favour of diversion, therapeutic jurisprudence and integrated support.

Diversion, therapeutic jurisprudence and integrated support

The case for diverting drug offenders away from criminal and custodial responses has been recognised in Australia and overseas for some time. Diversion can take a number forms, but broadly occurs at detection/arrest (by police) or at charge/hearing (by courts). The Australian Medical Association has endorsed expanded diversionary and non-custodial options as public health improvement measures.[138]

Diversion tends to lead to:

- **Lower reoffending rates**

  Victoria Police operate the Illicit Drug Diversion Initiative (IDDI), which provides access to diversion without charge for low level drug possession, contingent on participation in counselling and referral to treatment if necessary. IDDI was evaluated by the Australian Institute of Criminology in 2008, finding that 75 per cent of people did not reoffend following their diversion, and that of the 25 per cent that did, two thirds were offending at lower rates than prior to being diverted. Victoria Police indicated in its submission to the Victorian Parliament's methamphetamine inquiry that, in the five years since the evaluation, the program remains effective, with approximately 80 per cent of offenders not having further contact with police.[139]

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[131] Australian Medical Association (2012), "Position statement: Health and the Criminal Justice System", https://ama.com.au/position-statement/health-and-criminal-justice-system-2012, accessed 11 October 2016.

[132] Victorian Ombudsman (2015), *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne.

[133] Ibid.

[134] Schetzer (2013), *Beyond the prison gates: the experiences of people recently released from prison into homelessness and housing crisis*, https://www.piac.asn.au/wp-content/uploads/2013.05.10_hpls_report.pdf.

[135] Victorian Ombudsman (2015), p. 6.

[136] Ibid.

[137] Ibid, p. 56.

[138] Australian Medical Association (2012).

[139] Victoria Police (2013), *Submission to the Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria*, p. 21.

Utilisation of IDDI has increased by 17 per cent since 2010 to a yearly average of 49 per cent of those who are eligible. A record 1,634 Drug Diversions were issued in 2012-13.[140]

Similar results have been produced across the country.[141]

- **Improved health outcomes**

  Diversion programs are also attributed with significantly improving the health and wellbeing of participants. The 2014 evaluation of the Victorian Drug Court found that, between 2010 and 2013, 94 per cent of clients who completed all three phases of their Drug Treatment Order were classified as low risk for poor physical health. At the start of the program, 30 per cent were classified as medium risk and 11 per cent high risk.[142] Even clients who did not fully complete their program experienced a positive impact, with the proportion of medium risk participants reducing from 40 per cent to 26 per cent and high risk participants stable at 5 per cent.[143]

  Similar improvements in mental health and wellbeing were also recorded. For completers, 44 per cent commenced as psychiatrically low risk, 39 per cent medium and 17 per cent high. By completion, 89 per cent were psychiatrically low risk, 11 per cent were medium and no participants were rated as high risk.[144]

- **Reduced drug use**

  Drug courts usually aim to reduce drug use (typically to the point of abstinence) through therapy or pharmacotherapy treatment. Considering most clients report as daily users, the Victorian Drug Court has significantly reduced the drug use of clients over the three phases of the program. All completers were considered at low risk of drug and alcohol use, compared with 56 per cent considered high risk upon commencement.[145] Again, even partial completion reduced alcohol and drug use, with 60 per cent deemed high risk at commencement and just 10 per cent high risk at two-thirds' completion.[146]

Victoria also operates the Court Integrated Services Program (CISP) across three Magistrates Court sites. CISP can be applied to more serious and complex drug and drug-related offences.[147] CISP is available as a support program for offenders (at the pre-trial and/or bail stage) who have not accessed diversion, linking them to services such as drug and alcohol treatment, crisis accommodation, disability services and mental health services. It thus provides an integrated service delivery model for addressing the underlying drivers of an individual's offending. CISP was positively evaluated in 2009, having demonstrated:

- significant improvements in physical and mental health for clients in the period immediately after the program; and
- a significantly lower rate of re-offending in the months after they exited the program compared with offenders at other (non-CISP) court venues.[148]

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[140] Ibid.

[141] Australian Institute of Criminology (2008), "Police drug diversion: a study of criminal offending outcomes", http://www.aic.gov.au/media_library/publications/rpp/97/rpp097.pdf, p. 70.

[142] Magistrates Courts of Victoria (2014), *Evaluation of the Drug Court of Victoria*, https://www.magistratescourt.vic.gov.au/sites/default/files/141218%20Evaluation%20of%20the%20Drug%20Court%20of%20Victoria.pdf, p. 54.

[143] Ibid.

[144] Ibid, p. 55.

[145] Ibid, p. 56.

[146] Ibid.

[147] Magistrates Courts of Victoria (2017), "Court Integrated Services Program (CISP)", https://www.magistratescourt.vic.gov.au/court-support-services/court-integrated-services-program-cisp, accessed 6 March 2017.

[148] Department of Justice (2009), *Economic Evaluation of the Court Integrated Services Program (CISP): Final report on economic impacts of CISP*, https://www.magistratescourt.vic.gov.au/sites/default/files/Default/cisp_economic_evaluation_final_report.pdf.

We can further conclude that, given drug offenders who succeed in CISP are more likely to stay out of prison into the future, a range of cyclical problems are likely to be averted.

Next steps for diversion and therapeutic justice

Clearly, both Victoria Police and Courts Victoria have started to acknowledge the value of diversion and therapeutic supports to break offending cycles.

We develop more detailed ideas for how to move diversion forward in Chapter 6. However, it is fair to state here that the evidence points away from custodial and punitive responses to drug use, possession and related crime. Indeed, scaling up diversionary and related approaches is needed to start to achieve a population-level benefit.

Chapter 6: Recommendations and reform options

Key points

- A range of reform options are available to the Committee for recommendation, in light of the non-performance of Victoria's drug laws.
- Models of decriminalisation, regulated supply and supervised consumption around the world are associated with, and appear to help enable, better outcomes – including a reduction in harmful stigma.
- At the very least, the evidence is clear that these options should not be feared, ignored or dismissed as impractical.
- We have to think about law reform systematically. Changing laws cannot alone guarantee good outcomes: the details of reform models matter – as do the policies, programs and funding that support them. Victoria should fully explore these options.
- Whether the Committee's scope for law reform is large or small, a range of iterative (and less controversial) options are available and should be implemented immediately. These include:
    - a supervised consumption trial;
    - targeted overdose reduction measures;
    - a refreshed and properly resourced needle and syringe program;
    - a more affordable and accessible pharmacotherapy program;
    - a reliable specialist treatment system that models and meets demand;
    - a move to effective harm prevention and early intervention strategies to take pressure off specialist systems; and
    - better government transparency on performance, outputs and outcomes.

The Committee's Terms of Reference for this Inquiry ask that it "inquire into, consider and report [on] the practice of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law."

The most ambitious and wide-ranging law reforms that have taken place in other jurisdictions can be generally categorised as forms of either decriminalisation or regulated supply (a form of controlled legalisation). This chapter weighs some of the primary considerations associated with the two 'major' options and suggests the Victorian Law Reform Commission be engaged to develop a detailed options paper for the better regulation of drugs.

We have also presented a range of policy ideas and interventions that are warranted regardless of the Committee's appetite for major change. These options may themselves require legislative or regulatory change, but may not be considered 'law reforms' as such. Some recommendations would require federal or nationwide support if implementation is sought.

The interaction of stigma, public health and the criminal law

Moving away from a criminal model would be likely to have the overarching benefit of reducing the stigmatisation of people who use drugs.[149] History offers many examples of how law reform can help to

[149] Hughes and Stevens (2007), *The Effects Of Decriminalization Of Drug Use In Portugal*, http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_14.pdf.

destigmatise certain groups or identities, thus materially improving lives – the reduction in health inequalities that followed the passage of the United States' *Civil Rights Act* being perhaps the most famous example.[150]

It is also not the case that what has worked for smoking will work for other drugs. Although both involve the consumption of a psychoactive drug and both can result in harmful dependence, it is essential to consider that smoking tobacco is not experientially the same as the use of other (illicit) drugs. The cost-benefit calculation of pleasure derived (at least in the early stages) and harms borne in both the short and long term is not the same.

Even if there is not consensus on the need to destigmatise drug use, there is a strong case for avoiding 'achieving' that stigma by way of criminal sanctions.[151]

This would, in turn, be likely to increase help-seeking by drug users and reducing the psychosocial complexity of the supports provided.

Decriminalisation and regulated supply

Recommendations

1. Ask the Victorian Law Reform Commission to develop a discussion paper that considers how regulation could be better deployed to increase safety in the supply and consumption of drugs. The Commission should develop a graduated model for all major illicit drugs, keeping all options on the table – ranging from 'no change' or increased restrictions, through to decriminalisation and regulated supply – while always being informed by the harms, risks and prevalence of each substance considered.

Decriminalisation

Decriminalisation of drugs would not legalise them. A decriminalised drug remains prohibited, but the criminal penalty associated with it is removed.[152] This means a person who possesses or uses a decriminalised drug would have the substance confiscated on detection, but would not face a criminal charge; there would be no criminal conviction, sentence or record. The person may be required (or requested) to access alternative interventions, such as education, treatment for drug dependence or a range of other health and human services.

The avoidance of a criminal charge provides an immediate benefit: the person's employment or employability is not affected. Given the range of poor outcomes experienced by drug offenders (Chapter 5), the removal of a custodial sentence also improves their long-term prospects and saves the state the costs associated with incarceration. The positive effects demonstrated by diversion programs point to some of the likely benefits of decriminalisation, but scaled up to become the rule rather than the exception.

The scope of decriminalisation is generally considered to extend to drug use and possession, but not to trafficking, manufacturing or cultivation. A key argument in favour of decriminalisation is that it would free up law enforcement resources to focus on other problems, which might include trafficking and other more serious drug-related offences.

Decriminalisation would not displace the illicit drug trade, a fact worth considering in light of the unscrupulous practices, poor quality control, violence, large-scale money laundering and tax evasion endemic to organised crime.

[150] Hatzenbuehler (2013), "Stigma as a Fundamental Cause of Population Health Inequalities", *American Journal of Public Health*, 103(5): 813-821.

[151] Count the Costs, "Th War on Drugs: Promoting stigma and discrimination", http://www.countthecosts.org/sites/default/files/Stigma-briefing.pdf.

[152] Caulkins and Kilmer (2016), "Considering marijuana legalization carefully: insights for other jurisdictions from analysis for Vermont", *Addiction*, 111(12): 2082-2089.

Portugal and the Czech Republic remain the only countries in the modern era to have decriminalised all drugs (in 2001 and 2010, respectively). Portugal in particular remains the subject of great interest for people concerned with drug issues because of the longer time since decriminalisation was implemented (offering longer term trend data).

Since decriminalising, Portugal has seen long-term reductions in the burden on the criminal justice system (especially prisons), reductions in problematic drug use, reductions in drug-related HIV and AIDS, reductions in drug-related deaths and lower social costs of responding to drugs.[153] Access to drug treatment and reintegration services, including employment services, has gone up.[154] Portugal maintains one of the lowest drug-induced mortality rates in Europe – 4.5 deaths per million, compared with the European average of 19.2 deaths per million.[155] Importantly, the architect of Portugal's drug policy emphasises that their successes cannot be attributed to decriminalisation alone, but also a significant investment in health and harm reduction approaches.[156]

Although it is probably too early to draw definitive conclusions from the Czech Republic's decriminalisation experience, drug use appears to be stable, with the use of cannabis decreasing.[157] While the proportion of problem drug users appears to have increased, this has been driven mostly by a growth in methamphetamine use.[158] This is consistent with high and increasing levels of purity over the same period, which reached 71 per cent in 2013.[159] The Czech Republic maintains ones of the lowest drug-induced mortality rates in Europe – 5.2 deaths per million, compared with the European average of 19.2 deaths per million.[160]

In 2010, at the same time as decriminalising use and possession, the Czech Republic decriminalised the cultivation of small amounts of cannabis for personal use. It appears this has reduced the size of the black market.[161] The move toward differentiating different illicit substances and tailoring regulatory responses according to risk appears to be working. It has certainly not unlocked growth in either drug use or drug harms.

Regulated supply

In principle, the aim of establishing a regulated supply of a previously illicit drug would be to derive the main benefits of decriminalisation while also developing more direct controls over drug consumption, shrinking the black market and (possibly) deriving taxation revenue from drugs sold.[162]

The regulated supply of previously illicit drugs is a fairly recent phenomenon,[163] and has so far only applied to cannabis (we have excluded prescribed heroin from this section, as it is addressed in the next section, **Supervised consumption**). Uruguay, Canada and a number of US states have either legalised, or are in the process of

[153] Hughes (2017), "Chapter 11 Portuguese drug policy", in *European Drug Policies: The Ways of Reform*, Abingdon: Routledge.

[154] Ibid.

[155] EMCDDA (2016), *Portugal country overview*, http://www.emcdda.europa.eu/countries/portugal, accessed 8 March 2017.

[156] Goulão (2015), "The current state of development: Portuguese drug policy", http://www.issdp.org/wp-content/uploads/2015/09/JGoulao_SICAD_Porto-2-9-2015.pdf.

[157] Release (2016), *A Quiet Revolution: Drug Decriminalisation Across the Globe*, http://www.release.org.uk/sites/default/files/pdf/publications/A%20Quiet%20Revolution%20-%20Decriminalisation%20Across%20the%20Globe.pdf, p. 21.

[158] National Monitoring Centre for Drugs and Addiction (2014), *National Report: The Czech Republic 2013 Drug Situation*, p. 65.

[159] Ibid, p. 9.

[160] EMCDDA (2016), *Czech Republic country overview*, http://www.emcdda.europa.eu/countries/czech-republic, accessed 8 March 2017.

[161] National Monitoring Centre for Drugs and Addiction (2014), *National Report: The Czech Republic 2013 Drug Situation*, p. 177.

[162] NSW Bar Association Criminal Law Committee (2014).

[163] Caulkins and Kilmer (2016).

legalising, cannabis under a wide range of regulatory models.[164] In the Netherlands, cannabis is still illegal, but decriminalised for personal use: the country tolerates retail sales, but does not allow commercial production.[165]

Most experts agree it is too early to tell what the public health impacts of legal cannabis in the United States have been and that it is difficult to draw simple conclusions given the breadth of models implemented:[166,167]

- The Cato Institute has argued that there appear to be few, if any, detectable impacts on cannabis use or harm in states that have legalised it so far,[168] although Hall and Lynskey suggest it may take a decade or more to know legalisation's real effect, with historical precedent indicating increases in use should be expected over time.[169] (Of course, increases in use may not come with significant increases in harm.)
- RAND Corporation senior economist Rosalie Liccardo Pacula has suggested rapidly growing commercial cannabis markets are targeting young people. American policy academics Caulkins and Kilmer, who have studied regulation of cannabis extensively and advised governments considering a regulatory scheme, note the risk that commercial interests may seek to influence future public health policies.[170]
- Perhaps of greatest concern in the American context, the Colorado regulated market appears to have been taxed too heavily. The black market has shrunk significantly. However, it has not displaced illegal cannabis in many of the poor, urban communities of colour that have been disproportionately affected by the war on drugs.[171] The Drug Policy Alliance reports "while the number of marijuana possession arrests has dropped, the law enforcement practices that produce racial disparities in such arrests have not changed since the passage of Amendment 64."[172]

Such uncertainties and undesirable consequences are largely expected in new policy experiments. Regulatory challenges and other structural factors affecting the benefits of regulated supply should not be considered reason not to explore these options. As well-known Australian crime statistician Don Weatherburn has noted, all criminal prohibitions produce human and financial costs.[173] Prohibition of drugs undoubtedly does (Chapters 2-5). The fundamental question for policy makers is whether we believe they also produce benefits and that (for at least some outcomes) the benefits outweigh the costs.[174]

As no country has yet attempted legalisation of drugs apart from cannabis, it is currently impossible to answer this question. However, Caulkins and Kilmer sum up the major considerations as follows:

> Perhaps the most important insight [into lessons learned from cannabis legalisation] is that legalization is not a binary choice. In a very real sense the question: 'Should jurisdiction X legalize?' is ill-posed, and invites the response: 'That depends on what form the legalization would take'.[175]

Given that different drugs have fundamentally different effects, harms and dependence profiles, consideration of a differentiated model – one which approaches drugs based on objective parameters and a reasonable risk

[164] Pacula (2017), "Testimony: Regulating Medical Marijuana Markets – Insights from Scientific Evaluations of State Experiments", https://www.rand.org/content/dam/rand/pubs/testimonies/CT400/CT461/RAND_CT461.pdf.

[165] Caulkins and Kilmer (2016).

[166] Hall (2016), "Why it is probably too soon to assess the public health effects of legalisation of recreational cannabis use in the USA", *Lancet Psychiatry*, S2215-0366(16): 30071-2.

[167] Pacula (2017).

[168] Cato Institute (2016), *Dose of Reality: The Effect of State Marijuana Legalizations*, https://object.cato.org/sites/cato.org/files/pubs/pdf/pa799.pdf.

[169] Hall (2016), p. 904.

[170] Caulkins and Kilmer (2016).

[171] James (2016), "The Failed Promise of Legal Pot", *The Atlantic*, https://www.theatlantic.com/politics/archive/2016/05/legal-pot-and-the-black-market/481506/.

[172] Drug Policy Alliance (2015), *Marijuana Arrests in Colorado After the Passage of Amendment 64*, http://www.drugpolicy.org/sites/default/files/Colorado_Marijuana_Arrests_After_Amendment_64.pdf

[173] Weatherburn (2014), "'The abject failure of drug prohibition? Really?", *Australian & New Zealand Journal of Criminology* , 47(2).

[174] Ibid.

[175] Caulkins and Kilmer (2016).

calculation – is warranted. In light of consistent poor performance under our current laws, there is no reason not to ask an independent body to properly shape these options for future discussion in Victoria.

Supervised consumption

Recommendations

2. That the Committee:

a. recommend a supervised injecting facility be trialled in Richmond (perhaps by passage of the Private Member's Bill currently referred by the Parliament to the Committee for separate inquiry); and

b. should the facility be favourably evaluated and subsequently become permanent, develop options to trial supervised injectable heroin to people dependent on opioids who have not responded to other treatments.

Drug consumption rooms and supervised injecting facilities

Drug consumption rooms (DCRs) are professionally supervised health care facilities where people can consume drugs in safe conditions.[176] Supervised injecting facilities (SIF) – a form of DCR – are currently the subject of considerable debate in Victoria. A range of Penington Institute's stakeholders and colleagues have called for a SIF trial, or at least for the feasibility of a trial to be commissioned. North Richmond is currently considered the state's highest priority location, given its high concentration of fatal overdoses.[177]

In 2016 there were 90 drug consumption rooms operating worldwide in Australia (Sydney), Canada, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Spain and Switzerland.[178] Ireland and Scotland have plans to introduce SIFs during 2017.[179]

The effectiveness of drug consumption rooms in reducing deaths and disease and improving their clients' connections to services has been well-established. A review, last updated by the European Monitoring Centre for Drugs and Drug Addiction in 2016,[180] provides an up-to-date summary of their impact.

- **Engaging hard-to-reach people**

  DCRs reach, and stay in contact with, highly marginalised target populations. This contact results in immediate improvements in hygiene and safer use for clients, as well as wider health and public order benefits.[181]

- **Reduced injecting risks**

  SIF clients report reductions in injecting risk behaviour, such as the sharing of injecting equipment.[182]

- **Reduced deaths**

[176] Harm Reduction International (2016), *Global State of Harm Reduction Overview*, https://www.hri.global/files/2016/11/15/Global_Overview_2016.pdf, p. 18.
[177] Coroners Court of Victoria (2017), "Finding – Inquest into the Death of Ms A", Melbourne, http://www.coronerscourt.vic.gov.au/resources/d48c9cdc-8db0-45b5-83c2-5ea6918e3ccd/ms+a_+241816.pdf.
[178] Harm Reduction International (2016), p. 18.
[179] Ibid.
[180] EMCDDA (2016), *Drug consumption rooms: an overview of provision and evidence*, http://www.emcdda.europa.eu/system/files/publications/2734/Drug%20consumption%20rooms_update%202016.pdf.
[181] Ibid, p. 4.
[182] Ibid.

Australia's only SIF, in Sydney, has managed over 6000 overdoses, without any fatalities,[183] and a study of the Sydney facility showed fewer ambulance call-outs during its operating hours.[184] There are no recorded deaths inside a SIF anywhere in the world. SIFs may not be sufficiently scaled up to have a detectable impact on population level measures; however, some studies have suggested drug consumption rooms may contribute to reducing drug-related deaths at city level.[185]

- **Increased uptake of treatment services**

  SIFs increase uptake both of detoxification and of drug dependence treatment, including opioid substitution.[186]

- **Improved public amenity and safety**

  DCRs are associated with a decrease in public injecting and a reduction in the number of syringes discarded in the vicinity.[187]

- **No impact on local crime rates**

  Drug consumption rooms do not appear to lead to either an increase or decrease in thefts or robberies around the facility.[188]

There are some uncertainties about the impact of DCRs on population-level measures of drug use and harm. This is because of difficulties in attributing causal effects in complex systems, and because the service coverage of DCRs may not be sufficiently scaled up to be observable in headline figures.

However, the evidence is at least clear enough to suggest SIFs are worth trying in high needs areas – and should not be dismissed out of hand. Although the current focus is on a trial in North Richmond, a range of areas with high overdose death rates – including the CBD, Brimbank, Frankston, Greater Geelong, Port Philip and Greater Dandenong – would also be worthy of consideration.[189] A mix of fixed-site and mobile facilities could help to account for the different geographic layout of high needs areas, particularly given the growth of drug problems in Melbourne's growth corridors.[190]

We note a Private Member's Bill establishing an 18-month trial of a supervised injecting facility was introduced to the Parliament on 7 February 2017 and has been referred to the Committee.

However, we also note the Government's commitment not to introduce such a facility.

Heroin-assisted treatment

The science is now in on another aspect of supervised consumption – heroin-assisted treatment or 'supervised injectable heroin' (SIH). SIH involves prescribing pharmaceutical-grade (diacetylmorphine) heroin to someone dependent on opioids, which the patient then consumes.

[183] Uniting, "Uniting Medically Supervised Injecting Centre: Get to Know Our Story", https://uniting.org/__data/assets/pdf_file/0005/139370/Uniting-MSIC-Brochure-.pdf.

[184] Salmon et al (2010), "The impact of asupervised injecting facility onambulance call-outs in Sydney, Australia", *Addiction*, 105(4: 676-683.

[185] Strang et al (2015), "Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction", *British Journal of Psychiatry*, 207(1): 5-14.

[186] EMCDDA (2016), *Drug consumption rooms: an overview of provision and evidence*, p. 5.

[187] Ibid.

[188] Ibid.

[189] Coroners Court of Victoria (2016), "Finding – Inquest into the Death of Frank Edward Frood – Attachment C", Melbourne, http://www.coronerscourt.vic.gov.au/resources/2c8acec4-54f0-44e8-b1ad-c4b1bd701c14/frankedwardfrood_408012.pdf, pp. 10-11.

[190] Victorian Government (2016), *Victoria's Mental Health Services Annual Report 2015-16*, p. 43.

SIH treatment has emerged over the past 15 years as an intensive treatment for heroin users who have not responded to standard therapies, such as methadone, buprenorphine or drug dependence treatment.[191] Unlike other opioid replacement therapies, where take home doses are allowed for some patients, most countries only provide heroin for consumption in a clinical setting – such as a drug consumption room. SIH may be administered alongside methadone to provide a replacement therapy after the effects of the heroin wear off.[192]

A landmark meta-analysis was published by Strang et al in 2015,[193] providing a compelling synthesis of the results of six randomised SIH trials in six countries – Switzerland, the Netherlands, Spain, Germany, Canada and England – over 15 years. The findings were that SIH supports:

- a treatment retention rate at least as good, and often significantly better than, oral methadone;
- a reduction in the illicit use of heroin, often significantly better than methadone – even in programs with an excellent methadone treatment stream;
- an improvement across participants' self-reported measures of health and mental health;
- in the case of the Swiss trial, a reduction in crimes compared with the control group; and
- in the studies the that looked for it, a faster onset of benefits from SIH compared with the control group.

A separate 2005 review found that prescribing SIH or SIH plus methadone tends to reduce criminal activity among recipients.[194] A more recent study of the UK's prescribed heroin program found that patients receiving heroin were less likely to commit crimes to support their drug use than those receiving oral methadone.[195] While prescribed heroin may be more cost effective than methadone over a life time,[196] SIH may also be less safe than methadone treatment – requiring greater clinical management of risks. The Strang study estimates an overdose occurs at a rate of about 1 in every 6000 injections in supervised settings (far below street heroin rates). All have been safely managed by clinical staff.[197] Strang nevertheless suggests that SIH would generally only be available for people who have not responded to other treatments.[198]

In September 2016, in response to a constitutional challenge (on medical grounds), the Canadian Government established new regulations to enable medical practitioners to access pharmaceutical-grade diacetylmorphine heroin) where other treatments have failed.[199] Canada is also in the process of scaling up its use of drug consumption rooms in response to a badly escalating opioid overdose crisis.[200]

Next steps for supervised consumption

The evidence clearly points to giving medical practitioners the option of prescribing SIH for individual patients who have not responded to other treatments. Notwithstanding the Government's current opposition, should

[191] Strang et al (2015), p. 5.

[192] Wodak (2016), "Weekly dose: treating heroin dependence with heroin", *The Conversation*, 1 June 2016, https://theconversation.com/weekly-dose-treating-heroin-dependence-with-heroin-58424.

[193] Strang et al (2015), p. 5.

[194] Ferri et al (2006), "Heroin maintenance treatment for chronic heroin-dependent individuals: A Cochrane systematic review of effectiveness", *Journal of Substance Abuse Treatment*, 30(1):63-72, p. 63.

[195] Byford et al (2013), "Cost-effectiveness of injectable opioid treatment v. oral methadone for chronic heroin addiction", *British Journal of Psychiatry*, 203(5): 341-349.

[196] Nosyk et al (2012), "Cost-effectiveness of diacetylmorphine versus methadone for chronic opioid dependence refractory to treatment", *Canadian Medical Association Journal*, 184(6): E317-28.

[197] Strang et al (2015), 12.

[198] Strang et al (2015), 5.

[199] Government of Canada (2016)," Regulations Amending Certain Regulations Made Under the Controlled Drugs and Substances Act (Access to Diacetylmorphine for Emergency Treatment)", http://gazette.gc.ca/rp-pr/p2/2016/2016-09-07/html/sor-dors239-eng.php, accessed 9 March 2017.

[200] Medical Express (2017), "Canada authorizes new drug consumption rooms", *Medical Express*, 6 February 2017, https://medicalxpress.com/news/2017-02-canada-authorizes-drug-consumption-rooms.html.

Victoria pursue a medically supervised DCR in the future, this may be the logical setting in which to conduct a Victorian trial of SIH.

There would be legal implications for this, which we expect would broadly follow the reform pathway established for medicinal cannabis:

- A medical research trial may not require Commonwealth law reform, but would involve gaining approval to conduct medical research using a prohibited substance (that is, listed on Schedule 9 of the national Poisons Standard).
- Establishing SIH as a legitimate medical option for practitioners would require placing heroin on Schedule 8, alongside methadone and buprenorphine, as a substance "which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence." There would require a range of changes to Victorian law, particularly under the *Drugs, Poisons and Controlled Substances Act 1981 (Vic)*.

Reducing overdose – targeted measures

Recommendations

3. The Victorian Government should address regional overdose by:
    a. developing an evidence base for regional overdose prevention opportunities; and
    b. conducting an awareness-raising campaign.
4. The Victorian Government should ensure appropriate funding and access arrangements for naloxone, in order to unlock innovative models of overdose prevention, including free naloxone distribution from needle and syringe programs and other high-value service venues.
5. The Victorian Government should ensure appropriate funding and access arrangements for naloxone, in order to unlock innovative models of overdose prevention, including free naloxone distribution from needle and syringe programs and other high-value service venues.
6. The Victorian Government should regularly review and report on the impact of real-time prescription monitoring, including its use by practitioners and outcomes for people identified as at-risk.
7. The Victorian Government should work with the Commonwealth to ensure people identified as at-risk through prescription monitoring have access to support, especially addiction and chronic pain specialists.
8. The Victorian Government should ensure its medicinal cannabis advisory committee considers a broad range of potential public health benefits, including reductions in overdose, when advising on future access to medicinal cannabis for people who have chronic non-cancer pain.

We addressed the scale of Victoria's overdose problem in Chapter 4. Here, we propose some targeted measures to reduce both fatal and non-fatal overdose. These are distinct from other important strategies, including supervised consumption, pharmacotherapy, drug dependence treatment and prevention, which are addressed elsewhere in this submission.

Investing in targeted overdose prevention measures is worthwhile, given other services that have a preventative effect (such as drug treatment) often involve slow and non-linear pathways. By contrast, the consequences of overdose are severe, rapid and (often) irreversible.

In Australia, all levels of government must play a role

In Australia, all levels of government must collaborate to reduce overdose. There is a need to respond strongly across primary, secondary and tertiary health settings, as well as through human services and in local areas.

Penington Institute has lobbied the Commonwealth to lead national initiatives, including a national awareness campaign, Primary Health Network-led prevention and a more suitable funding scheme for purchasing naloxone (a medicine that reverses opioid overdose). The Victorian Government should seek more active participation from the Commonwealth in this space.

As demonstrated recently by the City of Yarra, local government can also play an enabling role – identifying community issues, bringing together the people affected and facilitating access to evidence-based options.

Victoria has the makings of a strong response

We have been pleased to see the Victorian Government acknowledge and respond to the growing problem of overdose. This has resulted, in particular, in two new rounds of funding, which are both modest but worthwhile:

- On 31 August 2016, on International Overdose Awareness Day, the Minister for Mental Health, the Hon Martin Foley MP, announced new funding would support peer-led networks to target six overdose 'hotspots' across greater metropolitan Melbourne and Geelong.[201]
- On 23 February 2017, the Minister announced a further $1.3 million to fund assertive outreach in the six hotspots, as well as subsidised naloxone, overdose training and drug user education across the state.[202]

These investments add to the Government's recent allocations to improve Victorians' access to alcohol and drug treatment[203] and develop real-time prescription monitoring.[204]

Incentivising performance

We also recommend the Government explore opportunities to provide an incentive for funded agencies to integrate, and regularly conduct, overdose prevention in their everyday business. This could take the form of ongoing dedicated funding, practice-based incentives for particular interventions or a mix of both.

Regional overdose

However, the significant growth in non-metropolitan overdose will not be addressed by local responses in Melbourne and Geelong. Moving beyond the hotspots would help to address the well-publicised growth in overdose in country Victoria in recent years: as noted in Chapter 4, the rate of overdose deaths in regional Victoria has grown 57 per cent (compared with 36 per cent for the state as a whole), and the number of deaths 64 per cent, since 2008.

Preventing overdose in the regions will require a different approach from what works in populous, well-serviced metropolitan areas. However, we first need to understand the growth in regional overdose – as an emerging problem, is has not yet been fully explained.

At present, we only have basic information on the demographics and risk factors that appear to be associated with regional overdose deaths. Regional pharmaceutical opioid users are more likely to have complex chronic

[201] Victorian Government (2016), "Remembering Those Lost to Overdose", released 31 August 2016, available via: http://www.premier.vic.gov.au/remembering-those-lost-to-overdose/.

[202] Victorian Government (2016), "Saving Lives – Preventing And Treating Overdose", released 23 February 2017, http://www.premier.vic.gov.au/saving-lives-preventing-and-treating-overdose/.

[203] Victorian Government (2015), "Ice Action Plan", released 5 March 2015, http://www.premier.vic.gov.au/ice-action-plan/.

[204] Victorian Government (2016), "Real Time Prescription Monitoring Will Save Lives", released 25 April 2016, http://www.premier.vic.gov.au/real-time-prescription-monitoring-will-save-lives/.

pain presentations and concurrent benzodiazepine problems.[205] As they are also less likely to inject,[206] it will not be sufficient to merely target traditional cohorts of injecting drug users through established venues such as needle and syringe programs. Strategies for finding and supporting this cohort are very underdeveloped.

It is imperative to establish a proper evidence base to inform a model of overdose prevention that will be effective in regional Victoria, incorporating a range of empirical data and the lived experiences of Victorians.

Naloxone should be widely available and affordable in the community

Naloxone is a medicine that safely reverses the effects of an overdose of opioids (both licit and illicit).[207] It has no potential for misuse, no serious side effects and no effect on someone who has not consumed opioids. Australia's ambulance officers and hospital emergency department staff save lives with naloxone every day.

Australia also has several small scale naloxone programs (including one operated by Penington Institute), which provide naloxone access and training to potential overdose witnesses in the community. These programs are fairly new, but are proving to be uniquely effective in preventing overdoses in hard-to-reach communities.[208] In the minutes and seconds that can mean the difference between fatal and non-fatal overdose, or between temporary or permanent injury, this is crucial.

However, despite a conservative estimate indicating at least 306,000 Australians use opioids in an illicit way each year,[209] consumer need for naloxone has failed to convert to market demand. This has led to frequent changes in the forms and distributors of naloxone in Australia, generating uncertainty in supply and stopping overdose prevention programs from designing functional, scalable programs.

On top of this, governments are yet to establish funding and distribution mechanisms that make sense for both the medicine and the end consumer.

Naloxone is fairly affordable if prescribed by a doctor (attracting a PBS subsidy under Schedule 4). However, once prescribed, a pharmacist must stock and supply it, and the recipient must be trained in how to use it (usually by a community health or needle and syringe program worker). This may seem a simple process, but willing prescribers are uncommon and it is difficult to engage high risk opioid users in services where they often face stigma and discrimination. It can become an arduous task for health workers to coordinate with multiple practitioners while keeping a client engaged.

Naloxone can be fairly conveniently obtained directly from a pharmacist (without a prescription, under Schedule 3). However, under Schedule 3 the medicine is not subsidised, and costs around $70. This is simply too expensive for the vast majority of people who need it. Further, the pharmacist must stock the medicine and be willing to spend the time showing their customer how to use it.

To sum up the quandary: naloxone, if accessed via a doctor, is affordable but inconvenient; via a pharmacist, it is fairly convenient but unaffordable. Neither is ideal.

In this context, the Victorian Government's announcement of a dedicated fund to subsidise naloxone at the state level is very welcome, but it is currently unclear how the fund will work – who will get access to it, if it is large enough, who will dispense the medicine and where. Nevertheless, this would be a significant step toward unlocking the true life-saving potential of naloxone.

[205] Nielsen et al (2015), "Changes in non-opioid substitution treatment episodes for pharmaceutical opioids and heroin from 2002 to 2011", *Drug and Alcohol Dependence*, 149 (2015) 212–219, p. 216.

[206] Ibid, p. 216.

[207] Because of their suppressant effect on the respiratory system, opioids – both licit (oxycodone, codeine, fentanyl, etc.) and illicit (heroin) – are the drug type most commonly implicated in fatal overdose in Australia.

[208] Olsen et al (2015), *Key Findings: Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Program, 2011- 2014*; final report, Canberra.

[209] AIHW (2014), *National Drug Strategy Household Survey detailed report 2013*.

Unlocking innovative models

A dedicated fund to make access to naloxone both convenient and affordable will allow health and human services workers to focus on what they do best: provide an engaging, high quality, health-oriented service to their clients.

With naloxone access no longer tied up, now is the time to develop innovative models of distribution that reflect its safety and ease of use. Around the world, naloxone is being provided to laypeople and non-medical professionals to use when needed: in the US, police officers administer nasal spray naloxone when responding to overdoses;[210] in the UK, large and successful trials have seen prison exiters with a known history of opioid use receive naloxone.[211]

Penington Institute therefore recommends the Government enable NSPs, drug treatment, outreach and other relevant services to directly dispense free naloxone to clients who need it (and train them to use it). Minor regulatory changes, if required, should not to be a barrier to achieving this essential innovation. We understand NSW is currently establishing such a trial.

Educating communities about overdose risks

The growth in regional overdose is adding to, rather than replacing, existing overdose risks among city-based injecting heroin users.[212] While the Government's immediate focus appears to be on targeted communication, a more wide-ranging awareness campaign is warranted. The evidence suggests that targeting drug users through traditional means (NSPs and so forth), while important, is no longer sufficient to reach the diversifying profile of people affected by overdose.

> "I want to thank you for all the work you do for this epidemic. We must put an end to fear and shame associated with addiction. Grief has consumed me over the loss of my 26 year old daughter in 2014. I will try to stay in the present and be a part of International Overdose Awareness Day."
>
> *— Patricia, mother and IOAD participant*
>
> *(Feedback to Penington Institute)*

An overdose awareness campaign should be led by evidence, with a focus on the characteristics of overdose growth in Victoria – that is, people in regional areas and metropolitan hotspots, prescription pharmaceuticals and polydrug use. It should target vulnerable populations – using advertising, media, public relations and social media – and provide practical information and advice to help people reduce their risk of overdose. The campaign should also engage family, friends and peers of people at risk of overdose to help them find a viable role in preventing an overdose outcome.

Just as crucially, overdose education must help to break down stigma. This is a key focus of International Overdose Awareness Day (IOAD), which occurs on 31 August each year and for which Penington Institute is the convenor.

Prescription monitoring

Penington Institute welcomes the introduction of prescription monitoring. It is an opportunity to gather real-time information about people who may be experiencing, or at risk of, drug dependence. The potential benefits in terms of early intervention are very significant.

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[210] Adapt Pharma (2016), "Adapt Pharma Partners with OH Attorney General DeWine to Guarantee Public Interest Price", released 1 December 2016, http://adaptpharma.com/adapt_press_release/december-1-2016-adapt-pharma-to-provide-narcan-nasal-spray-4mg-at-a-discounted-rate/.

[211] Medical Research Council UK (2014), "N-ALIVE", http://www.ctu.mrc.ac.uk/our_research/research_areas/other_conditions/studies/n_alive/, accessed 3 March 2017.

[212] Penington Institute (2016), *Australian Annual Overdose Report*.

However, this will be determined by practitioners' use of the information available. There is a real risk that some patients who are flagged as 'drug-seeking', rather than being identified and supported, will simply be locked out of health services (especially GP practices). This could result in displacement into the injection of illicit heroin or generate demand for counterfeit pharmaceuticals, an effect noted in the US as access to prescription opioids has been tightened.[213]

We recommend the Government measure, and control for, this effect as it develops and rolls out the prescription monitoring system.

Chronic pain treatments and medicinal cannabis

The high prevalence of significant and chronic non-cancer pain is well documented in Australia.[214] It has been described as an 'undiscovered health priority'.[215] GPs often prescribe powerful opioid painkillers to this patient group and dependency is common, even though only one-third benefit from their long term use.[216] GPs often lack the skills and knowledge to apply effective alternative pain treatments, but access to chronic pain specialists is also low, with an average public waiting time of 180 days to get an appointment and even longer to commence treatment.[217] Regional access to specialists is especially low.[218]

The proportion of people who have died from overdose who were chronic pain sufferers is unclear. However, it is likely that over-prescribing of opioids to people with chronic pain has, in part, led to an oversupply in the secondary market.

This suggests that the Government should be actively exploring as many alternative pain therapies as possible, including medicinal cannabis. Although the effectiveness of medicinal cannabis in relieving chronic non-cancer pain is still the subject of debate,[219] people who have self-initiated cannabis use to treat their chronic pain have reported improvements in symptoms. A recent Australian study surveyed 1514 people who had been prescribed pharmaceutical opioids for chronic non-cancer pain.[220] 16 per cent reported using cannabis to treat their pain, with an average reported pain relief from cannabis of 70 per cent, compared with an average relief from opioid painkillers of 50 per cent.[221] Among the cannabis users in the study, they tended to have more serious pain than most of the sample.[222]

A 2014 study published in the *Journal of the American Medical Association* matched medicinal cannabis availability with opioid overdoses, finding state-level medicinal cannabis laws are associated with a 25 per cent reduction in mortality from opioid abuse compared to states without such laws.

Overall, there is evidence at both the empirical and systematic level that medicinal cannabis may help reduce overdose. While Victoria's chronic non-cancer pain sufferers are not currently proposed to have access to

[213] McGreal (2016), "How cracking down on America's painkiller capital led to a heroin crisis", *The Guardian Online*, https://www.theguardian.com/science/2016/may/25/opioid-epidemic-prescription-painkillers-heroin-addiction, accessed 20 January 2017.
[214] VAADA (2014), "Position paper: Chronic Pain and AOD", http://www.vaada.org.au/wp-content/uploads/2014/05/VAADA-Chronic-Pain-position-paper1.pdf, accessed 20 January 2017.
[215] Ibid.
[216] Ibid.
[217] Ibid.
[218] Pain Australia (2015), "National Pain Strategy", http://www.painaustralia.org.au/advocacy/national-pain-strategy.html, accessed 20 January 2017.
[219] Degenhardt et al (2015), "Experience of adjunctive cannabis use for chronic non-cancer pain: Findings from the Pain and Opioids IN Treatment (POINT) study", *Drug and Alcohol Dependence*, 147: 144–150.
[220] Ibid.
[221] Ibid, p. 145.
[222] Ibid, p. 144.

medicinal cannabis, the Government has established an independent medical committee to advise on future widening of eligibility.[223]

The criteria for the this group's deliberations have not been published, but Penington Institute recommends the medical committee should consider a broad range of potential public health benefits – including reductions in overdose – when advising on future eligibility for chronic non-cancer pain.

Refreshing Victoria's needle and syringe program

Recommendations

9. The Victorian Government should refresh the Victorian needle and syringe program (NSP) by updating its aims, service models, coverage and equipment provided. A refreshed strategy should also revisit the legislative underpinnings for NSP services to ensure they reflect current best practice.

Needle and syringe programs (NSPs) have the core responsibilities of:

- preventing the transmission of blood borne viruses by dispensing sterile injecting equipment; and
- encouraging safer injecting practices.

At their best, NSPs also connect their clients with the support they need – including drug treatment, mental health and housing services. They are often their clients' only regular service touchpoint. As injecting drug use is associated with higher levels of drug dependence,[224] NSPs represent a unique opportunity to address the complex interactions of drug use, poor mental and physical health, socioeconomic exclusion and crime.

NSPs work uniquely well

NSPs are one of the most successful and cost-beneficial public health investments in Australia's history. In the decade 2000-2009 alone, NSPs averted an estimated 32,050 HIV infections and 96,667 hepatitis C (HCV) infections, generating a health care cost saving of $4 for every dollar spent, or $27 in economic savings for every dollar spent.[225] NSPs return more disability-adjusted life years than interventions addressing diabetes and impaired glucose tolerance, vaccinations, allied health, alcohol and drug dependence, lifestyle and in-patient interventions.[226]

In short, NSPs are serving the Victorian community – and government budgets – extremely well.

There is no strategic approach to NSP access and quality

However, as noted in Chapter 4, challenges remain in terms of HCV prevalence and persistent sharing rates. A range of factors contribute to the persistence of equipment sharing, but chief among them is restricted access: sterile equipment is not always available when injectors require it, due to geographic distance and/or the operating hours of existing NSPs.[227] The average age of NSP clients is also increasing, presenting a new challenge for ensuring access among people whose mobility and social connectedness are diminishing.[228]

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[223] Victorian Government (2016), "Order Establishing the Independent Medical Advisory Committee on Medicinal Cannabis", 16 August 2016, http://www.gazette.vic.gov.au/gazette/Gazettes2016/GG2016S252.pdf.

[224] Novak et al (2011), "Comparing Injection and Non-Injection Routes of Administration for Heroin, Methamphetamine, and Cocaine Uses in the United States", *Journal of Addictive Diseases*, 30:248–257, 2011.

[225] Commonwealth of Australia (2009), Department of Health and Ageing, *Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia 2009*, p. 8.

[226] *Ibid*.

[227] Dwyer et al (2002), *ABRIDUS: the Australian blood-borne virus risk and injecting drug use study*, Turning Point Alcohol and Drug Centre, Fitzroy, Victoria.

Many of Victoria's growth corridors, especially those on Melbourne's urban fringe, have insufficient coverage for a range of services. These same communities – Melton, Casey, Wyndham, Cardinia, Mitchell, Whittlesea – are experiencing high rates of disadvantage[229] and complex problems of health and crime.[230] There is consistent intelligence that these communities have insufficient access to health services,[231] including NSPs.[232] Demand for mental health services in growth areas have far outstripped projections – a situation driven primarily by escalating harms related to crystal methamphetamine.[233]

While these problems have been acknowledged by the Victorian Government,[234] NSPs have not been expressly considered as part of the response. Inadequate NSP access is not just a problem for the health of the community – it creates missed opportunities to engage people who are at high risk of drug dependence and crime.

We could cure hepatitis C in Australia – but not without investing in NSPs

We are also in a time where NSPs can help not just to prevent new cases of HCV, but eliminate the virus entirely. With the Commonwealth having invested over $1 billion to subsidise new and highly effective (approximately 90 per cent) HCV drug treatments to all people over 18 years,[235] Australia has an opportunity to significantly reduce the burden of disease presented by this virus.

However, to do this, people who inject drugs must be engaged in testing and treatment, and stubborn sharing rates must be minimised as much as possible (thus preventing the vast bulk of both new and re-infections of HCV). This requires engagement with injecting drug users – a diverse cohort for whom tried and tested pathways into HCV treatment do not yet exist. New treatment initiations – dominated by people who are no longer (or never were) injecting drug users – already appear to be dropping off since the treatments became universally available in April 2016.[236]

NSPs' workforce capacity is highly variable

A further challenge is the diverse workforce responsible for operating NSPs. Outside of busy primary NSPs – of which there are only 20 in Victoria, compared with about 170 registered public secondary NSPs and around 355 registered pharmacy NSPs – many NSP workers perform that function as an adjunct to their main role. Many are part time, occupy administrative or reception positions, are frequently under-trained, or receive no training whatsoever. They have often not been educated on the importance of NSPs, while frequently facing challenging work environments and variable levels of support from their employers.

Penington Institute, as the organisation funded to provide workforce development support for the Victorian NSP sector, conducted 179 site visits and delivered 105 NSP training events to 719 participants in 2016. However, the

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Southgate et al (2003), *Dealing with risk: a multidisciplinary study of injecting drug use, hepatitis C and other blood borne viruses in Australia*, National Drug and Alcohol Research Centre, UNSW, Sydney, NSW.

Anex (2008), "The graveyard shift: access to sterile injecting equipment in metropolitan Melbourne", Anex, Melbourne, Victoria.

[228] NDARC (2016), *Illicit Drug Reporting System: Drug Trends Bulletin December 2016*, https://dlnstorage.blob.core.windows.net/drt101/1831/idrs-december-2016_final.pdf, pp. 1-2.

[229] VAADA (2016), "State Budget Submission 2017/2018", p. 15.

[230] Victorian Government, Crime Statistics Agency (2017), "Explore crime by location", https://www.crimestatistics.vic.gov.au/explore-crime-by-location, accessed 24 January 2017.

[231] VAADA (2016), "State Budget Submission 2017/2018".

[232] HealthWest Partnership (2013), *No longer just an inner city issue: Meeting the demand for needles, syringes and Opioid Replacement Therapies (ORTs) across Melbourne's western suburbs*, available via http://healthwest.org.au/wp-content/uploads/2014/10/HW_No_longer_inner_city2.pdf, accessed 30 January 2017.

[233] Victorian Government (2016), *Victoria's Mental Health Services Annual Report 2015-16*, p. 43.

[234] Victorian Government (2016), "Planning For Melbourne's Rapid Population Growth", released 30 March 2016, available via: http://www.premier.vic.gov.au/planning-for-melbournes-rapid-population-growth/.

[235] Commonwealth of Australia (2015), "Turnbull Government Invests over $1 billion to Cure HEP C", http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley154.htm, accessed 10 January 2017.

[236] Kirby Institute (2016), "Monitoring hepatitis C treatment uptake in Australia", Issue 5, September 2016, http://kirby.unsw.edu.au/sites/default/files/hiv/attachment/Kirby_HepC_Newsletter_Issue5_2.pdf.

NSP workforce still lacks a minimum qualification or widely shared skillset, and many secondary and pharmacy NSPs, which receive no funding, are under-engaged in professional development.

A new strategic framework for NSPs in Victoria is warranted

A new strategic framework would consider a range of high-value opportunities to expand access, review and increase quality (including appropriateness of consumables), expand referral pathways, and identify a workforce development program that is tailored to a refreshed set of NSP priorities. Utilising NSPs to engage people at risk of problematic drug use and dependence is a chance to integrate and scale up the good practice already demonstrated by Victoria's NSP sector. They can positively engage parts of the Victorian community and find solutions that criminal justice responses have so far failed to produce.

NSPs in Victorian prisons

As at 2016, approximately 70 prisons in 13 countries have, at some point, implemented or trialled a prison NSP.[237,238] Australia is not one of them. Further, the Victorian Government does not appear to be considering their introduction. However, Penington Institute has long been a leading advocate of prison NSPs, and they warrant consideration by any inquiry considering options to reduce drug-related harm. We have therefore provided an overview of their benefits below.

The United Nations General Assembly, along with many of its key agencies, has long endorsed access to NSPs in prisons on the grounds of human rights and high effectiveness.[239] Although prison NSPs the share same basic aims and philosophical underpinnings, their implementation necessarily occurs in unique and complex settings, with no single approach to operations or reporting. This makes it difficult to create a statistical overview of prison NSPs' global impact. However, in 2003, Stöver and Nelles published a meta-analysis of 11 European prison NSP evaluations, in what is considered the most comprehensive study of its type. The authors found that in all 10 evaluations for which there was data:

- syringe distribution was not followed by an increase in drug use (in two cases these measures actually decreased) or injecting drug use;
- syringes were not misused, and disposal of used syringes was uncomplicated;
- syringe sharing was 'strongly reduced' in seven programs, with one program seeing either single cases and one seeing no change; and
- of the five prisons that collected data, the measured prevalence of HIV and HCV were strongly reduced in two and the other three saw no increase in prevalence.[240]

Although it is difficult to be absolutely comprehensive, to date, we are not aware of any recorded cases of prisoners using a needle as a weapon. Prison NSPs generally work on the basis of a one-for-one exchange and overseas evidence sees extremely high rates of return of used equipment, which is then safely disposed of. Two

[237] Stoove et al (2015), "Salvaging a prison needle and syringe program trial in Australia requires leadership and respect for evidence", *Medical Journal of Australia*, 203(8): 319-320.

[238] Harm Reduction International (2014), *Global State of Harm Reduction*, https://www.hri.global/files/2015/02/16/GSHR2014.pdf, p. 17.

Armenia, Belarus and Romania all saw their NSP services in prisons closed between 2012 to 2014. 8 countries currently operate prison NSPs: Germany, Iran, Kyrgyzstan, Luxembourg, Republic of Moldova, Spain, Switzerland and Tajikistan.

[239] *Resolution 45/111: Basic Principles for the Treatment of Prisoners*

The WHO, UNODC and UNAIDS continue to reflect this position through their work, most recently in UNAIDS' 2014 *Handbook for starting and managing needle and syringe programmes in prisons and other closed settings* and the WHO's 2014 *Prisons and Health*.

[240] Stöver and Nelles (2003), "Ten years of experience with needle and syringe exchange programmes in European prisons", *International Journal of Drug Policy*, 14(5-6): 437–444.

German prisons, one women's and one men's, have achieved return rates of 98.9 per cent and 98.3 per cent respectively.[241]

Further, in prison NSPs, prisoners are generally required to keep their one needle/syringe inside a rigid box and positioned in a predetermined place in their cell known about by officers. Therefore, the risk of needle stick injuries is likely to be lower in prisons with an NSP than in those without one. In Australia, a survey of prison officers found two-thirds had encountered a contraband needle/syringe in the course of their work, and 10 per cent of this group had received a needle stick injury.[242]

Drug rehabilitation programs should be part of a comprehensive package of health services offered to prisoners. Prisons that provide NSPs have found they help facilitate prison drug rehabilitation programs. In introducing a NSP, a prison adopts a harm reduction philosophy which can enhance staff and prisoner interaction. Prisoners no longer have to pretend to be "drug free", allowing for honest and open communication about the risks of drug use. As a result, prisons have found that since the establishment of NSPs, more prisoners have sought treatment for their drug problems.[243] Prisons with NSPs have subsequently seen other types of positive outcomes. In the years prior to implementing an NSP, the Swiss prison of Hindelbank averaged between one and three fatal heroin overdoses annually. Since the program has been in place, Hindelbank has experienced only one fatal heroin overdose in the past nine years.

Pharmacotherapy treatment in Victoria

Recommendations

10. The Victorian Government should establish a funding model to subsidise pharmacotherapy dispensing fees in Victoria. This will increase service coverage, access and quality in the pharmacotherapy system and be an enabling factor for other reforms (such as improving service integration and workforce resilience). Victoria could work with the Commonwealth on a national approach, but given perennial inaction on this issue, should be open to establishing a state-based system.

Pharmacotherapy for opioid dependence involves the provision of a pharmaceutical opioid as a replacement for heroin or other (illicitly consumed) opioids. This is referred to as opioid replacement, substitution or maintenance therapy (ORT). As the name suggests, ORT provides a managed opioid dose, via a less risky route of administration, and at an appropriate frequency, thus aiming to 'replace' illicit opioid use. ORT medicines available in Victoria are methadone, buprenorphine or buprenorphine-naloxone.

Victoria has a community-based ORT system, whereby medical practitioners (mostly GPs and some addiction medicine specialists) prescribe the medication and ORT clients have it dispensed to them at pharmacies. Most clients are required to attend a dosing point every day, and consume it on site to prevent diversion or misuse. Some clients, mostly those prescribed buprenorphine-naloxone, are eligible for take-home doses.[244] The Victorian Department of Health and Human Services provides training to doctors wishing to prescribe ORT medicines, although since 2013, any GP can prescribe buprenorphine-naloxone for up to five clients with undertaking training.[245]

[241] Jacob and Stöver (2000), "The transfer of harm-reduction strategies into prisons: needle exchange programmes in two German prisons", *International Journal of Drug Policy*, 11(5): 325–335.

[242] Larney and Dolan (2008), "An exploratory study of needlestick injuries among Australian prison officers", *International Journal of Prison Health*, 4(3):164-8, p. 164.

[243] World Health Organization (2007), *Interventions to address HIV in prisons: Needle and syringe programmes and decontamination strategies*, http://whqlibdoc.who.int/publications/2007/9789241595810_eng.pdf?ua=1, p. 14.

[244] AIHW (2015), *National opioid pharmacotherapy statistics 2014*, Bulletin no. 128, Cat. no. AUS 190, Canberra: AIHW, p. 4.

[245] Ibid, p. 12-13.

ORT is a highly effective treatment for opioid dependence – often described as the most effective, as well as the most preferred by people who use opioids themselves.[246] It is associated with reductions in heroin use, criminal activity, deaths due to overdose, and behaviours associated with a high risk of HIV transmission. It has also been demonstrated to improve health and social functioning.[247] These benefits apply broadly to both methadone and buprenorphine.[248] ORT is also highly cost effective.[249]

People who receive pharmacotherapy for more than one year, and who receive higher doses of their opioid replacement, tend to see greater benefits.[250]

Victoria's ORT system

There were 14,122 Victorian clients receiving pharmacotherapy on a snapshot day in 2015.[251] This number has hovered around 14,000 since 2011.[252] There has been modest growth in the number of registered prescribers since 2013, up from 821 to 1135 in 2015,[253] and in dosing points (pharmacies), up from 452 in 2009-10 to 588 in 2014-15.

However, these headlines figures mask significant access problems, especially for people living in regional areas.[254] On a snapshot day in 2015, 550 of Victoria's registered prescribers did not have any pharmacotherapy clients. Victoria has long had the highest average number of clients per dosing point,[255] but a relatively low average number of clients for prescriber,[256] suggesting difficulties in recruiting and maintaining participating pharmacies.

Perhaps even more concerning, the caseload of clients among prescribers is not evenly distributed. In 2010, 12 per cent of prescribers were responsible for 73 per cent of ORT clients across the state, raising questions about quality of care and vulnerabilities of an ageing prescriber workforce.[257] These figures have likely improved in recent years, but only partially.

Cost arrangements for ORT

ORT medicines are subsidised under section 100 of the *National Health Act 1953*, which means clients do not have to pay for them. However, pharmacies charge dispensing fees to their clients on a per-dose basis.

Efforts to make ORT work better in Victoria

Problems and weaknesses in Victoria's ORT system are long acknowledged and have been the subject of reviews and reforms. A major review was commissioned by the state government in 2010. It found Victoria's ORT

[246] CREIDU (2015), "Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention", http://creidu.edu.au/policy_briefs_and_submissions/10-opioid-pharmacotherapy-fees-a-long-standing-barrier-to-treatment-entry-and-retention, accessed 3 March 2017.

[247] King et al (2010), *Victorian Pharmacotherapy Review*, Sydney: NDARC, p.10.

[248] Ibid.

[249] Doran (2007), *Economic Evaluation of Interventions for Illicit Opioid Dependence: a review of evidence*, http://www.who.int/substance_abuse/activities/economic_evaluation_interventions.pdf.

[250] CREIDU (2015).

[251] AIHW (2015), *National opioid pharmacotherapy statistics data tables*, Table S1.

[252] Ibid.

[253] Ibid, Table s15.

[254] Parliament of Victoria (2014), *Inquiry into Community Pharmacy in Victoria: Report No. 3*, Melbourne.

[255] AIHW (2015), *National opioid pharmacotherapy statistics 2014*, p. 16.

[256] Ibid, p. 15.

[257] Australian Medical Association Victoria, "Opioid replacement therapy: changing lives", https://amavic.com.au/page/Member_Services/Publications__Communications/vicdoc/vicdoc_Features/Opioid_replacement_therapy_changing_lives/, accessed 3 March 2017.

fundamentals are sound, but that the system was increasingly strained from continued growth. Major findings related to:

- inadequate specialist system and poor referral and support pathways between specialist and primary care;
- insufficient treatment places (prescribers and dispensers);
- lack of program affordability for clients;
- workforce development and support issues; and
- quality of care issues.[258]

In 2014, the Victorian Government announced the establishment of five area-based pharmacotherapy networks to ensure a more local approach in connecting care, driving best practice and improving pharmacotherapy client outcomes.[259] The networks are tasked with finding local and regional solutions to reduce service gaps and workforce vulnerabilities. The Government expressly put dispensing fees out of scope when introducing the area-based networks.[260]

There is unmet need and churn in Victoria's pharmacotherapy system

Despite the Government's welcome focus on local coordination and care, given static client numbers, stable rates of opioid use and growing overdose rates, it is very likely there is unmet need for ORT in the state. Less than half of the Australians who are opioid-dependent are estimated to be in treatment on any one day[261] and, as noted, ORT is the most effective and most favoured treatment by people who use opioids.

Treatment retention is also a problem. As noted by the Centre for Research Excellence into Injecting Drug Use, "… cycling in and out of treatment is common […] It is important that a decision to exit treatment is planned and based on client needs and expectations […] The evidence indicates that coming off treatment prematurely often leads to relapse and poor outcomes."[262]

Affordability of ORT for clients

While many factors may lead to premature departure – for example, inadequate dosing, strained relationships with treating staff and treatment-related exposure to stigma and discrimination[263] – dispensing fees are commonly cited as a primary reason for involuntary discontinuation of treatment.[264] A seminal Victorian study described fees as the single biggest barrier to retention in treatment.[265]

Dispensing fees vary somewhat, with a daily cost to clients of between $1.50 and $10 (the median for methadone is around $4.65 and $5 for buprenorphine). This means fees could exceed $1800 over 12 months, and be as high as $3640.[266] With a significant number of people receiving ORT on a fixed income or receiving a government

[258] King et al (2010), *Victorian Pharmacotherapy Review*, p. 5.

[259] Victorian Government (2014), "Victorian Area-Based Pharmacotherapy Networks Fact Sheet", p. 1.

[260] Victorian Government (2013), "Enhancing the Victorian Community Based Pharmacotherapy System: Directions Paper, January 2013".

[261] CREIDU (2015).

[262] Ibid.

[263] Ibid.

[264] Rowe (2008), *A raw deal? : impact on the health of consumers relative to the cost of pharmacotherapy*, http://www.salvationarmy.org.au/Global/State%20pages/Victoria/St%20Kilda%20Crisis%20Centre/Articles%20Journals%20Pub/Publication_A_Raw_Deal.pdf.

[265] Ibid.

[266] CREIDU (2015), p. 2.

benefit, the impact of these costs is considerable.[267] It is not suggested that most pharmacies' fees are unfair or unreasonable.[268]

It is broadly accepted in Australia that ability to pay should not be a barrier to treatment in our health care system. In terms of its PBS arrangement, treatment for opioid dependence is treated differently from essentially every other health condition, raising equity issues. In this sense, the merits of bringing pharmacotherapy into line do not need a financial basis. However, there is also modelling to demonstrate that the cost of subsidising ORT in Australia would be outweighed by the financial savings associated with reduced health care and crime costs.[269]

Finally, there is empirical evidence that subsidised models would improve ORT outcomes. A review commissioned by the Pharmacy Guild of Australia in 2007 included a trial of full and partial subsidy models for ORT dispensing at selected pharmacies in South Australia, Victoria and NSW. The trials found improved client satisfaction with service and improved social, health and economic outcomes. From a pharmacy perspective, the trials indicated improved service and economic outcomes for pharmacies and their staff as well as improved relationships and communication between pharmacists/staff and clients.[270]

Next steps for ORT

Overall, there is compelling statistical, cost-benefit and empirical evidence to support a fee subsidy scheme for ORT in Victoria. Barriers to access that can be easily dismantled, and for which there is a favourable cost-benefit analysis, surely ought to be.

At present, the lack of a fee subsidy contributes more than any other factor to churn and service gaps in the system, and makes relations between clients and pharmacies unnecessarily strained, inhibiting the recruitment of additional dosing points.

The primary consideration for the Committee is whether this should be achieved at a national level, and administered by the Commonwealth, or whether Victoria should pursue a state-based system.

If sought at the Commonwealth level, it has been suggested that moving ORT medicines from section 100 to section 85 of the National Health Act would bring arrangements into line with the vast majority of other essential medicines in Australia. Under section 85, the Commonwealth covers the dispensing fee and patients are only obliged to make a co-payment for the medicine up to the annual safety net threshold. Both general and concessional safety nets are far lower than the average total dispensing fee cost under the current system, making all ORT clients financially better off.[271]

However, given ORT dispensing fees are such a long-ignored issue – despite almost all stakeholders supporting a move to section 85[272] – the prospect of change may be low. Victoria should therefore strongly consider introducing its own system. The subsidy scheme could be means tested – with the test being the presence of a Health Care Card, entitling the holder to a full fee subsidy. Further, while Victoria's area-based pharmacotherapy networks work to improve service coverage, it would be worth considering subsidising other costs associated with accessing ORT – particularly transport for people in regional areas.

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[267] Harm Reduction Victoria (2016), "Submission to Review of Pharmacy Remuneration and Regulation", http://www.health.gov.au/internet/main/publishing.nsf/Content/review-pharmacy-remuneration-regulation-submissions-cnt-7/$file/345-2016-09-23-harm-reduction-victoria-submission.pdf.

[268] King et al (2010), *Victorian Pharmacotherapy Review*, p. 102.

[269] Chalmers and Ritter (2012), "Subsidising patient dispensing fees: The cost of injecting equity into the opioid pharmacotherapy maintenance system", *Drug and Alcohol Review*, 31(7):911-7.

[270] Pharmacy Guild of Australia (2008), *A national funding model for pharmacotherapy treatment for opioid dependence in community pharmacy*, http://6cpa.com.au/wp-content/uploads/A-National-Funding-Model-for-Pharmacotherapy-Treatment-for-Opioid-Dependence-in-Community-Pharmacy-full-final-report.pdf, p. x.

[271] King et al (2010), *Victorian Pharmacotherapy Review*.

[272] Ibid, p. 101.

Specialist alcohol and other drug treatment

Recommendations

11. The Victorian Government should work with the Commonwealth and all states and territories to undertake comprehensive service planning to ensure a robust and flexible specialist drug treatment system. However, governments should actively plan to reduce the burden on the treatment system over time by investing in effective harm prevention and early intervention – while always meeting contemporary demand for specialist services.

We expect the Committee will hear in detail from others regarding the performance of Victoria's specialist alcohol and other drug (AOD) treatment system (including forensic services). This is a crucial aspect of any inquiry into Victoria's drug laws: the failure to treat dependence quickly leads to more problematic drug use, acquisitive and violent crime – putting pressure on law enforcement. (We have addressed the benefits of drug court models for people with persistent drug dependence and related offending in Chapter 5 above.)

Treatment must keep pace with demand to take pressure off Victoria's drug laws

Recent reviews both at both the state and national level have acknowledged serious access problems with the AOD system – problems which, at least in part, have been caused by chronic underfunding by governments.

> "Unless I wanted to spend like $30,000 and go to a private rehab… there was a six to nine month waiting list."
>
> *— Brooke, former ice user*
>
> *(Interview with Penington Institute)*

This insufficiency of drug treatment services is particularly bad for Australians living in the country: AOD services are overwhelmingly located in metropolitan and regional centres[273,274,275] – despite recent waste water analysis indicating double the prevalence of methamphetamine in regional Victoria compared with Melbourne.[276] The combined impact of these factors means regional and rural Australia is particularly susceptible to the adverse consequences of drug use: it is little surprise that country Australians now face the dual, growing harms of overdose and ice.

The Victorian Government, through the Premier's Ice Action Plan, has allocated an additional $24.2 million for treatment and rehabilitation services and the Commonwealth, through its response to the National Ice Taskforce, allocated $241.5 million to expand the capacity of AOD treatment (an undefined portion of which will come to this state).

These are welcome contributions to address critical waiting times and service coverage, which are well below community expectations – although it is far from clear that the funding will be enough to meet current demand.[277]

However, plainly it should not have required a series of extraordinary state, territory and national reviews into ice to verify that there were critical gaps in drug treatment. There is a clear need for a nationally coordinated approach to treatment quality and targeting, which would in turn necessitates effective monitoring of demand

[273] Australian Drug Foundation (2016), "The stepped care model: a useful intervention strategy", http://www.druginfo.adf.org.au/fact-sheets/the-stepped-care-model-a-useful-intervention-strategy-web-fact-sheet.vention-strategy-web-fact-sheet, 22 22February 2017.

[274] *Final Report of the National Ice Taskforce*, Chapter 6.

[275] Lloyd, B (2016), "Alcohol, Nicotine and Illicit Drug Testing in Waste Water in Victoria", https://www.eiseverywhere.com/file_uploads/80b0b940534a62a7a0f2646a5fa826of_222_BelindaLloyd.pdf.

Recent waste water analysis indicates double the prevalence of methamphetamine in regional Victoria compared with Melbourne.

[276] Ibid.

[277] Network of Australian State and Territory Alcohol and Other Drug Peak Bodies (2016): *Federal Election 2016 Position Document*, p. 2.

for these services. Recommendations 17-23 of the National Ice Taskforce Report propose such a system. However, so far the Commonwealth has only committed to improving data on treatment demand – but not necessarily doing anything with it.

Effective prevention and early intervention

Recommendations

12. The Victorian Government should develop a comprehensive strategy to invest in effective prevention and early intervention, thus relieving pressure on specialist drug treatment, the justice system and the community in general. The strategy must set realistic goals for people across the drug user spectrum, having the overarching aim of preventing progression to problematic use. Essential components include:

- localised, GP-led models of early intervention;
- developing effective diversion options for those most at risk of progressing to problematic drug use; and
- online approaches to harm prevention and reduction advice.

Victoria currently faces a backlog of people with serious drug problems who need treatment and cannot access it. The Government needs to bring service coverage up to an acceptable level and ensure the system can always respond to changes in demand.

However, engagement in treatment tends to occur once people have already progressed to problematic drug use and dependence. Even for people who were never going to respond to primary drug prevention efforts, a range of earlier intervention opportunities have likely, by that point, been missed. A second, related issue is the insufficiency of drug treatment services for Australians living in the country (addressed in the previous section), exposing Victorians living in regional and rural areas to high levels of drug harm.

> "We need bold solutions. We need earlier interventions and to consider options like the plan put forward by the Penington Institute to have GPs play a greater role in managing addicts."
>
> — *Sunday Herald Sun*
>
> *(12 March 2017, see footnote 292)*

Even with considerable new investment in treatment, the challenge of providing specialist services in country areas is not going away. Now is the time to explore options to reduce the burden on specialist treatment by investing in prevention and early intervention approaches that work.

Intervening earlier

There is a growing preference in public policy for well timed, high value interventions over later (often belated), more intensive and costly ones. It is better to prevent problems, or to stop them escalating, than to treat them.

Drug prevention itself is not new, with governments having dedicated significant resources to campaigns intended to reduce demand for drugs. These campaigns have generally been focused on discouraging all illicit drug use, rather than harmful use.[278]

It is difficult to be sure of the role these campaigns have had in keeping population level prevalence of drugs stable. Among Australians who do not use drugs, one survey found 47 per cent cited health and addiction concerns – the primary risks highlighted by drug prevention campaigns – as reasons for avoiding use.[279] It is

[278] Commonwealth of Australia (2015), *Draft National Drug Strategy 2016-2025*.
[279] NSW Bar Association Criminal Law Committee (2014).

therefore likely the campaigns have had some effect. (It should be noted that these campaigns need not come at the expense of stigmatising people who do use drugs, which is counterproductive.)

However, it is now clear that prevention efforts to date have not worked equally well for all groups (nor should they be expected to). They are generally insufficient to resist what the Lay Report found was a 'snowball' of social determinants that increases the risk of problematic drug use.[280] This is evident in the entrenched cycles of drug harm explored in Chapters 4 and 5.

> "Ice is causing extensive damage to individuals, families and communities. There are generally underlying and social factors contributing to someone's problematic drug use, so any response must address a range of factors including mental health, employment, housing and isolation."
>
> *— Dr Will Twycross*
> *Mansfield-based GP*
>
> *21 February 2017*

The challenge Victoria now has is to develop prevention programs that work for the people who need them – and fund them to a level such that their impact can be measured through population and service level data.[281] A prevention-oriented program needs to:

- determine who is as at risk of progressing from less to more serious use;
- meet them where they are; and
- provide a helpful intervention before escalation occurs.

Finding the right groups and basis for engagement

This Committee has already seen evidence that the majority of people who use drugs do not go on to experience serious harm and will never require, or access, specialist treatment. This is true even for harmful drugs such as ice.[282] Prevention has long acknowledged the need to target high-risk groups,[283] such as people in regional and remote areas, LGBTIQA people and Aboriginal and Torres Strait Islander people.

However, people who use drugs do not just see themselves as an agglomeration of risk factors, and cannot be engaged with purely on that basis. It is essential to understand their purpose and motivation for using drugs – recognising that these differ greatly – and meet them where they are.[284]

A useful segmentation of the ice consumer market,[285] based on research commissioned by the Commonwealth Department of Health, provides some guidance.[286] It found methamphetamine users fit into the following four broad categories, with numerous sub-groups and permutations thereof: experimental use; social use; situational/functional use and dependent use. Crucially, the research identified unique motivations and active decision making among all consumer segments. This can enables targeting different segments with tailored interventions; while success should be defined differently for each group, we should have the overarching aim of preventing the uptake of problematic drug use.

The study appears to be unique in Australia. As it was based on a small sample, more research is required to update and validate this framework. Similar segmentation should be conducted for all aspects of the illicit, synthetic and pharmaceutical drug market to inform targeted early intervention.

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[280] *Final Report of the National Ice Taskforce*, p. 21.

[281] Individual focus group evaluations are inadequate to demonstrate public benefit.

[282] UnitingCare ReGen (2015), *Submission to the Inquiry into crystal methamphetamine (ice) Joint Committee on Law Enforcement*, pp. 3-4.

[283] *National Ice Action Strategy 2015*, p. 22.

[284] Youth Support and Advocacy Service (2013), *Submission to the Law Reform, Drugs and Crime Prevention Committee Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria*, pp. 15-23.

[285] *Final Report of the National Ice Taskforce*, p. 20.

[286] Commonwealth of Australia (2008), Department of Health and Ageing, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia – exploratory research*, https://www.health.gov.au/internet/main/publishing.nsf/Content/B32EA1CE756C0B81CA257BF0001E4499/$File/methamphetamine-users.pdf.

Early Intervention opportunity 1: Preventing dependence and harm locally – led by GPs

The greatest and most pressing opportunity to prevent ice dependence and harms is locally, led by Australia's large network of general practitioners (GPs).

AOD treatment does not currently, and is unlikely to ever, fully service people living in regional and remote Australia. GPs need to be empowered to lead collaborative, community-controlled responses to drugs, connecting ice users to the health, social and economic infrastructure within their communities. Rather than raising drug use directly, GPs' patients often first present with the complications of drug problems, such as mental health issues.[287,288] This means improved screening can lift rates of early intervention, and clear follow-up options and pathways will make those interventions more effective.

Such a model – provided it is person-centred and adaptable to the realities of busy GP clinics – could make well-timed interventions that are far more geographically accessible than specialist treatment. This approach would fit well between online support services and intensive specialist treatment.

The likely benefits of this model have been discussed among health professionals for some time,[289] The Royal Australian College of General Practitioners (RACGP) has acknowledged GPs have the opportunity to better screen and intervene early to manage their patients' drug use – most recently in its Addiction Medicine Network's submission to the National Ice Taskforce.[290]

To be effective, this approach would necessitate appropriate training and support for doctors and a clear focus on *early* intervention, rather than managing severe dependency in general practice settings (which causes GPs concern). The RACGP has noted financial incentives for GPs to manage drug issues could be enhanced.[291]

Naturally, this means GPs cannot be expected to manage these issues alone: some patients may have complex health and socioeconomic situations before the onset of problematic drug use. Addressing these co-presenting and underlying risk factors will help to prevent drug use from escalating.

GP-led early intervention models should therefore seek to establish broad community support and make use of the existing local health, social and economic infrastructure. In regional and rural areas, where there is a lower level of service provision across the board, communities will need to be supported to adopt their own tailored, strengths-based approach, maximising the benefits of their existing assets.

Penington Institute has recently advised leading stakeholders in Mansfield, in the foothills of the Victorian alps, where services are struggling to cope with growth in problematic ice use.[292,293] We worked with local government, GPs, the hospital, police, courts and local criminal lawyers to develop a pilot. However, government is yet to establish clear pathways that would fund the model. Ultimately, a multi-site trial should be implemented and evaluated across different regional communities.

Early Intervention opportunity 2: Linking prevention and criminal justice diversion

[287] RACGP (2016), "Ice in general practice", http://www.racgp.org.au/download/Documents/Good%20Practice/2016/April/GP2016Apr-ice.pdf.

[288] *Final Report of the National Ice Taskforce*, pp. 34-35.

[289] Berends and Lubman (2013), "Obstacles to alcohol and drug care: Are Medicare Locals the answer?", *Australian Family Physician*, 42(5): 339-342.

[290] RACGP (2015), "RACGP Addition Medicine Network: Submission to the National Ice Taskforce", http://www.racgp.org.au/download/Documents/Reports/submission-to-ice-taskforce.pdf.

[291] RACGP (2015), p. 2.

[292] Sunday Herald Sun (2017), "Halt the evil ice flow", *Sunday Herald Sun*, 12 March 2017, http://www.heraldsun.com.au/news/opinion/halt-the-evil-ice-flow/news-story/38bdee04d7c4f03a714851268e912600.

[293] Zervos (2017), "Push for treatment reform for ice addicts", *Herald Sun*, 23 February 2017, http://www.heraldsun.com.au/news/victoria/push-for-treatment-reform-for-ice-addicts/news-story/361d8117c9fe8f8aaccd3bce43f4406f.

The evidence strongly endorses diversion from the criminal justice system for people who have committed low level drug offences.

Diversion programs vary in target cohort, eligibility, take-up and service model. The beneficiaries of simpler, police-level diversion are typically people arrested for drug use, possession or low level supply, and for the first time. Most are not drug dependent and the interventions are light-touch. On the other hand, court-managed diversion, especially through specialised drug courts, tends to focus on more complex clients with drug dependency and more serious offences. The interventions are more intensive and holistic, having regard to co-presenting issues, such as poor health, mental illness, unstable housing, transport, education and employment.

As explored in Chapter 5, Australian jurisdictions operating diversion programs (both by police and the courts) see significantly reduced rates of reoffending compared with offenders who do not access diversion. We know the model works for many people. Given most people who use drugs do not become dependent on them, this is not surprising: that most people's drug-related interactions with the justice system are one-off or transitory. Most people will never use ice in a way that generates significant, or repeated, drug-related offending.

> "When I was googling my symptoms, I used to go on this website and it was all really technical … they would just say "go to your nearest Emergency" and it actually scared me away.
>
> If I had a website to go to when I was using ice that was simple to understand and that gave me information about my symptoms, or where to get treated, it would have made an incredible, incredible difference on my using."
>
> *— Brooke, former ice user*
>
> *(Interview with Penington Institute)*

On the other hand, for the minority of people who do go on to commit serious drug-related crimes, most probably would have been eligible for diversion at some point. Some may have been diverted, others not.

A particular priority is to use diversion to identify people at greatest risk of progressing to problematic use and supporting them to prevent this from occurring. There is a clear opportunity to combine the early intervention benefits of police diversion with the holistic support model of better-practice court diversion. One strategy for achieving this would be to link diversion to local, GP-led models of care proposed above.

Australian governments need to work together to develop a consistent, best practice framework for diversion. This was a major finding from the Lay Report;[294] however, so far there has been no clear commitment from government. There is also a need for greater consistency in reporting on the use of diversion programs, especially where access to diversion is determined by police discretion.

Early Intervention opportunity 3: Online and digital approaches

There is cause to be positive about the use of online and digital approaches, provided it is complementary to more intensive interventions.

People who enter specialist AOD treatment often regard it is as humiliating; they often consider it evidence of their failure in self-management.[295] Online support may present a more convenient and less stigmatised choice. If properly developed and targeted, an online option for people experiencing methamphetamine harms could increase the chance of early help-seeking.

Penington Institute has recently launched its own contribution to this type of approach: UnderstandIce.org.au. The website aims to support young people who are using, or contemplating using, ice, as well as their friends and family. The site provides non-judgemental information about ice and its potential effects, and equips people

[294] *Final Report of the National Ice Taskforce*, Recommendation 31.

[295] Room, R. (2005), p. 152.

with practical knowledge and skills to help them manage their situation. The site also provides advice on what to do if ice becomes a problem and encourages people to seek support – both from professionals and from within their personal networks – if they need it.

Transparency in performance

Recommendations

13. The Victorian Government should report annually and in and integrated way on outputs, outcomes and expenditure in the enforcement of drug laws. This should include regular reporting that elucidates how individuals charged with drug or drug-related offences navigate health, treatment, police, courts and corrections systems.

14. The Victorian Government should work with the Commonwealth and states and territories to:

a. establish an outcomes-based national performance framework for the new National Drug Strategy; and

b. commission a comprehensive evaluation of Australia's policy and expenditure with regard to illicit drugs and drug use – the first in Australia's history.

A range of measures should be undertaken to improve reporting and evaluation of performance of Victoria's current drug policy. It is particularly important to elucidate the way individuals interact with a complex service system.

Performance reporting

Despite significant expenditure across justice, health and human service portfolios, the Victorian Government does not produce any regular reports on whether these systems are effectively delivering outcomes for drug issues.

While health, treatment, police, courts and corrections outputs are reported annually, they are siloed, with no way to track individuals, many of whom undoubtedly appear across all the datasets. This means we have no systematic way to analyse the experience of people who are charged with drug or drug-related offending.

Even within portfolios, it is not clear from public reporting what happens to people. This is particularly important for discretionary programs such as Victoria Police's diversion initiatives. While there is published information about whether people charged with drug use or possession are diverted, we do not know their outcomes. Nor do we know what proportion of people who are eligible for diversion actually get it, nor why, when eligible, they are not diverted (the most recent published information is from Victoria's last major drug inquiry, which was into ice, in 2013, where Victoria Police reported its diversion was only capturing about half of eligible offenders[296]). It is also unclear whether those denied diversion by police go on to be diverted by the courts (police prosecutors have discretion to oppose court-level diversion). Anecdotally, we expect there would be significant variation in these activities at the regional level and below.

Given significant policing of low level drug offences still occurs, these questions matter. In Victoria in 2013-2014, cannabis offences made up 41 per cent of total drug possession/use offences,[297] and in 2016, 74.5 per cent of

[296] Victoria Police (2013), *Submission to the Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria*, p. 21.
[297] Victoria Police (2014), *Section 6.3: Drug Possession/Use: Crime Statistics Official Release 2013-2014*.

possession charges resulted in arrests.[298] The vast majority of cannabis arrests (86 per cent) were related to possession.[299]

We have therefore recommended an integrated report, produced annually, which would make these activities transparent, linking together disparate information on the same issues, people and communities. The Committee may wish to recommend establishing this as a legislated requirement to ensure its quality and consistency.

National performance framework

Despite a notionally coordinated national strategy, there is a lack of transparency on the performance of governments' approach to drugs.

The Lay Report recommends Australian governments develop a national performance framework for the National Drug Strategy, including annual reporting.[300] The new Ministerial Drug and Alcohol Forum[301] would be the logical place to oversee these matters; however, so far we have seen no commitment to a national performance framework.

A national strategic review of expenditure

In light of persistent poor outcomes, Penington Institute has consistently called for the Commonwealth to conduct a broad-ranging inquiry into the effectiveness and efficiency of our current approach to drugs, including its impacts on the health, safety and human dignity of Australians and its socioeconomic impact. The Productivity Commission could do such work capably and with independence.

The Victorian Government should pursue this matter through the Council of Australian Governments. No such review has ever been undertaken in Australia's history[302] – it is well past time.

[298] Victorian Government, Crime Statistics Agency (2016), "Drug offences recorded, where principal offence was a drug offence by offence type, drug type and outcome – April 2010 to March 2016" (Table 3.1.).

[299] Commonwealth of Australia, Australian Institute of Criminology (2013), *Australian Crime: Facts and Figures 2013*, Canberra: AIC.

[300] Recommendations 32-33 of the *Final Report of the National Ice Taskforce*.

[301] *National Ice Action Strategy 2015*, p. 26.

[302] Hughes, C. (2015), *The Australian (illicit) drug policy timeline: 1985-2015*, Drug Policy Modelling Program (last updated 5 March 2015).

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