Answers to Questions on Notice

on

Drug and Alcohol Treatment in NSW

to the

General Purpose Standing Committee No. 2

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1. Introduction

Dr David Phillips and Mr Graeme Mitchell represented FamilyVoice Australia at the hearing of the Inquiry into Drug and Alcohol Treatment by the General Purpose Standing Committee No. 2 on Wednesday 3 April 2013.

A number of issues discussed at the hearing require further clarification. One of these has been highlighted as a question to be answered on notice, while additional information on the other issues is also included in this supplementary submission.

Questions were raised at the hearing on the appropriate response to abuse of alcohol and pharmaceutical drugs, however each of these is a separate challenge which raises different issues and potential solutions. Therefore, all our responses here focus on the core problem of illicit drugs and treatment options for those addicted to them.

2. Question on notice

2.1 Questions

On page 57 of the Transcript of Wednesday 3 April, Reverend the Hon. Fred Nile asked Dr Phillips and Mr Mitchell the following related questions:

1. *Was harm minimisation ever debated in the Parliament?*

2. *What action was taken regarding the recommendations of both the 2003 and the 2007 Federal Standing Committees on Family and Community Affairs that the strategy of harm minimisation be replaced with a new goal of harm prevention?*

2.2 Response

2.2.1 Road to Recovery 2003

The House of Representatives Standing Committee on Family and Community Affairs conducted an inquiry in 2003 into substance abuse in Australian communities. The subsequent report, 'Road to Recovery', summarised the findings leading to a number of recommendations.[1]

Recommendation 122 is particularly notable in the light of the current Inquiry:

> 11.18 **The committee recommends that the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people.**

The report was tabled on Monday, 8 September 2003.[2] It was referred to the Main Committee for a debate which was conducted on 11 September 2003.[3]

The following year, the Ministerial Council on Drug Strategy published the National Drug Strategy 2004-2009, which ignored the above recommendation and continued with a strategy focusing on harm minimisation.

2.2.2 The Winnable War on Drugs 2007

In 2007 another report was released by the House of Representatives Standing Committee on Family and Human Services.[4] The report criticised harm minimisation, with recommendation 8 proposing that:

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

It was tabled on 13 September 2007[5] and debated in the House on Wednesday 19 September.[6] There was overwhelming support for the report's recommendations, and a number of members told stories of 'harm minimisation survivors'.

On Saturday 24 November 2007 the ALP won the federal election.

Drug Free Australia issued a position statement that October supporting the recommendations of the report, along with the 2003 'Road to Recovery' report recommendations.[7]

In December 2007 Family Drug Support published 'An Opportunity Missed', criticising the report while partially or fully supporting two-thirds of its recommendations.[8]

Senator Mathias Cormann issued a press release on 24 November 2008 calling for a Rudd government response turning away from harm minimisation and toward the goal of prevention recommended by the 2007 report. No response has yet been tabled.[9]

3. Additional information

3.1 The National Drug Strategy

3.1.1 Questions

During the hearing of Wednesday 3 April, a question arose as to the origin of the National Drug Strategy. Reverend the Hon Fred Nile asked a number of related questions (page 56 of transcript):

> ***Reverend the Hon FRED NILE:*** *In your submission on page 1 you quote the National Drug Strategy 2010-2015, which states that the policy of harm minimisation will continue. Have you investigated as to who originated the drug strategy? Was it ever passed by a Federal or State Parliament, or is it a creation of drug bureaucrats? I am only asking that because I do not remember debating that in our State Parliament.*

3.1.2 Response

The National Drug Strategy (NDS) was developed as the National Campaign Against Drug Abuse in 1985, and continues to be updated and renewed on a five-yearly basis. The current NDS (2010-2015) and its predecessor (2004-2009) were published by the Ministerial Council on Drug Strategy.

The Council consists of health and law enforcement ministers from each state and territory as well as experts from the Australian Customs Service, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs and the Department of Education, Science and Training.

The NDS is created in consultation with the Intergovernmental Committee on Drugs. One of the Ministerial Council's three key objectives is to:

> *Consider matters submitted to the Council, through individual Council members, by the Intergovernmental Committee on Drugs (IGCD).* [10]

Although the NDS is endorsed by the Ministerial Council on Drug Strategy, it has never been debated in Parliament.

3.2 Drugs and comorbidity issues

FamilyVoice is aware that there are many social, economic, mental and physical health problems which can either lead to or exacerbate illicit drug dependency.

Box 1. Methadone in Melbourne

Dr David Parsons is a GP who worked for five years among drug-affected communities in Northern Metropolitan Melbourne.

Heroin addicts are a difficult group to treat. We used two opiate substances for substitution: methadone or buprenorphine (Subutex). Dependency would be shifted to one of these. It's very hard not to use a substitute because the withdrawal process is complicated and takes up a lot of resources. The program was designed as a long-term pathway to eventual reduction and perhaps a drug-free outcome.

When people started off the program with a good support structure around them, it worked well. But usually it was multi-factorial, with mental health issues and comorbidities. This makes it very hard.

Criminal behaviour commonly accompanies heroin use. The methadone program allowed people to escape from their dealers and criminal involvement and get a fix by simply entering a chemist. It created a bridge during which patients were more capable of investigating different therapy options, dealing with comorbidities and coping with other life issues.

Many patients were dealing with legal battles in the family law courts. With kids involved, and parents having been on drugs for decades, it becomes a big mess.

'Takeaways' caused much concern among health professionals. Usually, a patient filled their prescription for methadone at the chemist, and was required to take the dose under the observation of the pharmacist. In some cases, however, patients were given leave to 'take away' their methadone dose and consume it at home. This gave opportunities to rort the system, selling their methadone outside chemists and clinics.

Some local organisations were helping people come off drugs completely, however they were all overwhelmed with huge caseloads and had significant funding problems. Withdrawal centres reported frequent repeat visits. Patients would come out chemically clean, but enter back into their lives with all the underlying problems which led to their original drug abuse.

In terms of harm-minimisation I suppose there were benefits, but it was very hard to measure success.

FamilyVoice supports programs which involve a patient's family and support network, to help them be drug-free within a reasonable period of time. Long-term maintained dependency on methadone or other substitutes does not uphold the dignity of those struggling with drug addiction.

Dr Andrea Gordon, of Drug and Alcohol Services South Australia, addressed the question of comorbidities in a 2008 report entitled *Comorbidity of Mental Disorders and Substance Use*.[11] She says:

> Comorbidity or the co-occurrence of mental disorders and substance use disorders is common. The prevalence of comorbidity in the community and the complex interactions that occur between the two sets of disorders should raise doubts about the manner in which we continue to deal with each entity separately. Clinicians need to consider these problems as part of a whole complex of phenomena that are closely linked to one another.[12]

3.3 Sweden

In the transcript of the hearing on Wednesday 3 April 2013, on page 53, the Chairman mentioned claims that Sweden has high rate of death by drug overdose, despite the country's hard-line drug-free society policy.

3.3.1 Drug-related death rates

A report comparing the rates of drug-related deaths in the Netherlands and Sweden and forensic definitions of causes of death was published in 1998.[13] Inter-country comparison of statistical data is fraught with difficulties due to different definitions and data collection procedures. Table 1 summarises some major differences between data from the Netherlands and Sweden.

Table 1. Differences between the Netherlands and Sweden in reporting cause of death.

Page	Netherlands	Sweden
24	Underlying causes only. Poisoning includes accidental cause; homicide and suicide are excluded.	Underlying and contributory causes. Poisoning includes both accidents, suicides and homicides.
26	[Drug-related deaths based on the contributing cause of death] are not included in the Dutch statistics.	In Sweden, 30% of the drug-related deaths are based on the contributing cause of death
26	For the Netherlands, forensic examinations are carried out in case of (assumed) unnatural death, but only when legal authorities consider it to be necessary. The precise percentage is not known, but local studies indicate a percentage in the range of 30-40.	According to Swedish law, all cases where the influence of drugs is suspected or needs to be excluded have to undergo a forensic examination. Local follow-up studies of known drug addicts showed that up to 90% of those who died were examined forensically, also including a toxicological analysis.

On first glance, Sweden's morbidity and mortality statistics appear to show higher rates of death by drug overdose. On closer inspection this is shown to be an artefact of differences in recording cause of death.

For example, the Netherlands data includes deaths as drug-related if drugs are the underlying cause but not if they are a contributing cause, whereas Sweden includes both causes in drug-related death statistics. The 'poisoning' category in Swedish statistics includes suicides and homicides as well as accidents, whereas the Dutch data includes only accidental poisoning.

Drug-related deaths in Sweden are nearly always (90% of deaths of known addicts) followed up with forensic investigation. The final cause of death recorded often is based on the contributing cause of death, rather than the direct cause (30% of cases).

In the Netherlands, however, forensic examinations are rare. They are only required for unnatural deaths which authorities deem require further investigation. Only about 30-40% of unnatural deaths in the Netherlands are followed by forensic investigation.

3.3.2 Prevalence of drug use

During the 1960s Sweden was caught up in the drug epidemic that swept the world. Stockholm author Pelle Olsson describes the situation at that time:

> In the 60s cannabis started to get popular among big groups of young people. At this time Sweden had probably the highest prevalence of cannabis use in Europa. School surveys among 15-16 year old students showed that 30- 35 % of them had smoked hash or marijuana 1971 in Stockholm. In the country as a whole it was 15 %.[14]

In the book *Drug Precipice,*[15] Moffitt, Malouf and Thomson explain that:

> There was pressure for more liberal policies, and various experiments and changes followed.
>
> In a 1965 trial, medical practitioners were permitted to prescribe drugs for addicts in an effort to limit the harmful effects of drug abuse, offer care, and prevent users from committing crimes to finance their habit. Drug abuse was treated as a health matter, not a legal issue. In practice, patients nominated the drug and the dose required. In two years the amount of drugs prescribed increased by 300%. Drug-related crime to pay for drugs had not declined and crime in general had increased. In 1967, of 500 consecutive arrests for drug offences, one fourth claimed that they had obtained the drugs from someone who had obtained them by legal prescription. The experiment was terminated.[16]

A United Nations report on Sweden's drug policy,[17] published in 2007, reports that major changes began in 1968 when the Swedish parliament passed the Narcotic Drugs Act.

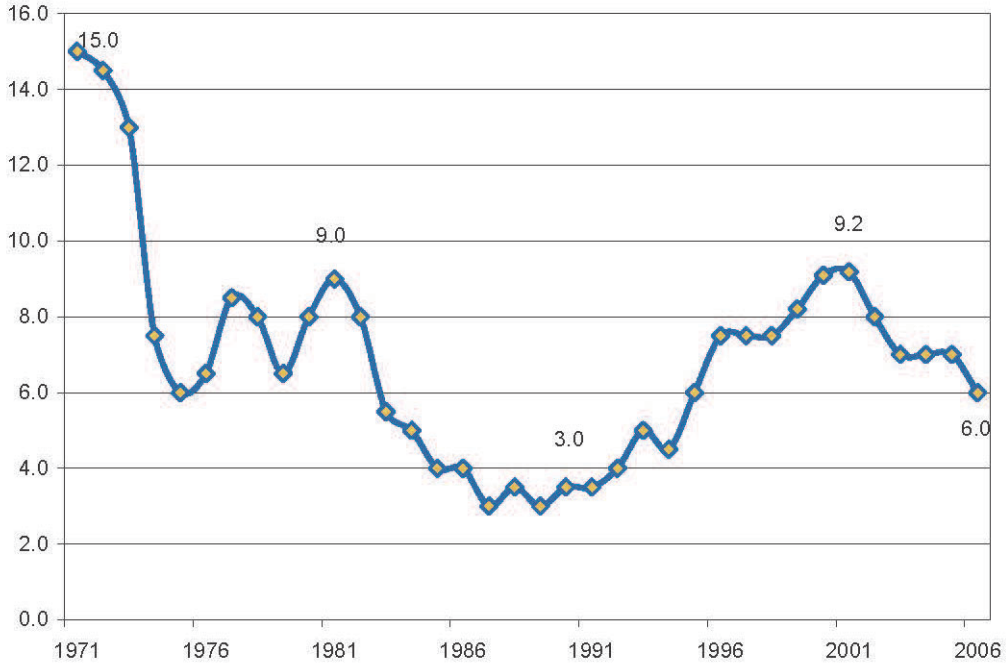
> The Act made the transfer, unlawful manufacture, acquisition and possession of drugs a punishable offence and lays down penalties for drug-related crime.
>
> Subsequently, in 1969, the Government of Sweden approved a ten-point programme for increasing public efforts against the drug problem… the ten-point programme is heavy on law enforcement measures… it also covers demand reduction issues, particularly the provision of treatment services to drug abusers and the prevention of drug abuse.[18]

The success of the tough-on-drugs policy is clear. Figure 5 from the report, reproduced below, shows that drug use among adolescents decreased 80 per cent over the next two decades.[19]

A rise in drug use during the 1990s (evident from figure 5) was associated with a general increase in drug abuse in Europe during that period. It also followed the stock market crash of 1987, when difficult economic conditions led Sweden to implement a severe austerity program. Health expenditure was slashed and its treatment system for drug addicts was heavily affected. Although the basic orientation of Swedish drug policy remained unchanged, the priority given to drug control, as reflected in budget allocations, declined sharply.[20]

The new millennium gave a new impetus to Swedish drug policy. The conclusion of the Drugs Commission in 2000 saw the adoption of a National Action Plan on Drugs and stronger political leadership on the drug issue. The result was a welcome decline in drug use, as is evident from figure 5.[21]

Figure 5: Life-time prevalence of drug use among 15-16 year old students in Sweden, 1971-2006



Source: CAN

Antonio Costa, Executive Director of the United Nations Office on Drugs and Crime makes this observation:

> Drug use in Europe has been expanding over the past three decades. More people experiment with drugs and more people become regular users, with all the problems this entails for already strained national health systems. There are thus suggestions, at the European level, that drug policies have failed to contain a widespread problem.
>
> Sweden is a notable exception. Drug use levels among students are lower than in the early 1970s. Life-time prevalence and regular drug use among students and among the general population are considerably lower than in the rest of Europe. In addition, bucking the general trend in Europe, drug abuse has actually declined in Sweden over the last five years. This is an achievement that deserves recognition. [22]

Australia can learn from Sweden's strong policy against illicit drug use. A move away from harm-minimisation and towards a drug-free society could benefit the people New South Wales and beyond.

4. Endnotes

1 *Road to Recovery: Report on the inquiry into substance abuse in Australian communities*, House of Representatives Standing Committee on Family and Community Affairs (2003). The full report can be found at: http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=fca/subabuse/report.htm

2 *House of Representatives Hansard*, Parliament of Australia (8 Sep 2003), 19549.

3 *House of Representatives Hansard*, Parliament of Australia (11 Sep 2003), 19935. http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=CHAMBER;id=chamber%2Fhansardr%2F2003-09-11%2F0154;query=Id%3A%22chamber%2Fhansardr%2F2003-09-11%2F0146%22

[4] House of Representatives Standing Committee on Family and Human Services, *The Winnable War on Drugs: The impact of illicit drug use on families*, (2007). The full report can be found at: http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=fhs/illicitdrugs/report.htm

[5] *House of Representatives Hansard*, Parliament of Australia (13 Sep 2007), 10.

[6] *House of Representatives Hansard*, Parliament of Australia (19 Sep 2007), 185.

[7] Drug Free Australia, 'Response to the House of Representatives "Inquiry into the Impact of Illicit Drugs on Families" and the associated report "The Winnable War on Drugs"' (October 2007): http://www.drugfree.org.au/fileadmin/Media/Global/DFA_BishopInquiryResponse.pdf

[8] Family Drug Support, 'An Opportunity Missed: A Considered Response to the 'Winnable War on Drugs' Report of the House Standing Committee on Family & Human Services' (December 2007): http://www.fds.org.au/pdf/AODResponsetoBishopReport.pdf

[9] Mathias Cormann, 'What about the winnable war on drugs Prime Minister?', Media Release (24 Nov 2008): http://www.mathiascormann.com.au/media/2008/11_November/24-11-2008_PMWhataboutwaronDrugs.pdf

[10] Ministerial Council on Drug Strategy, *National Drug Strategy*: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mcds-lp

[11] Andrea Gordon, *Comorbidity of Mental Disorders and Substance Use: A Brief Guide for the Primary Care Clinician*, Drug and Alcohol Services South Australia (2008).

[12] Gordon, *Comorbidity of Mental Disorders and Substance Use*, ix.

[13] Margriet van Laar & Wil de Zwart, *Feasibility Study of the Implementation of the Proposals Given in the Final Report of REITOX Sub-Task 3.3 – To Improve the Quality and Comparability of Data in Drug-Related Deaths: Final Report*, Trimbos Institute, Netherlands Institute of Mental Health and Addiction (July 1998).

[14] Pelle Olsson, 'History of illegal drugs in Sweden' (2008): http://www.pelleolsson.se/Drug%20abuse%20in%20Sweden.pdf

[15] Athol Moffitt, John Malouf and Craig Thompson, *Drug Precipice* (Sydney: UNSW Press, 1998).

[16] Moffitt et al., *Drug Precipice*, 78.

[17] United Nations Office on Drugs and Crime, *Sweden's Successful Drug Policy: A Review of the Evidence* (United Nations, Feb 2007): http://www.unodc.org/pdf/research/Swedish_drug_control.pdf

[18] *Sweden's Successful Drug Policy*, 10.

[19] *Sweden's Successful Drug Policy*, 26 fig. 5.

[20] *Sweden's Successful Drug Policy*, 29.

[21] *Sweden's Successful Drug Policy*, 35.

[22] *Sweden's Successful Drug Policy*, 5.