

Submission
No 23

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: Drug Policy Modelling Program

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Drug Policy Modelling Program Submission

Thank-you for the opportunity to provide a submission to the NSW Inquiry into Drug and Alcohol Treatment. The Drug Policy Modelling Program (DPMP) is a dedicated drug and alcohol policy research and practice program, which aims to improve Australia's capacity to respond to alcohol and other drug related harms.

People who experience problems with alcohol and other drugs and become dependent on substances are a highly vulnerable group in our society. There is significant stigma associated with drug dependence^{1 2}, and these people are frequently marginalised. This has implications for the ways in which NSW provides AOD treatment:

1. Treatment needs to be available across a spectrum of service types, according to an individual's needs and goals, and particularly be integrated with primary care services to reduce marginalisation;
2. Treatment needs to be provided in high quality settings, with best available facilities and should be practiced ethically, and with respect for the patient (one way in which stigma can be reinforced is through poor quality physical facilities for patients);
3. Treatment should be based on best-available evidence of efficacy, effectiveness and cost-effectiveness. It is not appropriate or conscionable to provide ineffective treatments to people who are vulnerable and seeking a way out of their problems. The naltrexone implant is an example of a treatment that is not yet proven in its efficacy or cost-effectiveness but is taken up because people who are dependent on drugs are vulnerable and desperate to find a 'miracle cure'.
4. Treatment is one part of a continuum of helping people with drug dependency, and must be complemented with other life-saving services for those dependent on drugs (such as supervised injecting centres, needle and syringe programs, overdose prevention services and so on). These harm reduction approaches have been shown to be effective.
5. An overall balanced approach for NSW between clinical treatment services, harm reduction services and education is essential. International experience attests to the success of balanced strategies.

Given these principles, we have focussed our comments below under five headings:

1. Treatment with naltrexone
2. Funding for alcohol and other drug treatment
3. Services other than formal treatment – harm reduction interventions
4. School-based drug education
5. Lessons from abroad

¹ AIVL. (2011). *"Why wouldn't I discriminate against all of them?" A report on stigma and discrimination towards the injecting drug user community*. Canberra: Australian Injecting and Illicit Drug Users League.

² Lloyd, C. (2010). *Sinning and sinned against: The stigmatisation of problem drug users*. London: UK Drug Policy Commission (UKDPC).

1. Naltrexone treatment

Currently oral naltrexone (tablet form) is registered in Australia for use for both opioid detoxification and maintenance treatment, but it is not listed on the Pharmaceutical Benefits Scheme (PBS) for these indications (it is listed for the treatment of alcohol dependence).

While oral naltrexone may be more effective than a placebo in limiting heroin use, this relies on the patient remaining in treatment, and retention in treatment with oral naltrexone is very poor³. This makes oral naltrexone a less effective treatment for heroin dependence than other treatments like methadone and buprenorphine.

One way of potentially improving treatment retention is to switch from an oral naltrexone tablet, to an implant (naltrexone implanted under the skin in slow-release formula). A literature review on the effectiveness of naltrexone implants conducted by the National Health and Medical Research Council (NHMRC) concluded that *"Naltrexone implants are an experimental product and as such should only be used in the context of a well conducted [randomised controlled trial] RCT with sufficient sample size, appropriate duration of treatment and follow up, regular robust monitoring, provision of a comprehensive psychosocial treatment program, and with comparison to current best practice. Until these trials have occurred and the relevant data are available and validated, the efficacy of the treatment, alone or in comparison to conventional first line treatments, cannot be determined."*⁴

DPMP supports the NHMRC scientific view and naltrexone implants should not be available in NSW unless under trial conditions or until such time as the product has been proven safe and efficacious.

2. Funding for alcohol and other drug treatment

The most recent estimates of funding at the national level (for 2002/2003) indicated that only 17% of government expenditure was directed at treatment (compared to 55% on law enforcement and 23% prevention)⁵. The DPMP is close to finalising a new Australian drug budget that will provide an updated estimate of Australia's treatment investment relative to law enforcement, prevention and harm reduction.

There has been no systematic and independent endeavour to document the current levels of AOD treatment funding in NSW. The current funding arrangements are complex with multiple funding bodies. The state government funds both public AOD treatment (through the LHD system) and funds non-government organisations to provide treatment; the Commonwealth government also funds NSW treatment (for example through the Substance Misuse Prevention and Service Improvement Grant Fund (<http://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-fund>) and the NGO Treatment Grants Program (<http://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-ngotgp>).

There is also private sector treatment (eg private methadone clinics, and private hospitals) and charitable organisations (eg Salvation Army). Often the funding received

³ Adi, Y., Juarez-Garcia, A., Wang, D., Jowett, S., Frew, E., Day, E., Bayliss, S., Roberts, T., Burls, A. (2007). Oral naltrexone as a treatment for relapse prevention in formerly opioid-dependent drug users: A systematic review and economic evaluation. *Health Technology Assessment*, 11, 1-85.

⁴ NHMRC. (2010). NHMRC Literature Review: Naltrexone Implants for Opioid Dependence; on-line at: http://www.nhmrc.gov.au/files_nhmrc/file/your_health/ps0005_naltrexone_implant_treatment_literature_review.pdf

⁵ Moore, T. (2005). Monograph No. 1: What is Australia's 'drug budget'? The policy mix of illicit drug-related government spending in Australia. *DPMP Monograph Series*. Fitzroy: Turning Point Alcohol and Drug Centre.

by any one service comes from multiple sources at the same time. For example, an NGO may receive some funds from the NSW government, some from the Commonwealth, income from patient co-payments and donations from the general public (and via fund-raising). There is an atmosphere of funding uncertainty for AOD treatment services – palpable in relation to the short contract terms for funding. This often impacts negatively on retention of qualified staff.

It seems obvious, but the ability to assess whether the level of funding for AOD treatment is adequate resides in establishing the current extent of funding. Comparisons could then be made with funding available to other chronic, relapsing conditions (such as asthma, diabetes and so on). These data on current levels of funding in NSW are not available.

The Drug and Alcohol Clinical Care and Prevention Model (DA-CCP) project will provide the first national planning estimate of the funds required to provide an adequate level of AOD treatment to those people alcohol and or drug dependent⁶. This project, due to be completed in April 2013, will provide the basis for NSW to assess the appropriate level of funding that should be provided.

3. Essential services other than formal treatment

Supervised injecting facilities

Supervised Injecting Facilities (SIFs) are a well-known, and at times controversial public policy measure to reduce the harms associated with injecting drug use. SIFs are also known as 'Supervised Injecting Sites', 'Safe/Safer Injecting Rooms', 'Medically Supervised Injecting Centres', and variations thereof. Within SIFs, attendees are provided with clean injecting equipment, in particular sterilized needles and syringes, as well as a range of other services which may include access to healthcare, counselling, drug treatment and social services. Drugs are not provided to users. As of 2010, there were at least 92 such facilities operating in 61 cities worldwide⁷.

A substantial amount of literature has been published on SIFs. Indeed, we have recently published an annotated bibliography⁸ ([http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/Bulletin5/\\$file/DPMP+Bulletin+22.pdf](http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/Bulletin5/$file/DPMP+Bulletin+22.pdf)) of all the available SIF literature (to April, 2012).

We located 133 papers and reports that provided reviews, outcome studies, economic evaluations, policy analyses and descriptions of SIFs from across the globe. Studies of SIFs have examined a wide range of outcomes. The vast majority of the outcome studies have been undertaken on the SIFs in Vancouver (16 studies) and Sydney (10 studies). Perhaps the most crucial outcomes of SIFs are related to a reduction in overdose events, as this is one of the prime reasons for their establishment. Marshall et al. (2011)⁹ found a 35% decrease in overdose mortality in the area around the Vancouver SIF following its opening, a larger increase than the rest of the city over the same time period. Milloy et

⁶ The Director of Drug Policy Modelling Program, Prof Alison Ritter has been the Chair of the Expert Reference group for DA-CCP and centrally involved in its development.

⁷ Hedrich, D., Kerr, T., & Dubois-Arber, F. (2010). Drug consumption facilities in Europe and beyond. Lisbon: EMCDDA.

⁸ De Vel-Palumbo, M., Matthew-Simmons, F., Shanahan, M., & Ritter, A. (2013). Bulletin No. 22: Supervised Injecting Facilities: What the literature tells us. *DPMP Bulletin Series*. Sydney: National Drug and Alcohol Research Centre.

⁹ Marshall, B.D.L., Milloy, M.J., Wood, E., Montaner, J.S.G., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: A retrospective population-based study. *The Lancet*, 377, 1429-1437.

al. (2008)¹⁰ has also suggested that deaths were averted due to the Vancouver SIF. In Australia, Salmon et al. (2010)¹¹ found a significant decline in the number of opioid related ambulance call outs around the SIF in Kings Cross, compared with the rest of New South Wales. Other outcomes investigated include changes in injecting practices, entry into drug treatment, public amenity (for instance a reduction in publically discarded syringes and public drug use), and decreased crime. There have been 7 separate economic evaluations of SIFs in Vancouver and Sydney. These have sought to determine the financial costs and savings associated with these facilities, generally measuring the savings associated with the number of HIV/HCV infections that are avoided by their use. Each of these assessments has shown that the savings provided by SIFs outweigh the costs, making these facilities "cost-saving".

Naloxone service provision

Naloxone (trade name Narcan) is a safe, effective, short-acting opioid antagonist, which reverses the effects of opioids and respiratory depression. Naloxone is not a drug of dependence; it does not produce intoxication and has no effect on people who do not have opioids in their system. It has been used for over 40 years by medical professionals, particularly in emergency medicine. Since the 1990's there have been calls internationally for naloxone to be available for administration by lay-persons, potential overdose witnesses and drug-using peers. A recent US study concluded that distribution of naloxone to potential overdose witnesses is highly cost-effective and can reduce mortality even by conservative estimates¹². UK research has shown that overdose management training and take-home naloxone given to drug users in treatment substantially improved knowledge of overdose risk amongst treatment clients, and gave them confidence in their ability to respond to overdose incidents¹³.

Drug policy experts have called for the removal of scheduling and legislative barriers in Australia that currently prevent easy access to naloxone for administration by potential overdose witnesses (for example Lenton, Dietze, Degenhardt, Darke and Butler in the Medical Journal of Australia 2009¹⁴, and Drug & Alcohol Review 2009¹⁵). These experts stated unequivocally that: "*In our view, the international evidence clearly indicates that increased naloxone availability will prevent many cases of fatal overdose, that conducting a trial in Australia is now unnecessary, and that naloxone should be made available without delay to be administered by peers in cases of opioid overdose.*" DPMP supports this statement. The distribution of naloxone for administration by lay potential overdose witnesses has recently been supported by the Australia Medical Association, the Victorian, ACT and SA Governments, as well as internationally, for example by the American Medical Association. We urge the NSW Government to follow. Legislative

¹⁰ Milloy, M.-J., S., Kerr, T., Mathias, R., Zhang, R., Montaner, J.S., Tyndall, M., & Wood, E. (2008). Non-fatal overdose among a cohort of active injection drug users recruited from a supervised injection facility. *The American Journal of Drug and Alcohol Abuse*, 34, 499-509.

¹¹ Salmon, A.M., Van Beek, I., Amin, J., Kaldor, J., & Maher, L. (2010). The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia. *Addiction*, 105, 676-683.

¹² Coffin, P.O., & Sullivan, S.D. (2013). Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Annals of Internal Medicine*, 158, 1-9.

¹³ Strang, J., Manning, V., Mayet, S., Best, D., Titherington, E., Santana, L., Offor, E., & Semmler, C. (2008). Overdose training and take-home naloxone for opiate users: Prospective cohort study of impact on knowledge and attitudes and subsequent management of overdoses. *Addiction*, 103, 1648-1657.

¹⁴ Lenton, S., Dietze, P., Degenhardt, L., Darke, S., and Butler, T. (2009). Naloxone for administration by peers in cases of heroin overdose. *Medicine Journal of Australia*, 198, 469.

¹⁵ Lenton, S., Dietze, P., Degenhardt, L., Darke, S., and Butler, T. (2009). Now is the time to take steps to allow peer access to naloxone for heroin overdose in Australia. *Drug and Alcohol Review*, 28, 583-585.

measures should be taken in NSW to ensure the protection of people who respond to medical emergencies so as to protect overdose witnesses against prosecution (i.e. 'Good Samaritan legislation'); naloxone should be rescheduled to ensure its widespread availability to potential overdose witnesses; and, the effectiveness of intranasal administration of naloxone should continue to be explored as a possible alternative to intramuscular administration.

Needle syringe programs

Needle syringe programs have been proven to be highly effective and cost-effective services that reduce the transmission of blood borne virus, protecting both individual drug users and the community¹⁶. Australia has been at the forefront of needle syringe programs internationally since 1985, however there are still gaps in Australia and in NSW's service provision in this area. There is a need for greater coverage and after-hours access to services (e.g. vending machines). And also a need for a wider range of equipment to be available, including wide bore syringes and pill filters. There are also policy and legislative barriers, such as the limits on the amount and type of equipment that can be provided, and legal impediments to carrying equipment, and peer-distribution of equipment¹⁷. The demonstrated efficacy and cost-effectiveness of NSP means that improvements in the program as mentioned here would produce further social, health and economic benefit to NSW.

4. School-based drug education

School-based programs to reduce alcohol, tobacco and drug use have been widespread since the 1970's. Originally concentrated on the provision of education and information alone, the variety of programs have progressed to be more focussed on personal development (known as 'affective education') and social skills training. The more well-known and promoted school-based programs that use a social learning framework and contain multiple components include Life Skills Training, the D.A.R.E. programs, Project ALERT¹⁸ and Life Education (Australia)¹⁹. The common elements within such programs include alcohol and drug awareness education, social and peer resistance skills, normative feedback, and psycho-social skills.

There have been three systematic reviews of school-based AOD prevention interventions: one in relation to alcohol²⁰, one in relation to illicit drugs²¹ and one in relation to tobacco²².

The alcohol review²³ found 53 studies of school-based universal prevention for alcohol. Six out of 11 studies that used alcohol-specific interventions showed effectiveness

¹⁶ Wodak, A. and Cooney, A. (2006). Do needle syringe programs reduce HIV infection among injecting drug users: A comprehensive review of the international evidence. *Substance Use & Misuse*, 41, 777–813.

¹⁷ AIVL. (2010). *Legislative and policy barriers to needle & syringe programs and injecting equipment access for people who inject drugs*. Canberra: Australian Injecting and Illicit Drug Users League.

¹⁸ Ellickson, P.L., & Bell, R.M. (1990, March 16). Drug prevention in junior high: A multi-site longitudinal test. *Science*, 247, 1299-1305.

¹⁹ <http://www.lifeeducation.org.au/>

²⁰ Foxcroft, D.R., & Tsertsvadze, A. (2011). Universal school-based prevention programs for alcohol misuse in young people. *Cochrane Database Systematic Review*, 5, No. CD009113.

²¹ Faggiano, F., Vigna-Taglianti, F.D., Versino, E., Zambon, A., Borraccino, A., & Lemma, P. (2007). School-based prevention for illicit drug use: A systematic review. *Preventive Medicine*, 46, 385-396.

²² Thomas, R.E., & Perera, R. (2008). School-based programmes for preventing smoking. *Cochrane Database of Systematic Reviews*, 3, No.: CD001293.

relative to standard curriculum (5 studies found no effects). Fourteen out of 39 studies which examined generic interventions including things such as life skills training showed effectiveness regarding alcohol (with 24 studies finding no effects). Those studies that had positive effects largely found these on the outcome variables of drunkenness and binge drinking. The authors of the systematic review conclude, in relation to school-based alcohol prevention programs, that "current evidence suggests that certain generic psychosocial and developmental prevention programs can be effective" (p. 2).

The tobacco systematic review of school-based tobacco prevention programs²⁴ located 23 randomised studies, of which half found positive effects on smoking of the interventions. They draw cautious conclusions of the effectiveness of anti-smoking school programs.

The systematic review of school-based illicit drug prevention programs²⁵ located 32 studies to include in their review, the vast majority of which (n=28) hailed from the US. They found positive effects for knowledge-based programs in increasing knowledge (although note that the relationship between increased knowledge and subsequent drug use is not clear), and positive effects for skills-based programs. However, the majority of the studies measured outcomes immediately after (n=18 studies) or at one year (n=13 studies) post-intervention. They concluded "skills-based programs appear to be effective in deterring early-stage drug use" (p. 1).

Across all types of school-based drug prevention, the program with the highest level of support is the Life Skills Training Program²⁶. A number of reviews conclude that programs that are generic psychosocial interventions are the most effective²⁷. Any investment in school-based prevention interventions would be best modelled on these programs.

Given the popularity and ubiquity of school-based AOD prevention programs, there have been substantial attempts to ensure that programs are based on research evidence. To this end, the USA has generated a number of lists of approved drug prevention programs. Schools may not deliver programs that are outside these lists. There has been significant controversy about the decision-making processes for inclusion on these approved drug prevention program lists^{28 29 30}.

²³ Foxcroft, D.R., & Tsertsvadze, A. (2011). Universal school-based prevention programs for alcohol misuse in young people. *Cochrane Database Systematic Review*, 5, No. CD009113.

²⁴ Thomas, R.E., & Perera, R. (2008). School-based programmes for preventing smoking. *Cochrane Database of Systematic Reviews*, 3, No.: CD001293.

²⁵ Faggiano, F., Vigna-Taglianti, F.D., Versino, E., Zambon, A., Borraccino, A., & Lemma, P. (2007). School-based prevention for illicit drug use: A systematic review. *Preventive Medicine*, 46, 385-396.

²⁶ Botvin, G.J., & Kantor, L.W. (2000). Preventing alcohol and tobacco use through life skills training. *Alcohol Research and Health*, 24, 250-257.

²⁷ Tobler, N.S., Roona, M.R., Ochshom, P., Marshall, D.G., Streke, A.V., & Stackpole, K.M. (2000). School-based adolescent drug prevention programs: 1998 meta-analysis. *Journal of Primary Prevention*, 20, 275-336.

²⁸ Gandhi, A. G., Murphy-Graham, E., Petrosino, A., Chrismer, S. S., & Weiss, C. H. (2007). The devil is in the details: Examining the evidence for "proven" school-based drug abuse prevention programs. *Evaluation Review*, 31, 43-74.

²⁹ Gorman, D. M., & Huber, J. C. (2009). The social construction of "evidence-based" drug prevention programs: a reanalysis of data from the drug abuse resistance education (DARE) program. *Evaluation Review*, 33, 396-414.

³⁰ Midford, R. (2010). Drug prevention programmes for young people: where have we been and where should we be going? *Addiction*, 105, 1688-1695.

As alluded to earlier, consideration should be given to the extent to which school-based prevention programs are the best form of universal prevention. The other universal prevention programs include mass media campaigns and community-wide interventions, such as Strengthening Families³¹ and Communities that Care³². A systematic review of the effectiveness of *mass media campaigns* (in this instance termed anti-illicit drug public service announcements)³³ found seven randomised trials and four observational trials. The results indicated that public service announcements had a limited impact on the intention to use illicit drugs or on illicit drug use amongst the target population. Only one of the seven randomised trials showed a statistically significant positive effect. Indeed two other RCTs found evidence that public service announcements increased intention to use drugs. On the other hand, Strengthening Families and Communities that care, both multi-component community based programs have been found to have significant positive effects on alcohol and other drug use.^{34 35 36}

5. Lessons from abroad

In late 2012 DPMP wrote an overview of four different drug policies in Europe which covered Portugal, Switzerland, the Netherlands and Sweden³⁷. This is available online (http://www.australia21.org.au/publications/press_releases/Australia21-disc%20paper-hughes&wodak-SEP12.pdf) for the Committee. Here we provide some salient aspects of the experiences in Sweden and Switzerland, followed by some notes on the current UK situation.

The lessons from these countries for NSW are:

- There is no such thing as a perfect policy.
- But, a particularly striking trend is that the levels of problematic drug use, overdose and HIV/AIDS, are decreasing or stable amongst those nations that prioritise harm reduction (Switzerland, Portugal and the Netherlands).
- Conversely, the nation with the lowest emphasis upon harm reduction (Sweden) has increasing rates of problematic drug use, overdose and HIV/AIDS
- The UK has undergone substantial reform around 'recovery'. This has been associated with devolution of powers to local areas. There are no data available yet to determine whether the UK reforms have produced positive results.

Sweden: The primary goal of Swedish drug policy is "a narcotics-free Sweden"³⁸. Sweden uses a combination of health promotion, prevention, law enforcement and compulsory and

³¹ <http://www.strengtheningfamiliesprogram.org/>

³² http://www.rch.org.au/ctc/about_us/Implementing_Communities_That_Care_in_your_community/

³³ Werb, D., Mills, E. J., DeBeck, K., Kerr, T., Montaner, J. S. G., & Wood, E. (2011). The effectiveness of anti-illicit-drug public-service announcements: a systematic review and meta-analysis. *Journal of Epidemiology and Community Health*, 65, 834-840.

³⁴ Biglan, A., Ary, D.V., Smolkowski, K., Duncan, T.E., & Black, C.A. (2000). A randomized controlled trial of a community intervention to prevent adolescent tobacco use. *Tobacco Control*, 9, 24-32.

³⁵ Cuijpers, P. (2003). Three decades of drug prevention research. *Drugs: Education, Prevention and Policy*, 10, 7-20.

³⁶ Perry, C.L., Williams, C.L., Komro, K.A., Veblen-Mortenson, S., Stigler, M.H., Munson, K.A., Farbaksh, K., Jones, R.M., & Forster, J.L. (2002). Project Northland: Long-term outcomes of community action to reduce adolescent alcohol use. *Health Education Research*, 17, 117-132.

³⁷ Hughes, C., & Wodak, A. (2012). A background paper for an Australia21 Roundtable, Melbourne, Friday, 6th July 2012 addressing the question: "What can Australia learn from different approaches to drugs in Europe including especially Portugal, Switzerland, the Netherlands and Sweden?" Australia21, Canberra.

³⁸ Wooditch, A. (2011). Sweden. In M. A. R. Kleiman & J. E. Hawdon (Eds.), *The encyclopedia of drug policy* (Vol. 2, pp. 752-753). Thousand Oaks,: SAGE Publications.

non-compulsory treatment. Most drug treatment emphasises abstinence: with an absence of explicit 'harm reduction' policies. Moreover, even though the Drugs Commission in Sweden states that drug users can be offered help without the requirement of an immediate and/or long-lasting drug-free life, the Commission advises against legal prescription of heroin, safe injection rooms and other low-threshold programmes. There is also a preference against needle and syringe programs. Sweden places a strong emphasis upon criminalisation and enforcement. Possession has been a criminal offence under the Narcotic Drugs Punishment Act since 1967, and drug use since 1988³⁹.

In Sweden the prevalence of drug use among young people is lower than in the 1970s (from 15% to 6-7%). Yet general population data only became available in 2004. Such data point to a stabilisation in cannabis use and/or an increase in 2009. The apparent increase was greatest for males, particularly for males aged 16-24, amongst whom recent use was reported to have more than doubled (from 4.8% to 11.1%)⁴⁰.

The level of problem drug use specifically increased. For example there were an estimated 15,000 users in 1979, 19,000 users in 1992 and 26,000 in 1998 (from 1.8 PDUs per 1000 inhabitants to 2.9 per 1000 inhabitants)⁴¹. There was a further increase to 28,000 PDU in 2001. Moreover, drug-induced deaths in Sweden have increased significantly. Indeed, even examining the deaths coded using ICD protocols (the more conservative estimate) deaths have more than doubled between 1993 and 2008, to a new peak of 241 cases in 2008 along.

Finally, while the prevalence of IDU-related HIV cases has remained low, particularly after a decline between 1989 to 2000 there was an HIV outbreak in 2006 in the domestic IDU population in Stockholm⁴². As a response, intensified testing and other activities resulted in more HIV infected IDUs being detected. A subsequent regional study in Stockholm identified further cases of HIV as well as high rates of other infectious diseases (including 82% HCV positive)⁴³.

The trends in relation to problematic drug use are of increasing concern. For example, while the 2010 evaluation of the Swedish action plan noted achievements in the development of a solid knowledge base for prevention of drug use, it also highlighted the increase in observed harmful consequences of the drug use phenomenon, such as drug-related morbidity, mortality and crime in Sweden⁴⁴. Whether or how this will be addressed remains unknown.

³⁹ Boekhout van Solinge, T. (1997). The Swedish drug control policy. An in-depth review and analysis. Amsterdam: CEDRO.

⁴⁰ Swedish National Institute of Public Health. (2010). 2010 National Report (2009 data) to the EMCDDA by the REITOX National Focal Point: Sweden: New development, trends and in-depth information on selected issues. Östersund: Swedish National Institute of Public Health.

⁴¹ *ibid*

⁴² *ibid*

⁴³ There is much contention about the outcomes of the Swedish approach. For example, the United Nations Office on Drugs and Crime (2006) issued a report titled "*Sweden's successful drug policy: A review of the evidence*" which concluded, as per the title, that the approach has been one of the most successful in Europe. "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." But many of the UNODC's conclusions have been challenged (2010).

⁴⁴ Swedish National Institute of Public Health. (2010). 2010 National Report (2009 data) to the EMCDDA by the REITOX National Focal Point: Sweden: New development, trends and in-depth information on selected issues. Östersund: Swedish National Institute of Public Health.

Switzerland pioneered a four-pillared approach: prevention, treatment, law enforcement and most critically harm reduction. Indeed, while prevention and treatment have long been emphasized⁴⁵ Switzerland has become a fore-runner in trailing and expanding harm reduction services. They were the first nation to trial heroin assisted treatment (HAT) (from 1994-1996), and following the passing of the *Ordinance governing the medical prescription of heroin in 1999* HAT has become a mainstream policy, applied in 2007 to approximately 5% of the total opiate dependent population (more than in any other nation)⁴⁶. Switzerland have also placed a strong emphasis upon provision of needle syringe programs and consumption rooms.

The central objective of the Swiss drug policy is a 'reduction in drug-related problems'. The most recent strategy notes that non-use of drugs is the norm, but also the need for a pragmatic, public health focus:

To a certain extent drug use constitutes an undeniable reality.... it should occur in such a way that users expose themselves to the least possible risk (e.g. HIV infection) and their quality of life be affected as little as possible. One aspect of this is that they should remain integrated in society or become better integrated⁴⁷.

Fears were raised at the time of the reform that the provision of low threshold methadone and harm reduction services may increase the attractiveness of heroin. Nevertheless, at the general population use of any illicit substance other than cannabis has remained low. For example in 2007 only 4.3% of females aged 15-39 and 8.1% of males reporting lifetime use of any drug other than cannabis⁴⁸. Equally significantly the number of heroin dependent users is estimated to have declined by approximately 30% (from 29, 000 in 1994 to 23,000 in 2002).

Arguably the best evidence of the change in the pattern of regular heroin use comes from a study of a Zurich treatment population. Nordt and Stohler (2006)⁴⁹ used the case register of substitution treatments for 7256 patients (covering 76% of those treated between 1991 and 2005). They noted how the number of clients reporting regular use of heroin rose steeply, from 80 people in 1975, to 850 in 1990, before declining substantially to about 150 users in 2002. The number of drug-induced deaths and prevalence of IDU-related HIV followed a similar pattern. For example, countering the earlier expansion, drug-related deaths decreased from 350-400 per annum in the 1990s to 150-200 per annum in the 2000s.

The **UK** government's 2010 Drug Strategy (*'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'*) represents a departure from previous strategy documents. Although a focus on prevention and demand and supply reduction remains, there is now an increased emphasis placed upon improving 'recovery' outcomes for those identified as drug and alcohol dependent.

⁴⁵ The Narcotics Act first stipulated in 1975 that cantons had to carry out prevention work and offer therapy to dependent drug users (Federal Office of Public Health 2006).

⁴⁶ Reuter, P., & Schnoz, D. (2009). Assessing drug problems and policies in Switzerland, 1998-2007 Bern: Swiss Federal Office of Public Health.

⁴⁷ Swiss Confederation. (2006). *Switzerland's national drugs policy: The federal government's third package of measures to reduce drug-related problems (MaPaDro III) 2006-2011*. Bern: Swiss Confederation.

⁴⁸ Reuter, P., & Schnoz, D. (2009). Assessing drug problems and policies in Switzerland, 1998-2007 Bern: Swiss Federal Office of Public Health.

⁴⁹ Nordt, C., & Stohler, R. (2006). Incidence of heroin use in Zurich, Switzerland: A treatment case register analysis. *The Lancet*, 367, 830-1834.

The policy and practice environment in which this strategy is being implemented is also undergoing fundamental change and reform, during a period of unprecedented cuts to public sector budgets.

In contrast to the strong central government oversight which characterised previous drug strategies, there is now a greater devolution of powers and responsibilities to local areas, as part of a 'localism' agenda. This has also seen the delivery of a growing number of public services opened up to competition involving the public, private and voluntary sectors. There has also been a growing shift towards outcomes-based commissioning, under which services receive a proportion of their overall funding based on the outcomes they have demonstrably achieved with their respective client groups. A series of drug and alcohol recovery 'payment by results' (PbR) schemes using this model are currently being piloted in eight English areas and are the subject of an independent evaluation⁵⁰.

There are a further two significant developments from April 2013 which are likely to have a significant - but as yet uncertain - impact on the delivery of the drug strategy in England. These relate to the creation of Public Health England and the work of newly elected Police and Crime Commissioners

The establishment of Public Health England heralds the creation of a new public health system within local authorities which will include Health and Well-being Boards who will assume responsibility for the funding and commissioning of a broad range of local primary health services, including substance misuse treatment and recovery services.

Police and Crime Commissioners also assume responsibility for deciding how best to allocate policing resources, via a Community Safety Fund, to deliver local policing priorities. This includes determining priorities, strategy and funding for different types of 'drug-related' policing i.e. the use of cannabis warnings, diversion work, acquisitive crime, and responses to possession, supply and trafficking offences. Police and Crime Commissioners are accountable to their local electorates (and stand for election every four years).

6. Concluding comments

NSW is in a position to substantially improve its current provision of alcohol and other drug treatment by focussing on key principles: these principles include quality treatment provision, with service models based on research evidence of effectiveness. Reducing stigma and marginalisation should be a priority. A balanced approach is required where equal weight is given to tertiary treatment services, primary care services and harm reduction services.

We would be happy to expand on any of the information provided within our submission.

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⁵⁰ The performance of the Coalition government's flagship PbR scheme, which seeks to move people from welfare support into employment, has recently been described by an influential cross-party groups of MPs as "extremely poor". See: <http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/work-programme/>

