



Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug use

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SUBMISSION of Families and Friends for Drug Law Reform¹ to the inquiry of the Australian Productivity Commission into the Social and Economic Benefits of Improving Mental Health

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¹ Families and Friends for Drug Law Reform acknowledges with much gratitude the incisive comments and other help of Virginia Hart in the preparation of this submission. Bill Bush.

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INTRODUCTION

Objective of submission

1. This paper argues that the burden of mental illness in Australia is in a large measure increased by the coincidence of illicit drug abuse and other mental illness. It suggests that the reliance on the criminal law works to create and foster the social and economic conditions that drive mental illness. There is much Australian research that supports these linkages and which show, in the wording of the Treasurer's reference to the Commission that attention to drug policy offers the prospect: "of improving mental health to support economic participation and enhancing productivity and economic growth" (Issues paper, p.iii).

2. The object of this submission is to examine how sectors beyond health including drug policy and justice can contribute to improving mental health and economic participation and productivity. It seeks to identify how much of the current burden of disease attributed to mental health conditions can be attributed to the policy response to illicit drugs rather than the drugs themselves. On this basis it argues that substantial social and economic benefits could be realised by the adoption of a regulatory approach informed by health and familiar psychosocial principles in place of the existing reliance upon the coercive processes of the criminal law. In a final section the paper points to the encouraging experience of other countries that have at least to some extent ceased to rely upon the coercive processes of the criminal law as the primary instrument to limit the availability of drugs.

Drug abuse as a mental health disorder

3. This submission puts the case that the productivity commission should consider that "substance use disorders and autism spectrum disorders fall within the scope of this inquiry" (Issues paper, p. 5). The commission's issues

paper acknowledges this:

“Almost half of all Australian adults have met the diagnostic criteria for an anxiety, mood or substance use disorder at some point in their lives, and around 20% will meet the criteria in a given year (ABS 2008)” (Issues paper, p. 1).

4. Substance dependence is itself classified a mental health condition and this is recognised around Australia through drug and alcohol services being generally grouped with other mental health services. There is generally joint management of substance dependence and other mental health problems. Addiction or dependence is a health disorder. The generally recognised criteria that are used for dependence on illicit drugs are the same criteria as are used for all psychoactive substances: the International Classification of Diseases (ICD) of the World Health Organization and the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. The different diagnostic criteria are described in the guidelines for management of co-occurring alcohol and other drug and mental health conditions (Marel *et al.* 2016, p. 5):

Drug abuse as a disability

5. While substance dependency is incontrovertibly a mental disorder, it also amounts to a recognised disability within the meaning of the *Disability Discrimination Act*. “A decision of the Federal Court has suggested that it may be unlawful under the Disability Discrimination Act to discriminate against a person solely on the ground that the person has an addiction to or dependence on a prohibited drug (Marsden case 2000).’ The case “concerned an opioid dependent person who was removed from a club and deprived of membership. A Senate inquiry reported that the case “ . . . is noteworthy for the recognition that drug addiction falls within the definition of "disability" under the Act. “It is against the law to discriminate against a person because of disability (Senate 2004 paras 1.8-1.11).

6. The Australian Human Rights Commission summarises the legal situation as follows:

“Drug use can help manage physical or mental disabilities. It is against the law to discriminate against a person because of disability. There are some limited exceptions and exemptions.

Example: It could be unlawful discrimination if an employer refuses to hire the best candidate for the job because it was discovered that the prospective employee was taking anti-depressant medication to treat depression where the medication did not affect the candidate’s ability to do the job.

Some cases of drug addiction are covered by the definition of disability in the *Disability Discrimination Act*.

Example: It could be unlawful discrimination if a hotel refuses to serve a person who has an addiction to methadone.

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Drug addiction can lead to impairment of physical and mental capacity. The definition of disability under the Disability Discrimination Act includes the total or partial loss of a person's bodily or mental functions. The Act does not exclude disability that has been caused by a drug addiction.

It is not unlawful to discriminate against an employee on the basis of disability if the person cannot perform the inherent requirements of a job after reasonable adjustments have been made" (AHRC).

7. From a medical view substance dependency is a chronic relapsing condition but it can also be viewed as a disability and what is more, a disability that with right policy settings, does not undermine the capacity of dependent people from taking responsibility for their own lives, those dependent upon them and indeed from participation in the economy as responsible taxpaying citizens. Drug policy has been imprisoned by a moral straitjacket that has imposed drug freeness as the absolute priority upon dependent drug users. This priority dooms many drug users to failure. For example, if a drug using parent ordered to "become clean" on pain of losing custody of their children, an unhealthy dynamic is set up with a tug-of-war between the insistence by the state on abstinence and the obligations of love and responsibility that drug using parents feel as much as any others towards their children. The outcome of this dynamic is all too often disastrous. There is no other area of public policy that so intrudes into the autonomy of the citizen than drug policy. The policy seeks to control what the citizen may or may not ingest. Drug policy from this point of view is thus a most extreme form of nanny state overreach. It is also a viewpoint that undermines its own objective by impeding recovery. It does this by reinforcing the alienation and other factors that commonly motivated drug users to dabble with drugs in the first place.

8. There is, for example, much evidence that people addicted to opiates, while receiving maintenance doses of artificial or other opiates, are capable of leading the life of a responsible citizen engaged in society and the economy. Becoming drug free should and can be subservient to the protection of life and well-being. Strong evidence endorses methadone maintenance. It is the best researched treatment for heroin dependency. A Cochrane Review found that:

"Methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment and decreases heroin use better than treatments that do not utilise opioid replacement therapy" (Mattick *et al.* 2003).

9. Cochrane reviews are intended to provide high quality and independent findings to inform healthcare decision-making. They combine the results of the world's best medical research studies and are recognised as the gold standard in evidence-based health care.

CORRELATION BETWEEN ADDICTION AND OTHER MENTAL HEALTH DISORDERS

10. At one level the position that we put to the commission is counterintuitive. Drug dependency is incontrovertibly closely correlated with mental illness and other health and social problems. This section describes some of these correlations. In doing so, it lays down the foundation for the next section that addresses the

proposition that drug policy itself better explains the correlation rather than any pharmacological effect of the drugs themselves.

Co-occurrence of drug abuse and other mental health conditions the expectation rather than the exception

11. The crossover between substance dependency and other mental health conditions is so common that the Senate Select Committee on Mental Health in 2006 termed it “the expectation not the exception” (Senate 2006 Chapt .14). That Committee lamented that:

“Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system.” (Senate Mental Health (2006) §2.29).

“Population estimates indicate that more than one-third of individuals with an AOD use disorder have at least one comorbid mental health disorder; however, the rate is even higher among those in AOD treatment programs. Additionally, there are a large number of people who present to AOD treatment who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder” (Marel *et al.* 2016, p. xi).

12. Dr Paul Mullen, clinical director of the Victorian Institute of Forensic Mental Health and Professor of Forensic Psychiatry at Monash University has written of the growing recourse to substance abuse by people with mental illnesses:

“The evidence is mounting that the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing. In one of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995” (Mullen 2001, 17).

Cannabis

13. “Among people with mental illness, particularly psychosis, the rates of cannabis dependence are significantly higher than the general community. Weekly cannabis use has been shown to be 3.3 times more prevalent among people with psychosis than among the general population. People with anxiety and depression also show higher rates of heavy cannabis use.

“While there is limited data at present, it suggests that heavy cannabis use is also significantly more evident among indigenous populations and that up to one in two cannabis users in remote communities experience adverse mental health effects. . . . There is a significant and growing body of evidence on the relationship between mental illness and cannabis.” (MHCA 2006 p. 7).

- “There is a 2 to 3 times greater incidence of psychotic symptoms among those who used cannabis . . .” (*ibid.*).
- “More frequent cannabis use is associated with higher relapse rates for people with psychosis and more severe symptoms were associated with increased risk of cannabis relapse
- Cannabis can induce schizophrenia-like symptoms in otherwise healthy individuals” (MHCA 2006 p. 8).

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14. “The need for effective treatment for adults as a prevention mechanism for children is particularly evident for people with psychosis, given that 59 per cent of women with psychosis are mothers and 25 per cent of men with psychosis are fathers. . . .there is a population of adults who are heavily dependent on cannabis and have serious mental illness. There do not appear to be effective treatments available for this group in Australia at this time” (*Ibid.*).

Crystal methamphetamine

15. There is a strong correlation between use of ice and mental health issues. The most common mental health issues experienced by methamphetamine users are psychosis, depression and anxiety. In addition, in 2013, fewer than 60 per cent of users reported moderate, high or very high levels of psychological distress, compared with around 40 per cent of all illicit drug users and 30 per cent of the general population” (PMC 2015 p. 34).

16. One of the key clinical differences between psychostimulants—such as ice—and other illicit drugs is that psychostimulants can induce psychosis. People experiencing psychosis are unable to distinguish what is real—they lose contact with reality. Psychosis induced by methamphetamine is primarily characterised by persecutory delusions and hallucinations. Users have reported that the persecutory delusions often take the form of a feeling that others wish to harm or threaten them. Users have also said that the hallucinations often involve hearing voices that make insulting remarks or command them to do certain things.

17. In a survey of people who use methamphetamine at least monthly, McKetin and colleagues found that around one in four had experienced psychosis in the past year. This prevalence of psychosis is 11 times higher than the general Australian population. Methamphetamine-induced psychosis can last from a few hours to a few days and subsides when the drug is no longer in the body. However, some people experience more chronic symptoms, especially those with a pre-existing psychotic disorder. Mood disorders and anxiety are also associated with methamphetamine use. Darke and colleagues say that, compared with psychosis, depression and anxiety can be “more common, more chronic and potentially more debilitating”. . . .There are links between chronic methamphetamine use and damage to the brain. In particular, chronic users of the drug have been found to have abnormalities in brain function, including depleted levels of the neurotransmitter dopamine. Neurotransmitters are chemicals in the brain that transmit information. Dopamine is important in regulation of movement, cognitive processes such as attention, working memory and motivational behaviour (*ibid* pp 34-35).

18. Patients suffering from these florid conditions induced by methamphetamines are a challenge to treat and manage and, in mental health units, can disrupt the recovery of others experiencing similar psychoses who are not drug users.

Violence

19. Psychotic symptoms and heavy alcohol consumption increased the risk of violent behaviour. However, the increase in violence also occurred independently of

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psychotic symptoms and alcohol consumption, which suggests a direct relationship between methamphetamine dose and violent behaviour (PMC 2015 p. 36).

Misuse of prescription pain medications

20. According to a survey of the Australian Bureau of Statistics of drug induced deaths in 2016 "Prescription painkillers such as oxycodone, morphine and codeine . . . were present in over 30% of deaths" (ABS 2016). The misuse of prescription painkillers bears in several ways upon mental health and illicit drug policy:

- a) people who have developed a dependency on licit opiates used to medicate their physical pain are likely to turn to illicit sources if they are unable to secure the medication through legitimate channels;
- b) there is a large increase in overdoses (including many fatal) of prescription medications;
- a) we can expect Australia to follow the trend in the United States where misuse of addictive pain killing opiates has contributed to an epidemic of "diseases of despair" referring to the interconnected trends in fatal drug overdose, alcohol-related disease, and suicide" (Dasgupta, Beletsky & Ciccarone 2017) and related "deaths of despair". There, "health appears to be a more significant issue for prime age men's participation in the labor force than for prime age women's. There, many prime age men who are out of the labour force are afflicted with despair that exacerbate "many of the physical, emotional and mental health-related problems" (Krueger 2017);
- b) there is a long history of inadequate pain medication for those who have become dependent on illicit opiates;
- c) there is a dire shortage of pain treatment specialists in the ACT as indicated by the long waiting lists.

21. The predicament of those seeking pain relief will be aggravated by the imposition of restrictions on over the counter medications. In the United States, clamping down on outpatient opioid analgesic prescriptions has seen the "national overdose death rate [surge] 38% during those years." There is a likelihood that the well intentioned restrictions on access to pain killers will have unintended consequences such as has occurred in the United States where those seeking pain relief have had recourse to "illicitly manufactured fentanyl and its analogs which are increasingly present in counterfeit pills and heroin" (Dasgupta, Beletsky & Ciccarone 2017).

Mental disorders as predictors of drug abuse

Depression:

22. While "there is good evidence to suggest that early onset drug use may lead to an increased risk of depression, even after controlling for a wide range of potentially confounding (or common) variables" "there is no strong evidence from community-based cohort studies to suggest that depression independently increases the risk of drug dependence later in life" (Degenhardt 2008 pp. 139 & 141)

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Anxiety

23. The common co-occurrence of anxiety and substance use disorders points to anxiety being a potent risk factor for abuse of sedative drugs like benzodiazepines, opioids, cannabis and alcohol (Mattick & O'Brien 2018, p.124. "Epidemiological studies indicate that anxiety disorders and alcohol and drug disorders commonly co-occur. These disorders, alone and together, have serious health and social consequences (*ibid.*, p.129).

Schizophrenia

24. Substance abuse problems are becoming more prevalent among persons with schizophrenia increasing from 8.3% in 1975 to 26.1% in 1995 (Wallace *et al.* 2004, 721).

Co-occurrence of chronic intractable and costly social problems

25. "Clients with comorbid mental health conditions often have a variety of other medical, family, and social problems (e.g., housing, employment, welfare, legal problems)" (Marel *et al.* 2016 p. xi).

"Given the multitude of problems with which clients present to treatment, the goal of any service should be to improve clients' quality of life across all domains, including health, social welfare and housing, employment, criminal justice, and of course, AOD and mental health. As such, these Guidelines adopt a holistic health care approach to the management and treatment of comorbidity, which is based on the adage 'Treat the person, not the illness'. It is essential to consider the whole person, taking into account psychological, physical, and sociodemographic perspectives when consulting with clients with comorbid mental health conditions (Figure 1)" (Marel *et al.* 2016 p.4).

26. As will be touched on in more detail below, many people experiencing the following problems also suffer from a substance abuse disorder:

- a) imprisonment
- b) crime
- c) homelessness
- d) child protection
- e) suicide
- f) poverty
- g) unemployment
- h) welfare dependence
- i) Indigenous disadvantage.

27. This submission will also consider the extent that drug policy:

- a) fosters and intensifies risk factors for mental illness among populations not otherwise at significant risk.
- b) recruits those suffering from mental disorders.
- c) perpetuates and aggravates mental disorders in those already experiencing them.

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- d) aggravates and reinforces the very risk factors that led to drug use in the first place and undermines protective factors that are known to guard against drug use.

Drug law reform as a means of ameliorating the burden of disease attributed to mental ill health.

28. This submission urges the commission to consider the likelihood that a drug policy framework that places health and social welfare, will substantially lessen the overall burden of mental illness. At the very least there exists a significant body of evidence in support of a health and social welfare. The very least possibility should be accorded serious consideration. Not only would it be likely that a health and social with welfare approach reduce the burden of mental ill health but could be expected to reduce the burden of other social problems known to precipitate or aggravate mental illness.

DRUG POLICY AS A DRIVER OF MENTAL ILLNESS

29. It is thought that the strong association of mental illness with substance abuse arises because each influences the other. As the comorbidity guidelines put it: “ . . .the relationship between comorbid conditions is one of mutual influence” (Marel *et al.* 2016 p. 7). This section suggests how this takes place by reference to what is known of risk factors and the social determinants of health and well-being. It groups the influencing factors under five headings:

- 1) Drug policy stimulates the supply of illicit drugs;
- 2) it is known from personality factors that a large percentage of youth is at risk of illicit drug use and that these factors are also predictors of mental health disorders;
- 3) Drug abuse intensifies risk factors for mental disorders;
- 4) The coercive processes of the criminal law mandated by prohibition aggravate or even trigger mental ill-health; and
- 5) Mental illness intensifies the risk factors for drug abuse thus creating a vicious circle thereby bequeathing drug abuse and social disadvantage to subsequent generations.

This paper now looks in turn at each of these factors.

DRUG POLICY STIMULATES THE SUPPLY OF ILLICIT DRUGS

30. If illicit drugs were not available people wouldn't be using them and there would not be the clustering of mental health problems that so characterises those who abuse them. In this world of the imagination there would also be no concentration of risk factors associated with drug abuse that drive other risk factors for mental illness. Put in other words, the burden of mental health disease would be very substantially lightened if law enforcement were successful in eliminating or at least substantially reducing the supply of illicit drugs.

31. It is a paradox that a trade prohibited by the criminal law actually stimulates that trade but it is a paradox that can be appreciated when one considers:

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- a) the extent that the supply of prohibited substances has actually flourished under prohibition;
- b) the extent that new drugs or more potent variants of existing drugs have come to market under prohibition; and
- c) the obstacles in the way of it ever being likely that law enforcement could suppress such a lucrative black market trade.

The illicit drug trade has flourished under prohibition

32. With its prime focus on supply reduction, the acid test of prohibition is its success in substantially reducing the availability of the prohibited drugs. In that it has been a lamentable failure. The following potted history of the advent of illicit drugs in Australia while they were banned shows at the very least prohibition has been ineffective.

Cannabis

33. In 1938 *Smith's Weekly* reported the "first appearance in Australia" of cannabis (Manderson 1993 p. 63). The 2016 household survey found that 10.4% of the population over 14 years old (over 2 million Australians) had used it in the last year.

Heroin

34. Australia consumed 5 kg of heroin (all of it legal) on the eve of the ban on its importation in 1953 (Manderson 1993 p. 63). By the end of the century the National Crime Authority estimated Australians were using 350 kg per million (all of it illegal) (NCA 2001 p. 21).

Crystal methamphetamine

35. Initially at least, purified potent crystalline methamphetamine was not manufactured in Australia. It was imported (McKetin & McLaren 2004, 4). The first mention in the *Australian illicit drug report* of the more potent forms of methamphetamine imported from South East Asian being found in Australia was in the report of 1996-97 (AIDR 1997, 56). "There are already signs," it noted, "of this occurring:

- there has been an increase in the number and size of seizures of ice (crystalline methylamphetamine hydrochloride);
- amphetamines in tablet form, manufactured overseas, are starting to appear in larger quantities in Australia;
- there has been an increase in the number of Customs seizures of amphetamines" (AIDR 1997, 56).

At the time "most ice available in Australia [was] believed to be imported from the Philippines" (AIDR 1997, 62).

36. A year or two after that first appearance, the then Commissioner of the AFP told a *Herald Sun* journalist that Asian crime syndicates had carried out marketing research that showed a bigger demand for amphetamine-like substances in the form of swallowed pills than for an injected drug like heroin:

"They are making speed pills that look like ecstasy and in many cases they attempt to pass it off as ecstasy. Some people might think these tablets are

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sexier than heroin. And the syndicates have their market research which tells them that these days people are more prepared to pop a pill than inject themselves,' he said" (Mr Keelty quoted in Moor 2001b, p. 1).

37. The failure of supply reduction to limit the availability of drugs to users can also be gauged by different market indicators. Price, purity, reports of ease of availability, level of seizures and such like all shine light on the state of the black market. If law enforcement were successful one would expect to see low levels of seizure, rising price, decreasing levels of purity and reports of reduced availability. Instead one sees the opposite: just as a large fish catch points to a healthy fish stock, so reports by users of easy availability and high level of law enforcement seizures point to a flush drug market and thus law enforcement failure rather than the success of which law enforcers and politicians like to boast. A declining or steady retail price and steady or rising reports of purity of seized drugs also confirm a fully supplied black market. In submissions to the Joint Parliamentary Committee on the Australian Crime Commission, Families and Friends for Drug Law Reform examined in detail these market indicators and criticised the Drug Harms Index devised by the Australian Federal Police (FFDLR 2005 & FFDLR 2006). The Drug Harms Index uses as a marker of success the notional harm avoided by every unit of an illicit drug that has been seized. The only trouble is again that this index claims as law enforcement success, seizure of greater quantities and seizure of new more harmful drugs – both markers that are really proof of failure.

Cocaine

38. The 2016 household survey reported that "Recent cocaine use has been increasing since 2004, and is at the highest rate in 15 years": Recent usage of cocaine grew from 0.5% of the population in 1993 to 2.7% in 2016. 9% of the population (about 1.9 million people) have used it at some point in their lifetime. This represented a significant increase from 8.1% reported in the 2013 household survey (AHS 2016pp 51 & 53).

Size of the drug black market

39. In 2012 the Bureau of Statistics researchers came up with an estimate of the total value of domestic and imported drugs in 2010 at \$7.574 billion (Gajewski and Cullen 2012). Using a different approach, the Australian Crime Commission estimated that in 2013 – 14 illicit drugs constituted \$4.4 billion of the cost to Australia of serious and organised crime. The amount was said to take "into account health impacts, money lost to the economy through international payments made for illicit importations, and estimates of the size of the illicit drug markets and lost productivity output of drug users" (ACC 2015).

New and more potent drugs brought to market

40. As this submission explores below, the presence of prohibition and demand is only part of the story. The psychology of drug users and user dealers and the practical limitations facing law enforcement such as the wealth at the disposal of staggeringly wealthy criminals to corrupt and otherwise smooth the way to enable their evil trade, served as additional stimulants of it. One evidence of this is the agility and responsiveness of the market demand and how it may even expand and diversify product offerings. This is illustrated by some developments in the drug market in Victoria.

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41. It is instructive to compare with the latest surveys the early surveys of drug users (the illicit drugs reporting system (IDRS)) and (the ecstasy and related drugs reporting system (EDRS)). These surveys have been coordinated for many years by the National Drug and Alcohol Research Centre at the University of New South Wales. The first Victorian IDRS was undertaken in 1997 and in 2003 the first EDRS or Party Drug Initiative (PDI), as it was initially termed. The 2015 surveys depicted a much more complex drug scene. The 2015 survey reported "a significant rebound in the percentage of daily heroin users" compared to 1998 when "heroin continues to be readily available in Melbourne." Cocaine in 1998 was barely detectable (p. 39) whereas in 2015 67% of participants reported a lifetime cocaine use and 9% reported having used that drug in the previous six months (p. 21). In 1998 crystal methamphetamine was unknown. Amphetamines was reported in the form of "speed" (page 33). By 2015 there had been a switch from speed powder so that "participants most commonly reported recently using crystal methamphetamine or ice (69%). In 2015 cannabis was "ubiquitous" and "among recent users, hydroponically grown cannabis was smoked most" (EDRS Vict 2015, pp. 9 & 22). A majority of participants in the 2015 EDRS survey commented that both hydroponic and bush cannabis were 'easy' or 'very easy' to obtain (page 46). The 1998 survey noted only "a continuing trend towards hydroponic production" (p. 45). Potency was stable. The 1998 survey identified other drugs used by participants, most notably benzodiazepines. By 2015 both the IDRS and EDRS surveys reported a significantly larger range of other drugs (EDRS Vict 2015, table 2 p. 8), an emerging street market for the antipsychotic medication quetiapine, use of pharmaceutical stimulants (p. 32) and use of new psychoactive substances and synthetic cannabinoids (IDRS Vict 2015 p. 34).

42. What must be among the most egregious examples of criminal entrepreneurship and nefarious influence was revealed to the *Herald Sun* in June 2001 by the then Commissioner of the Australian Federal Police. This was at the time of the so-called heroin drought when a substantial reduction in heroin supply was accompanied by a surge in import of high potency methamphetamine. The Commissioner revealed that Asian organised crime gangs had "done market research that tells them that these days people are more prepared to pop a pill than inject themselves" (Moor 2001b) and that as a result they made, "a business decision by Asian organised crime gangs to switch from heroin production as their major source of income to the making of methamphetamine, or speed, tablets." The Commissioner stressed that there had been "a conscious" decision "to move the market away from heroin into something that is far easier to put into the marketplace" (Moor 2001a). The general manager, Australian Federal Police National Operations, confirmed the accuracy of this report in evidence he gave on 16 August 2002 to the House of Representatives Family and Community Affairs Committee inquiring into substance abuse in Australian communities (McDevitt 2002, 1,221). There is a continuing debate whether the 2000 – 2001 heroin drought was brought about by law enforcement effort but the decision to swap drug exports to Australia has not been challenged.

43. The advent of an attractive new drug like crystal methamphetamine repeated in Australia what has happened in many other countries and with many other drugs. Time and again prohibition has motivated organised criminals to replace existing drugs with more potent new ones which produce far greater harm. This occurred during alcohol prohibition in the United States when more concentrated spirits

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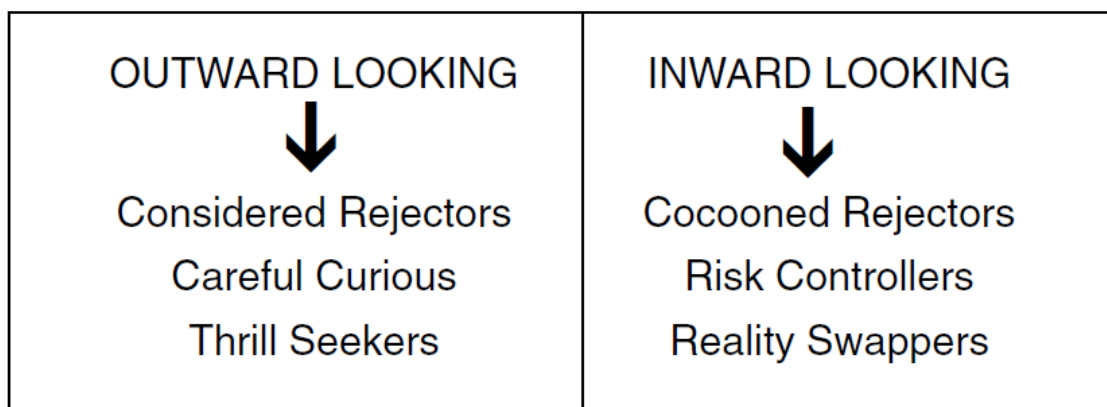
displaced less potent and bulkier beers or in Pakistan and hill tribe villages in Indochina where heroin rapidly displaced traditional opium smoking (Seccombe 1995).

“The consequence of an illicit market governed almost exclusively by the need to maximise profits, is that it becomes increasingly dominated by the more concentrated, potent and risky drug products and preparations that offer the greatest profits—injecting heroin, crack cocaine, and methamphetamine for example” (Transform Drug Policy Foundation 2009, p. 38).

Illicit drugs are attractive to a large proportion of the population and particularly to young adults

The psychological drivers of illicit drug use

44. To state the obvious often overlooked in the analysis of drug policy, drug use is a human behaviour motivated principally by psychological factors. An insight into these factors is provided by the identification in household surveys of the “Motivations/factors that influence decision to use illicit drugs.” (AHS 2013, p.68). The Howard government also commissioned important research into the factors leading young people to take drugs. This research revealed that illicit drugs are potentially attractive to a wide range of young people of normal personality types (Blue Moon Research & Planning Pty Ltd (2000)). The following account is drawn from pp. 1-30 of this report and in particular pp. 27-29. There are those who tend to be outward looking and those who tend to be inward looking. Within each group there are some who will be very likely to try drugs - the thrill seekers in the outward looking group and the reality swappers of the inward lookers who feel the need of the support that they think drugs will provide them. Considered rejectors (outward lookers) and cocooned rejectors (inward lookers) are never likely to have any truck with drugs. But there are within the extremes of each of the inward and outward groups (the careful curious and the risk controllers) who may well try drugs.



Reality Swappers of the introspective group are not particularly happy or secure in their lives, and they do not feel in control of things. They are inclined to try drugs, to avoid pain, or particularly in the case of stimulants, seek to compensate themselves for their perceived inadequacies – in other words as a form of self medication to compensate for social awkwardness and other perceived shortcomings of their personality.

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45. At the other end of the scale among the outward lookers were “thrill seekers” who were prepared to take risks. Comprising 20% of 15-24 year olds, they “. . . enjoyed the excitement of drugs, the ‘buzz’, the sense of risk, the excitement and the belief that drugs were ‘cool’. Their curiosity and pursuit of excitement could tempt them to trial ‘hard’ drugs, despite their awareness of the potential dangers.” Among the less confident inward lookers were “reality swappers” comprising 16% of 15-24 year olds. They “believed that the reality they experience while on drugs was better than the ‘straight’ world. They believed they lacked the self-respect, love and interests that their peers enjoyed. Moreover while they often acknowledged that their problems were increased because of the drugs they took, the only relief they knew was through drug-taking.” The heaviest drug users were likely to come from these two groups.

46. The 37% of “thrill seekers” and “reality swappers” “showed a moderate level of use or potential use of illegal drugs”. In short, among the young population there is a large proportion of personality types with a moderate or high potential risk of using illicit drugs. Those in the household survey citing curiosity as the reason they first used an illicit substance (66%), those wanting to do something exciting (19.2%) and wanting to enhance an experience (13.3%) are probably “thrill seekers”. Some of the personality qualities such as preparedness to experiment and take risks that predispose young people to use are qualities that are generally admired. It is important that drug policy be informed by what is known that moves people to take up drugs. In fact, drug policy continues to be fashioned and implemented on the false assumption that the threat of the consequences of being caught will deter the uptake and use of drugs.

47. It is important to take into account all these psychological factors in framing a public policy response. What has been achieved in the reduction of tobacco smoking which has never been made illegal has lessons. Furthermore, it is said of the Dutch that despite their liberal ways, their success in keeping drug use significantly lower than in Australia is achieved by transforming drug use from something daring and cool to something boring.

48. Appreciation of the psychology underpinning the attraction of illicit drugs helps counter the objection that to move away from prohibition of the possession of small quantities of drugs for personal use would send the wrong message and lead to greater drug use. The author of this submission has just heard a presentation by Dr Caitlin Hughes of the National Drug and Alcohol Research Centre at the University of New South Wales citing multiple surveys that have shown this fear is unfounded. In fact, potent psychological factors are at play as the law presently stands

Why law enforcement is incapable of suppressing drug use.

Retail level drug trade – impossibility of suppression

49. For all the very considerable effort that is put into drug law enforcement, it is a fantasy to believe that it would ever be successful in suppressing the drug trade at the retail level. Many of the reasons for the resilience of the retail drug trade have been addressed but for convenience reasons 12 of them are summarised below:

- (i) With two willing parties to drug transactions, drug dealing is not reported. Transactions in the marketing of illicit drugs are unlike most crimes where there is a willing perpetrator and unwilling victim. In the trading of drugs both parties have a strong interest in keeping the transaction secret. This sets drug

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dealing apart from the victims of most crimes. In other words, the drug trade exists under the radar.

(ii) The direct peer to peer marketing system of the retail and other lower levels of the drug trade (Windle & Daniel Briggs 2015) replicate the persuasive person-to-person retailing strategy of [enterprises like Amway which in 2016](#) engaged “107 million people around the world . . . with direct selling, driving more than US \$182.6 billion in direct retail sales. Based on 2016 revenues, Amway, Avon, Herbalife, Vorwerk and Mary Kay are the top five global direct selling companies (Amway). [This] shows, a highly effective marketing strategy”;

(iii) Consensual direct marketing schemes of addictive substances are highly resistant to police penetration.

(iv) Higher prices brought about by drug law enforcement fail to deter most dependent users whose demand for substances to which they are addicted is largely inelastic.

(v) The very high profit margins allow criminal enterprises to outspend law enforcement agencies in hiding their tracks and facilitating their trade by money laundering, corruption and violence to intimidate witnesses and competitors (ACC 2015 pp. 8 & 9). Thus, money laundering, violence and corruption support and conceal “serious and organised activity” (ACC 2015 p. 5). It is therefore very hard to detect and catch those near the top of the distribution pyramid. In the words of a retired Tasmanian Police Commissioner and member of the Board of Control of the Australian Bureau of Criminal Intelligence, Mr John Johnson:

“I don't think [police action is] having any effect on the supply in Australia. I think that [what] we do quite regularly when we catch some of the Mr Bigs is that we make life much easier for some of the other Mr Bigs who haven't been prosecuted and caught. We've put their competition in prison and left the world open for them and they're extremely difficult to catch and they go on with their business” (APGDLR 1997).

(vi) Motivated by the prospect of quick and easy money, there is an endless supply of middle level dealers prepared to run the risk of apprehension in return for wealth. The addicted user who deals to feed a habit is the disposable bottom layer of the distribution pyramid, the cannon fodder of the drug war. At most, local policing merely displaces the market.

(vii) There is only a small chance that drug users will ever be arrested. For a deterrence to be effective, it should be swift and certain. Drug law enforcement is neither (Kleiman, 2009). Based on the most recent Australian usage and arrest rates, there is less than a 2% chance of ever being caught;

(viii) Drug law enforcement and drug dealers both aim to maximise the price of drugs: law enforcement in order to put them out of reach of drug users and dealers in order to maximise their profit. In other words, the objectives of law enforcement and dealers coincide, ensuring a continuing supply of drugs.

(ix) In addition to deterrence, drug law enforcement aims to put drugs out of reach of consumers by raising their price. Given that demand from dependent

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drug users is relatively inelastic, raising the price of drugs, far from moderating demand and thus supply, serves as an incentive to supply. The Australian Crime Commission is well aware that profit attracts further supply:

“ . . . the price paid for methylamphetamine in Australia is among the highest in the world, making the importation of the drug and its precursor chemicals an attractive target for transnational crime groups” (ACC 2015, p.3);

(x) law enforcement is never able to seize more than a small proportion of the profits of the drug trade. The Australian Bureau of Statistics has supported research into the estimation of the size of the Australian illicit drug trade. This study estimated that in 2010 the trade in illicit drugs was worth \$7,574 million of which “cannabis” represented \$4,889 million (Cullen & Gajewski 2012 p. 12). Even if all the \$93.3 million that the AFP confiscated in 2016 – 17 (AFP 2016-17 p. 30) represented drug proceeds, this would be a mere 1.23 percent of the estimated annual value six years before of the black market economy for all illicit drugs and 1.91 percent of the cannabis market.

(xi) For risk taking young people the illicit status of certain substances is a challenge that they rise to. Drugs have the attraction of forbidden fruit. Other countries with a better grasp of adolescent psychology have successfully made illicit drugs boring.

(xii) Other less confident young people try drugs to avoid pain or, in the words of the household survey, to “improve [their] mood/to stop feeling unhappy” – This is a form of self medication combating unhappiness or social awkwardness.

Wholesale level drug trade and production – impossibility of suppression

50. The resilience of the wholesale drug trade is ensured not only by the massive wealth which it can deploy to corrupt and otherwise facilitate its prosperity but also its malleability and adaptability. What law enforcement agencies have singularly failed to do is to identify what it would take to fatally wound the illicit wholesale drug market. The only serious effort that we are aware of to take this step was reported in a confidential briefing paper prepared in 2003 at the instance of the Home Office for the British Cabinet. The paper was leaked by *The Guardian* in 2005. To put a drug dealer out of business requires seizures at a sustained high level that have never been achieved. As the Home Office paper put it:

“A sustained seizure rate of over 60% is required to put a successful trafficker out of business. Anecdotal evidence suggests that seizure rates as high as 80% may be needed in some cases. Sustained successful interventions on this scale have never been achieved.”

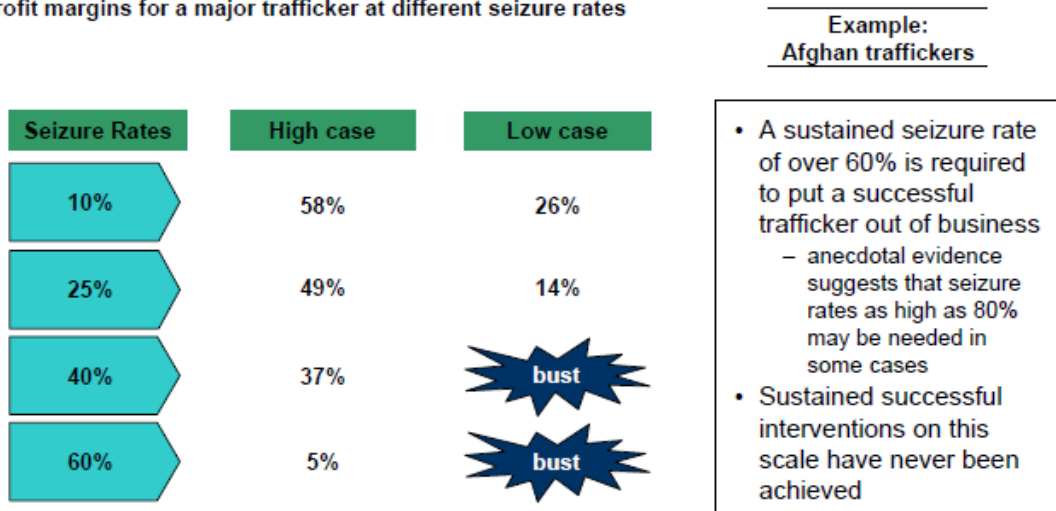
51. And it would indeed need to be higher than 80% in the case of cocaine where, as the Australian Crime Commission commented, “Organised criminals can achieve profit mark-ups of more than 6,100 per cent compared with the wholesale cocaine price in Mexico” (ACC 2011).

Figure 1: Seizure rates required to put a major trafficker out of business

CONFIDENTIAL: POLICY

The high seizure rates required to put a major trafficker out of business pose a substantial challenge to law enforcement

Profit margins for a major trafficker at different seizure rates



Source: HMG data, team analysis

73

SOURCE: United Kingdom 2003, p. 73.

DRUG POLICY AS A DRIVER OF KNOWN RISK FACTORS FOR MENTAL ILLNESS

52. American studies have found that:

“ . . . *two thirds* of the common vulnerability to different types of illicit drug use disorders was explained by shared environmental factors. This is not surprising, given that there is a wealth of evidence that a number of factors are common to both mental disorders and substance use disorders. For example, social disadvantage is more common among persons who are problematic substance users . . . ; who meet criteria for mood disorders and anxiety disorders . . . ; and who meet criteria for psychotic disorders, and there is evidence to suggest that this is not merely because of social drift after developing the disorder For all these groups of disorders, studies have shown that there are higher rates of separation and divorce, and a lower likelihood that persons will be married or in a defacto relationship

There is also a number of other factors that have been similarly associated with substance use disorders and with mental disorders, such as parental psychiatric illness and family dysfunction . . . It is possible that these social factors serve to increase the apparent ‘comorbidity’ of mental disorders” (Degenhardt, Hall & Lynskey 2003 pp. 18-19).

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53. The relationship between mental illness and drug abuse can be bidirectional as in the case of anxiety and sedatives. "The relationship between the different anxiety disorders and drug disorders is likely to be complex and bidirectional. One disorder can frequently mimic, and exacerbate and worsen, the symptoms of the other, and, as such, have an impact on prognosis and treatment. People with co-occurring drug use and anxiety disorders often have a more severe level of disability over time, and a poorer treatment response" (Mattick & O'Brien 2008 p. 129).

Alienation and stigmatisation

54. Harsh, discriminatory attitudes to drug users are widespread and intense. A visiting American television judge told a cheering audience in Brisbane that we should "Give 'em dirty needles and let 'em die" (*Courier Mail*, 17/11/99, p.12). In sentencing a woman in Adelaide on a prostitution charge a Magistrate told her:

"We dicks pay for your life. It's your choice to be a junkie and die in the gutter. No one gives a shit, but you're going to kill that woman who is your mother, damn you to death." (*Advertiser*, 1/5/03, p. 7)

55. Research commissioned by the Injecting and Illicit Drug Users League revealed a pervasive stereotypical portrait of "junkies":

"[They] look thin, gaunt, pale with bad teeth and track marks. Likely to be unemployed and possibly homeless, living off their family, or in a run down place with others. There is a strong likelihood that the person is a criminal who will steal (or other illegal/ immoral activities) to get money for drugs. They are not to be trusted and are irresponsible and selfish in their behaviour to others, as they are addicted to their drug and are only concerned with fulfilling their addiction" (Parr & Bullen 2010, p.23).

56. The survey found that drug users are shunned. "Almost all respondents among the general public expressed reluctance to be around the person they suspect may inject drugs." There was fear of what the drug users are or may do and a "secondary fear of 'guilt by association' meaning that by being around some one who injects drugs, the individual might be subject to the same type of stigma and/or discrimination." The general public has "little empathy overall for people who inject drugs believing they choose to start and then to continue to inject drugs, so therefore, should deal with negative consequences."

The stigma serves to deter dependent drug users burdened by other serious mental health problems from accessing treatment and psychosocial support. In a paper on the mental health needs of clients of the medically supervised injecting centre in King's Cross, "qualitative research suggests substantial barriers to accessing treatment among MSIC clients, including unwillingness precipitated by stigma and discrimination"(Goodhew 2016).

57. The pervasiveness of stigma is apparent at another level. It impedes even access to medicinal cannabis for research and treatment. The criminalisation of drug use has also undermined the potential medical use of the drug that may now be prescribed around the country.

- Criminalising cannabis has impeded research on its medical benefits; and
- Criminalisation has distorted the focus of research with research effort directed at the identification of its harms rather than its likely benefits.

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- It has led to the existing cumbersome, bureaucratic procedure that impedes access to the drug across Australia. The illegality of cannabis creates stigma, disapproval and judgement that constrains the legal channel for access to it.
- It contributes to the refusal of doctors to educate themselves about the benefits of cannabis for their patients.

In the words of Dr David Caldicott there has been "a century of missed scientific research to be conducted before allowing access" (Volteface 2018)

58. In spite of the legalisation of access to cannabis through the medical profession, its criminalisation still impedes access to it by those who stand to benefit from it. We are aware that the stigma in New South Wales has constrained the public advocacy of a group representing people suffering from conditions like epilepsy for which cannabis is recognised by medical science as therapeutic.

Homelessness

59. There is "empirical evidence that a lack of social capital and/or behavioural problems, such as mental ill health and substance misuse, are more prevalent among the homeless" (Johnson, Scutella, Tseng, & Wood 2015 p. 7).

"...the availability of housing and housing status (including homelessness) consistently appears as a risk factor for injection initiation across a range of settings. For example, Roy *et al.* found that homelessness was the key risk factor for injection initiation among street-involved youth in Montreal. They further posited a causal pathway to injection initiation, as they note that the risk of injection initiation has been shown to be associated with the level of social integration of people who use drugs into society, and that a lack of access to housing impacts an individual's capacity for social integration. Similarly, in a study of injection initiation in three Australian settings, Abelson *et al.* hypothesized that homelessness was a proxy measure for social and family disadvantage, which placed people at higher risk of initiation. Indeed, the fact that much of the observational research on injection initiation is restricted to samples of street youth who experience entrenched and chronic housing instability is evidence of the strong role that housing status is assumed to play in heightening injection initiation risk" (Werb *et al.* 2018).

Homelessness and mental illness

60. Mental illness is much more common among homeless people than in the general community. A study of a large number of people in inner-city hostels in Sydney found that at least 75% had at least one significant mental health disorder. "A 1998 study reported that about 75% of homeless people contacted through inner-city hostels in Sydney had at least one significant mental disorder (as defined by formal diagnostic tests). The prevalence was higher for women (81%) than men (73%)." In contrast, the expected prevalence rate in the Australian population of at least one mental disorder is just 18%. (Forell, McCarron & Schetzer 2005, p. 51). The Homelessness Task force noted that: "About one third of SAAP clients required intensive and/or ongoing assistance with mental health issues (FAHCSIA 2008, p. 8). More recent assessments of the situation report increasing prevalence of mental illness among the homeless:

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“The Australian Government’s national approach to reducing homelessness identifies untreated mental health as one of the main pathways into homelessness, and has given priority to this vulnerable group (COAG 2009). Specialist homelessness agencies support many people with mental health issues, providing a range of health, housing and general services. Clients with a current mental health issue . . . make up the fastest growing client group in the [Specialist Homelessness Services] SHS population. Increased rates of identification, greater community awareness and reduced stigma about mental health have all potentially driven the increase in self-identification and reporting of mental illness among SHS clients. On average, this client group has grown at a rate of 13% per year since 2011–12 (Table 6.2.1). The increase has been faster for females, growing at an average rate of 14% per year since 2011–12. The equivalent growth rate for males over this period was 11%. The rate of service use by clients with a mental health issue has increased 50% in 5 years, from 20 people per 10,000 population in 2011–12 to 30 people in 2015–16. Similar to the general SHS population, the majority of clients with a current mental health issue were female (58%) in 2015–16” (AIHW 2017).

61. A British survey found “. . . a staggering 76% of interviewees who lived on the streets or in hostels, had some form of mental health problem –either diagnosed by a doctor (65%) or self identified (11%)” (St Mungo’s 2009 p. 4).

“Homelessness and inappropriate housing expose people with mental illness to a wide range of risk factors for their mental and physical health and wellbeing. These include violence and abuse, harmful alcohol and other drug use, poor nutrition and sleep, severe social isolation, lack of amenities for self-care, disease, and even exposure to the elements. All of these are major stressors that are highly likely to compromise mental and physical wellbeing and pose additional challenges for providing continuing care” (Rickwood 2005 p. 36).

62. Rickwood attributes the high coincidence of mental illness and homelessness in part at least to deinstitutionalisation of mental health services. “Of major concern is the level of homelessness experienced by people with mental illness. An unintended consequence of the deinstitutionalisation that has taken place over the period of the National Mental Health Strategy has been an increase in the number of people with mental illness who are homeless or inadequately housed. Data collated by the AIHW on supported accommodation programs show that mental illness, directly and indirectly, is a major contributor to homelessness” (Rickwood 2005, p. 36).

63. For all that, a large survey of those likely to enter homelessness came up with the surprising finding that “individuals diagnosed with bipolar or schizophrenia are at a lower risk of homelessness than those without similar diagnosed conditions” (Johnson, Scutella, Tseng, & Wood 2015, p. 45). The survey does not make clear whether these personal characteristics were considered separately (*ibid.*, appendix 2 pp.54-59 & table 1). One wonders whether their co-occurrence or their co-occurrence with incarceration may have altered the situation. The authors speculated that the explanation of their finding may be because “those diagnosed are more likely to be receiving treatment and care (even institutionalised care), thereby lowering the chances of experiencing homelessness compared to those

undiagnosed but with other risk factors” (*ibid.*, p. 26). They noted that that “implies that those diagnosed but not receiving treatment and support are more likely to become and remain homeless”. They added that “If, this is indeed the case it emphasises the crucial role that health services play in the prevention of homelessness among people with a severe mental illness”. (*ibid.*, pp. 45-46). This possibility reinforces the thesis of this paper that mental health is to improve if those who abuse drugs are no longer treated as criminals. As things stand the criminal law or the threat of its application tends to disrupt treatment.

“The risks of homelessness are significantly greater for those recently incarcerated, which includes those coming out of juvenile justice, adult prison or remand. The recently incarcerated variable has a relatively large marginal effect at 9.7 percentage points, despite it only affecting 3 per cent of the sample” (*ibid.*, p. 26).

64. The survey of Johnson and others is consistent with the 2018 figures of the Australian Bureau of Statistics of the main reasons why people experience, or are at risk of, homelessness. Mental health and “substance use” issues are each dwarfed by reasons like financial difficulties, relationship/family breakdown, domestic and family violence and housing crisis (AIHW 2018). These surveys and the high prevalence of mental health problems among the homeless, point to homelessness being a potent driver of both substance dependency and other mental illnesses. Particularly when these conditions co-occur, the burden upon agencies working to support the homeless is rendered vastly more complex, thus straining already scarce resources.

Homelessness as a multiplier of other problems

65. Just as homelessness is a consequence of a range of earlier “problems”, of “risk factors” or of “determinants” uncompensated by “protective factors,” so the experience of homelessness can intensify existing problems or precipitate new ones. In this way human beings can be caught up in a vortex of disadvantage that increasingly plays out in their own life and in the life of their children and others dependent on them. In this way, disadvantage is guaranteed to echo down generations. Two disadvantages commonly intensified or precipitated by homelessness are mental ill health and crime.

Substance dependence as a compounder of disadvantage of the homeless

66. The high level of mental health and other health problems among the primary homeless lead commentators to suggest that street homelessness should be viewed as a health rather than a bricks and mortar problem (St Mungo’s 2009 p. 4). Society is indeed conflicted in how it should respond to primary homelessness: the law has it that a large proportion of rough sleepers are criminals. This is not so much because of the law on street offences (see Forell, McCarron & Schetzer 2005, pp. 108-09) but because of the high proportion of homeless people afflicted with a substance abuse disorder. It is noteworthy that the substances of greatest impact are not so much stereotypical alcohol as illicit drugs.

“ . . . Homeless people as a group are more likely to encounter the law than other groups because of their greater involvement in illicit drug taking. Further, their lack of financial resources may also mean that homeless people use illegal means to get sufficient money to support their addiction” (Forell, McCarron & Schetzer 2005, p. 111)

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67. The Commonwealth's Homelessness Taskforce, which noted that 12 per cent of Supported Accommodation Assistance Program (SAAP) clients reported a mental health problem other than a substance use one, added that:

"19 per cent reported a substance use problem and another 5 per cent reported both a mental health and a substance use problem. The majority of these clients were men aged between 25 and 44 years".

68. Much higher prevalence has been detected in a particularly large Victorian survey. This survey was conducted in 2005-06 of 4,291 homeless people in Melbourne. It found that 43 per cent had substance use problems (Johnson & Chamberlain 2007 p. 5). The drugs concerned were predominantly illicit rather than alcohol or prescription medications:

"The most common drug was heroin, but a minority identified alcohol or other prescription drugs. This is consistent with recent findings indicating that drugs have displaced alcohol as the most abused substance among the homeless, particularly among the young" (Johnson & Chamberlain 2007 p. 5)

69. Substance dependence is regarded as a risk factor for homelessness as well as many other disadvantages but the large Melbourne study suggests that homelessness is itself an even more potent risk factor for substance abuse:

"We identified that 1,940 people, or 43 per cent of the sample, had substance use issues. Table 2 shows that two-thirds (66 per cent) of them developed substance use problems after they became homeless. Our data confirm that substance use is common among the homeless population, but for most people drug use follows homelessness. Drug use is an adaptive response to an unpleasant and stressful environment and drug use creates new problems for many people" (Johnson & Chamberlain 2007 p. 8).

70. Here we have another of those self perpetuating vortices of disadvantage. Disadvantage and other risk factors lead to homelessness. Homelessness is likely to lead to the mental disorder of substance dependence. The substance concerned is likely to be an illicit drug like heroin. Criminal prosecution and imprisonment is a likely consequence of abuse of illicit drugs. Imprisonment is likely to compound or create other mental health problems and remove chances of employment and stable housing. Is there any way of breaking this downward cycle of disadvantage?

71. Rickwood emphatically believes that establishing people in stable accommodation does:

"Appropriate accommodation not only removes the risks associated with unsuitable accommodation or homelessness, but also provides a base from which a person can focus on their recovery. It enables people to develop links with organisations and services within their community, and allows them to channel their energy into other factors supportive of their ongoing wellbeing (such as education or employment)" (Rickwood 2006 p. 36).

72. Substance dependence is often the most urgent issue in the lives of many rough sleepers whose resulting chaotic lifestyle sabotages their dreams and best of intentions. Effectively addressing this can bring stability that facilitates them securing and maintaining housing.

73. We have seen that submitting drug users to the processes of the criminal law is implicated in many of the social disadvantages that they experience. Treating

someone as a criminal serves to marginalise them, to push them on to the edges of society. Johann Hari in the conclusion of his book, *Chasing the Scream*, writes of his former partner:

"You confront the addict, shame him into seeing how he has gone wrong, and threaten to cut him out of your life if he won't get help and stop using. It is the logic of the drug war, applied to your private life. I had tried that way before. It always failed. Now I could see why. He coped with his childhood by cutting himself off. He obsessively connected with his chemicals because he couldn't connect with another human being for long. So when I threatened to cut him off – when I threatened to end one of the few connections that worked, for him and me – I was threatening to deepen his addiction." (Hari 2015 p. 293).

74. At the end of his long journey towards enlightenment Hari concludes: "The opposite of addiction isn't sobriety. It's connection. It's all I can offer. It's all that will help him in the end. If you are alone, you cannot escape addiction. If you love, you have a chance. For a hundred years we have been singing war songs about addicts. All along, we should have been singing love songs to them." (Hari 2015 p. 293).

School dropout

75. The illegality of drugs moves many educational authorities to take far more punitive action in cases of drug use than they do in the case of tobacco and alcohol. This reaction can generate risk factors for mental illness. While there is no strong evidence that depression independently increases the risks of drug dependence later in life, (Degenhardt p.141) "early onset cannabis use and alcohol use (but not tobacco) are both associated with an increased risk of major depression by the age of 27 years (*ibid.*, 139).

76. Current Education Department guidelines for NSW public schools mandate immediate suspension and referral to the police. "Suspension is to occur immediately if the substance is being represented by the student as an illegal substance, or on confirmation that the substance is, in fact, illegal" (NSW DOEC 2015). Punitive policies are also adopted by private schools. An angry Prof. David Penington declared himself to be "simply appalled at the Prime Minister's statement praising PLC (Pymble Ladies College) in Sydney for expelling nine girls for allegedly handling marijuana. We know a large number of those girls in that school will have used it, and to say that expulsion is part of the solution is fundamentally wrong. One of the risk factors of going to heroin is leaving school early, or having been dismissed from school early. We've got political leadership not willing to listen to the facts" (Prof. David Penington quoted in *The Age* (Melb) 1st Edition Friday 28 May, 1999 pp. A16-A17).

77. Use and other involvement with illicit drugs are significant reasons for suspension and dropout from schools. In 2012, for example, 749 students were suspended for up to 20 days for "Possession or use of a suspected illegal substance." These suspensions do not include drug dealing. Anecdotal evidence suggests that a significant proportion of the 8,692 students who were suspended for "Serious criminal behaviour related to the school" were participating in the distribution of drugs to their peers. Adolescents are attracted to this by the ready money. Most suspensions occur to students in years 7 to 10 (NSW DOEC 2013).

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78. A study of school dropout across the United States found that “prior use of cigarettes, marijuana, and other illicit drugs increases the propensity to drop out and the earlier the initiation into drugs, the greater the probability of premature school leaving.” (Mensch & Kandel).

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Crime

79. The Senate Select Committee on Mental Health made much of the co-occurrence of substance abuse and mental illness among people caught up in the criminal justice system. It termed this “the expectation not the exception”. That committee lamented that:

“Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system.” (Senate 2006 §2.29).

80. The report pointed out the increase in dual diagnosis which was seen as flowing from the failure to meet mental health needs and the increased focus on law and order to control behavioural problems:

“In recent years the rising incidence of co-morbidity, as it is also termed, has supported a substantial increase in the number of people with mental illness in gaol. Predominating among these are young men and Indigenous people, a disproportionate number being women. Submissions to this inquiry took the view that this trend is a direct consequence of the failure to adequately respond to the mental health needs of people with dual diagnosis, combined with an increased focus on law and order models to control perceived behavioural problems.” (Senate 2006, §5.36).

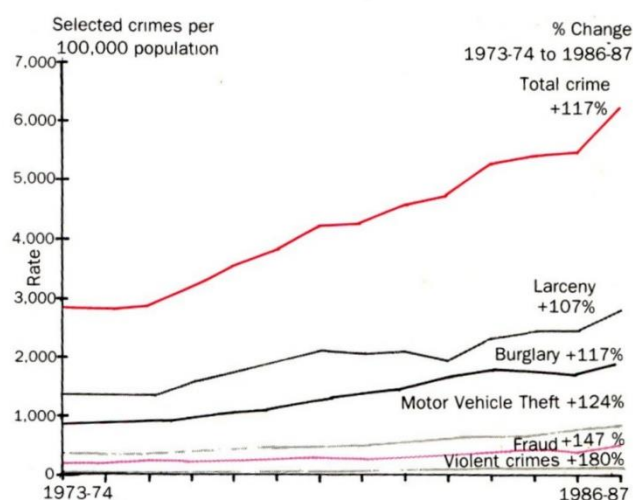
81. The most common crimes then tended to be those committed by people seeking to raise the funds to support their habit or committed under the influence of drugs. A 1990 study pointed out that short-term trends (1973 – 74 to 1986 – 87) indicated that the:

“Total numbers of crimes have increased.

- Per capita rates of crimes reported to police generally show increases....
- Among the violent crimes, serious assaults increased by 236% ,.... And robbery by 78%
- Property crimes, of which stealing accounts the half, increased by 89%”. (Mukherjee, Neuhaus & Walker (1990) p.7).

Chart 1: Crime statistics 1973 – 74 to 1986 – 87
Total crime, Larceny, Burglary, Motor vehicle theft, Fraud and violent crimes

Figure 1.3 Selected crime statistics show increases in most crimes - 1



Source: Mukherjee, Neuhaus & Walker (1990) p. 7.

82. An evaluation by the Burnett Institute of drug policies in the ACT prison reported that:

“Nearly four in five respondents with a history of drug use reported that they were under the influence of alcohol and/or drugs when they committed the offence for which they were imprisoned. Similar proportions reported that their current imprisonment episode was related to their alcohol and/or drug use. These data are indicative of the close relationship between crime and drug use and in turn the potential benefit of effective drug and alcohol policy and service provision on reducing crime and incarceration rates” (Stoové & Kirwan, 2010, p. 123).

83. In 2002 the Institute of Criminology had commented that crime was still rising: “in terms of property crime the evidence is one of significant increases over the past 20 years, particularly for break and enter and motor vehicle theft” (Makkai (2002) p. 111).). In 2010 Australia was still experiencing “high levels of property crime” (AIC 2012 p. 5.)

84. The increasing association between crime on the one hand and the combination of substance abuse and other mental disorders on the other is a point made by Dr Paul Mullen. The growing association between mental health, illicit drug use and crime was also stressed in much evidence put to the Mental Health Council's landmark *Not for service* report. For example, the Victorian Network for Carers of People with a Mental Illness made the point that:

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“During the past decade, there has been a 50% expansion in the Australian prison system yet those close to grassroots services argue that much of the recent increase in the Australian prison population can be explained by unmet mental health needs, subsequent illegal use of drugs as a form of self-medication, and the eventual intervention of the criminal justice system” (MHCA 2005 p. 436)

85. In this way, the use of illegal substances has become a common pathway by which people with a pre-existing mental health problem end up in the criminal justice system. Often abuse of a substance starts as a form of self-medication to alleviate symptoms of a mental health condition. Substance abuse can thus mask other mental health conditions.

Prisons

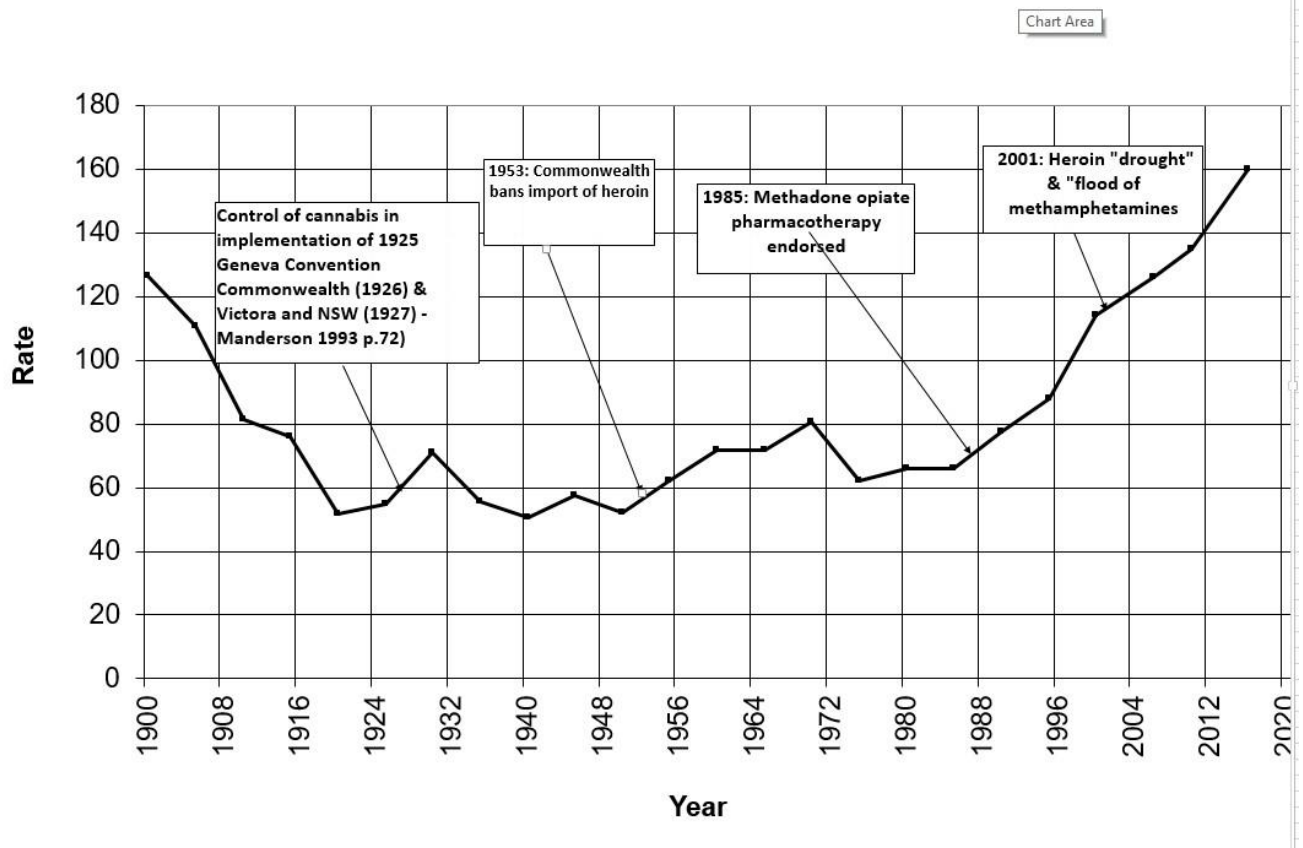
The growth in imprisonment

86. For 80 years of the 20th century to the early 90s Australia had an incarceration rate of below 80 prisoners per 100,000 of the population. As the following chart shows, the century was book ended by much higher incarceration rates. In 1900 we incarcerated 126.8 Australians for every 100,000 of the population and this incarceration rate was falling while in 2000 the rate was 108.39 and rising sharply.

87. The rate of increase may have slackened somewhat in the last few years but prisons remain a huge and costly burden on the government, the people in them, their families and the broader community. According to the latest report on corrective services of the Productivity Commission, in 2011-12, on average, 29,213 people per day were held in Australian prisons – an increase of 1.7 per cent from the 2010-11 (p. 8.5). Nationally, 18.9 per cent of the total prisoner population (excluding periodic detainees) were held in privately operated facilities (Productivity Commission (2013a) p. C.5).

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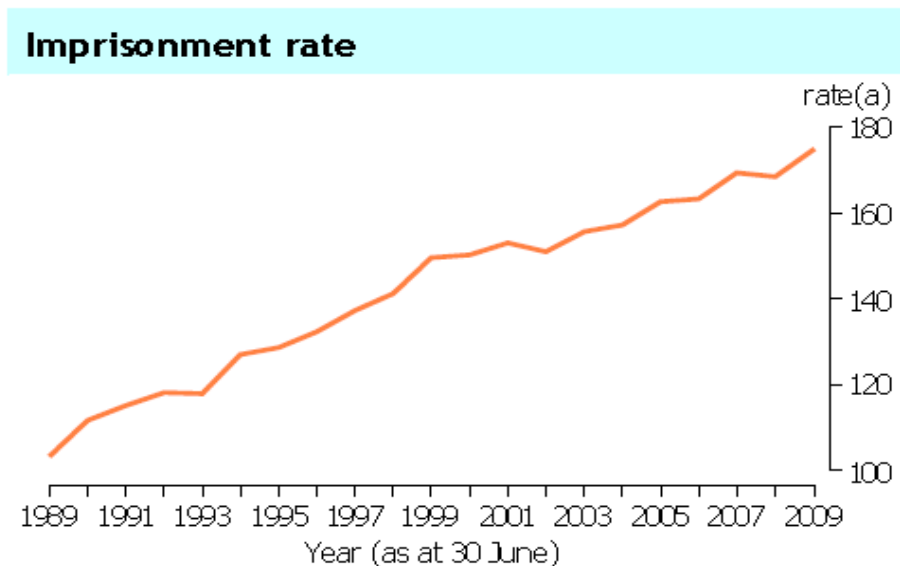
Daily average rate of prisoners in Australia 1900-2016



SOURCE: The Cambridge handbook of Australian criminology (2002), table 1.3, p. 16 & ABS, Australian crime: facts & figures 2004, p. 92 & World Prison Brief (<http://www.prisonstudies.org/country/australia> visited 3/4/2019)

88. The former Institute of Criminology remarked that: "Between 1984 and 2005, the overall imprisonment rate increased from 88 to 163 per 100,000 adult population." (AIC 2007, p. 84). The Bureau of Statistics reckons that an imprisonment rate of 175 prisoners per 100,000 adults on 30 June 2009 represents an increase "by around two-thirds" since 1989 (ABS 2010 p. 1). This amounts to an increase of 85% or, as the Institute of Criminology puts it, "an average 5% a year since 1984" (AIC 2007, p. 84). If the Cambridge Handbook of Australian criminology is to be believed, the incarceration rate in 1985 was 66.06 per 100,000 rather than 88 (Graycar & Grabosky (2002), table 1.3 p. 16) thus producing an even more alarming surge in imprisonment at the end of the century of 147%. As of 30 June 2018 there were 42,974 people in Australian prisons. This constituted a rate of 221 per 100,000 (ABS 2019).

Chart 2: Imprisonment rate 1989 – 2009



(a) Prisoners per 100,000 people aged 18 years and over. From 1989 to 1993 rate is for people aged 17 years and over.

Source: Australian Prisoners: results of the National Prison Census, 30 June, issues 1989-1993, Australian Institute of Criminology; [Prisoners in Australia, 2004](#) and [2009](#) (ABS cat. no. 4517.0)

SOURCE: ABS (2010) p. 1.

89. This surge led to a boom in prison-building, for Australia had outgrown its capacity which had dated from an earlier boom in prison-building between 1852 and 1880 (Graycar & Grabosky (2002), p. 17).

90. Unlike the trend in recent years when incarceration rates continued to rise while crime rates were falling (AIC 2012), the tick-up in the prison population from the 1970s matched an increase in the crime rate.

91. It has been suggested that a reason that prisons have come to house so many people with mental disorders is because of the closure from the 1960s of mental asylums in a process termed deinstitutionalisation. In 2006 the Senate Select committee on mental health reported that: "Australia had around 30,000 acute care psychiatric beds in the 1960s. The number of public beds had fallen to around 8,000 at the time of the development of the National Mental Health Strategy (NMHS), and is now around 6,000" (Senate 2006, para. 8.4). In our opinion any impetus of deinstitutionalisation to fill prisons with people who are mentally ill is supercharged by drug policy. This is the most credible explanation of the high prevalence of co-occurring substance abuse disorders and other mental health conditions.

92. The consequence of this deinstitutionalisation without adequate complementary community care was highlighted in the grand survey of lived experience of consumers, carers and others in the *Not for Service report* [MHCA 2005]:

"this report concludes that government promises to establish adequate, networked, community based services to replace institutional care have not materialised. Reverberating through this report are the voices of consumers, advocates, families, workers and politicians who give accounts of

homelessness, lack of inpatient and community services, over-reliance on pharmaceutical treatment, undue confinement, imprisonment in gaols, and suicide" (Savy 2005).

93. Ten years later Dr Sebastien Rosenberg observed that "Australia's mental health system is in crisis" and that:

"One key reason for this is the "missing middle". Most of Australia's asylums were closed by the 1990s, though the Australian Institute of Health and Welfare reports there are still 1,831 acute and sub-acute beds operating in specialist psychiatric hospitals (as opposed to general hospitals), costing more than half a billion dollars annually.

"It is widely accepted that on closing the asylums, Australia failed to invest in an alternative model of community mental health care. This means that for people seeking mental health assistance, there are few alternatives between the GP's surgery and the hospital emergency department.

"These alternatives reflect the financial demarcation between the federal government, which pays for primary care, and the states and territories, which manage hospitals. Nobody currently "owns" or has responsibility for community mental health services" (Rosenberg 2015).

Inefficacy of prisons as a crime prevention measure

Recidivism

94. Sending people to prison inflicts a pain or harm upon them, namely it deprives them of the fundamental right to freedom. Furthermore, doing so comes at a very high economic cost to the community. The infliction of such harm could be justified, only, if at all, if it made the community safer but there is reason to believe that it has the opposite effect. This effectiveness is, of course, achieved while an offender is incarcerated – imprisonment thus disables those detained from committing crimes in the community while they are detained. On the other hand the community has a right to expect much more from its prisons.

95. The Australian Bureau of Statistics neatly summarises the effect that imprisonment is intended to have and goes on to doubt their efficacy:

"Imprisonment aims to prevent crime and enhance community safety by removing offenders from the public arena and acting as a deterrent to potential offenders, as well as meeting society's need for reparation or retribution for crimes committed. However, while a period of imprisonment may deter some people from re-offending, in others it may foster further criminal behaviour" (ABS 2010b p. 1)

96. The fact of the matter is that the threat of imprisonment is an ineffective means of deterring offending in the first place and, worse than that, there is strong evidence that imprisonment in the Australian system increases the likelihood of reoffending by those who graduate from a prison. All too often imprisonment is justified in the eyes of politicians and the public as simply a means of making people suffer in revenge for a crime that they may have committed.

97. As a means of reducing crime there is little room for doubt that incarceration as practised in Australia is a very inefficient social intervention. This is evident from

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the following table and chart of recidivism (expressed as the rates of Prisoners released who returned to prison) in the 2019 *Report of Government Services* compiled by the Productivity Commission (PC Rog 2019).

Table 1: Prisoners released who returned to prison under sentence within two years (per cent)

Table CA.4 Adults released from prison who returned to prison with a new sentence within two years - time series (per cent) (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2017-18	%	50.8	43.7	42.7	38.5	37.1	46.3	44.2	55.9	45.6
2016-17	%	51.3	43.6	40.2	37.8	36.2	44.3	38.6	57.1	44.8
2015-16	%	50.7	42.8	39.7	38.1	36.9	39.8	41.0	58.3	44.6
2014-15	%	48.1	44.1	40.9	36.2	38.1	39.9	38.7	59.5	44.5
2013-14	%	45.8	39.5	39.8	39.0	38.4	39.3	41.9	59.1	43.0

Adults released from prison who returned to corrective services with a new correctional sanction within two years - time series (per cent) (a), (c), (d)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2017-18	%	55.8	58.2	53.7	45.3	45.7	55.5	69.9	58.7	54.2
2016-17	%	55.8	57.7	51.1	44.9	45.0	55.0	58.5	60.1	53.4
2015-16	%	55.1	55.6	49.8	45.7	46.1	49.8	61.3	61.0	52.6
2014-15	%	52.9	53.7	49.1	42.7	46.0	50.0	59.8	61.6	51.3
2013-14	%	50.3	48.7	48.0	45.2	48.7	49.4	62.9	61.4	49.9

(a) Refers to all prisoners released following a term of sentenced imprisonment including prisoners subject to correctional supervision following release, that is, offenders released on parole or other community corrections orders. Data include returns to prison resulting from the cancellation of a parole order.

(b) Includes released prisoners who returned to prison only or who returned to both prison and community corrections.

(c) Rates for SA from 2013-14 onwards reflect legislative changes introduced in August 2012 that provides opportunity for parole to be cancelled for a breach of any condition, resulting in return to prison to serve the remaining sentence(s). Previously, breaches of only certain types of conditions would result in cancellation of parole.

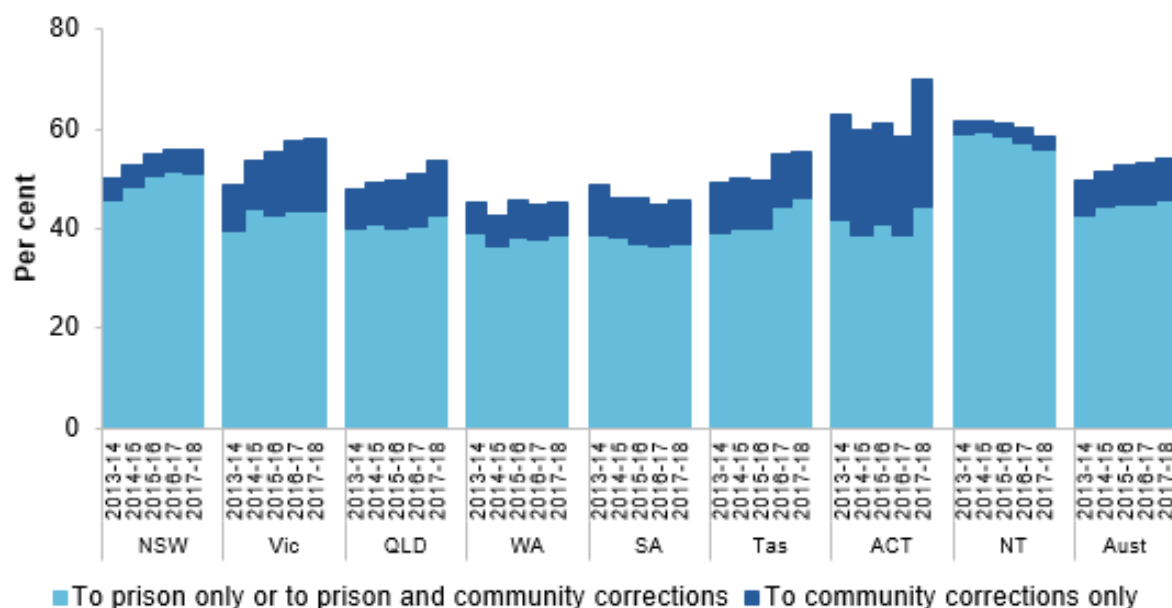
(d) Includes a prison sentence or a community corrections order.

Source: Australian State and Territory governments (unpublished).

SOURCE: PC Rog 2019

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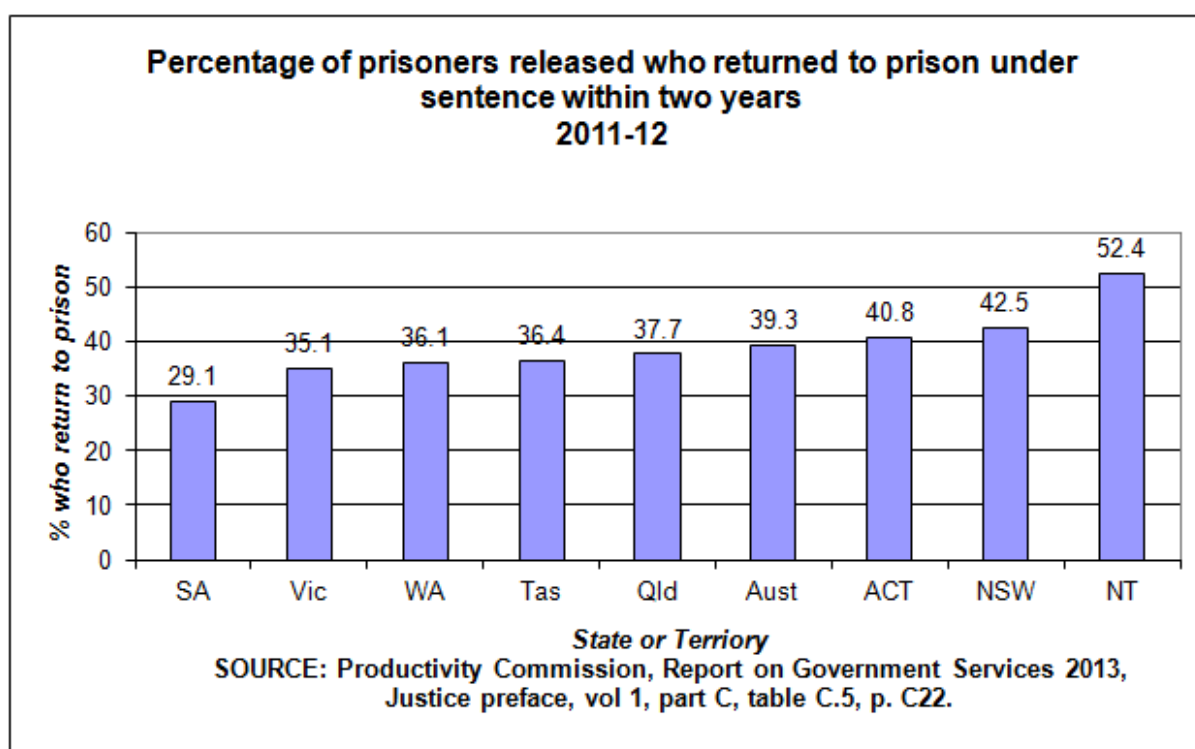
Prisoners returned to corrective services with a new correctional sanction within two years of release (per cent) visited



SOURCE: <https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/justice> visited 5/2/2019.

98. The rate of return to prison varies greatly between jurisdictions. The rate in the Northern Territory at 55.9% (the highest) is almost half as big again as that of South Australia at 37.1% (the lowest). Clearly some Australian prison systems perform better than others. It is concerning that, as the following chart shows, just six years ago the rate of return of prisoners should have been so much lower. The trend is in the wrong direction.

Chart 3: percentage of prisoners released who returned to prison under sentence within two years 2011 – 12.



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99. Analysis by the Bureau of Statistics also throws doubt on the utility of prison. It followed a cohort of people released from prison between 1994 and 1997 and measured whether they had returned to prison within 10 years of their release. It found that two in five of those released had been reimprisoned within 10 years (ABS 2010, p. 3).

100. The rate of re-imprisonment for those who had earlier served time for property offences – crimes that are particularly associated with illicit drug use – was even higher:

“Members of the 1994–1997 release cohort who had been in prison for burglary or theft had the highest reimprisonment rates (58% and 53% respectively)” ABS 2010a p. 4).

101. Perhaps the gravest indictment of imprisonment revealed in the ABS study was that the more one has been in prison the more likely one is to reoffend: “reimprisonment was strongly associated with already being a recidivist prisoner, as opposed to being in prison for the first time . . . Younger prisoners were more likely than older prisoners to be reimprisoned following release. Within 10 years of being released, the reimprisonment rate for the teenager group (those aged 17–19 years when released) was 61%, compared with 23% for those aged 35 years and over.” (ABS 2010a p.2).

102. This study lends credence to the folk wisdom that prisons are colleges of crime.

Harms associated with imprisonment

103. Prisons inflict not just the intended harm of deprivation of liberty, but also aggravate and even create many of the problems that were a factor in people being sent to prison in the first place. Not least among these is the presence of illicit drugs. These are present in prison to such an extent that non-drug users known to commence drug use while in prison: “prison environments have been identified as sites of injection initiation” (Werb *et al.* 2018 & Gore, Bird & Ross 1995).

104. The overwhelming majority of people in Australian prisons suffer from both a substance abuse disorder and a dependency upon an illicit drug, possibly in combination also with an alcohol disorder. It is the expectation that prisoners will have some other mental health disorder in combination with a substance abuse problem. The detailed 2003 mental health survey by New South Wales Justice Health showed that of 63.7% of men and 74.5% of women had a substance use disorder. In the same group some 22% of men and 37% of women suffered from alcohol dependence or alcohol use (Butler & Allnutt (2003) the table 3, p. 14). The 2009 New South Wales inmate health survey suggested that even more inmates were using illicit drugs:

“The proportion of IHS participants who reported having ever used an illicit drug increased from 71% in 1996 to 81% in 2001, and then increased again slightly to 84% in 2009 (Table 5.6.1). Reported lifetime prevalence of illicit drug use increased steadily among men (from 69% to 80% to 86%), while decreasing slightly among women, from 82% in 1996 to 78% in 2009” (Indig *et al.*, (2010a) p.107).

105. The health survey in 2010 of the new ACT prison revealed that 79% of inmates had been under the influence of alcohol or other drugs at the time of committing the offence that led to their imprisonment, that 67% had ever injected

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drugs and that 53% were currently on a methadone maintenance program - a pharmacotherapy appropriate for opiates dependent drug users (ACT Health 2011 table 9, p. 11).

106. The findings of the Drug use monitoring program (DUMA) of police detainees which has been undertaken since 1999 at a number of sites around Australia by the Institute of Criminology have been summarised as follows:

“In its most recent annual report the AIC presented findings that two in every three offenders (66%) detained by the police tested positive to at least one drug, not including alcohol; female detainees were more likely to test positive (73% vs. 65%) and almost half (47%) of those who had been charged with an offence in the preceding 12 months reported having taken drugs at the time of that prior offending. The findings from the DUMA program leave little doubt that substance misuse is more prevalent among offenders than in the general community” (Payne & Gaffney (2012)).

107. The Institute of Criminology also confirms the results of the inmate health surveys such as those mentioned above:

Among incarcerated offenders, the results are much the same. In a survey of adult male prisoners in 2001, the AIC’s Drug Use Careers of Offenders (DUCO) study found that 62 percent of adult male prisoners reported being under the influence of alcohol or illegal drugs at the time of the offence that later resulted in their incarceration (Payne & Gaffney (2012)).

COERCIVE PROCESSES OF THE CRIMINAL LAW MANDATED BY PROHIBITION AGGRAVATE MENTAL ILL-HEALTH

108. Drug users, having been detected, become entangled in the stressful, coercive processes of the criminal law, notably arrest, incurring fines and possibly even imprisonment. This stress typically aggravates existing mental health problems and precipitates others where they did not exist.

Child Protection

109. The ineffectiveness of drug treatments leaves an increasing number of children exposed to greater risk of becoming mentally ill or disordered themselves by virtue of the addiction of their parents, other adults or their peers. In particular, the substance dependence of parents is a risk factor directly associated with their children developing a mental illness or disorder. It also contributes to other recognised risk factors of mental illness or disorder such as low birth weight, neglect and school drop out (DOHAC 2000, 16). It is patently clear, as this brief survey illustrates, that illicit drug use is intimately associated with child neglect and abuse either directly or through its known links to other potent risk factors for those harms.

110. A 2004 Report to the ACT Government recognised and paid particular attention to this group.

“Of particular relevance to this Review is the identification of a number of client groups requiring special attention, many of which also find themselves as clients of child protection services:

- families, the fastest growing group of clients, some of whom are experiencing second- and third-generation poverty, joblessness,

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homelessness and/or domestic violence as a result of inadequate interventions;

- accompanying children, many of whom have experienced trauma (such as witnessing domestic violence), live in insecure accommodation, and are enduring the effects of situational factors such as drug and alcohol use, problem gambling and mental health problems”(Vardon 2004 p.46)

111. It is patently clear, as this brief survey illustrates, that illicit drug use is intimately associated with child neglect and abuse either directly or through its known links to other potent risk factors for those harms.

Suicide

112. The Bureau of Statistics has pointed out that accidental poisonings including drug overdoses are among the leading causes of death for the youngest cohort (ABS 2016): “The link between drug and alcohol abuse has been identified as a significant risk factor in suicide, this is particularly unsettling for a country battling with alcohol binge drinking and recreational and prescription drug abuse problems.’ . . . Ryan McGlaughlin, CEO of Suicide Prevention Australia added ‘The research suggests that the risk of suicide among drug users is between four and fourteen times that of the general population; due to the effects of drug abuse on psychological, social and health factors” (SPA 2011).

113. The link between drug use and suicide is confirmed in a meta analysis of 64 studies. The analysis published in the reputable peer reviewed journal, *Drug and Alcohol Dependence* utilised the statistical concept of standardized mortality ratios that reveal the extent to which death in a study population exceeds the rate of the population at large:

“ . . . standardized mortality ratio (SMR) is a relative index of mortality, expressing the mortality experience of a given study population relative to that of a comparison (“standard”) population. In this study, the SMRs were used to estimate whether risk for suicide among those with specific alcohol or drug use disorders were at greater risk than expected in the general population. SMRs were calculated by dividing the observed number of suicides by the expected number of suicides and multiplying by 100, in order to yield results without decimals as . . . “ (Wilcox *et al.* 2004, p. S13).

114. The meta-analysis showed that while alcohol use disorder was a high risk factor for suicide, it was far exceeded by risk factors associated with the consumption of illicit drugs. Someone with an alcohol use disorder was almost 10 times more likely to attempt suicide than a member of the community at large (being just a heavy drinker raises one's risk of suicide by 3.5 times), the risk factor for those with an opioid use disorder was 13 more times more likely, intravenous drug users were between 13 and 14 times more likely and mixed drug users (those we would refer to as polydrug users) an astounding 16 to 17 times more likely (Wilcox *et al.* 2004).

MENTAL DISORDERS AS AN INTENSIFIER OF RISK FACTORS FOR DRUG ABUSE

Schooling

115. “Depressive disorder may lead to difficulties in completing study and work commitments, which may in turn lead to difficulties finding employment, increasing the risk of AOD misuse [41-43]” (Marel *et al.* 2016 p. 8)

THE FEEDBACK LOOP: DRUG POLICY AS A AN INTENSIFIER OF RISK FACTORS FOR BOTH MENTAL ILLNESS AND SUBSTANCE ABUSE

Schooling

116. “Research has shown that the presence of early onset AOD [Alcohol and Other Drugs] use reduces the likelihood of completing high school, entering tertiary education, and completing tertiary education. This poor level of education may lead to later life difficulties (e.g., unemployment) that may lead to other problems, such as depression. Similarly, the reverse is possible, whereby a depressive disorder may lead to difficulties in completing study and work commitments, which may in turn lead to difficulties finding employment, increasing the risk of AOD misuse” (Marel *et al.* 2016 p. 8).

Impact on treatment services of co-occurrence of drug abuse and mental illness

117. The evidence points to a high and still increasing level of comorbid substance abuse and mental illness or disorders.

“The use of illicit drugs such as cannabis and psychostimulants such as amphetamines and cocaine is . . . higher amongst young adults with severe mental illness compared to either the general population or to other psychiatric comparison groups” (Baker *et al.* 2004, 155).

This is putting more pressure on the health system and families than they can bear.

“Hospital morbidity data show a dramatic rise in the number of psychotic disorders due to psychostimulant use from 200 in 1998-99, to 1,028 in 1999-2000 and a further but smaller increase to 1,252 in 2000-01” (*ibid.*, 156).

118. Drug users are particularly difficult to connect with mental health and indeed other health services:

“Despite high rates of mental health problems, [people who inject drugs] PWID often encounter multiple barriers to accessing relevant services, ranging from clinician attitudes to the systems within which they work. Early evaluation of MSIC found that of those PWID registered to use the service, only 42 % were clients of local services targeted to their needs . . .” (Goodhew *et al.* 2016)

119. A vivid picture of the complexity of the needs of hard to reach populations of drug users is found in the following description of a survey of many of the clients of the Sydney medically supervised injecting centre (MSIC):

“The broad population of [people who inject drugs] PWID is characterised by low educational attainment and employment rates and high rates of incarceration and unstable housing. Such attributes are exaggerated among MSIC’s clients, of whom 92 % report unemployment and 65 % report unstable housing. Additionally, PWID commonly have limited social networks, as rejection by non-using friends often leads to social isolation, a well-documented risk factor for poor mental health. Such social determinants of health are associated with mental health problems, and consistent with these associations, PWID have documented elevated rates of mood, anxiety, personality and psychotic disorders; posttraumatic stress disorder (PTSD);

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and suicidality and self-harm. Trauma exposures such as being witness to serious injury or death, being involved in a life-threatening accident, being threatened with a weapon, being held captive or kidnapped and being sexually abused as a child are commonly experienced by people with substance dependence. These traumas usually occur before the onset of substance abuse disorders and increase the risk of later mental health problems” (Goodhew *et al.* 2016)

120. Professor Kavanagh of the Mental Health Centre at the Royal Brisbane Hospital has warned that “effective management of comorbidity is likely to be critical to the cost-effectiveness of services.” There are, he has written, “particularly high proportions [of comorbidity] seen in services for more serious problems (such as in-patient wards) and in younger patients. If these patients are not effectively treated, this will have a substantial impact on the overall effectiveness of the service. In practice, management of comorbidity becomes ‘core business’ for the service, whether or not this is recognised” (Kavanagh 2001, 64).

121. In order to cope with crises, scarce resources are being siphoned away from already chronically under funded services providing low and medium level interventions – that is, from most cost effective to least cost effective interventions. Of course, this deprivation of resources from where needs are low or medium leads more people into crisis thus compounding the health, social and fiscal problems. Rosenberg speaks of a “missing middle”:

“ . . . for people seeking mental health assistance, there are few alternatives between the GP’s surgery and the hospital emergency department.

“These alternatives reflect the financial demarcation between the federal government, which pays for primary care, and the states and territories, which manage hospitals. Nobody currently “owns” or has responsibility for community mental health services.

“The federal government has been ramping up investment in primary mental health care. This has been principally through the [Better Access](#) program, now costing taxpayers more than A\$15 million per week, mostly in payments to psychologists. Apart from a [small sample](#) of selected consumers in 2010, we know little about the merit of this spending other than it has continually increased since the program was introduced in November 2006.

“In relation to hospitals, costs increase but the [rate of access to care](#) does not. People often refer to the grim term ‘the revolving door’, when people are admitted with acute symptoms of mental illness and are at risk of harm to themselves or others. They are commonly stabilised, provided with some medication and then discharged with little or no ongoing community support. They can become unwell again quickly and need re-admission” (Rosenberg 2015).

122. The link between drug dependence and mental illness or disorders is not confined to the pharmacological effects of the drug concerned. The Commission should not therefore rest content with a platitudinous recommendation that illicit drugs, because they have deleterious effects, should be made less available.

Drug abuse as an initiator and driver of intergenerational disadvantage

123. Illicit drugs are potentially attractive to a wide range of young people of normal personality types without any particular additional risk factors (Blue Moon 2000). Drug law enforcement, far from eliminating or even reducing supply of those drugs, stimulates their availability. Most of those who try drugs will cease using them as they grow older but a small proportion will become dependent on them. Those who do or who are unlucky enough to be among the few caught by the police, are likely to accumulate a set of risk factors that they would not otherwise acquire. They may, for example, be expelled from school, thus truncating their education. In securing their supply of drugs or while arrested or imprisoned they will find themselves mixing with a deviant criminal peer group. They may even be enticed to deal in drugs in order to finance their own supply. Their relationship with their families and "straight" friends" will be stretched to a breaking point. The net result of this is that their own children will probably grow up in an environment populated by many, many more risk factors than they did. Dependence on illicit drugs thus adds to the risk factors that make it more likely that adolescents will acquire a mental illness and engage in crime. Like a snowball, young people endowed with a surfeit of risk factors and paucity of protective ones are likely to acquire more and more risk factors as they roll through life. They are particularly at danger at points of transition such as leaving school and family breakup.

124. Risk factors for mental illness involving use of illicit drugs and linked to child neglect and abuse are increasingly being amplified down generations. Put in another way, drug abuse is a risk factor for mental illness and the policy response to it drives other risk factors for mental illness which in combination resonate down generations. A small proportion of people who use drugs become addicted. Their own addiction will be a risk factor in itself and will also contribute to a larger set of risk factors for their own children, not least of mental disorders, because:

- (a) substance abuse by parents is a risk factor for adverse mental health outcomes during the infancy and childhood of children of these parents (DHAC 2000, pp. 49, 74).
- (b) substance abuse by children is a risk factor for other negative outcomes like school failure which amplify the risk of the children developing a mental disorder (DHAC 2000 p. 16).
- (c) Substantial substance abuse in a neighbourhood is a risk factor for violence and other crime in that neighbourhood which in turn amplifies the risk of those in the neighbourhood developing a mental disorder (DHAC 2000 p. 16).

125. In the first generation of drug using parents, it is likely that grandparents will be around to help out. A further generation on and there are likely to be more risk factors impinging on the children. In that second generation of drug using parents there are likely to be fewer protective factors such as the influence of grandparents able to provide support. This has long been a serious problem in the ACT. The then director of Marymead, an ACT family support service, said in 2001:

BENEFITS OF IMPROVING MENTAL HEALTH

“[W]e’re now certainly seeing second generation families. Of course, there are children who are resilient, who will break out of the lifestyle of drug abuse but there are others who have not been able to escape that and it’s really quite difficult to imagine how they’re going to find their way out of that” (Mickleburgh 2001).

Economic impact of co-occurrence drug abuse and mental illness

126. Existing health services strain to engage and cope with the needs of people who are struggling with both a drug dependence and other serious mental health conditions. Those people will often be severely disadvantaged and stand in acute need of other health services for their physical conditions and social services such as housing. The more complex a person’s needs, the more difficult and costly it is for existing services to meet them. This part briefly surveys aspects of drug policy that hold out the promise of substantial financial benefit and better outcomes. The survey is limited to situations where attempts have been made to estimate costs of existing policy and hint at possible savings. Needless to say, in most if not all situations not even that level of rudimentary estimation is available.

MONEY SPENT ON DRUG LAW ENFORCEMENT IS BOTH WASTEFUL AND A DRIVER OF MENTAL ILLNESS

Loss of revenue and cost of combating organised crime

127. As opposed to tobacco and alcohol, Governments receive no revenue from illicit drugs. The turnover of the illicit drug market is outside the GST regime.

Twenty-two years ago *Access Economics* estimated the annual Australian turnover of the criminal drug trade was \$7 billion (Access Economics 1997). In its 2005 yearbook, the UN Office of Drugs and Crime estimated the illicit drug market for Oceania to be US\$16bn which represented 5% of its estimate of the World Drug Market of US\$322bn (UNODC 2005 vol. 1, p. 128). The Oceania figures overwhelmingly represent those of Australia (only figures from Australia and New Zealand were included [in that region]) (UNODC 2005 vol. 2 pp. 254ff).

128. Drugs constitute the lion’s share of the estimated annual cost of organised crime to Australia which was said in 2010 to be some \$15 billion a year (McClelland & O’Conner (2010)).

129. Not only has drug policy been ineffective in quarantining the Australian population from illicit drugs, it has, as discussed earlier, actually stimulated their supply. Given both the drugs themselves and the ineffective measures taken to reduce their accessibility are drivers of mental illness, the money would be far better spent on other strategies that reduced the burden of mental ill health.

“Substantial funds have been devoted to drug prevention in Australia. According to the Australia Institute of Health and Welfare (AIHW), the Australian government spent \$142.2 million on the prevention of hazardous and harmful drug use in 2000 – 01. This represents 15% of the total national expenditure (\$987 million) on core public health activities, making drug prevention the fourth most highly funded public health activity, after organised immunisation, communicable disease control and selected health promotion (Spooner and Hetherington 2004, p. 5).

Treatment more effective in supply reduction than drug law enforcement

130. Treatment is recognised as more effective in reducing the availability of illicit drugs than law enforcement. It does so by reducing the demand from consumers at the local retail level. Drug users who are unable to finance their habit will typically resort to property crime or deal in drugs. If confined to supplying their drug using peers dealing can be regarded as more honourable than scamming funds from their family (Braithwaite 2001 p.228) or property crime. Attracting dependent drug users into treatment thus removes them from the person to person illicit distribution system. In the words of Swiss criminologists:

“Drug trafficking is by far the most frequent offence committed by drug-addicts, but the rate is very much reduced by drug prescription programs. Since new users tend to be recruited by addicts in their own social networks, getting drug-addicts out of crime (and drug trafficking) might contribute to slowing down the recruitment of new users of illegal drugs” (Killias, Aebi & Ribeaud 2005, pp. 187-98).

131. With the co-occurrence of substance dependence and other mental health issues being the expectation rather than the exception, drug policy should be at the centre of strategies to engage in treatment this population, which is notoriously hard to engage. A comparative study of the 92 drug consumption rooms (DCR) and supervised injecting facilities (SIFs) currently operating in 11 countries including Australia point to the crucial role that these can play in the engagement of difficult-to-reach drug users with a plethora of mental health and other needs (Belackova *et al.* 2019). The latest European Drug Report describes the opportunities that low threshold services like drug consumption rooms provide to engage severely dependent, alienated drug users not only with mental and other health services but also a range of social services that can address the many and varied risk factors for those health conditions:

“Supervised drug consumption facilities are spaces where drug users can consume drugs in hygienic and safer conditions. This intervention aims both to prevent overdoses from occurring and to ensure that professional support is available if an overdose occurs. These facilities typically provide access to a wide range of medical and social services, as well as referral to drug treatment, and are able to attract hard-to-reach populations of users. Individual facilities supervise large numbers of consumptions, which otherwise would have taken place in the streets or in other risky circumstances. There is growing evidence of their benefits, which include reductions in risk behaviour, overdose mortality and transmission of infections, as well as increased drug users’ access to treatment and other health and social services. At the same time, they can help to reduce drug use in public and improve public amenity in areas surrounding urban drug markets. Such facilities now operate in 56 cities in 6 EU countries and Norway; 78 facilities in total. In Germany, where such facilities have been operating since the early 1990s, legal regulations have recently been revised to allow them to supervise lower-risk types of use, such as snorting, smoking and inhaling. In addition, two of the 16 Federal states have begun to permit their use by people in substitution treatment” (EMCDDA 2018, p. 79).

132. The following studies support effectiveness of treatment leading to reduced availability of illicit drugs include:

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- A highly regarded study on the control of cocaine undertaken by the Drug Policy Research Center of RAND in California found that “the least costly supply-control program (domestic enforcement) costs 7.3 times as much as treatment to achieve the same consumption reduction.” The study compared the relative effectiveness of treatment with various forms of law enforcement in achieving a reduction in the number of users, the quantity of the drug consumed and the societal costs of crime and lost productivity that arise from use of the drug. The study estimated that “the costs of crime and lost productivity are reduced by \$7.46 for every dollar spent on treatment.” Described in other terms, domestic law enforcement, the most efficient form of law enforcement, “costs 4 times as much as treatment for a given amount of user reduction, 7 times as much for consumption reduction, and 15 times as much for societal cost reduction.” (Rydell & Everingham 1994 pp. xv-xvi).
- Controlled trials of comprehensive methadone maintenance and comparative observational studies have all shown that this treatment is more effective than either placebo or no treatment in retaining people in treatment and in reducing opioid use. Larger comparative observational studies have confirmed this (Ward, Mattick & Hall 1992, 20-21 & 39).
- The drug trafficking by those admitted to the Swiss program of heroin assisted treatment declined from that committed in the six months before compared to the 6 months after admission by 57% (Killias, Aebi & Ribeaud 2005, p. 196 & Uchtenhagen *et al.* 1999 pp. 64-69). The flow on effect of this reduction is probably reflected in a large reduction in the recruitment of new heroin users. Since the introduction there of prescription heroin in 1995, a study reported in *The Lancet* of the canton of Zurich has shown a large decline in the recruitment of new heroin users:

“The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%” (Nordt & Stohler 2006).

133. Treatment is recognised as more effective in reducing consumption of illicit drugs than law enforcement by reducing the demand from consumers and of suppliers at the local retail level. Typically illicit drug users deal in drugs in order to pay for their habit. Attracting them into treatment thus removes them from the illicit distribution system.

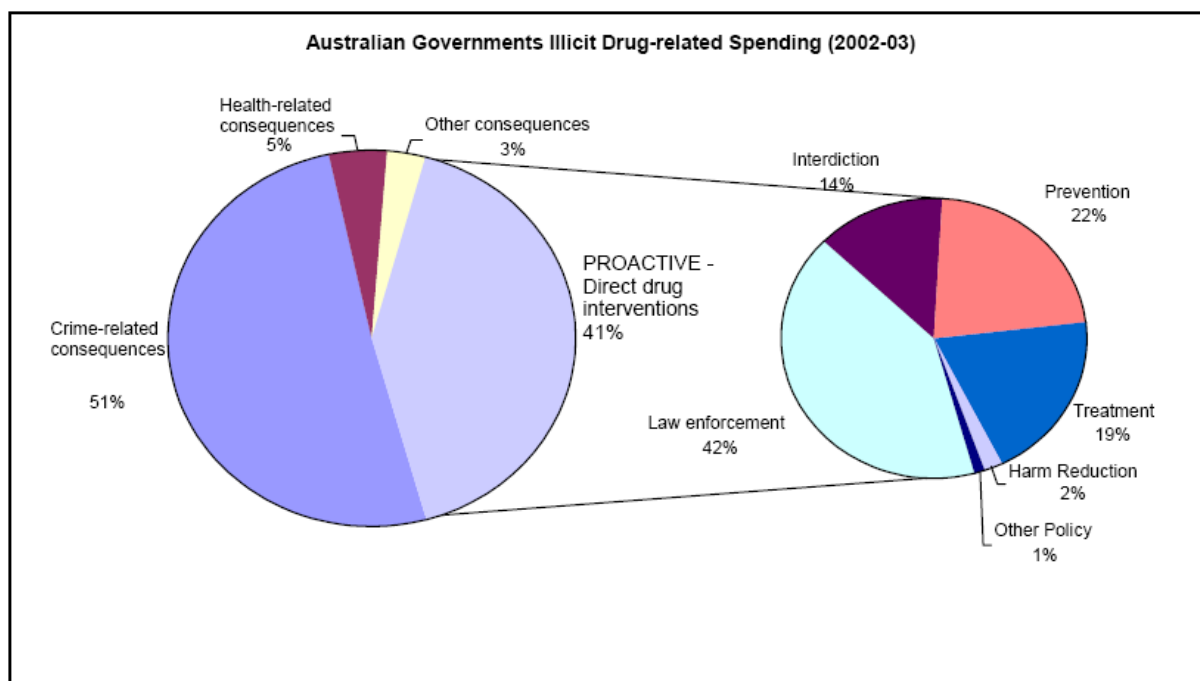
“The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%” (Nordt & Stohler 2006).

134. In defiance of the knowledge that a health approach is far more effective than drug law enforcement in reducing the availability of drugs, Australian governments, under the pretence of taking a “balanced approach”, persist in dispensing the lion’s share on law enforcement. Different estimates have been made over the years of Australia’s “drug budget”. Using 2002-03 figures, research of the Drug Policy Monitoring Project estimated that the annual expenditure of Australian governments was \$3.2bn (Moore 2005)

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Of this, direct spending on drug interventions amounts to \$1.3bn or 41% and the consequences of illicit drug use amount to \$1.9bn or 59%.

Law enforcement including interdiction costs absorbs by far most of the direct spending (56%), prevention 22%, treatment only 19% and harm reduction a mere 2%.



SOURCE: Moore 2005.

Crime-related costs also form a huge proportion of the consequential costs of government expenditure amounting to 51% of the entire government expenditure (direct and indirect) related to illicit drugs.

135. Estimates have also been commissioned by the Commonwealth Department of Health. Methodologies have evolved or varied so that different surveys are not directly comparable. Using 1998 – 99 figures the social costs of illicit drugs were given as \$m5,107.0 (Collins & Lapsley 2002 p. ix). Five years later utilising 2004-05 figures the same authors produced an estimate of \$m6,915.4 in tangible social costs (Collins & Lapsley 2008, table 33).

136. The Australia Institute of Health and Welfare (AIHW), estimated that in 2000 – 01 the Australian government spent \$142.2 million on prevention of hazardous and harmful drug use. This represented 15% of the total national expenditure of \$987 million on core public health activities (Spooner and Hetherington 2004, p. 5).

137. Illicit drugs are utilised regularly by only a small proportion of the population. The resulting costs are disproportionately high compared to the costs of, say, alcohol, which is used regularly by a much larger proportion of the population.

138. While government budgetary health costs of illicit drugs (\$258.9m) are just 16% of those of alcohol (\$1,555.3m), the government budgetary crime costs of illicit drugs of (\$2,212.3m) are 2.27 times the crime costs of alcohol (\$974.6) (Collins & Lapsley 2008, pp. 68-69 & 72-73 utilising 2004-05 figures).

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139. State and territory governments bear by far the majority of the spending (84.1%, or \$2,264.8 million) while the Federal Government accounts for 15.9% (\$427.0 million) (Collins & Lapsley 2008, pp.72-73). In 2003 Business incurred \$3,523 million of a total of \$6,154 million of tangible costs of illicit drug use, Government \$2,048 million and individuals (\$583 million) (Collins & Lapsley 2007).

Greater engagement in and more effective treatment.

140. Removal of the threat of detection and prosecution of drug users (what has been termed Damocles sword, Braithwaite 2001) would probably lead to less disruption to users in treatment and less deterrence of drug users seeking treatment. Existing diversion and drug courts have the criminal law as the gatekeeper and ultimate enforcer of treatment. Substantial doubt hangs over the usefulness of compulsory treatment given the importance of personal commitment to overcome an addiction: "Overall, there is limited empirical evidence demonstrating the effectiveness of compulsory AOD treatment" (Pritchard, Mugavin & Swan 2007). Dependency alone without any threat of current criminal sanctions is a powerful incentive to seek treatment. A lot of money is at stake. According to a 2013 estimate of the cost under current drug policies:

"The total estimated health expenditure on AOD treatment in Australia for 2012/2013 was AUD\$1 212 877 157. This represents \$52.92 per person (estimated resident population, 2012/2013) and 0.08% of GDP (Table 1).

"The highest proportion is state/territory AOD treatment grant funding (41.2%), followed by public hospitals (15%), then private hospitals (10.8%), followed by the Commonwealth AOD treatment grants (10.7%). . . . As can be seen, the state/territory government contribution is 50.7%, compared with 31.4% for the Commonwealth and 17.8% for private expenditure. When only government funding is considered, the split between Commonwealth and state/territories is 38% and 62%, respectively" (Ritter, Chalmers & Berends 2015).

Harm reduction interventions (such as needle syringe programs) were excluded from that estimate (*Ibid.*, p.398).

Extra burden on welfare agencies required to serve people with complex needs involving substance dependency alone or in combination with other mental health problems

141. Mental illness aggravated or even brought about by measures mandated by existing drug policy are just one of the unintended consequences of that policy. This paper has already touched upon crime, school dropout, child protection and suicide, welfare dependency and homelessness as other harms traceable to the disruption brought about by drug policy. Indeed it is likely that the abuse of illicit substances and the policies adopted to combat that abuse are deeply implicated in virtually all of Australia's most intractable and costly social problems. In the United States drug policy has had economy wide impacts most notably exemplified by the world's highest incarceration rate of 693 per 100,000 (World Prison Brief 2014) (a rate that is declining while Australia's is rising) but also in a decline in the workforce participation rate. The paper turns briefly to these two phenomena.

Workforce participation

142. Government is concerned about the impact of drug abuse on workforce participation. The former Minister for Social Services, Mr Porter, claimed "that

unemployed people are over three times more likely to use meth/amphetamines, and 1.5 times more likely to use cannabis, when compared with employed people". He makes no mention of unemployment being a potent risk factor for substance abuse or of the unemployed who have become addicted to pharmaceutical opiates in the course of treatment of chronic pain.

143. The Ice Task Force observed that:

"Many regional areas face economic challenges, such as high unemployment, that contribute to social problems like illicit drug use. As at April 2015, Cairns and outback Queensland faced youth unemployment of over 20 per cent, and youth unemployment in western New South Wales was over 22 per cent. This compares with an overall youth unemployment rate of around 14 per cent for Australia" (PMC 2015 p.104).

144. The minister's reaction shows that he does not understand addiction. He sees it as viable applying financial pressure on drug users to leverage them into employment. Yes, unemployment may contribute to drug abuse but this will be largely because of the anxiety that comes with unemployment and poverty, a condition that cutting off Social Security will only intensify. The end result is likely to be an even more complex drug problem, the burden of which is likely to be borne by the parents and other family members of drug users.

145. An indication of the extent of the evolving problem of analgesics is given by a survey of the Australian Bureau of Statistics of drug induced deaths. These have increased in recent years to the level of the 1990s with the difference that rather than the implicated drug being heroin, "Prescription painkillers such as oxycodone, morphine and codeine . . . were present in over 30% of deaths in 2016." (ABS 2016). The following illustrates the extent to which this phenomenon is already impacting on country towns:

"Issues relating to heart and blood pressure are big health problems in the town, in line with the rest of the country. But racing up the charts is the use of pain medications, such as the opioids – a subject that has received a lot of publicity in the United States and the Trump administration. In the pharmacy Doug starts talking to me about Australia's impending ban on over-the-counter codeine products that also contain opioids. He says regional communities will suffer because lower-dose codeine products are used to treat short-term pain, like a football injury or falling off a horse, especially when you can't easily get to see a doctor, as is so often the case in small towns.

"I have heard about the rising use of opioids and tracked the debate in the United States. I question his resistance to the ban. So he invites me behind the counter to see the physical manifestation of his biggest concern. The pharmaceutical dispensing station, Dougo shows me his 'Drugs of Addiction', or DD, safe. It's large 1.5 m, and it's full of boxes, neatly stacked according to brand. 'It will last a week,' he says" (Chan 2018).

146. Australia is following the United States where the dependence on prescription opioids is having economy-wide effects. Princeton University research published just this year revealed that 40% of prime age men who are out of the labour force report that pain prevents them working full-time and that nearly 2/3 of them take prescription medication to relieve the pain (Krueger 2017). Here in the past year well over 1 million Australians (4.8%) misused prescription pharmaceuticals (AHS 2016).

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Eliminate their legitimate supply by cutting down on doctor shopping and they will quickly turn to the illicit black market.

147. The United States began experiencing serious problems of dependency on pain medications well before Australia. There it has been shown that: “on-the-job injuries can give rise to chronically painful conditions, potentially resulting in a downward spiral of disability and poverty” (Dasgupta, Beletsky & Ciccarone 2017).

148. So widespread is the problem in America that depressed labour force participation has become intertwined with the opioid crisis:

“Nearly half of prime age [not in the labor force] men take pain medication on a daily basis, and in nearly two-thirds of these cases they take prescription pain medication. Labor force participation has fallen more in areas where relatively more opioid pain medication is prescribed. . . . Prime age men who are out of the labor force report that they experience notably low levels of emotional well-being throughout their days and that they derive relatively little meaning from their daily activities” (Krueger (2017)).

149. In essence this study shows how drug policy concerning the mass use of prescription medications is having serious economy wide and societal impacts in the United States. The same can be expected to occur in Australia. It would be remissful in the extreme for the drug strategy to say nothing of this emerging threat.

Incarceration

150. If reoffending is to be addressed, the two most prominent characteristics of those sentenced to prison must be addressed. These are dependence on illicit substances as are more than two thirds of prisoners and a range of other serious mental health conditions that afflict about the same proportion. The predicament of women is even worse. So crowded are prisons with people suffering from mental health conditions that they have become modern day mental health institutions. In a large measure the drug laws are drivers of this situation, not in terms of imprisonment for minor use and possession charges, but in terms of young people becoming mixed up with a criminal peer group, being enticed by the easy money of drug dealing and property crime to fund their dependency – possibilities enhanced by common pre-existing factors like anxiety and youthful risk taking.

151. The Institute of Public Affairs has called out the very high cost of incarceration in Australia:

“Australian prisons are among the most expensive in the world. Among countries for which 2014 data is available, Australia had the fifth highest per prisoner annual prison cost. The cost of putting one person in prison for a year was \$109,500. Only Sweden, Norway, the Netherlands and Luxembourg had higher costs” (Bushnell 2017, p.4)

152. It does not make sense to invest heavily in compulsory treatment when there is a crying shortage of treatment slots for those who seek it voluntarily. A Sydney treatment service has described the situation in the following terms:

“Prolonged meth[amphetamine] use is known to contribute to drug-induced psychosis. As meth addiction ravages the nation, many people may need a stay in a psychiatric hospital to stabilise before they can begin addiction treatment.

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“However, psychiatric beds are also being reduced across the country, which means that hospital space is available only as a last resort. Because of this shortage of available resources, people are only being offered help after a serious incident, rather than early on — in an effort to prevent further danger for the addict and the people around them.

“Psychiatric bed space is dwindling, and addiction treatment centres are overloaded. Treatment providers at Sydney’s Odyssey House say that they are now seeing more people present with meth as their primary addiction than alcohol. With a high demand for space, once people enter treatment they are not receiving it for as long as necessary to successfully achieve long-term addiction recovery. People are waiting months to enter treatment and meanwhile delving further into the addictive cycle and court systems’ (Cabin 2015).

153. In all likelihood, plugging gaps in voluntary services is cheaper and more effective, not to mention cheaper, in reducing offending than compulsory services embedded in the criminal justice system (White 2016). The ACT Tobacco and Other Drug Association (ATODA) reports that “Reduced involvement in crime was the number one self-reported outcome of specialist AOD treatment in the ACT, with 91% of service users reporting a reduced involvement in crime since accessing the service” (ATODA budget sub).

154. Even a conviction, much less a prison sentence, in the government’s proposed “reintegration centre” can destroy a young Australian’s life chances.

155. Similar considerations operate in the case of older Australians. There is absolutely no community interest or benefit in disrupting the well established life of a latter day tax paying family man reliving his hippie days for whom a drug charge would mean a loss of livelihood, family and disgrace.

Mental institutions

156. A new approach would have a much greater role for the range of mostly non-government organisations which, over many decades, have built skills in the provision of psycho-social support – living skills, housing and employment support, increasingly mixed with specialist and even clinical skills. These organisations receive only around 7% of Australia’s mental health budget.

EXPERIENCES OF COUNTRIES THAT HAVE ABANDONED PROCESSING DRUG USERS AS CRIMINALS

157. The burden of mental illness in Australia is in a large measure increased by the coincidence of illicit drug abuse and other mental illness. This paper has suggested that the reliance on the criminal law works to create and foster the social and economic conditions that drive mental illness. In this final section we briefly consider the experience of other countries that, at least to some extent, have ceased to rely upon the coercive processes of the criminal law to control drugs. Increasingly countries are claiming a large margin of appreciation in the interpretation of the multilateral drug treaties, thereby giving themselves the discretion to adapt their domestic drug policy to meet their own particular needs. European countries, in particular, have taken advantage of the recognised exclusion from the rigours of the convention of the use of classified substances for scientific and medical purposes and, in place of prosecution and conviction, to implement “measures for the

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treatment, education, aftercare, rehabilitation or social reintegration of the offender” (1988 Convention, art. 3(4)). In the words of a British think tank: “Drug policy around the world is a patchwork of approaches shaped by different cultural, political and social landscapes” (Transform Drug Policy Foundation 2018).

158. The impact of many of the recent reforms such as regulated availability of cannabis in Uruguay, the United States and Canada have yet to be fully assessed but more and more countries such as Ireland and Norway are considering implementation of a Portuguese style drug policy.

159. In the 1980s, Australia led the world in ameliorating the rigours of the criminal law on drug users by applying principles of harm minimisation. This took the form of making sterile syringes available to minimise the risk of transmission of HIV and other blood borne viruses; providing for the dispensation of the artificial opiate, methadone; substituting expiation notice systems for standard prosecution in the case of minor cannabis offences and diversion schemes that have seen drug users referred to education and treatment rather than being subjected to the usual processes of the criminal law. These successful steps were taken with the express intention of minimising the disruption to the life of drug users, it being realised that a conviction for a criminal offence and imprisonment disrupted the family, social life and work of people. With a conviction it is extremely difficult for anyone to secure employment and impossible to travel to some countries. Studies have documented the beneficial outcome of many of these measures (Lenton *et al.* 1998, x) but in virtually all cases the criminal law has remained the gatekeeper for processing drug users and criminal sanctions serve as the ultimate enforcer in the event of failure to comply with the ameliorating measure. In other words, the life of the drug user and particularly the dependent drug user is perpetually threatened by the Damocles sword of criminal sanctions.

160. Australia has long since lost its pre-eminence and world leadership in drug policy innovation. Other countries, particularly in Europe, Canada and, at least in the case of cannabis, the United States, have stolen a march on Australia and it is to the experience of these countries that we now briefly turn.

THE UNITED KINGDOM:

161. The United Kingdom is unique in always having permitted heroin to be prescribed to addicted patients as recommended by the Rolleston Committee in 1926. Moreover, the drug continues to be widely used as an analgesic for intractable pain. The right of doctors to continue prescribing it as a pharmacotherapy to treat opiate addiction was substantially curtailed in 1956. Since then only a small number of specialist doctors have been permitted to continue to prescribe heroin for this purpose. Only some 300 receive that treatment (Metrebian *et al.* 2006). From 1982 until 1995, Dr John Marks in Liverpool expanded a heroin prescription program from a dozen people to more than 400 for opiate dependent drug users. The situation of patients treated at this clinic improved markedly (Hari 2015, pp.207-14).

THE NETHERLANDS:

162. Decriminalisation of the use of drugs and introduction in 1976 of a policy not to prosecute them for possession. Thenceforth, in application of an expediency principle under Dutch law, those who use the drug are not prosecuted for possession of small quantities for personal use. Cannabis is openly tolerated in coffee shops where it may be consumed.

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163. In 1998 the Netherlands followed Switzerland in conducting a heroin trial. The Swiss study had not precisely compared the efficacy of diacetylmorphine (i.e. heroin) with the gold standard opiate substitution treatment of methadone. This was done in The Netherlands where a group of treatment-resistant heroin addicts who had already been treated with methadone was prescribed heroin in combination with methadone. These were compared with another group on methadone alone (Van Den Brink, 2003). The trial “validated indicators of physical health, mental status, and social functioning”.

GERMANY:

164. Substitution therapy is possible in seven locations, namely Bonn, Frankfurt am Main, Hamburg, Hannover, Karlsruhe, Cologne and München where a trial had taken place. Further localities have yet to be established. According to the government, at the end of the year in 2010, 360 patients were receiving artificial heroin at public expense (Deutsches Ärzteblatt 2011).

PORTUGAL:

165. Portugal decriminalised the personal possession of all drugs in 2001. This means that, while it is no longer a criminal offence to possess drugs for personal use, it is still an administrative violation, punishable by penalties such as fines or community service. The specific penalty to be applied is decided by ‘Commissions for the Dissuasion of Drug Addiction’, which are regional panels made up of legal, health and social work professionals.

“In reality, the vast majority of those referred to the commissions by the police have their cases ‘suspended’, effectively meaning they receive no penalty. People who are dependent on drugs are encouraged to seek treatment, but are rarely sanctioned if they choose not to – the commissions’ aim is for people to enter treatment voluntarily; they do not attempt to force them to do so” (Murkin 2014)

SWITZERLAND:

166. In the years leading up to the announcement in 1992 by the Swiss Federal Council to undertake an intervention research program on the diversified prescription of narcotic substances, Switzerland was experiencing a severe heroin problem. Realising that years of repressive drug law enforcement was not reducing the problem, the authorities in Zurich decided to set aside a park outside the railway station as an area in which drug users could, without intervention by the police, use their drugs. This became the notorious needle park and a scandal of the city. This led to the 1992 announcement of a heroin trial undertaken in accordance with a general study plan of November 1993. The plan required that those admitted be at least 20 years of age, have a heroin dependency of at least two years and have repeatedly failed previous treatments. The Swiss had to guide them only the small-scale trial undertaken by Doctor Marks in Liverpool. The trailblazing Swiss initiative attracted worldwide attention including much criticism. The data collected over three years between January between 1994 and 1996 was carefully evaluated (Uchtenhagen *et al.* (1999) p. 1 & Rihs-Middel and Hämig 2005). It showed remarkable improvement in the well-being of dependent heroin users on the program. So positive were the findings that Switzerland thereupon incorporated heroin prescription into its national drug policy. This was challenged by those championing a drug free approach and made the subject of two national referenda both of which endorsed the program. Meanwhile the World Health Organization

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reviewed the results of the trial. It confirmed the achievement of the spectacular results but criticised the study's design on the ground that it was not possible to determine whether the improvements derived from the prescription of heroin or the significant psychosocial support provided to the drug users (WHO 1999). This qualification was used by the Australian Government of the time as a further ground for rejecting a heroin trial in Australia. It also influenced the design of a trial by The Netherlands which ensured that its trial compared opiate dependent drug users receiving heroin (diamorphine) with standard methadone.

IMPROVEMENTS IN HEALTH AND SOCIAL INTEGRATION

Fall in involvement in crime

167. *Liverpool* Police reported "that in the 18 months before getting a prescription from Dr. Marks, [the 142 heroin and cocaine addicts studied in the area] received, on average, 6.88 criminal convictions, mostly for theft and robbery. In the 18 months afterwards, that figure fell to an average of 0.44 criminal convictions. In other words: there was a 93 percent drop in theft and burglary. "“You could see them transform in front of your own eyes,” an amazed [Inspector] Lofts told a newspaper: “They came in in outrageous condition, stealing daily to pay for illegal drugs; and became, most of them, very amiable, reasonable law-abiding people.” (Hari p. 211).

The drop in shoplifting was so massive that Marks & Spencer publicly praised the intervention and sponsored the first world conference on harm reduction and drug taking in Liverpool in 1990" (Hari p. 214).

168. *Switzerland* On the basis of self reporting there was a reduction of 94 per cent or more in the “prevalence and incidence rates of self-reported criminality after one year of treatment in the programme, compared to the time before admission.” These reductions were confirmed from police records and self reported victimisation which drug users themselves often experience. Overall “ . . . street robberies (a crime typically committed by drug addicts) have dropped in Zurich (City and Canton) by about 70 per cent between 1993 and 1996” (Killias, Aebi & Ribeaud 2005, p. 197).

169. So spectacular has been the reduction in crime of those receiving prescribed heroin that a noted Swiss criminologist has concluded: “In all, heroin treatment constitutes without doubt one of the most efficacious crime prevention measures ever trialled.” (Killias *et al* 2002 p. 80).

A cost benefit analysis of the analysis found that it was “that for every franc invested in the program there is a benefit of CHF1.75.” The authors added:

“Knowing, however, that the largest part of costs were accounted for whereas benefits were estimated only very partially, one could argue that the cost-benefit ratio of the program is even higher. Basing ourselves on data found in the literature, we believe that a cost-benefit ratio between 3 and 5 would be more realistic. Thus, society would recover, in the shape of benefits, between three and five times the amount invested in the program” (Gutzwiller & Steffen 1999 p. 7).

170. *Portugal* “The proportion of drug-related offenders (defined as those who committed offences under the influence of drugs and/or to fund drug consumption) in the Portuguese prison population also declined, from 44% in 1999, to just under 21% in 2012 . . . During the same period, there was a reduction in recorded cases of other, more complex crimes typically committed by people who are dependent on

drugs, such as thefts from homes and businesses” (Murkin 2014). It is a mark of the effectiveness of program that it was maintained by a succession of governments of different political persuasions and in spite of severe economic troubles in the country.

Decline in drug use

171. *Liverpool*: “[Drug use] actually fell – including among the people who weren’t being given a prescription. Research published in the proceedings of the *Royal College of Physicians of Edinburgh* compared Widnes, which had a heroin clinic, to the very similar Liverpool borough of Bootle, which didn’t. In Bootle, there were 207.54 drug users per hundred thousand people; in Widnes it was just 15.83 – a twelvefold decrease.” (Hari p. 213).

172. *Netherlands*: No country exceeds the Netherlands’ permissive reputation for cannabis with its so-called “coffee shops”. In spite of those using the drug not being prosecuted for possession of small quantities, the usage of cannabis (and indeed) of other drugs is substantially lower there than in Australia and the United States (Netherlands 2008).

“Countries with more stringent policies towards illegal drug use did not have lower levels of such drug use than countries with more liberal policies. In the Netherlands, for example, which has more liberal policies than the US, 1.9% of people reported cocaine use and 19.8% reported cannabis use. (Greenwald 2009, p. 25).

173. *Switzerland*: Participants on the heroin trial reported a dramatic reduction in use of heroin in the first six months of treatment and in the following six-month period a further, albeit less pronounced, progression was found. Cocaine consumption as reported by the patients and corrected for urine samples also showed a marked progressive tendency to reduction (Uchtenhagen *et al.* (1999) 55). Decrease in consumption of illicit heroin and cocaine “reduces the risk of continued contacts with the drug market” (Uchtenhagen *et al.* (1999) p. 58)

174. A study of the canton of Zurich, reported in *The Lancet*, has shown a large decline in the number of new heroin users. This study was carried out after the trial ended and while heroin prescription had become a standard treatment:

“The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%” (Nordt & Stohler 2006, p. 1,833).

175. *Portugal*:

- “• Levels of drug use are below the European average
- Drug use has declined among those aged 15-24, the population most at risk of initiating drug use
- Lifetime drug use among the general population has increased slightly, in line with trends
- lifetime use is widely considered to be the least accurate measure of a country’s current drug use situation
- Rates of past-year and past-month drug use among the general population – which are seen as the best indicators of evolving drug use trends – have decreased
- Between 2000 and 2005 (the most recent years for which data are available) rates of problematic drug use and injecting drug use decreased

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- Drug use among adolescents decreased for several years following decriminalisation, but has since risen to around 2003 levels
- Rates of continuation of drug use (i.e. the proportion of the population that have ever used an illicit drug and continue to do so) have decreased.

176. Overall, this suggests that removing criminal penalties for personal drug possession did not cause an increase in levels of drug use" (Murkin 2014).

Decline in drug trade

177. *Liverpool:* "On the streets of the neighbourhood, the drug gangs started to recede. [Dr Marks] overstated it at the time when he said drug dealing had been totally wiped out – the writer Will Self, reporting on the ground, asked around and learned there was still dealers to be found. But the police said there were far fewer than before – Inspector Lofts explained at the time: "Since the clinics opened, the street heroin dealer has slowly but surely abandoned the streets of Warrington and Widnes."" (Hari p. 211).

Improvement in general well-being

178. *The Netherlands:* The group of treatment-resistant heroin addicts who had already been treated with methadone and who were prescribed heroin in combination with methadone were compared with another group on methadone alone. The study concluded that:

"... the treatment with heroin in combination with methadone is more effective than the continuation of methadone alone. With this additional heroin therapy, the patients can benefit from the treatment with respect to their health and their social functioning. This applies to both intravenous and inhalation administrations of heroin. In a number of patients there is an indication for continuation of treatment."

179. On its completion, the study had to face a problem of what to do with patients whose condition had markedly improved from the combination of methadone and heroin therapy. It was found that:

"... discontinuation of the heroin prescription in most patients who benefited from the treatment resulted in a serious deterioration of the health status within two months of stopping."

180. In summary for those receiving combination therapy,

"Undesirable effects with regard to the health of the patients and problems associated with control and management during the treatment were relatively scarce leading to the overall conclusion "... that treatment with heroin is practicable, at least under the conditions described in the protocols of the [study]. The costs of the treatment are presented in the report. ... [Thus] supervised medical co-prescription of heroin may be a useful supplement to the existing treatment options for chronic heroin addicts" (van den Brink *et al.* 2002 p. i)

181. The Dutch results are all the more spectacular in that the interventions brought improvements to those who had been using for an average of 16 years, had been on methadone for 12 years and had high levels of physical, mental and social dysfunction.

182. *Germany*: In the estimation of the city authorities, the success of the project is unambiguously positive. Up to now every controlled heroin prescription has been based on an exceptional authorization of the Federal Institute of Medicine and Medical Products. The project has been extended three times, each for half a year, up to the end of June this year (*Deutsches Ärzteblatt* 2007).

183. The health department of the city of Frankfurt stressed that for a particular group the controlled prescription of heroin is the only promising entrance to therapy and has long since proved itself. The city began the pilot scheme in 2003 with just under 100 drug addicts. The city wants the group expanded up to 150 clients.

184. According to information of the health department nearly all the Frankfurt study participants have found an apartment, even though many had previously been homeless. Some had even gained employment. The study has also shown in other cities that a stabilised social situation of drug addicts reduces the corresponding level of criminality. (*Deutsches Ärzteblatt* 2007)

Improvement in physical health

185. *Switzerland*: "There was a marked regression in particular in the area of injection related skin diseases. Underweight conditions after 18 months of treatment primarily involved patients with HIV infection. The need for medical treatment was considered to be about the same level as after 12 months of treatment" (Uchtenhagen *et al.* (1999) p. 48).

186. *Portugal*: "Although the number of newly diagnosed HIV cases among people who inject drugs in Portugal is well above the European average, it has declined dramatically over the past decade, falling from 1,016 to 56 between 2001 and 2012. Over the same period, the number of new cases of AIDS among people who inject drugs also decreased, from 568 to 38. A similar, downward trend has been observed for cases of Hepatitis C and B among clients of drug treatment centres, despite an increase in the number of people seeking treatment" (Murkin 2014 and similarly Goulão 2015).

Improvement in mental health

187. *Switzerland*: In the Swiss trial of heroin maintenance, the proportion of patients with good mental status increased from 64% on admission to 82% after 18 months & those with poor status halved from 36% to 18% (Uchtenhagen *et al.* (1999) 51). "The decrease in aggressive behaviour also showed further improvement after the 12th month of treatment" (p. 53)

Pregnancies

188. *Switzerland*: the physical state of health of women on the trial was impaired. All had suffered hepatitis B and 10 women also had hepatitis C. Two were HIV positive. Psychological features included depression, eating disorders and personality disorders. The course of pregnancies and births, with the exception of one spontaneous abortion during withdrawal, went without complications. No malformations occurred in the children and there were no sudden infant deaths (Uchtenhagen *et al.* (1999) 54).

Poverty

189. *Switzerland*: Pharmacotherapies have helped dependent users to reintegrate into the community in other ways. "Financial debts constitute a serious impediment to social integration; they represent a major obstacle and have a demoralising effect. . . . Debts decreased continuously during the [pharmacotherapy] treatment period.

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After 18 months of treatment, one third of patients were debt free and a further quarter were only moderately indebted" (Uchtenhagen *et al.* (1999) p. 60).

Welfare dependency

190. *Switzerland*: The number of patients receiving welfare increased slightly before dropping below that of the initial value in the third six-month treatment period. The group progression is significant. It is noteworthy that not always the same patients were involved. More than a third of those initially requiring welfare no longer needed this type of support, and more than a third of those who were originally independent of welfare later received it, as this income was reduced (Uchtenhagen *et al.* (1999) p. 61).

Housing

191. *Switzerland*: "homelessness decreased and patients no longer had to live in institutions. Even the non-dependent form of accommodation in lodgings decreased, whereas independent accommodation became more common . . . Unstable living conditions dropped below half the initial value, stable living conditions increased accordingly. These changes were continuous over the entire treatment period and are highly significant" (Uchtenhagen *et al.* (1999) pp. 58-59).

Employment

192. *Switzerland*: "The result is impressive: despite a difficult labour market situation, there was nearly a twofold increase in permanent employment whereas unemployment dropped to less than half. The differences are highly significant. It also became evident that 28% of those unemployed on admission found regular employment and 24% of those originally working temporary had found a permanent job. The changes occurred predominantly during the first year of treatment" (Uchtenhagen *et al.* (1999) pp. 59-60).

Social contacts

193. *Switzerland*: the circle of friends and contacts of dependent drug users is typically other drug users. There were " . . . clear changes in contact with drug users. The proportion of those who had contact with drug users several times weekly fell to less than half during the first year of treatment. Accordingly, the number of those increased who rarely or never had such contact. It [was] unclear to what extent new contacts with drug users relate to other patients participating in the programme" (Uchtenhagen *et al.* (1999) pp. 61-62).

194. One can do no better than end with a quote by Johann Hari summing up the triumph of Swiss drug policy: " "The number of addicts dying every year fell dramatically, the proportion with permanent jobs tripled, and every single one had a home. A third of all addicts who had been on welfare came off it altogether. And just as in Liverpool, the pyramid selling by addicts crumbled to sand" (Hari, p. 222).

CONCLUSION

195. It is manifest from this short summary that countries that have ceased to process drug use as a crime have reaped a large benefit and have shown the hollowness of the fear that removing the threat of criminal sanction would promote an increase in usage of dangerous drugs. The benefits range beyond the particular focus of the Productivity Commission's present reference, namely mental health. In a large measure this is because mental health status was not specifically measured though it was in the case of the Swiss trial of heroin assisted treatment. As is shown by the measured improvements in other domains, the overall well-being of drug

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users is improved. Such improvements are known to have a bearing upon mental health of drug users. Reducing contact with a criminal peer group, less involvement in crime and less time spent in prison all constitute reduction in potent risk factors for mental illness. What is abundantly clear is that removing the Damocles sword of criminal sanctions facilitates engagement of drug users with services providing treatment and social support.

196. And, one must emphasise in the context of the terms that the Treasurer framed his reference to the Productivity Commission, the changes to drug policy have produced large cost savings with potential economy wide benefits. If co-occurring substance dependency and other mental health issues are the expectation rather than the exception, then the Commission has no choice but to advise how drug policy may be better framed so as to improve mental health. Dividends will be greater economic participation and enhancement of productivity and economic growth, not to mention the general well-being of society.

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