
Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants



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Professor Dan Howard SC
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Report
Volume 2 of 4
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Part B:

The adequacy of our responses and options to strengthen them



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Chapter 10. A whole-of-government drug policy for NSW

- 10.1 As discussed in Chapter 4, NSW does not have an overarching whole-of-government AOD strategy or policy. The Inquiry heard evidence linking the lack of such a strategy or policy to a failure to effectively treat and prevent harm in NSW.¹ The absence of a state government strategy is also contrary to the National Drug Strategy 2017–2026, which states that it is expected *‘that each jurisdiction will develop their own accompanying strategy action plan which details the local priorities and activities to be progressed during the [National Drug] Strategy lifespan’*.²
- 10.2 The development and implementation of AOD policy is complex, and requires consideration of international law, order, national culture, public health and civil liberties.³ There is also a range of complex and interconnected factors that impact upon drug use within society, including fundamental social factors and social inequalities. Other state policies, such as those relating to education, social welfare and justice responses, all intersect with and influence AOD issues.
- 10.3 The Inquiry heard that policy, problems, proposals and politics all need to align in order to create a window of opportunity for policy change.⁴ The NSW Drug Summit of 1999, discussed in Chapter 2, is an example of such an opportunity leading to change.⁵ A similar window of opportunity exists now for the NSW Government to determine the future direction of AOD policy and to be an innovator and leader in this field, as it has been in the past.
- 10.4 The Inquiry heard evidence that an effective AOD policy (including funding) requires a whole-of-government response.⁶ The National Drug Strategy implicitly supports a whole-of-government response by recommending that governments take a balanced approach across the three pillars of harm minimisation: demand reduction, supply reduction and harm reduction.⁷ The Inquiry also received submissions supporting a balanced approach across the National Drug Strategy pillars.⁸
- 10.5 As noted in the Foreword to this report, although the terms of reference for this Inquiry are confined to ATS, properly addressing issues around ATS requires an effective overarching AOD policy in NSW.
- 10.6 The evidence heard by this Inquiry has demonstrated that any new state-wide AOD strategy or policy must have a number of key features to be effective. Each feature, and the evidence demonstrating its relevance, is discussed in turn below.

Recognising the use of drugs as a health and social issue

- 10.7 The overarching policy direction for drug policy should have a health and social focus, rather than treating drug use as a criminal issue, and the focus of drug policy ought to be on reducing harm:⁹ *‘... the threshold step is redefining drugs as primarily a health and social issue rather than primarily a law enforcement issue’*.¹⁰ The literature also supports a health and social focus to minimise harms.¹¹
- 10.8 The importance of expressly reframing the nature of the problem that AOD policy is seeking to address as a health and social issue cannot be overstated. The positioning of drugs as a *‘problem’* developed during the past century and national and international legislative measures have defined that problem as one of drug *use* rather than drug *harms*.¹² Measures to respond to the drug problem have rarely been based on health or social concerns.¹³ The Inquiry heard that a focus on drug *‘use’* as a problem has led to discussions about drug policy that *‘skip over some of the nuance and subtlety that the conversation does need to retain’*.¹⁴

- 10.9 Professor Alison Ritter, Director, Drug Policy Modelling Program (DPMP), Social Policy Research Centre, UNSW Sydney, told the Inquiry that the cause of societal problems is not always agreed, and the way in which a problem is framed in public discourse can shape alternate policy responses. In some circumstances problems are constructed to justify policy responses.¹⁵ Professor Ritter used the development of national methamphetamine policy in the late 1990s to early 2000s as an example. According to Professor Ritter, at that time in public discourse *‘there were two versions of what the problem was’*.¹⁶
- 10.10 One characterisation of *‘the problem’*, as described by Professor Ritter, was that there was a population-wide epidemic of methamphetamine use, the solution to that problem being to enhance supply reduction efforts by controlling precursor chemicals. This was the problem and policy response that ultimately prevailed. Another characterisation of *‘the problem’* was that there *‘was not an ice epidemic in the epidemiological sense of the term. What there was were some severely affected individuals who were injecting crystal methamphetamine in a dependent fashion and were experiencing huge amounts of harm and this was occurring in rural and regional communities, in particular’*.¹⁷ According to Professor Ritter, had that version of the problem prevailed, the policy response would have focused on harm reduction and treatment responses.
- 10.11 In this context, it is important to note that solutions to policy issues can contribute to the problem if they themselves cause harms.¹⁸ For example, drug policies that are symbolic of *‘toughness’* can further exclude and marginalise those who are disadvantaged.¹⁹ As Edwina Lloyd, Councillor of Lismore City Council and Trial Advocate at the Aboriginal Legal Service (NSW/ACT), told the Inquiry:
- ‘As long as substances are criminalised, people using them will be stigmatised, alienated and they’ll suffer more harm. For many people, though, using substances does not lead to experiencing substance use disorder and they’re not actually harming anyone, yet arresting and charging, convicting, we’re causing more harm, we’re reducing their employment prospects, we’re disrupting their lives, their relationships, alienating them, stigmatising them and separating them from community.’*²⁰
- 10.12 Evidence to the Inquiry highlighted the ineffectiveness of *‘zero tolerance’*,²¹ *‘just say no’*²² and *‘war on drugs’*²³ approaches. Such strategies lead to arrests and incarceration, and increase the number of people, particularly young people and Aboriginal people, who are criminalised (see Chapter 20).²⁴ Punitive drug policies and laws have also been found to undermine people’s right to health, due to people who use drugs being stigmatised and driven away from health services.²⁵
- 10.13 Frameworks geared towards prohibition aim to reduce drug availability, and increase prices, but the Inquiry heard that they can have limited deterrent effects on people affected by substance use disorder.²⁶ They do not necessarily lead to reductions in drug-related harm,²⁷ and have a positive association with HIV prevalence among people who inject drugs.²⁸ Internationally, the evidence suggests that law enforcement-focused approaches to AOD policy have not adequately addressed drug use and harms, or comorbid health or social issues of people who use drugs. They are widely considered to have caused more harm than good.²⁹ For example, the United States takes a criminal justice approach to drug policy and has a very high level of enforcement intensity. Despite this, rates of occasional and problematic drug use are both very high, as are rates of crime, violence and HIV.³⁰

- 10.14 Describing the drug problem as a health and social problem and shifting the focus of AOD policy away from criminal justice responses can have a range of benefits, including reducing barriers to treatment, reducing stigma, improving integration and partnerships across sectors, and redirecting resources towards the treatment sector.³¹ A public health focus can also emphasise prevention and treatment to reduce harm.³² Responses to the 2014 Global Drug Survey demonstrated that hypothetical changes to liberalise drug policy would increase confidence in help-seeking among people who use drugs in Australia. The change to the ‘severe criminal justice penalties’ that are currently incurred for some drug offences was cited as one of the reasons for this projected increase in confidence.³³
- 10.15 Dr Caitlin Hughes, Associate Professor and Matthew Flinders Fellow, Centre for Crime Policy and Research, Flinders University, told the Inquiry that the evidence suggests alternative responses to criminalisation can significantly reduce health, economic and social harms.³⁴ In her evidence, Professor Ritter articulated an approach to AOD policy based on pragmatism and compassion:

‘Well, the question ... becomes the extent to which NSW chooses a pragmatic and humanist approach towards drugs and chooses policies that reflect, you know, non-stigmatising, non-marginalisation policies, policies that express compassion and care for people and policies that acknowledge – from the pragmatic point of view, policies that acknowledge that people use drugs.’³⁵

- 10.16 This approach was also supported by Dr Marianne Jauncey, Medical Director of Uniting Medically Supervised Injecting Centre, who said:

‘I think first and foremost being honest about drug use and the reality that it occurs and not being frightened of that, not running away from that and not putting our head in the sand, dealing with the world as it is, not as we may wish it to be, and that means a pragmatic response...’³⁶

Ensuring AOD policy is evidence based, consistent with international direction and respectful of human rights

- 10.17 As described in Chapter 4, drug policy is shaped by ideological, cultural and social contexts and is not based on evidence alone. This is the case in many social and public policy arenas, yet the gap between the evidence base and policy decisions has been described as ‘striking’ in the field of drug policy.³⁷ It is also important to note that evidence is only one necessary input into policy processes. The Inquiry heard that an absence of evidence should not prevent innovation through logical and rational attempts to reduce drug-related harms.

‘There are examples of the introduction of significant reform in the absence of evidence. So needle syringe programs. There was no evidence of their cost-effectiveness. There was good logic and there was medical experience about clean injecting ... so it had a rational basis to it, but there wasn’t randomised control trials or cost-effectiveness analyses. All of that came many years later ...’³⁸

- 10.18 Clearly, when evidence is available, it should be used to inform decision making, not least because evidence-based approaches can guide resources to where they are most needed, such as prevention, treatment and harm reduction.³⁹ This aspect of drug policy was highlighted in the 2016 report of a group of health research experts convened as a Commission on Drug Policy by Johns Hopkins University and *The Lancet*. In its report, the Commission noted:

‘Standard public health and scientific approaches that should be part of policymaking on drugs have been rejected in the pursuit of prohibition. The idea of reducing the harm of many kinds of human behaviour is central to public policy in traffic safety, tobacco and alcohol regulation, food safety, safety in sports and recreation, and many other areas of human life where the behaviour in question is not prohibited. But explicitly seeking to reduce drug-related harms through policy and programmes and to balance prohibition with harm reduction is regularly resisted in drug control ...

‘Drug policy that is dismissive of extensive evidence of its own negative impact and of approaches that could improve health outcomes is bad for all concerned. Countries have failed to recognise and correct the health and human rights harms that pursuit of prohibition and drug suppression have caused, and, in doing so, neglect their legal responsibilities. They readily incarcerate people for minor offences but then neglect their duty to provide health services in custodial settings. They recognise uncontrolled illegal markets as the consequence of their policies, but do little to protect people from toxic, adulterated drugs that are inevitable in illegal markets or the violence of organised criminals, which is often made worse by policing. They waste public resources on policies that do not demonstrably impede the functioning of drug markets, and miss opportunities to invest public resources wisely in proven health services for people often too frightened to seek services.’⁴⁰

- 10.19 Human rights should be of central importance in the development of AOD policy.⁴¹ However, as referred to by the Commission on Drug Policy in the extract above, international illicit drug policy has been described as being inconsistent with human rights norms.⁴² In this context, the Inquiry notes that the United Nations System Chief Executives Board for Coordination recently made commitments to support the development and implementation of drug policies that are *‘truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented and sustainable responses’*.⁴³ This included a commitment to promote the rebalancing of policies and interventions towards public health approaches. Pragmatic public health and social inclusion policies have been introduced by countries such as Portugal and Switzerland to address these human rights concerns.⁴⁴ These countries, along with the Netherlands, were described by Professor Ritter, DPMP, as having *‘compassionate’* principles underpinning their drug policies.⁴⁵
- 10.20 NSW, unlike other states and territories in Australia, does not have a Charter of Human Rights that can guide the development of policies such as those governing responses to ATS.⁴⁶ However, the Inquiry considers that the express commitments to human rights in the international context described above provide strong direction for drug policy in NSW, and such principles should form the basis for policy development and implementation at the whole-of-government level.

The harm minimisation framework

- 10.21 The harm minimisation framework is described in detail in Chapter 4. An acknowledgment that a proportion of the population will use drugs, regardless of restrictions on such substances, is a key aspect of a harm minimisation approach to AOD policy – described as a *‘value-neutral’* approach to drug use and people who use drugs.⁴⁷

- 10.22 Harm minimisation is the overarching objective of the National Drug Strategy and, necessarily, is integral to AOD policy in NSW. The Inquiry supports the pillars of supply reduction, demand reduction and harm reduction and recognises them as the basis of an effective approach to addressing drug use and harms. However, there is scope to refine and strengthen that approach.
- 10.23 The DPMP at UNSW Sydney advised the Inquiry that discussions within the drug policy community support a reconceptualisation of the three pillars.⁴⁸ In one reconceptualisation of the model, preferred by the DPMP, supply reduction, demand reduction and harm reduction are articulated as '*goals*' of AOD policy, supported by the following '*actions*' or '*pillars*':⁴⁹
- prevention
 - treatment
 - harm reduction
 - laws and regulation
 - law enforcement
 - social welfare.
- 10.24 The DPMP submitted to the Inquiry that breaking down the three goals of supply, demand and harm reduction into more precise pillars would assist in a more nuanced articulation of drug policy. These more precise areas of action are mutually reinforcing and align to each of the three goals in various ways. For example, law enforcement has typically been associated (almost synonymously) as primarily a supply reduction strategy. Under the reconceptualised approach discussed above, law enforcement can be seen as an action that contributes to the goals of demand reduction as well as supply reduction, disentangling the action (law enforcement) and responsible agency (NSW Police Force and federal agencies) from any particular overarching goal. The DPMP also submitted by way of example that treatment can contribute to supply reduction and that social welfare can contribute to both demand and supply reduction.⁵⁰
- 10.25 As noted in the Inquiry's *Issues Paper 1 – Use Prevalence and Policy Framework*, Switzerland's national drug policy adopts a '*four pillars*' approach, reflecting a shift to a health-focused approach to harm minimisation that targets prevention, treatment, harm reduction and enforcement.⁵¹ A similar model was implemented by the city of Vancouver in 2001 in response to high rates of overdose deaths and HIV and hepatitis C transmission.⁵² In Australia, prevention and treatment fall under the demand reduction pillar, despite their different purposes and strategies. The Inquiry notes that the 2018 report of the Law Reform, Road and Community Safety Committee of the Parliament of Victoria, *Inquiry into drug law reform*, recommended the Victorian Government develop a new drug policy based on the four pillars approach.⁵³
- 10.26 There is logic and merit in reconceptualising the three pillars approach in a manner consistent with an holistic and whole-of-government approach to drug policy. Accordingly, the Inquiry recommends that consideration be given to developing future AOD policy consistent with a reconceptualised approach to the three pillars.

Ensuring an appropriate distribution of resources and activity to meet the overarching objective of harm minimisation

- 10.27 The Inquiry heard a range of evidence expressing the view that there is an imbalance of resources and activity across the pillars of supply, demand and harm reduction.⁵⁴ The evidence suggests that since the first National Drug Strategy in 1985, resourcing has shifted towards supply reduction, with minimal corresponding investment in harm reduction: *'About 65% of the Australian effort directed towards illicit drugs in this instance is supply reduction and around between 2% and 5% of investment is directed towards harm reduction.'*⁵⁵
- 10.28 This evidence is consistent with the literature. Following a number of royal commissions and inquiries in the 1970s and 1980s, more resources were directed to law enforcement agencies.⁵⁶ As discussed in Chapter 4, estimates of drug policy expenditure in Australia have shown that the majority is spent on enforcement.⁵⁷
- 10.29 An analysis of 2009–10 funding for illicit drug policy activities across all Australian governments found that about 64.9% of funding was directed towards law enforcement compared to 9.5% towards prevention, 22% towards treatment and only 2.2% towards harm reduction.⁵⁸ The National Drug Research Institute has estimated the total societal costs of methamphetamine, reporting that the criminal justice sector is the single largest cost area, at about 65% of the total cost.⁵⁹ This significant cost comes primarily from imprisonment (\$902.9 million) and police activities (\$836.9 million).⁶⁰ In contrast, the report found that health care, child maltreatment and prevention/harm reduction measures were estimated to be 12% of the total cost.⁶¹
- 10.30 Such analyses suggest that the allocation of funds across AOD responses are heavily weighted towards law enforcement responses to ATS. Australia is not unique in allocating the majority of drug-related government expenditure on law enforcement. A 2008 study indicated that the Netherlands, Sweden and the United States have very similar mixes of policy spending to Australia despite apparently different drug policy settings and institutional structures.⁶² Law enforcement spending dominates in all four countries. Professor Ritter told the Inquiry that the balance or imbalance across the pillars of the National Drug Strategy reflects political support for different positions.⁶³ However, it is important to note that law enforcement is also generally more costly than other drug-related policy responses.⁶⁴
- 10.31 Although these law enforcement responses are important and necessary, there is an apparent imbalance between the three pillars of the National Drug Strategy. Professor Ritter commented that the recent affirmation by the United Nations System Chief Executives Board for Coordination that the direction of its own drug policy would be changed *'to promote a rebalancing of drug policies and interventions towards public health approaches'* is a clear acknowledgment of a current imbalance.⁶⁵ Law enforcement has been, and should remain, a central approach to illicit drug policy. However, as described earlier, there is a strong argument that the adverse effects of a supply-centric approach outweigh its benefits.⁶⁶ Further, submissions and research received by the Inquiry suggest that an emphasis on law enforcement and criminal justice responses at the expense of demand and harm reduction measures may not be the most effective allocation of resources.⁶⁷ Public health and harm reduction goals of drug policy are legitimate and necessary aspects of policy, and should be resourced accordingly.

10.32 The evidence suggests that there is a need for a more appropriate distribution of resources and activities between the three pillars of supply, demand and harm reduction. However, ‘*appropriate*’ distribution does not necessarily mean that equal amounts of resourcing are allocated to each goal or pillar of AOD policy.⁶⁸ For example, as already noted, policing and law enforcement are more expensive than other policy responses, including harm reduction measures,⁶⁹ meaning that the concept of balance across the pillars is not necessarily determined by amount of funding alone.

10.33 Finding the appropriate balance is a complex undertaking, given ordinary budgetary constraints and the competing agendas and priorities within illicit drug policy. There is also a lack of:

‘... a strong enough body of evidence to make detailed, definitive statements about the optimal allocation, owing to the complex web of causes of drug use and drug-related harm, and the complex relationships between activities and outcomes.’⁷⁰

10.34 Nevertheless, it appears there has been a historical ‘*skew*’ towards supply reduction that requires recalibration in order to ensure an appropriate balance across the pillars.

Recognising that the use of drugs occurs along a spectrum, and interventions to address different types of use should be articulated in policy

10.35 Historically, Australian drug policies have not differentiated between the various types of drug use, such as experimental use as distinct from dependent use. While all types of drug use can affect a person’s health and wellbeing, the types and extent of harms can differ markedly. Chapter 5 describes what is known about the spectrum of drug use.

10.36 Professor Ritter referred to the need to distinguish between types of use in the following evidence:

‘There are multiple problems of ATS. There is no doubt there is a problem with people who are injecting crystal methamphetamine regularly, every day, many times a day. They have no treatment ... they are in a dire situation for their physical health, their mental health and their social circumstances. The response to that – the appropriate policy solutions to that problem is very different from the problem of music festivals and young people consuming MDMA, for example, which is a different construction of the problem. So actually there are multiple problems requiring multiple solutions, but politically often it’s just one that gets picked up and carried forward.’⁷¹

10.37 An effective illicit drug policy must recognise and respond to these different types of use, ensuring that policy responses, actions and interventions are tailored to groups of people who use drugs and their varying levels of vulnerability and risk of harm. For example, harm reduction messages targeted at people who use drugs experimentally are likely to be very different to those targeted at people who are dependent on drugs. Harm reduction is further discussed in Chapter 15.

Addressing the occurrence and impact of polydrug use

10.38 Polydrug use is a pattern of drug use where people use more than one type of drug (including alcohol and other licit substances) at different times or at the same time. This pattern of drug use is common among those who use ATS. Chapter 5 describes polydrug use and its associated harms.

- 10.39 As with the different types of use discussed above, polydrug use should be recognised and addressed through AOD policy. Strategies and actions should consider the increased range of harms that an individual may experience when they use more than one type of drug.

Addressing the social determinants of drug use holistically, recognising risk and protective factors

- 10.40 As discussed in Chapter 3, a range of economic, social, political and individual factors can influence a person's health. In general, people from lower socioeconomic backgrounds with less income, wealth and education are at greater risk of poor health than more advantaged people.⁷²
- 10.41 People who use drugs may have a range of complex social and health needs, and require holistic policy and service responses to address those broader needs. The evidence before the Inquiry suggests that drug use, and dependent drug use in particular, often occurs in a context of broad socioeconomic disadvantage.⁷³ The Royal Australasian College of Physicians submitted that '*drug and alcohol addiction is a complex, chronic and relapsing health issue*' with '*complex biological, psychological and social underpinnings*'. Further, it noted the impacts of social determinants, environmental factors and early adverse life experiences on a person's use of substances. Because of these factors, policies to break cycles of disadvantage need to reduce risk factors for health inequalities, and should cross portfolios outside of health.⁷⁴
- 10.42 It is well recognised in the literature that drug use and its associated harms disproportionately affect vulnerable people, and are often rooted in inequality.⁷⁵ Chapter 3 sets out evidence that the use of drugs is associated with a number of factors, including physical and mental ill-health, trauma in adulthood and childhood, problem gambling, socioeconomic disadvantage, homelessness and chronic psychological and physiological stresses.⁷⁶ This association needs to be recognised and addressed in any AOD policy response.
- 10.43 As discussed further in Chapter 12, vulnerability to engage in drug use often depends on the presence of risk and protective factors.⁷⁷ The Alcohol and Drug Foundation noted that there are a number of factors that protect against harms associated with drug use, including strong and resilient families and communities, education, social interaction and support and good coping and decision-making skills.⁷⁸ As a result, AOD policy responses ought to recognise and address the risk factors that increase a person's susceptibility to social, behavioural and health problems, and the protective factors which can mitigate these risks.
- 10.44 People receiving treatment for their drug use also frequently have complex care needs that require input from a range of service providers as a result of the broad range of social factors that inform drug use.⁷⁹ The Inquiry heard evidence that opportunities for intervention are missed when people who use AOD present to mainstream health services and do not receive appropriate referrals, care coordination or discharge plans or support.⁸⁰ At the Inquiry's Planning and Funding Roundtable, AOD health experts unanimously supported a whole-of-government response to provide an holistic and connected response to AOD problems, and address issues such as stigma, discrimination, prevention, harm reduction, housing, employment and criminal justice issues.⁸¹ Any future state-wide AOD policy must acknowledge and adopt such an approach.

Recognising and addressing the significant impact of stigma experienced by people who use drugs

- 10.45 The Inquiry heard that stigma is a major barrier to drug policy reform.⁸² As detailed in Chapter 9, the impact of stigma and discrimination on people who use drugs is immense and affects individuals, families and support networks. This stigma was described to the Inquiry as pervasive, powerful, profound, entrenched and ever present.⁸³
- 10.46 Policies themselves can divide and categorise people according to their identity, conduct or circumstances.⁸⁴ Such divisions can stigmatise and marginalise based on what is considered to be immoral behaviour or action.⁸⁵ The criminalisation of illicit drugs reinforces such stigma,⁸⁶ with Dr Don Weatherburn, Adjunct Professor, University of Sydney Law School and former director of the NSW Bureau of Crime Statistics and Research, telling the Inquiry there is no doubt that the prohibition of drugs contributes to stigma.⁸⁷
- 10.47 The National Drug Strategy refers to stigma, but there is very little detail in policy or strategy that guides how stigma can be addressed.⁸⁸ A coordinated and whole-of-government approach to AOD policy in NSW should not only recognise the stigma attached to the use of drugs, but should also direct action for addressing it. This is a necessary step in achieving other AOD policy goals, such as shifting focus to health and social responses.

‘People should be encouraged to move into healthcare settings or treatment if they feel that they need it, or to receive education and support if they need it. And we can’t do that – we can’t even contemplate that if we don’t address stigma because of that strong relationship between stigma and health care and people’s reticence to engage with services because of this history of stigma and discrimination.’⁸⁹

Recognising the varying impact of drugs in different population groups and that interventions should be designed to meet the needs of these groups

- 10.48 As described in Chapters 8 and 16, ATS use affects certain population groups differently or more than others. This can be due to higher rates of ATS use, higher-risk use, individualised reasons for use and/or particular barriers to treatment and support.
- 10.49 Understanding how these groups use ATS, the drivers of their use and how ATS affects them is important to ensuring service responses that meet their needs. Interventions should be designed so as to meet the particular needs of these groups of people, which the Inquiry has identified are:
- Aboriginal people and communities
 - culturally and linguistically diverse communities
 - people identifying as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI+)
 - people in contact with the criminal justice system
 - people in particular occupations
 - people living in regional, rural or remote NSW
 - people with a mental health condition
 - people with a cognitive disability
 - pregnant women
 - older people
 - people experiencing homelessness
 - young people.

- 10.50 The Inquiry has not included older people as a priority population in the context of ATS use for the reasons discussed in Chapter 8. However, it is noted that older people are included as a priority population under the National Drug Strategy and accordingly will also be included in the Inquiry's recommendation below for a whole-of-government AOD policy.

AOD policy must include the perspective and input of people with lived experience of drug use

- 10.51 People with lived experience provide an important perspective on policy issues.⁹⁰ Input from people with lived experience of AOD use into AOD policy will assist to align policy responses to the actual needs of people who use drugs. Accordingly, people with lived experience should play a meaningful part in the development of drug policy to ensure that any such policy is credible and effective.⁹¹
- 10.52 The Inquiry received a number of submissions that highlighted the importance of consumer involvement in the development of policy and practice to take into account their experience and needs.⁹²
- 10.53 The NSW Users and AIDS Association argued that a top-down approach will not work to support highly marginalised people accessing health care. It noted that its Consumer Academy, a program that aims to empower consumers to participate in AOD treatment service design through training, has led to a number of participants taking places on the NSW Ministry of Health Consumer Advisory Council. It submitted:

*'If we want to improve the system, we must empower consumers to formally raise issues when service delivery is poor. At the moment, this ability does not exist. Even with an organisation such as [NSW Users and AIDS Association], which is highly connected into professional networks, has challenged what we believe is unfair treatment by the system, our power to create change is limited or non-existent. We need a complaints system with teeth, and we need resources to support consumers to raise issues when they encounter them.'*⁹³

- 10.54 The DPMP's submission to the Inquiry argued that including people with lived experience of AOD use in policy, planning and practice about their own health can challenge stigma, discrimination and uninformed opinions. The submission also stated that such consumer participation should go beyond a 'tick a box' process, and that consumers should be seen as key stakeholders.⁹⁴

Recommendation 5:

That the NSW Government develop and implement, as a matter of priority, a whole-of-government AOD policy that:

1. recognises that the use of drugs is a health and social issue
2. prioritises health and social responses to drug use and recognises the harms associated with punitive responses
3. is evidence based, consistent with international direction and respectful of human rights
4. maintains harm minimisation as the overarching objective, in alignment with the National Drug Strategy but repositions supply, demand and harm reduction as goals, with 'pillars' to achieve these goals including social welfare, prevention, treatment, harm reduction, law enforcement and legislation/regulation
5. ensures an appropriate distribution of resources and activity to meet the overarching objective of harm minimisation
6. recognises that drug use occurs across a spectrum of use, and articulates objectives and interventions to prevent the uptake of drugs, as well as for users across that spectrum
7. addresses the occurrence and impact of polydrug use
8. ensures that policy and service responses for people who use drugs and their families address their broader social and health needs holistically
9. acknowledges the social determinants of drug use and of drug dependence
10. recognises and seeks to address the risk factors associated with the use of drugs, including social vulnerability and exclusion, family vulnerability or family history of drug use, history of trauma (including intergenerational trauma), lack of engagement with education and employment, unstable accommodation and poor physical or mental health
11. recognises and promotes protective factors against drug use, including strong and resilient families and communities, education, social interaction and support, good coping and decision-making skills, and good general health
12. recognises and seeks to address the nature, extent and impact of stigma experienced by people who use drugs
13. recognises the needs of priority populations, including:
 - Aboriginal people and communities
 - culturally and linguistically diverse communities
 - people identifying as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI+)
 - people in contact with the criminal justice system
 - people in particular occupations
 - people living in regional, rural or remote NSW
 - people with a mental health condition
 - people with a cognitive disability
 - pregnant women
 - older people
 - people experiencing homelessness
 - young people

and incorporates interventions designed to address the needs of each of these groups
14. includes in its design the perspective and input of people with lived experience of drug use.

A Drug Action Plan for NSW

- 10.55 An Action Plan should be developed to support implementation and coordination of activity undertaken pursuant to the new AOD policy, to ‘*synchronise activities towards a common goal*’.⁹⁵ Such coordination involves setting priorities, allocating resources, collaborative implementation and evaluation of progress and outcomes. Without a structured, transparent action plan there is a risk of fragmented responses, reduced accountability, questions about legitimacy and internal conflicts.⁹⁶
- 10.56 A key aspect of any such plan should be a clearly articulated framework by which to measure the success of its implementation. As described in Chapter 4, the success of the National Drug Strategy is measured by reviewing and reporting against the following headline indicators:
- average age of uptake of drugs, by drug type
 - recent use of any drug (people living in households)
 - arrestees’ illicit drug use in the month before committing an offence
 - victims of drug-related incidents
 - drug-related burden of disease (including mortality).
- 10.57 The literature suggests that the measures of success used by a jurisdiction should be relevant to the intent of the jurisdiction’s drug policy,⁹⁷ an approach reflected in the practice of other countries. For example, low prevalence of use in Sweden is considered to be generally indicative of the success of its uniform zero tolerance approach. However, in the Netherlands, prevalence is generally higher, but the decreasing number of people who are dependent on drugs and the improved health and longevity of those with dependence is likewise considered to be indicative of the success of its local drug policies.⁹⁸
- 10.58 In developing an AOD policy for NSW, consideration should be given to measures that will be used to assess the success of such a policy. Consistent with the recommended focus of such a policy on health and social harms outlined above, and emerging global best practice, measures relating to reductions in drug-related mortality, health problems, drug-related societal harms and disadvantage would be appropriate to include.⁹⁹ Measuring such outcomes would also contribute to a better understanding of drug-related harm and how these harms can be addressed, as discussed in Chapter 7.
- 10.59 Appropriate outcomes and indicators should be developed in consultation with relevant stakeholders after development of the whole-of-government policy outlined above.

Recommendation 6:

That the NSW Government develop a Drug Action Plan to support the coordinated implementation of activity under the NSW AOD policy, relevant Commonwealth policies, recommendations of this Inquiry and other relevant reviews and inquiries, and that this plan should be accompanied and supported by an agreed set of outcome indicators.

Developing leadership on AOD policy in the NSW Government

- 10.60 AOD policy and responses in NSW are currently developed by various agencies and led by individual ministers with discrete responsibilities.
- 10.61 The Minister for Health and Medical Research has responsibility for NSW public hospitals, health services and medical research. The NSW Ministry of Health supports the executive and statutory functions of the health portfolio ministers and health cluster. Within the Ministry of Health, the Alcohol and Other Drugs Branch has responsibility for developing, managing and coordinating the Ministry's policy, strategy and program funding relating to the prevention, minimisation and treatment of AOD-related harm.¹⁰⁰
- 10.62 The Minister for Police and Emergency Services oversees the NSW Police Force. This Minister has responsibility for many of the law enforcement measures and programs responding to AOD and drug diversion strategies.¹⁰¹ Both the NSW Minister for Health and the NSW Minister for Police represent NSW on national AOD committees, such as the Ministerial Drug and Alcohol Forum.
- 10.63 Other ministers who contribute to AOD policy and responses include the Attorney-General and Minister for the Prevention of Domestic Violence, the Minister for Education and Early Childhood Learning and the Minister for Families, Communities and Disability Services.
- 10.64 Although having multiple ministers accountable for one policy is not unique, it requires strong coordination and agreement between the relevant ministers. For example, the Prime Minister and Cabinet's *Cabinet implementation unit toolkit* recommends that if:

*'... multiple ministers have an interest, it's best for a single lead minister to be agreed and for their agency to become the lead agency. The lead agency has responsibility for coordinating the efforts of the other agencies.'*¹⁰²

- 10.65 Following the NSW Drug Summit in 1999, the Office of Drug Policy was established in The Cabinet Office to *'coordinate drug policy across Government and to monitor and facilitate progress in implementing the Government Plan of Action in response to the Drug Summit'*.¹⁰³ Key functions included:
- overseeing and driving implementation of the response
 - monitoring the four-year Drug Summit Budget
 - developing an evaluation framework and evaluation plans
 - advising on the evaluation of programs.¹⁰⁴
- 10.66 To support the Office of Drug Policy, staff were seconded from NSW Police, the Attorney-General's department, and the departments of Health and Education and Training.¹⁰⁵ Witnesses to the Inquiry expressed support for the Office of Drug Policy and for central agency accountability and leadership. For example, Larry Pierce, CEO, Network of Alcohol and other Drugs Agencies, attributed the significant positive impact of the 1999 Drug Summit in part to the success of the cross-government oversight provided through the Office of Drug Policy.¹⁰⁶ Mr Pierce told the Health Services roundtable that when these centralised processes *'collapsed'*, the *'accountability and visibility of what was happening started to disappear'*.¹⁰⁷

*'... I think we need to return to that kind of notion of a coordinated whole-of-government approach to the drug and alcohol issue in concert and closely planned and coordinated with the federal funders so that both buckets of money are well spent.'*¹⁰⁸

10.67 The Inquiry has heard that the current ministerial arrangements in NSW do not facilitate whole-of-government AOD policy and that strong political leadership is lacking. Without this leadership, it is likely to be difficult to create substantial reform and improvements within the sector. Mr Pierce told the Health Service Responses roundtable that without ministerial-level leadership, strategic whole-of-government planning of AOD policy is currently *'sitting on a shelf starved of any attention.'*¹⁰⁹

10.68 In 2015, the Commonwealth National Ice Taskforce sought to address these shortcomings by recommending that:

*'Commonwealth, state and territory governments should introduce a simplified governance model to support greater cohesion and coordination of law enforcement, health, education and other responses to drug misuse in Australia, with a direct line of authority to relevant ministers responsible for contributing to a national approach.'*¹¹⁰

10.69 It does not appear that this recommendation has been implemented by NSW. The failure to do so and the consequent lack of centralised planning and governance is likely to be contributing to duplication and non-coordination of responses to ATS. For example, the Inquiry heard that Corrective Services NSW, NSW Police and NSW Health are all currently developing separate drug strategies.¹¹¹ There was no evidence that these agencies are collaborating on or communicating about the development of these strategies.

10.70 The evidence of the success of central leadership suggests that there is merit in one person being appointed as Minister responsible for AOD, with responsibility for developing a whole-of-government AOD policy for NSW that draws on findings and recommendations from this Inquiry, other relevant inquiries and relevant coronial inquests.

10.71 There should also be a central agency supporting the minister by coordinating drug policy across government and monitoring and facilitating progress in implementing the NSW Drug Action Plan, once developed. The Inquiry notes that the Department of Premier and Cabinet submitted that the placement of any such agency should be at the discretion of the relevant minister, once appointed.¹¹² However, it appears to the Inquiry that such an agency would be best situated within the Department of Premier and Cabinet, given the evidence that a similar placement within government was a substantial contributor to the success of the implementation of the 1999 Drug Summit.

Expert advisory group

10.72 To further support a new Minister for AOD in their development and implementation of the NSW AOD Policy and Drug Action Plan, there is an opportunity to establish a Ministerial Advisory Group constituted of experts, representatives of priority populations and communities, and individuals with lived experience of AOD use. Evidence about how to approach difficult problems of public policy, such as that presented by ATS use, supports the use of such an advisory body.¹¹³

10.73 As an example, the Australian National Advisory Council on Alcohol and Drugs was established in December 2014 as the principal expert advisory body to the Commonwealth Government on issues relating to AOD.¹¹⁴ The Australian National Advisory Council on Alcohol and Drugs reports directly to the Commonwealth minister responsible for AOD policy, providing advice on current and emerging AOD issues.¹¹⁵

Recommendation 7:

- A. That the Premier appoint a dedicated Minister with a drug and alcohol portfolio to oversee and coordinate the implementation of the Special Commission of Inquiry's recommendations, which should include overseeing the development of the NSW AOD policy and Drug Action Plan.
- B. That a unit be established in the Department of Premier and Cabinet to lead this work.
- C. That a Ministerial Advisory Group be established to support the minister responsible for leading the development and implementation of the NSW AOD policy and Drug Action Plan with representation from:
 - the academic, research, justice, health, treatment provision and drug education sectors
 - Aboriginal organisations or community groups
 - people with lived experience of drug use and their communities
 - each of the priority populations identified in the NSW AOD policy.

Improving intergovernmental governance

Need for clear roles and accountability across government

- 10.74 As already noted, an environment where multiple agencies are responsible for a policy response necessitates that each agency has a clear understanding of its role and responsibilities.¹¹⁶ Such clarity is particularly important in a federation such as Australia.
- 10.75 Joint Commonwealth-state responsibility for AOD policy and responses has created uncertainty around funding and a lack of accountability across the system.¹¹⁷ Professor Ritter, Director, DPMP described it as '*a complete mess of roles*'.¹¹⁸
- 10.76 Providing additional role clarity and having clear accountabilities between Commonwealth and state agencies would improve AOD service delivery, discussed further in Chapter 14. The Ministerial Drug and Alcohol Forum has the opportunity to take the lead and provide this additional clarity and drive policy reform. However, the evidence suggests that the Ministerial Drug and Alcohol Forum may not be operating effectively.

Ministerial Drug and Alcohol Forum

- 10.77 The Commonwealth Department of Health's website states that the Ministerial Drug and Alcohol Forum meets up to three times each year.¹¹⁹ However, the evidence to the Inquiry shows that NSW Health has not provided any papers or advice to NSW members of Ministerial Drug and Alcohol Forum to support their participation in the forum since 2017.¹²⁰ The Ministerial Drug and Alcohol Forum has not met since June 2018 and it does not appear to have a work plan for 2018 or 2019. It has also not yet met the requirement for it to report annually to the Council of Australian Governments (COAG) for 2018.¹²¹ The Ministerial Drug and Alcohol Forum Secretariat advised the Inquiry in September 2019 that the:

'National Drug Strategy Committee is currently in the process of finalising [National Drug Strategy] reporting templates and preparing the 2018 NDS Annual Report. These reports will be used to measure the success of the NDS and will be published by the [Ministerial Drug and Alcohol Forum] on the Ministerial Drug and Alcohol Forum webpage (<https://www.health.gov.au/committees-and-groups/ministerial-drug-and-alcohol-forum-mdaf>).'¹²²

- 10.78 The Secretariat was unable to provide a definite date for publication of the 2018 annual report.
- 10.79 Submissions to the Inquiry highlighted a lack of transparency and accountability in relation to the Ministerial Drug and Alcohol Forum,¹²³ and the Australian National Audit Office has recommended the Ministerial Drug and Alcohol Forum improve its public reporting, transparency, evaluation planning and monitoring of progress.¹²⁴
- 10.80 The Inquiry sees the Ministerial Drug and Alcohol Forum and the National Drug Strategy Committee as an important governance mechanism for the cross-government planning and coordination of AOD policy, but the lack of progress and national leadership by the Ministerial Drug and Alcohol Forum is a failure of national and cross-government leadership. There is an important opportunity for NSW to advocate for improvements to intergovernmental governance as a means of driving reform and improving coordination and accountability in relation to AOD policy. As the NSW Government agencies that support NSW's participation in Ministerial Drug and Alcohol Forum, NSW Health and the NSW Department of Communities and Justice have a responsibility to work towards the Ministerial Drug and Alcohol Forum's effective operation.

Recommendation 8:

That NSW Health and the NSW Department of Communities and Justice collaborate with the Commonwealth Government and with other states and territories to improve national leadership of AOD policy by:

- advocating to increase the frequency of Ministerial Drug and Alcohol Forum meetings
- working with Ministerial Drug and Alcohol Forum members to develop a work plan with clear actions and deliverables
- tracking the Ministerial Drug and Alcohol Forum's progress against the workplan
- producing appropriate briefings and documents to support the Ministerial Drug and Alcohol Forum and the work plan.

Improving funding arrangements

More transparency in funding decisions

- 10.81 Lack of central agency oversight and guidance on specific program and initiative funding reduces the level of transparency across the AOD sector. It may also limit the ability of government to review the best practice application of funding models.
- 10.82 For example, in response to a request for information about the outcomes of NSW Health's consultation with AOD service providers and consumers following the 2017 *NSW Parliamentary inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales*, NSW Health informed the Inquiry that one of the needs identified in that process is increased service availability, particularly in rural and regional areas.¹²⁵

- 10.83 NSW Health referred to various strategies that had been implemented and were in progress to address this need, including that it is establishing a new AOD residential rehabilitation service in Goulburn *‘in response to a commitment by the NSW Government’*¹²⁶ (an election commitment to spend \$6.2 million on establishing the service over four years from 2020–21).¹²⁷ This commitment was of particular interest to the Inquiry given that it was the most significant new AOD-specific investment in the 2019–20 Budget Papers and was announced during the work of the Inquiry.
- 10.84 The Inquiry summonsed copies of any departmental or ministerial office staff briefings, or budget bids, in relation to this \$6.2 million investment. The Inquiry received Treasury costings supporting the \$6.2 million expense, but no policy advice or planning documents.¹²⁸
- 10.85 This absence of supporting documentation makes it difficult for the Inquiry to identify the underlying policy basis for the decision to prioritise investment in the Goulburn region over other parts of the state.

An AOD state outcome for the purposes of outcome budgeting

- 10.86 Since the 2018–19 Budget, the NSW Government budget has been moving towards an outcome-budgeting approach.¹²⁹ In the 2017–18 Budget papers, NSW Treasury described the change as moving away from a budget process that only considers minor changes to the state expenditure, to a process that considers the full state budget.¹³⁰
- 10.87 Under this approach, the NSW Government allocates funding at the level of a *‘state outcome’*, or to a category of agency expenditure, rather than to a specific program or service.¹³¹ State outcomes are meant to cover all activities delivered by the NSW Government and to provide a clear statement of what the government is trying to achieve.¹³²
- 10.88 NSW Treasury guidelines describe outcome budgeting as a whole-of-government approach to *‘managing agency resources and for decision-making by the government’*.¹³³ It is intended to operate as a common framework that directs planning to the achievement of specified outcomes and that encourages cross-agency collaboration and a whole-of-government perspective.¹³⁴
- 10.89 There is currently no direct focus on AOD within the outcome-budgeting framework. NSW Treasury identified several state outcomes in the 2019–20 Budget that are likely to deliver services to address the use of and harms associated with the use of illicit drugs (see Table 10.1).¹³⁵

Table 10.1 State outcomes relevant to AOD

State outcome	Outcome indicator(s)
Provide a Safe and Affordable Place to Live	<ul style="list-style-type: none"> Proportion of young people who move from Specialist Homelessness Service to long-term accommodation
Mentally Healthy Communities	<ul style="list-style-type: none"> Pathways to community living (originally cohort transitions)
	<ul style="list-style-type: none"> Acute post-discharge community care
Breaking the Cycle of Reoffending	<ul style="list-style-type: none"> Proportion of young people that have a discharge and transition plan on release from Juvenile Justice custody
	<ul style="list-style-type: none"> Proportion of young people that have participated in an offence-focused intervention program

- 10.90 NSW Treasury has also identified various ‘*programs*’¹³⁶ that it considers to be linked to AOD responses including:¹³⁷
- family and domestic violence
 - homelessness
 - juvenile community offender management
 - adult custodial offender management – public
 - adult custodial offender management – private
 - adult community offender management
 - adult offender management services.
- 10.91 The state outcomes and programs identified (and their associated program performance measures) are not AOD-specific. A specific focus on AOD within the NSW Government’s outcome-budgeting framework, would improve the financial and performance oversight and accountability of a central government AOD agency as proposed by the Inquiry.

Recommendation 9:

That the NSW Government introduce a specific AOD outcome indicator into the outcome-budgeting framework.

Alternative revenue sources

- 10.92 As discussed in Chapter 14, there is insufficient funding to adequately fund current and required AOD treatment services. Further, as set out above in this chapter, there is a need for a more appropriate level of investment across all pillars of the National Drug Strategy.
- 10.93 The state’s financial resources are finite and any new source of expenditure often comes at the expense of funding for existing programs. In recognition of this, the Inquiry has examined whether there may be additional revenue sources for the NSW Government that could be directed towards strengthening NSW’s response to ATS.
- 10.94 Proceeds of crime refers to the profit or assets purchased through criminal activity. Australian law enforcement agencies can confiscate these profits and assets to deprive criminals of the benefits of their criminal acts and to reduce the capital available to fund future criminal ventures.¹³⁸ The proceeds can be used to benefit the community through crime prevention, law enforcement and measures relating to diversion or treatment of drugs.¹³⁹
- 10.95 Three Acts support law enforcement agencies to trace, restrain and confiscate the proceeds of crime. The Commonwealth operates pursuant to the *Proceeds of Crime Act 2002* (Cth) (*POCA*) and NSW pursuant to the *Confiscation of Proceeds of Crime Act 1989* (NSW) and the *Criminal Assets Recovery Act 1990* (NSW).
- 10.96 POCA mainly relates to crimes against Commonwealth law. It can also be used to confiscate proceeds of crime against foreign law or state law. Once confiscated, assets are paid into an account (the Confiscated Assets Account) and can be shared with those jurisdictions and foreign countries that made a significant contribution to the recovery under the equitable sharing program.¹⁴⁰
- 10.97 Over the financial years 2010–11 to 2015–16, the Commonwealth Minister for Justice approved the distribution of \$161 million pursuant to *POCA* s 298, of which \$12 million was provided to the NSW Police for their involvement in the Polaris waterfront crime taskforce,¹⁴¹ \$51.3 million was provided to the Australian Federal Police and \$29 million was provided to the Australian Crime Commission.¹⁴²

- 10.98 During 2017–18, the sale of property under the proceeds of crime legislation resulted in \$33 million being paid into the Confiscated Assets Account, and \$38 million was spent,¹⁴³ most of it on Commonwealth crime prevention initiatives.¹⁴⁴
- 10.99 The *Confiscation of Proceeds of Crime Act 1989* (NSW) involves the recovery of assets associated with a crime after conviction in NSW. All funds collected under this Act are paid into the Victims Support Fund,¹⁴⁵ a fund established under the *Victims Rights and Support Act 2013* (NSW) and controlled and managed by the Secretary of the Department of Communities and Justice.¹⁴⁶
- 10.100 NSW Police advised the Inquiry that the total value of funds recovered as a result of proceedings initiated under the *Confiscation of Proceeds of Crime Act 1989* (NSW) in the period between 1 January 2014 and 28 June 2019 was approximately \$9.44 million.¹⁴⁷ Although it is possible to determine the amount of confiscated funds under this Act that relate to ATS, the Inquiry has been informed that to identify these funds would be a significant resource burden, making it impractical.¹⁴⁸ The Attorney-General is the responsible Minister for the Act.
- 10.101 The *Criminal Assets Recovery Act 1990* (NSW) allows for the restraint and recovery of assets suspected of criminal origins without a criminal conviction.¹⁴⁹ Assets recovered through this Act are deposited into the Confiscated Proceeds Account established by the NSW Treasurer.¹⁵⁰ Funds in the Confiscated Proceeds Account may be applied to a range of purposes as directed by the Treasurer in consultation with the relevant minister, including to aid drug rehabilitation or drug education.¹⁵¹ However, a significant proportion of the payments made into the Confiscated Proceeds Account are to be paid into the Victims Support Fund.¹⁵²
- 10.102 In 2017–18, the estimated realisable value of the various confiscation orders made pursuant to provisions of the *Criminal Assets Recovery Act 1990* (NSW) was more than \$29.3 million.¹⁵³ The preceding five-year average was approximately \$27.5 million.¹⁵⁴ The Minister for Police is the responsible Minister for the Act.
- 10.103 Given the clear link between drug-related crime and harms associated with drug use, the Inquiry considers it appropriate that consideration be given to directing additional funds collected from the proceeds of crime towards AOD treatment services.¹⁵⁵

Recommendation 10:

That the NSW Government consider making additional funds recovered under the *Confiscation of Proceeds of Crime Act 1989* (NSW) and the *Criminal Assets Recovery Act 1990* (NSW) available for the provision of AOD treatment.

References

- 1 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3226.37-3227.17 (Pierce); NSW Users and Aids Association, Submission No 137 (undated, received 25 May 2019) 2.
- 2 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 3.
- 3 Isabella Benfer et al, 'The Impact of Drug Policy Liberalisation on Willingness to Seek Help for Problem Drug Use: A Comparison of 20 Countries' (2018) 56 *International Journal of Drug Policy* 162, 162.
- 4 John Kingdon, 'How do Issues Get on Public Policy Agendas?' in William Julius Wilson (ed), *Sociology and the Public Agenda* (SAGE Publications, 2013) 2-3; Harm Reduction Hearing, Sydney, 23 September 2019, TS 4161.45-4162.27, TS 4169.26-33 (Professor Ritter).
- 5 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4180.19-4181.17 (Professor Ritter).
- 6 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3864.39-3865.2 (Pierce).
- 7 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 1.
- 8 New South Wales Council for Civil Liberties, Submission No 70 (7 May 2019) 4-5; ACON, Submission No 77 (May 2019) 11.
- 9 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3978.42-3979.2, TS 3979.36 (Dr Wodak), TS 4016.27-4017.15 (Professor Gallop); TS 4013.45 (Dr Hughes); TS 3971.27 (Lloyd).
- 10 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3979.36 (Dr Wodak).
- 11 Louisa Degenhardt et al, 'Strategies to Reduce Drug-related Harm: Responding to the Evidence Base' (2019) 394(10208) *The Lancet* 1490, 1492.
- 12 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4172.31-40 (Professor Ritter).
- 13 Peter Miller, 'A Critical Review of the Harm Minimization Ideology in Australia' (2001) 11(2) *Critical Public Health* 167, 168.
- 14 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3989.35-26 (Professor Seear).
- 15 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4163.42 (Professor Ritter). See also Carol Bacchi, 'Problematizations in Alcohol Policy: WHO's 'Alcohol Problems'' (2015) 42(2) *Contemporary Drug Problems* 130, 131.
- 16 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4163.1-2 (Professor Ritter).
- 17 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4163.14-24 (Professor Ritter).
- 18 Cary Bennett, 'Drug Law Enforcement: A Study in the Interplay of Power and Resistance' (2010) 22(1) *Current Issues in Criminal Justice* 117, 131.
- 19 Alex Stevens, Telling policy stories: Governmental use of evidence and policy on drugs and crime, in Alex Stevens in *Drugs, Crime and Public Health: The Political Economy of Drug Policy* (Taylor & Francis Group, 2010) 66-67.
- 20 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3971.5-11 (Lloyd).
- 21 Sydney (General) Hearing, Sydney, 9 May 2019, TS 270.12 (Dr Brett).
- 22 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4262.22-23 (Dr Jauncey).
- 23 Lismore Hearing, Lismore, 14 May 2019, TS 616.35-37 (Lloyd).
- 24 Carolyn Chatwin, 'Five Steps Towards a More Effective Global Drug Policy, Chapter 8' in Roger Matthews, *What is to Be Done About Crime and Punishment?* (Palgrave Macmillan UK, 2016) 199; Dubbo Hearing, Dubbo, 5 June 2019, TS 1586.35-37 (Superintendent McKenna); Lismore Hearing, Lismore, 14 May 2019, TS 622.35-623.6 (Lloyd).
- 25 The Lancet Editorial, 'Reforming International Drug Policy' (2016) 387(10026) *The Lancet* 1347.
- 26 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4055.28-33 (Lloyd).
- 27 Cary Bennett, 'Drug Law Enforcement: A Study in the Interplay of Power and Resistance' (2010) 22(1) *Current Issues in Criminal Justice* 117, 127.
- 28 Samuel Friedman et al, 'Relationships of deterrence and law enforcement to drug-related harms among drug injectors in US metropolitan areas' (2006) 20 *AIDS* 93.
- 29 Mónica Soares et al, 'Tackling Harm Reduction, Human Rights and Drug Uses on Recreational Environments: Tensions, Potentialities and Learnings from the Kosmicare Project (Portugal)' (2017) 112 *Revista Crítica de Ciências Sociais* 3; Cary Bennett, 'Drug Law Enforcement: A Study in the Interplay of Power and Resistance' (2010) 22(1) *Current Issues in Criminal Justice* 117; Alex Wodak, 'The Abject Failure of Drug Prohibition' (2014) 47(2) *Australian and New Zealand Journal of Criminology* 190; Konstantinos Alexandris Polomarkakis, 'Drug Law Enforcement Revisited: The 'War' Against the War on Drugs' (2017) 47(3) *Journal of Drug Issues* 396; Joanne Csete et al, 'Public Health and International Drug Policy' (2016) 387(10026) *The Lancet* 1427.
- 30 Thomas Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2009 [online edition]) chapter 14, 10-11.
- 31 Isabella Benfer et al, 'The Impact of Drug Policy Liberalisation on Willingness to Seek Help for Problem Drug Use: A Comparison of 20 Countries' (2018) 56 *International Journal of Drug Policy* 162, 163.
- 32 Duane McBride et al, 'Reflections on Drug Policy' (2009) 39(1) *Journal of Drug Issues* 71, 78-79.
- 33 Isabella Benfer et al, 'The Impact of Drug Policy Liberalisation on Willingness to Seek Help for Problem Drug Use: A Comparison of 20 Countries' (2018) 56 *International Journal of Drug Policy* 162, 165.
- 34 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3986.12-21 (Professor Hughes).
- 35 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4161.30-34 (Professor Ritter).
- 36 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4269.12-16 (Dr Jauncey).
- 37 Carolyn Chatwin, 'Five Steps Towards a More Effective Global Drug Policy' Chapter 8 in Roger Matthews, *What is to Be Done About Crime and Punishment?* (Palgrave Macmillan UK, 2016) 209-10; Evan Wood et al, 'Vienna Declaration: A Call for Evidence-Based Drug Policies' (2010) 376(9738) *The Lancet* 310, 312.
- 38 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4169.35-40 (Professor Ritter).
- 39 Evan Wood et al, 'Vienna Declaration: A Call for Evidence-Based Drug Policies' (2010) 376(9738) *The Lancet* 310, 310.
- 40 Joanne Csete et al, 'Public Health and International Drug Policy' (2016) 387(10026) *The Lancet* 1427, 1429.
- 41 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3976.35-37 (Professor Seear); Carolyn Chatwin, 'Five Steps Towards a More Effective Global Drug Policy', in Roger Matthews, *What is to Be Done About Crime and Punishment?* (Palgrave Macmillan UK, 2016) 205.
- 42 Joanne Csete et al, 'Public Health and International Drug Policy' (2016) 387(10026) *The Lancet* 1427, 1427.

- 43 United Nations System, Chief Executives Board for Coordination, *Second regular session of 2018: Summary of deliberations* (Summary, 18 January 2019) annex 'United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration' 12.
- 44 Isabella Benfer et al, 'The Impact of Drug Policy Liberalisation on Willingness to Seek Help for Problem Drug Use: A Comparison of 20 Countries' (2018) 56 *International Journal of Drug Policy* 162, 163.
- 45 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4161.7-10 (Professor Ritter).
- 46 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4167.5-9 (Professor Ritter).
- 47 Peter Miller, 'A Critical Review of the Harm Minimization Ideology in Australia' (2001) 11(2) *Critical Public Health* 167, 168.
- 48 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 6.
- 49 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 6.
- 50 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 6.
- 51 Jean-Felix Savary, Chris Hallam and Dave Bewley-Taylor, The Beckley Foundation Drug Policy Programme, *The Swiss Four Pillars Policy: An Evolution from Local Experimentation to Federal Law* (Briefing Paper No 18, May 2009) 4.
- 52 Donald Macpherson, *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver* (Report, 24 April 2001) 2.
- 53 Law Reform, Road and Community Safety Committee, Victorian Parliament, *Inquiry into drug law reform* (Final Report, March 2018) 72-74.
- 54 Penington Institute, Submission No 56 (May 2019) 4, 20; New South Wales Council of Civil Liberties, Submission No 70 (7 May 2019) 4; ACON, Submission No 77 (May 2019) 11-12; Harm Reduction Hearing, Sydney, Exhibit A, Tab 71, Statement of Dr Stephen Bright to the inquest into deaths at music festivals, 27 May 2019, [12]; Harm Reduction Hearing, Sydney, Exhibit A, Tab 72A, Transcript of evidence given by Dr Stephen Bright on Day 10 of the inquest into deaths at music festivals, 19 July 2019, TS 943.18-944.5; Network of Alcohol and Other Drugs Agencies, Preliminary Submission No 32 (January 2019) 3-4; Sydney General Hearing, Sydney, 8 May 2019, TS 184.39-185.8 (Dr Harrod).
- 55 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4159.28-30 (Professor Ritter).
- 56 United Nations Office on Drugs and Crime, *Drug Policy and Results in Australia* (Report, October 2018) 24.
- 57 Alison Ritter, Ross McLeod and Marian Shanahan, *Government Drug Policy Expenditure in Australia – 2009/10* (Monograph No 24, June 2013) 1 See also document addendum dated 20 August 2013.
- 58 Alison Ritter, Ross McLeod and Marian Shanahan, *Government Drug Policy Expenditure in Australia – 2009/10* (Monograph No 24, June 2013) 1 See also document addendum dated 20 August 2013.
- 59 Robert Tait and Steve Allsop, National Drug Research Institute, Curtin University, *The Social Costs of Methamphetamine in Australia 2013/14* (Report, 2016) 5.
- 60 Robert Tait and Steve Allsop, National Drug Research Institute, Curtin University, *The Social Costs of Methamphetamine in Australia 2013/14*, (Report, 2016) 98.
- 61 Robert Tait and Steve Allsop, National Drug Research Institute, Curtin University, 'The Social Costs of Methamphetamine in Australia 2013/14' (Report, 2016) 5.
- 62 Timothy Moore, 'The Size and Mix of Government Spending on Illicit Drug Policy in Australia' (2008) 27(4) *Drug and Alcohol Review* 404, 411.
- 63 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4159.44-46 (Professor Ritter).
- 64 Timothy Moore, 'The Size and Mix of Government Spending on Illicit Drug Policy in Australia' (2008) 27(4) *Drug and Alcohol Review* 404, 412.
- 65 United Nations System, Chief Executives Board for Coordination, *Second regular session of 2018: Summary of deliberations* (Summary, 18 January 2019) annex (United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration) 12-14; Harm Reduction Hearing, Sydney, 23 September 2019, TS 4166.37-44 (Professor Ritter).
- 66 Konstantinos Alexandris Polomarkakis, 'Drug Law Enforcement Revisited: The 'War' Against the War on Drugs' (2017) 47(3) *Journal of Drug Issues* 396, 396.
- 67 Royal Australasian College of Physicians, Submission No 47 (May 2019) 6, 8; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 7; National Drug and Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 11; Positive Life NSW and HIV/AIDS Legal Centre, Submission No 82 (7 May 2019) 5; National Centre for Clinical Research on Emerging Drugs, Preliminary Submission No 73 (31 January 2019) 2; Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians, Preliminary Submission No 85 (31 January 2019) 3; Konstantinos Alexandris Polomarkakis, 'Drug Law Enforcement Revisited: The 'War' Against the War on Drugs' (2017) 47(3) *Journal of Drug Issues* 396, 401; Thomas Kerr, Will Small and Evan Wood, 'The public health and social impacts of drug market enforcement: A review of the evidence' (2005) 16(4) *International Journal of Drug Policy* 210; Lisa Maher and David Dixon, 'Policing and Public Health' (1999) 39(4) *British Journal of Criminology* 488, 508-509; Peter Miller, 'A Critical Review of the Harm Minimization Ideology in Australia' (2001) 11(2) *Critical Public Health* 167, 169; Isabella Benfer et al, 'The Impact of Drug Policy Liberalisation on Willingness to Seek Help for Problem Drug Use: A Comparison of 20 Countries' (2018) 56 *International Journal of Drug Policy* 162, 163.
- 68 Siggins Miller, *Evaluation and Monitoring of the National Drug Strategy 2004-2009: Findings and Recommendations* (Final Report, Volume 1, April 2009) 36-38.
- 69 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4159.35-37 (Professor Ritter) Timothy Moore, 'The Size and Mix of Government Spending on Illicit Drug Policy in Australia' (2008) 27 *Drug and Alcohol Review* 404, 409.
- 70 Siggins Miller, *Evaluation and Monitoring of the National Drug Strategy 2004-2009: Findings and Recommendations* (Final Report, Volume 1, April 2009).
- 71 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4163.33-41 (Professor Ritter).
- 72 Australian Institute of Health and Welfare, *Commonwealth Australia's health 2016* (Report, 2016) 128; Paula Braveman, and Laura Gottlieb, 'The social determinants of health: it's time to consider the causes of the causes' (2014) 129(S2) *Public health reports* 19.
- 73 For example, Mission Australia noted in its submission to the Inquiry 'that the intersectional relationship between housing and homelessness, mental health, financial stress, alcohol and drugs and other related factors should be closely considered in all policy, strategy and program development as part of broader harm minimisation measures': Mission Australia, Submission No 66 (2019) 2; NSW Council of Social Service, Submission No 54 (7 May 2019).
- 74 Royal Australasian College of Physicians, Submission No 47 (May 2019) 3-4.
- 75 Carolyn Chatwin, 'Five Steps Towards a More Effective Global Drug Policy', in Roger Matthews, *What is to Be Done About Crime and Punishment?* (Palgrave Macmillan UK, 2016) 204.
- 76 Catherine Spooner and Kate Hetherington, National Drug and Alcohol Research Centre, UNSW Sydney, *Social determinants of drug use* (Technical Report No 228, 2004) vii; The Buttery, Submission No 105 (undated, received 9 May 2019) 3.

- 77 Catherine Spooner and Kate Hetherington, National Drug and Alcohol Research Centre, UNSW Sydney, *Social determinants of drug use* (Technical Report No 228, 2004) vii.
- 78 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 5-6.
- 79 Sydney (General) Hearing, Sydney, 9 May 2019, TS 275.24-35 (Dr Brett); Lismore Hearing, Lismore, 15 May 2019, TS 740.5-741.4 (Drs Helliwell and Hudson), TS 734.22-735.5 (Dr Helliwell), TS 760.1-19 (Robinson); TS 827.3-37 (Lendrum); Nowra Hearing, Nowra, 30 May 2019, TS 1091.7-45 (Norrie and Bryant); East Maitland Hearing, East Maitland, 19 June 2019, TS 1975.21-1976.33 (Terry).
- 80 Lismore Hearing, Lismore, 14 May 2019, TS 658.5-659.13, 659.45-660.18 (Dr Davies).
- 81 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3864.39-3865.20 (Pierce and Hewett).
- 82 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4161.6-7 (Professor Ritter).
- 83 Sydney (General) Hearing, Sydney, Exhibit B, Tab 20, Statement of Mary Harrod, 30 April 2019, 8-9; Harm Reduction Hearing, Sydney, 23 September 2019, TS 4160.30-32 (Professor Ritter); Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3973.40-42 (Madden); Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 9; Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2694.36-41 (Dr Vaux).
- 84 Kari Lancaster et al, 'Stigma and Subjectivities: Examining the Textured Relationship Between Lived Experience and Opinions About Drug Policy Among People with Inject Drugs' (2015) 22(3) *Drugs Education, Prevention and Policy* 224, 225, citing Deborah Stone, 'Forward' in Anne Schneider and Helen Ingram, *Deserving and Entitled: Social Constructions and Public Policy* (State University of New York Press, 2005) ix-xiii.
- 85 Kari Lancaster et al, 'Stigma and Subjectivities: Examining the Textured Relationship Between Lived Experience and Opinions About Drug Policy Among People with Inject Drugs' (2015) 22(3) *Drugs education, prevention and policy* 224, 225.
- 86 Isabella Benfer et al, 'The Impact of Drug Policy Liberalisation on Willingness to Seek Help for Problem Drug Use: A Comparison of 20 Countries' (2018) 56 *International Journal of Drug Policy* 162, 163.
- 87 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3970.1 (Dr Weatherburn).
- 88 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4003.45-4004.5 (Professor Seear).
- 89 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4003.38-43 (Professor Seear).
- 90 Kari Lancaster et al, 'Stigma and Subjectivities: Examining the Textured Relationship Between Lived Experience and Opinions About Drug Policy Among People with Inject Drugs' (2015) 22(3) *Drugs education, prevention and policy* 224, 224.
- 91 Rebecca Askew and Melissa Bone, 'Deconstructing Prohibitionist Ideology: A Sociocognitive Approach to Understand Opinions on UK Drug Policy and the Law' (2019) 74 *International Journal of Drug Policy* 33, 33.
- 92 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 6; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 13; Network of Alcohol and other Drugs Agencies, Submission No 79 (May 2019) 16; South Western Sydney Primary Health Network, Submission No 91 (7 May 2019) 3.
- 93 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 6.
- 94 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 13.
- 95 Caitlin Hughes, Michael Lodge and Alison Ritter, *The coordination of Australian illicit drug policy: a governance perspective* (Monograph No 18, January 2010) 1.
- 96 Caitlin Hughes, Alison Ritter and Nicholas Mabbitt, 'Drug policy coordination: Identifying and assessing dimensions of coordination' (2013) 24(3) *International Journal of Drug Policy* 244, 244.
- 97 Peter D A Cohen, 'The Relationship between drug use prevalence estimation and policy interests' in EMCDDA, *Estimating the Prevalence of Problem Drug Use in Europe* (Scientific Monograph Series, No 1, 1997) 27, 28.
- 98 Carolyn Chatwin, 'Five Steps Towards a More Effective Global Drug Policy', in Roger Matthews, *What is to Be Done About Crime and Punishment?* (Palgrave Macmillan UK, 2016) 211.
- 99 Isabella Benfer et al, 'The Impact of Drug Policy Liberalisation on Willingness to Seek Help for Problem Drug Use: A Comparison of 20 Countries' (2018) 56 *International Journal of Drug Policy* 162, 163, citing Peter Reuter and Franz Trautmann (eds), *Global Illicit Drug Markets 1998-2007* (Report, 2009); Joanne Csete et al, 'Public Health and International Drug Policy' (2016) 387(10026) *The Lancet* 1427, 1470.
- 100 'About us', *NSW Health* (Web Page) <<https://www.health.nsw.gov.au/aod/Pages/about.aspx#>>.
- 101 'Drugs', *NSW Police Force* (Web Page) <https://www.police.nsw.gov.au/crime/drugs_and_alcohol/drugs>.
- 102 Department of the Prime Minister and Cabinet, Commonwealth Government, *Cabinet implementation Unit Toolkit: 2 Governance* (2013) 4.
- 103 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 450, Response of the Department of Premier and Cabinet dated 16 October 2019, to Request for Information dated 17 September 2019, [1].
- 104 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 450, Response of the Department of Premier and Cabinet dated 16 October 2019, to Request for Information dated 17 September 2019, [2].
- 105 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 450, Response of the Department of Premier and Cabinet dated 16 October 2019, to Request for Information dated 17 September 2019, [1].
- 106 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3854.33-3855.36 (Pierce).
- 107 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3231.22 (Pierce).
- 108 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3231.35-38 (Pierce).
- 109 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3855.32 (Pierce).
- 110 Department of the Prime Minister and Cabinet, Commonwealth, *Final Report of the National Ice Taskforce 2015* (2015) xiv.
- 111 Custodial Hearing, Sydney, Exhibit A, Tab 2, Statement of Jeremy Tucker, 14 June 2019, [38]; Custodial Hearing, Sydney, 26 September 2019, TS 4465.16-4466.24 (Tucker); Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 68, Response of NSW Police dated 17 September 2019 to Request for Information dated 26 August 2019, 'NSWPF Response Table', [5]; Tab 35, Response of NSW Police dated 7 August 2019, to Request for Information dated 2 July 2019, 'Letter from Natalie Marsic to Commissioner', [1]-[2]; Tab 593, Response of NSW Health dated 2 October 2019, to Summons to Produce G01, dated 4 September 2019, Item 16, 'Draft NSW Health Alcohol and Other Drugs Strategy'.
- 112 Natasha Luschwitz, Closing Submissions on behalf of Department of Premier and Cabinet, 5 November 2019.
- 113 Australian Public Service Commission, *Tackling Wicked Problems: A Public Policy Perspective* (Archived Publication, 2007) Chapter 2, 'Characteristics of Wicked Problems'.
- 114 Australian National Advisory Council on Alcohol and Other Drugs, Department of Health, Australian Government, *ANACAD Summary of Activities 2015-2016* (Publication, 23 February 2017) 1.
- 115 Australian National Advisory Council on Alcohol and Other Drugs, Department of Health, Australian Government, *ANACAD Summary of Activities 2015-2016* (Publication, 23 February 2017) 1.

- 116 Australian Public Service Commission, *Building better governance: Clear Accountability Mechanisms* (Archived Publication, 2007) 'Part one - What is public sector governance?'.
 117 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3858.23-28 (Professor Ritter); Health Service Responses Roundtable, 20 August 2019, TS 3331.18-32 (Rao).
 118 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3858.39-40 (Professor Ritter).
 119 Department of Health, Commonwealth Government, 'Committees and groups', Ministerial Drug and Alcohol Forum (MDAF) (Web Page, 26 February 2019) <<https://www.health.gov.au/committees-and-groups/ministerial-drug-and-alcohol-forum-mdaf>>.
 120 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 706, Response of NSW Health dated 2 October 2019 to Summons to Produce G01 dated 4 September 2019, 'Letter from Dr Kerry Chant – response to Summons to Produce G01', 4.
 121 Australian National Audit Office, Auditor-General, *National Ice Action Strategy Rollout: Department of Health* (Report No 9, 2019–20) 8.
 122 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 428, Response of Julie Anne Anderson dated 10 September 2019, to Request for Information dated 2 September 2019.
 123 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 6.
 124 Australian National Audit Office, Auditor-General, *National Ice Action Strategy Rollout: Department of Health* (Report No 9 of 2019-20, September 2019) Recommendations 1-5, 10.
 125 Tendered in Chambers on 13 December 2019, Exhibit Z, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 1.
 126 Tendered in Chambers on 13 December 2019, Exhibit Z, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 1-2.
 127 NSW Treasury NSW Government, *The NSW Budget 2019-2020 – Election Commitments* (Budget Overview, 2018) 12.
 128 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 578, Response of NSW Health dated 2 October 2019, to Summons to Produce G01 dated 4 September 2019, 'Policy advice from Treasury - Goulburn Residential Rehabilitation'.
 129 NSW Treasury; *NSW Budget 2017-18* (Budget Paper No 1, June 2017) 44; NSW Treasury, 'Outcome Budgeting', *Treasury* (Web Page, 10 July 2018) <<https://www.treasury.nsw.gov.au/budget-financial-management/reform/outcome-budgeting>>; NSW Treasury, *TPP 18-09 Outcome Budgeting* (Report, December 2018).
 130 NSW Treasury; *NSW Budget 2017-18* (Budget Paper No 1, June 2017) 44.
 131 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 452, Response of NSW Treasury dated 17 July 2019, to Request for Information dated 28 June 2019, 1.
 132 NSW Treasury, NSW Government, *TPP18-09 Outcome Budgeting Policy and Guidelines Paper* (December 2018) ii.
 133 NSW Treasury, NSW Government, *TPP18-09 Outcome Budgeting Policy and Guidelines Paper* (December 2018) ii.
 134 NSW Treasury, NSW Government, *TPP18-09 Outcome Budgeting Policy and Guidelines Paper* (December 2018) ii.
 135 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 452, Response of NSW Treasury dated 17 July 2019, to Request for Information dated 28 June 2019, 11.
 136 NSW Treasury, NSW Government, *TPP18-09 Outcome Budgeting Policy and Guidelines Paper* (December 2018) v; This outcome-budgeting approach, "Programs" include all activities, tasks, division or functions of an agency.
 137 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 452, Response of NSW Treasury dated 17 July 2019, to Request for Information dated 28 June 2019, 2, 11-12.
 138 Australian Institute of Criminology, Australian Government, *Confiscation of the proceeds of crime: federal overview* (Publication, No 01, 2008) 1.
 139 Australian National Audit Office, Australian Government, *Performance Audit: Proceeds of Crime* (Report, No 43 of 2016-17, 2017) 10.
 140 Australian Institute of Criminology, Australian Government, *Confiscation of the proceeds of crime: federal overview* (Publication, No 01, 2008) 1.
 141 Australian National Audit Office, Australian Government, *Performance Audit: Proceeds of Crime* (Report, No 43 of 2016-17, 2017) 42.
 142 Australian National Audit Office, Australian Government, *Performance Audit: Proceeds of Crime* (Report, No 43 of 2016-17, 2017) 42.
 143 Australian Financial Security Authority, Australian Government, *Annual Report 2017-18: Report on performance* (2018) 37.
 144 Australian Financial Security Authority, Australian Government, *Annual Report 2017-18: Report on performance* (2018) 37.
 145 *Victims Rights and Support Act 2013* (NSW) s 15(a).
 146 *Victims Rights and Support Act 2013* (NSW) s 14(1).
 147 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 32, Response of NSW Police Force dated 5 July 2019, to Request for Information dated 24 June 2019.
 148 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 32, Response of NSW Police Force dated 5 July 2019, to Request for Information dated 24 June 2019.
 149 Australian Institute of Criminology, Australian Government, *Confiscation of the proceeds of crime: federal overview* (Publication No 01, 2008) 1.
 150 NSW Crime Commission, Submission No 107 (undated) 4; *Criminal Assets Recovery Act 1990* (NSW) ss 32(1), 32(2).
 151 NSW Crime Commission, Submission No 107 (undated) 4; *Criminal Assets Recovery Act 1990* (NSW) s 32(3)(d).
 152 *Criminal Assets Recovery Act 1990* (NSW) s 32(3)(c).
 153 New South Wales Crime Commission, *Annual Report 2017-18* (2018) 38.
 154 New South Wales Crime Commission, *Annual Report 2017-18* (Report, 2018) 38.
 155 See, for example Moree Shire Council, Submission No 72, (undated, received 7 May 2019) 27.

Chapter 11. Criminal law reform

Introduction

- 11.1 Since the mid-20th Century, NSW has taken a prohibitionist approach to drugs, including ATS, a key element of which is the criminalisation of the use or possession of drugs for personal consumption.
- 11.2 It is a criminal offence under the *Drug Misuse and Trafficking Act 1985* (NSW) (DMT Act) to self-administer prohibited drugs¹ and/or possess prohibited drugs for personal consumption in NSW² (collectively referred to as simple possession), including crystal methamphetamine and ATS.
- 11.3 Although prohibition is intended to reduce the supply and demand for drugs, it is increasingly recognised that the criminalisation of simple possession does not work to achieve these ends, and instead causes significant harm to people convicted of those offences – harm that is wholly disproportionate to the underlying conduct. There are calls from many parts of the community to implement responses to simple possession that do not involve the criminal justice system. This shift in understanding is reflected in the fact that all states and territories in Australia, including NSW, have implemented schemes by which people in possession of cannabis are not prosecuted; and many states and territories also extend such schemes to other prohibited drugs.
- 11.4 This chapter examines the harms associated with prohibition and various ways in which reform of the criminal law may ameliorate those harms, with a focus on different models of decriminalisation used in Australia and internationally. The approach of other jurisdictions will be considered, with an analysis of the various elements of different schemes.
- 11.5 Involvement with the criminal justice system starts at arrest, and for many people, continues through a process of charging, conviction and sentencing. However, there are many points during the criminal justice process when a person may be diverted from further involvement in the justice system; these can be before charging, between conviction and sentence or after sentence.
- 11.6 This chapter is divided into three parts: ‘Decriminalisation’, ‘Diversion’ and ‘Other reforms’.
- 11.7 The first part of this chapter (Decriminalisation) is concerned with reform to the current approach to simple possession offences, with examination of models that repeal criminal sanctions altogether or divert people away from the criminal justice system before they are charged (pre-charge diversion). It includes consideration of alternatives to the criminalisation or prosecution of simple possession offences.
- 11.8 The second part of this chapter (Diversion) examines options that interrupt a person’s journey through the criminal justice system after the person has been charged (post-charge diversion).
- 11.9 The third part (Other reforms) examines the legislative regime by which convictions become ‘spent’ and the operation of the newly enacted s 25C *Crimes Act 1900* (NSW), which contains the offence ‘supply of drugs causing death’.

- 11.10 As detailed earlier in the report, the vast majority of people who use ATS also use other prohibited drugs and the harms caused by the current prohibitionist approach in NSW to simple possession apply to all prohibited drugs.* As observed by the Drug Policy Modelling Program (DPMP), Social Policy Research Centre, UNSW Sydney, to confine legislative reform to offences concerning ATS only would fail to address the problems identified with the continued criminalisation of simple possession offences.³ Accordingly, the following discussion and recommendations relate to all prohibited drugs.⁴

Decriminalisation

- 11.11 In the following discussion, the term ‘decriminalisation’ is used to refer to the removal or non-enforcement of criminal penalties for simple possession offences. Decriminalisation may be effected by operation of law (*de jure*) or by operation of policy (*de facto*). Decriminalisation includes true decriminalisation, whereby simple possession offences are removed from the criminal law in their entirety, and schemes whereby simple possession offences are not enforced (also known as ‘depenalisation’).
- 11.12 Decriminalisation is not the same as legalisation. To properly understand and consider the recommendations made in this chapter, it is essential to appreciate the difference between decriminalisation and legalisation.
- 11.13 In the case of legalisation, it is lawful to manufacture, produce and trade drugs in a legitimate market, subject to any regulatory controls of the governing state (as is the case with pharmaceutical drugs, alcohol and tobacco).
- 11.14 In contrast, decriminalisation of simple possession does not involve the decriminalisation of other drug offences such as supply and manufacture. Under a decriminalisation model, if a person is detected carrying drugs for personal use the drugs are confiscated.⁵ Nor does decriminalisation of simple possession offences change the application of the law to other criminal conduct, including offences committed to obtain drugs (for example, property offences committed to financially support drug dependence) and offences committed under the influence of drugs (for example, acts of violence or dangerous driving). People who commit such offences continue to be liable for prosecution under the criminal law.
- 11.15 To describe the removal of a criminal offence (decriminalisation) as equivalent to legalising drugs is apt to mislead.
- 11.16 The Inquiry received much anecdotal evidence of the involvement of crystal methamphetamine with violence and violent offending. The Inquiry finds that the current data are not sufficiently comprehensive or reliable to enable sound conclusions to be drawn about the correlation between crystal methamphetamine use and violence. Recommendations directed to improving data collection and research in relation to this important issue are discussed in Chapters 19 and 21.
- 11.17 The Inquiry recognises that there are victims of violent crime committed by people under the influence of ATS who may be concerned if the decriminalisation of simple possession reduces the culpability of offenders who commit acts of violence under the influence of ATS. However, as discussed above, the decriminalisation of simple possession does not change the application of the law to any other conduct – any person who commits crime, including acts of violence, will continue to be liable to prosecution.

* See the discussion later in this chapter under ‘Does the criminalisation of simple possession cause harms? If so, to what extent?’.

Key terms

For the purposes of this report, the following definitions are used:

De jure

De jure is a Latin term (literally translated ‘from/of/by/in the law’) used in this report to describe models of decriminalisation and diversion that are implemented by legislation that changes the law.

De facto

De facto is a Latin term (literally translated ‘from/of/by/in the fact’) used in this report to describe models of decriminalisation and diversion that are implemented by creating or amending policies, guidelines or procedures that guide the administration of government.

Prohibition

Prohibition refers to policy that seeks to reduce the supply and demand for drugs by classifying them as ‘prohibited’. Prohibition is implemented through the use of criminal or civil offence provisions with consequences such as imprisonment, penalties and/or confiscation.

Criminalisation

Criminalisation is a legislative model that implements a policy of prohibition via the criminal law and criminal justice system. Criminalisation maintains as criminal offences the use or possession of prohibited drugs.

Decriminalisation

Decriminalisation removes or limits the application of the criminal offence of simple possession of prohibited drugs and may introduce one or more administrative responses to the conduct.

All true decriminalisation models are *de jure*, in that legislative amendment is required to repeal the criminal offences or create an exemption to the criminal offences. The only example of true decriminalisation in NSW is the use and possession of prohibited drugs by a person at the Uniting Medically Supervised Injecting Centre. Section 36N of the *Drug Misuse and Trafficking Act 1985* (NSW) exempts from criminal liability a person possessing and administering a small quantity of a prescribed substance in a licensed supervised injection centre.

‘Decriminalisation’ is also used to describe *de jure* and *de facto* models where criminal offences are retained but alternatives to prosecution are introduced (sometimes called ‘depenalisation’). This type of decriminalisation operates within a model of prohibition and allows for a response to simple possession that is less punitive than the conventional criminal justice response, while retaining the potential for a person to be charged, convicted and punished for the offences.

An example of *de jure* decriminalisation in NSW is the extension of the NSW Criminal Infringement Notice Scheme for simple possession of all prohibited drugs (Drug CIN), introduced in 2019 by amendments to the *Criminal Procedure Regulation 2017* (NSW) which permits a penalty notice to be issued for those offences.⁶ Drug CINs are discussed further from paragraph 11.251.

An example of *de facto* decriminalisation in NSW is the Cannabis Cautioning Scheme (discussed further from paragraph 11.237) where police may exercise a discretion to caution offenders detected with small amounts of cannabis rather than charge them.

Depenalisation

As discussed above, the term ‘depenalisation’ is sometimes used in a broad sense to describe decriminalisation schemes that retain simple possession as a criminal offence but introduce alternative responses.

However, a narrower definition of depenalisation used in some of the academic literature discussed in this chapter describes a *de facto* model, in which police have no response to simple possession, or a minimal response (e.g. issuing a warning). For the purpose of this report, the narrower meaning of depenalisation will be referred to as ‘depenalisation (police discretion)’.

Because simple possession continues to be a criminal offence under a depenalisation model, there are certain circumstances where a person may be prosecuted for simple possession. Whether a person is prosecuted will be determined by the application of the eligibility criteria of the policy or legislation and/or at the discretion of police.

Civil/administrative responses

Many models of decriminalisation involve a range of civil and administrative measures which may include:

- a caution
- a civil penalty (i.e. a fine)
- educational responses, such as the provision of a pamphlet or other information or the requirement to attend an education session
- voluntary or mandatory health and/or social responses such as a referral to assessment, counselling or treatment.
- other administrative responses (e.g. warnings, driver’s licence suspension, restricting international travel, work orders, seizing property, association restrictions)
- any combination of the above.

Legalisation

Legalisation repeals simple possession as criminal offences and permits the manufacture and supply of such drugs in a legitimate market. The legalisation of prohibited drugs must be effected by law and requires significant reform.

Problems with prohibition

- 11.18 In simple terms, prohibition is a legislative model that seeks to minimise drug-related harm by limiting the supply of, and demand for, prohibited drugs through the prohibition and criminalisation of all drug-related activity. It is an approach predicated on the assumption that intercepting the supply of drugs, and prosecuting people who supply and use drugs, coupled with a public discourse that emphasises the harms of drug use and reinforces social norms protective against drug use, will prevent people from using drugs and so reduce harm.⁷
- 11.19 The following discussion examines: the rationale supporting a policy of prohibition; whether it is successful in achieving its stated aims; and the extent to which continuing with a policy of prohibition is justifiable, in light of its unintended and serious negative impacts.

The criminal law as a means of social regulation

- 11.20 The extent to which the state should interfere with the personal autonomy of the citizen is the issue at the heart of all criminal law jurisprudence. Consideration of reform to the criminal law as it applies to simple possession requires consideration of the basis upon which possession of drugs is criminalised – that is, why an activity such as personal drug use should be the subject of the criminal sanctions. Although there are multiple perspectives from which to consider the legitimacy of laws, the most common lens through which the criminal law is analysed is through the ‘harm principle’ approach and the ‘morals-based’ approach, or a combination of the two.
- 11.21 The harm principle posits that the state is justified in prohibiting conduct that causes harm only where there is no other equally effective means to prevent that harm.⁸ Some formulations of the harm principle broaden the concept of the prevention of harm to the ‘welfare’ of others.⁹

‘It is always a good reason in support of penal legislation that it would probably be effective in preventing (eliminating, reducing) harm to persons other than the actor and there is probably no other means that is equally effective at no greater cost to other values.’¹⁰

- 11.22 Framing the principle as a justification for when the law may permissibly interfere with the citizen’s autonomy, rather than when it must interfere, necessarily involves consideration of the law’s effectiveness and proportionality. Where a law is not effective to prevent the harm to which it is directed, or where it does so at disproportionate cost, then it fails to satisfy the criteria by which the legitimacy of penal legislation is judged according to the harm principle approach.¹¹ The need for this limiting factor is particularly important in the field of criminal law, where the state exerts ultimate power over an individual, through punishment and deprivation of liberty. As such, liberal systems ‘embrace restraints on [their] pursuit of societal aims out of respect for the autonomy of the individuals who may be subject to the system’.¹²
- 11.23 A morals-based approach to the role of the criminal law contends that the state may properly criminalise acts that offend a shared public morality, which should be protected.¹³ In contrast to the harm principle approach,¹⁴ a morals-based approach permits the criminal law to prohibit conduct for a person’s ‘own good’. This approach has been strongly criticised, particularly because of the subjectivity involved in determining what is or should be the shared morality: ‘A theory about morality and the criminal law must be based on a defensible definition of morality, not one which confuses it with mere feelings of distaste and disgust.’¹⁵
- 11.24 Classical theories of criminal punishment that justify the imposition of criminal sanctions as a form of retribution incorporate elements of a morals-based theory of criminal law.¹⁶
- 11.25 Some contemporary analyses combine harm principle and morals-based approaches, arguing that both harm and some concept of ‘wrongfulness’ are required to justify the application of the criminal law¹⁷ and that the intervention of the criminal law is only warranted where it is ‘best’ for society.¹⁸ These approaches to criminalisation acknowledge that even where conduct may be a legitimate matter for state intervention through the criminal law, there are other matters that must also be considered and that limit the appropriate exercise of criminalisation. These factors include the importance of the autonomy or freedom of the individual¹⁹ and the costs (financial or otherwise) of criminalisation.²⁰
- 11.26 A harm principle or hybrid approach is generally considered to be consistent with a human rights-based approach to the criminal law,²¹ which recognises that use of the criminal law as a means of social regulation should be a strategy of last resort.²²

- 11.27 Such limits are also reflected in, and supported by, modern understanding of human rights. Article 29 of the *Universal Declaration of Human Rights* refers to precisely this balance:

(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.

(2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.²³

- 11.28 As noted above, on a harm principle or hybrid approach, questions of effectiveness and proportionality are integral to consideration of whether conduct should be proscribed. Even where the conduct may be considered an appropriate subject for criminalisation, there is a principled basis not to proscribe that conduct:

1. where criminalisation is not effective to address the harms it seeks to address
2. where criminalisation is outweighed by other harms, or
3. where less coercive measures are equally or more effective.

- 11.29 The following discussion addresses the questions of first, whether the continuing criminalisation of the offence of simple possession is effective to address the harms caused by that conduct; second, whether the criminalisation of that conduct itself causes harms, and if so, to what extent; and third, whether reform of the criminal law is required to better address the harms caused by drug use.

Is criminalisation effective?

- 11.30 As noted above, a prohibitionist approach to drug policy aims to reduce supply and demand by criminalising drug use and possession and related conduct. Some researchers maintain that there is evidence which suggests that prohibition constrains drug consumption.²⁴ However, the weight of evidence and research discussed here and later in this chapter from paragraph 11.284 suggests otherwise.

- 11.31 The evidence before the Inquiry indicates that the criminalisation of simple possession offences is not effective to reduce supply or demand. The availability of crystal methamphetamine appears to remain high²⁵ and the consumption of methamphetamine has been increasing:²⁶

- The National Ice Action Strategy 2015 noted that crystal methamphetamine and other methamphetamine was widely available, and its price remained stable, despite significant efforts of law enforcement, including large seizures of ATS.²⁷
- Recent national wastewater drug monitoring shows that the total weight of methamphetamine consumed nationally in 2018 was estimated at 9,847kg, up from 8,405kg in 2016.²⁸
- In the two years ending December 2018, NSW Bureau of Crime Statistics and Research (BOCSAR) records that arrests for possession of amphetamines in NSW increased by 9.7%²⁹ and 8.6% in the 24 months ending June 2019.³⁰

- 11.32 The claim that law enforcement efforts have had limited impact on reducing the supply of prohibited drugs is confirmed by the NSW Crime Commission, which noted in its 2016 Annual Report that although seizures and arrests have increased, *'they have had little, if any, effect on the quantities of prohibited drugs available for consumption in Australia'*.³¹ In its submission to the Inquiry, the NSW Crime Commission observed that *'the current law enforcement response to the importation, supply and distribution of [methamphetamine] in NSW is not very effective in reducing the production and supply in the State'*.³²
- 11.33 It is salient to note the observations of various serving and former police Commissioners in Australia that *'we can't arrest our way out of our problems'* with drugs and drug use.³³
- 11.34 In its submission to the Inquiry, the NSW Bar Association argued that the conventional justification for criminal sanctions for simple possession offences do not support criminalisation as an effective supply or demand reduction strategy. Punishment and retribution imposed under the criminal law to achieve a deterrent effect *'can be a blunt, and sometimes brutal, mechanism of community education and control'*, and heavier penalties do not have increased deterrent effect.³⁴ A review of Australian decriminalisation policies concluded that they had little to no impact on people's decision to use cannabis or other drugs.³⁵
- 11.35 The NSW Bar Association referred to the importance of recognising that drug dependence is a medical condition – in the absence of concomitant crime (which may be punished in its own right), it is difficult to justify criminal sanctions to punish behaviour symptomatic of a health condition. The NSW Bar Association also observed that the compulsion involved in drug dependence argues against the effectiveness of personal deterrence³⁶ for people who are dependent on drugs,³⁷ a view echoed by participants at the Inquiry's Decriminalisation Roundtable. Councillor Edwina Lloyd of Lismore City Council and a trial advocate with the Aboriginal Legal Service (ALS) noted:
- '[S]omeone that's suffering substance use disorder doesn't care about the legality of the drug, doesn't care whether the drug is prohibited or not; they're just going to use it notwithstanding. And that's evidenced by the very high risk of recidivism that we see of drug-related crime, the very long criminal records that I see of my clients that are using substances problematically ...'*³⁸
- 11.36 Similarly, Dr Alex Wodak, President, Australian Drug Law Reform Foundation, observed: *'[P]eople have lost their health, lost their family, lost their home, lost any savings they had, lost a career, lost everything that anyone reasonably would hold dear to them and they still use drugs.'*³⁹
- 11.37 The Penington Institute also submitted that law enforcement efforts have *had 'little substantive or lasting progress'* in reducing the supply of illicit drugs to the Australian market.⁴⁰
- 11.38 The evidence and submissions received by the Inquiry are consistent with international experience. In 2019, the Joint United Nations Programme on HIV/AIDS (UNAIDS) observed that *'[t]he billions of dollars spent each year on efforts to reduce the supply of and demand for illicit drugs have not resulted in a reduction of the overall number of people who use drugs'*.⁴¹
- 11.39 The evidence is compelling in support of the conclusion that a prohibitionist approach to simple possession has failed to reduce supply and failed to reduce demand. It does not effectively address the harm to which it is directed.

- 11.40 As discussed in the next section, the criminalisation of simple possession also causes significant harms.

Does the criminalisation of simple possession cause harms? If so, to what extent?

- 11.41 The Inquiry received many submissions and heard a large amount of compelling evidence about the nature and extent of harm caused by the criminalisation of simple possession. Criminalisation is directly associated with adverse impacts on employment, earning prospects, access to housing, access to treatment, relationships and wellbeing. Many of these harms are the secondary impacts of people receiving a criminal record or coming into contact with the criminal justice system. As explained in detail in Chapter 9, criminalisation of drug use and possession is also a powerful source of stigma.
- 11.42 There is abundant international and Australian research into the serious, unintended impacts of criminalisation of personal drug use on the health and socioeconomic wellbeing of people who use drugs.
- 11.43 In 2018, the Global Commission on Drug Policy – a body comprised of former heads of state, human rights and global health experts, business leaders, economists and United Nations leaders – noted that the criminalisation of drug consumption and possession for personal use is increasingly recognised as an obstacle to the effectiveness of health policies. It also noted that criminalisation undermines the rule of law and fuels prejudices, stigma and discrimination against people and communities.⁴² The Commission argued that the criminalisation of drugs for personal use causes extensive harm – more harm than the drugs themselves – while failing to extinguish the market for illicit drugs.⁴³
- 11.44 UNAIDS noted that multiple United Nations and regional human rights bodies have found that criminalisation of activities related to personal drug use can negatively affect a person's health and wellbeing. Each of them has recommended decriminalisation of activities relating to such use.⁴⁴
- 11.45 The Centre for Social Research in Health, UNSW Sydney, submitted that prohibition and criminalisation of drugs have many perverse or unintended impacts that have increased the health, social and economic harms associated with drugs.⁴⁵

*'Policies meant to prohibit or greatly suppress drugs present a paradox. They are portrayed and defended vigorously by many policy makers as necessary to preserve public health and safety, and yet the evidence suggests that they have contributed directly and indirectly to lethal violence, communicable-disease transmission, discrimination, forced displacement, unnecessary physical pain and the undermining of people's right to health.'*⁴⁶

- 11.46 The NSW Bar Association noted in its 2014 *Drug Law Reform* discussion paper that criminalisation of people who use drugs exacerbates the marginalisation of people who may have been exposed to trauma and has far-reaching and long-lasting negative effects, such as affecting access to employment, housing and education.⁴⁷
- 11.47 The NSW Bar Association listed the costs associated with the prohibitionist approach including: stigmatisation of people who use drugs; socialisation with other people who use drugs and with criminals; inability to control the quality and potency of illicit drugs, which may lead to overdose; health and social risks of imprisonment, including lost income; increased risk of engagement in prostitution and other illegal activities; adverse impacts on public amenity due to public 'drug dealing', use and discarded injecting equipment and harms to police-community relations.⁴⁸

- 11.48 Research compared the outcomes of people diverted through the Cannabis Expiation Notice scheme in SA and people given a criminal sentence in WA (pre-2004 decriminalisation). It found that the people given criminal penalties were more likely to suffer negative consequences for employment, relationships and accommodation as a result of their cannabis charge, and were more likely to come into further contact with the criminal justice system than the SA (non-criminalised) individuals.⁴⁹

Contact with the criminal justice system

- 11.49 People who are charged with simple possession in NSW necessarily come into contact with the criminal justice system, including police, the courts and, in some cases, corrective services or the prison system.

- 11.50 Contact with the criminal justice system, particularly incarceration, has long-term adverse impacts on employment, housing, education and relationships.⁵⁰ Incarceration has criminogenic effects that increase the likelihood of recidivism and additional criminal behaviour, particularly for drug offenders.⁵¹

- 11.51 In 1970, in *An honest politician's guide to crime control*, criminologists Norval Morris and Gordon Hawkins asserted that, in relation to narcotics and drug abuse:

*'[T]here seems to be no doubt ... that the policy of criminalisation and the operations of criminal justice agencies in this field have in themselves been criminogenic without measurably diminishing the extent of the drug problem or reducing the supply of narcotics entering the country.'*⁵²

- 11.52 Leone Crayden, CEO of The Buttery, a not-for-profit organisation providing rehabilitation services on the north coast of NSW, gave evidence about the impact of contact with the criminal justice system on a person's employment prospects.

*'Many of our clients – probably about 30 to 40% of people that come to us, have come from jail. So it's hard for them to get a job after being incarcerated, let alone after their last – where their last address was us, The Buttery, is a very difficult thing for people to get employment.'*⁵³

- 11.53 The Penington Institute also submitted that contact with the criminal justice system is harmful to individuals, and that a criminal conviction and possibly incarceration are likely to exacerbate the significant challenges already faced by people with dependence on methamphetamine.⁵⁴

- 11.54 People who are incarcerated may experience further harms, discussed in Chapter 20, including that:

- Imprisonment may increase the risk of re-offending.⁵⁵
- People withdraw from drugs in police or court cells, which are ill-prepared to support withdrawal.
- Inmates and detainees may be exposed to more serious offenders while in custody.
- Drugs are readily available in custody.
- Drug use in custody is often high risk, associated with violence and high rates of transmission of blood-borne viruses.
- It is difficult for people to access or complete appropriate AOD programs in custody – a factor that may affect parole decisions.
- People in custody have difficulties accessing rehabilitation on release.

- 11.55 The harms of criminalisation extend to the families and communities of people who come into contact with the criminal justice system. Incarceration, for example, has a range of negative impacts on the children and family members of inmates. The Global Commission on Drug Policy noted the impact on children of having incarcerated parents and reported that around the world, mothers and pregnant women who use drugs fear seeking support or accessing harm reduction or treatment services due to the risk that their children might be taken away from them.⁵⁶
- 11.56 As a witness in a private hearing informed the Inquiry: *‘There is definitely a huge stigma attached to having a parent in jail and it causes the child embarrassment when they are asked what their dad and mum do. They are bullied and excluded through no fault of their own’.*⁵⁷

Criminalisation as a source of stigma

- 11.57 As described in Chapter 9, there is growing recognition of the negative impacts of ATS-related stigma on the people who use ATS and their families.⁵⁸ Drug-related stigma manifests in discrimination, marginalisation, social exclusion and poor health and social outcomes. It is a critical barrier to drug treatment and other services.⁵⁹ The Inquiry has heard evidence of many compelling examples of the impact of stigma (see Chapter 9).
- 11.58 Stigma has been identified in submissions as a barrier to the self-disclosure of ATS use,⁶⁰ and a barrier to the person or their families seeking⁶¹ or accessing treatment services.⁶²
- 11.59 The research, submissions and evidence before the Inquiry indicate that the criminalisation of simple possession offences is itself a source of stigma and compounds existing stigma associated with prohibited drugs. Some scholars suggest that drug-related stigma may be caused or compounded by prevailing legal frameworks governing drugs and drug use.⁶³
- 11.60 In its submission to the Inquiry, The Public Defenders referred to the stigma associated with being arrested and charged.⁶⁴ Positive Life and HIV/AIDS Legal Centre and the DPMP each submitted that the criminalisation of simple possession offences increases the stigmatisation experienced by people who use drugs.⁶⁵ Positive Life and HIV/AIDS Legal Centre also asserted that over-policing and the use of strip searches (both directly related to the criminalisation of simple possession offences) contributes significantly to the stigmatisation of ATS use.⁶⁶
- 11.61 As Dr Don Weatherburn, Adjunct Professor, University of Sydney Law School, and former director of the NSW Bureau of Crime Statistics and Research, succinctly observed at the Decriminalisation Roundtable: *‘There’s no questioning that prohibition generates a stigma. That’s what every criminal offence does.’*⁶⁷
- 11.62 Professor Kate Seear, Associate Professor in Law, Monash University, also identified the criminalisation of simple possession offences as a fundamental barrier to addressing stigma:
- ‘... I did try to look at those questions about how we can actually reduce stigma, given these international and domestic calls to do so, for all of the reasons the Commission has identified. And, in my view, we can’t do it while retaining criminalisation of use and possession ...’*⁶⁸
- 11.63 Professor Alison Ritter, Director, DPMP, referred to recent reforms in Germany, where criminal sanctions were removed for simple possession. This has led to increased access to treatment and harm reduction services by people who use drugs, which has been attributed to the role of decriminalisation in reducing stigma.

*'[A]nd what's interesting with their particular model is they didn't introduce any alternate sanction ... they, basically, removed the criminal penalties for use and possession by law, but then didn't place any additional requirements on people who use drugs. But ... they've nevertheless, seen many more people accessing treatment and harm reduction services through voluntary means. And this is largely because you're reducing the stigma.'*⁶⁹

- 11.64 Dr Caitlin Hughes, Associate Professor and Matthew Flinders Fellow, Centre for Crime Policy and Research, Flinders University, referred to the Czech Republic as another example that demonstrates decriminalising drugs is an important means of reducing stigma.⁷⁰

Organised crime

- 11.65 Prohibition is also a driving force behind the growth of organised crime. In 2016, the NSW Crime Commission confirmed that prohibition drives the growth of organised crime, which reached unprecedented levels in NSW that year.⁷¹ The NSW Crime Commission reported that the growth of organised crime is almost entirely driven by the prohibited drug market.

'The illicit drug trade continues to be the main stream of income for organised crime groups operating in Australia. Drugs that are predominantly manufactured overseas including cocaine and amphetamine-type stimulants (ATS), continue to command high prices domestically when compared with their cost offshore. As a consequence, international crime groups have continued, and likely have increased, their efforts in importing prohibited drugs into Australia in the last 12 months.'

*According to statistical reporting, mainstream crime has been slowly reduced over time. According to the Bureau of Crime Statistics and Research (BOCSAR), for the five-year period prior to March 2016, the majority of crime types were reducing, with the exception of domestic violence, sexual assault, fraud and theft associated with stealing from retail stores. However, the observed situation in relation to organised crime is considered by the Commission to be the opposite of the mainstream crime statistics.'*⁷²

- 11.66 The latest annual report of the NSW Crime Commission reported that established crime networks in Australia appear to be increasing their efforts to import larger quantities of drugs, new groups of players are entering the Australian market, and it is highly likely that Australia will experience an increase in the number of importations of larger quantities in years to come.⁷³
- 11.67 In 2014, the NSW Bar Association also expressed the view that prohibition is associated with the creation of an unregulated black market for illicit drugs, a rise in organised crime and drug-related violence and crime.⁷⁴

The disproportionate impact of criminalisation on Aboriginal people

- 11.68 The criminalisation of simple possession has a disproportionate impact on Aboriginal people, including through the high prevalence of secondary offending associated with the imposition of fines.⁷⁵ Research has also shown that Aboriginal people are less likely to be diverted away from the criminal justice system through existing diversionary schemes (discussed further in Chapter 16).⁷⁶

- 11.69 In the 12 months to July 2019, most people charged in NSW with possession of amphetamines as their principal offence received a fine, with an average penalty of \$473.⁷⁷ The ALS highlighted the significance of such a fine when compared with the Newstart allowance. The Inquiry notes that Newstart currently pays between \$504.70 and \$604 per fortnight. The ALS submitted that fining people who have limited income often leads to 'secondary offending', most commonly driving where a licence has been suspended due to failure to pay a fine.⁷⁸ While secondary offending is not limited to Aboriginal people, the ALS pointed out that the most common offence that Aboriginal offenders committed in 2017 was traffic and vehicle-related offences, which the ALS submitted was the consequence of unpaid fines.⁷⁹ Detective Acting Superintendent Michael Cook, Acting Commander, Drug and Firearms Squad, NSW Police Force, gave evidence that *'[i]n rural communities, where you're required to travel from place to place, where public transport isn't as available as it is in metropolitan areas, that's the – secondary offending can be a real issue for those communities'*.⁸⁰
- 11.70 The Inquiry also heard that Aboriginal people experience inequality in accessing diversionary schemes in NSW, as discussed later in this chapter from paragraph 11.211.⁸¹ An evaluation of the Cannabis Cautioning Scheme found that Aboriginal people were much less likely than non-Aboriginal people to receive a caution under that scheme.⁸² Young Aboriginal offenders have also been found to be significantly less likely to be diverted under the *Young Offenders Act 1997* (NSW).⁸³ Evidence suggests that strict eligibility criteria,⁸⁴ Aboriginal people's lack of trust in the police,⁸⁵ and the inconsistent use of police discretion⁸⁶ lead to lower diversions rates for Aboriginal people.

The continuing criminalisation of simple possession causes harm

- 11.71 The literature, submissions and evidence before the Inquiry clearly demonstrate that the continuing criminalisation of simple possession of prohibited drugs, including ATS, causes significant, unintended and disproportionate harms to those people detected with small amounts of prohibited drugs intended for personal use. These harms outweigh any benefit served by simple possession being criminalised.

Reform is required to address harms caused by ATS

- 11.72 The conclusion that the criminalisation of simple possession is not effective to address the harms caused by drugs and itself causes disproportionate harm to people who use drugs prompts consideration of how the state's legislative and/or policy framework should be reformed to improve NSW's response to crystal methamphetamine and ATS.
- 11.73 The starting point for this discussion requires recognition that, as discussed elsewhere in this report, drug dependence is a health and social problem, and this should be reflected in any proposed reform to the criminal law as it applies to simple possession. It is also helpful to review international and national (including interstate and territory) drug policy in relation to the decriminalisation of simple possession.

Drug use is a health and social problem

- 11.74 Recognition that drug use is a health and social issue that requires a health and social response⁸⁷ is fundamental to meaningful consideration of the reform of the criminal law as it applies to simple possession and the most appropriate models of decriminalisation and diversion.
- 11.75 This sentiment was expressed in many submissions received by the Inquiry, with calls to shift the focus of drug policy in relation to simple possession from one involving criminal justice responses to one in which health needs and social supports are paramount.⁸⁸

- 11.76 As discussed in Chapter 3, the social determinants of drug use are complex.⁸⁹ The Royal Australasian College of Physicians explained that substance dependence is a complex issue, *'not simply a personal choice'*.

*'The underlying causes of drug and alcohol addiction can be primarily attributable to environmental factors and early adverse life experiences such as trauma, abuse, a chaotic childhood or home, parent's use and attitudes, and peer and commercial influence, and also to biological factors including genetics, being male, and concurrent mental health disorders. Other social determinants that impact on a person's substance use and dependency include their socioeconomic status, housing status and security and education... We are seeing the increasing emergence of intergenerational cycles of poverty, substance use, mental health and many other social problems.'*⁹⁰

- 11.77 The social determinants of drug use are particularly relevant for Aboriginal people and communities as they have also experienced intergenerational trauma. Dr Thalia Anthony, Associate Professor of Law at UTS Sydney and lead researcher on an Australian Research Council Project on the criminal sentencing of Aboriginal women in NSW, submitted that Aboriginal women in NSW correctional centres have consistently said that issues relating to drugs, including crystal methamphetamine, arise due to deep-seated trauma and grief.⁹¹ She submitted that such trauma and grief is intergenerational and ongoing and manifests particularly as a result of:⁹²

- the removal of their children and other interventions by the NSW Department of Families and Community Services (now the Department of Communities and Justice)
- risks to the health and wellbeing of their children and family
- homelessness, poverty and unemployment
- imprisonment and other criminal justice interventions
- experiences of sexual assault and violence to themselves and/or family
- the premature passing of family members
- experiences of social and cultural alienation and racism.

- 11.78 Dr Anthony submitted:

*'The taking of drugs is not regarded by the Aboriginal women in prison as a choice but as a necessary coping mechanism, sometimes described as 'self-medication', for their grief and trauma. Accordingly, policy responses to 'ice' should be mindful that the drug is a band aid for underlying issues and confronting the symptom alone rather than the cause is short-sighted, at least for Aboriginal women.'*⁹³

- 11.79 There is an incontrovertible association of drug use with disadvantage and issues relating to education, employment, health, housing, social marginalisation, poverty, impulsiveness, dependence and mental illness.⁹⁴ Any meaningful strategy to address harmful drug use must contemplate the broader social determinants of use, and recognise that the drivers of dependence are powerful factors that impede the ability of people who are dependent on drugs to manage their drug use. Such a strategy must also manage issues that underlie drug use and abuse (such as using drugs to cope with trauma or other major life events), and the associated physical, psychological and social effects of regular use, withdrawal and recovery.⁹⁵ Any reform of the criminal law must be consistent with this broader strategy.
- 11.80 The NSW Bar Association submitted that a public health approach that creates an environment to support treatment and allows people who use drugs to be included in society would be a better model than the current criminal law approach.⁹⁶

- 11.81 All participants of the Decriminalisation Roundtable agreed with Dr Wodak, Australian Drug Law Reform Foundation, who said that, to respond to the problem of drugs and prohibition, *'the threshold step is redefining drugs as primarily a health and social issue rather than primarily a law enforcement issue'*.⁹⁷ Consistent with this approach, most participants advocated to remove criminal responses to simple possession offences. Professor Ritter, DPMP, said a criminal response to drug use is inappropriate and noted that *'what we need is a health and social response'*.⁹⁸ Similarly, Cr Lloyd, Lismore City Council, expressed the view that people who use drugs need *'our political leaders to accept the war on drugs is over and to put down their weapons and treat this as a health and social issue'*.⁹⁹
- 11.82 There is broad-ranging support across the community for treating drug use as a health and social issue with a focus on the causes of drug use. In the report of the 2015 Australia21 roundtable of law enforcement and other practitioners, researchers and advocates, Mick Palmer, former Commissioner of both the NT and the Australian Federal Police, observed:

*'While the drug supply market remains unregulated and in the hands of organised criminals who reap huge financial rewards from their endeavours, police will always be chasing their tails or playing catch-up. Law enforcement needs to be relieved of the responsibility of treating recreational and social users as criminals. The user end of the illicit drug market needs to be dealt with primarily as a social and health issue. We must find a way to change the focus to causes, not simply symptoms. This change is already occurring in a number of countries, with demonstrably beneficial outcomes.'*¹⁰⁰

International drug policy

- 11.83 Global drug policy has undergone a profound transformation in recent years. As described in Chapter 2, since the early 1900s, a policy of prohibition has been adopted in Australia and other Western democracies. This was grounded in the temperance movement, which considered drug and alcohol use to be *'morally irresponsible'* and to cause *'violence, indolence, poverty and social decay'*.¹⁰¹ It provided the ideological basis for international efforts to control the trafficking of drugs.¹⁰²
- 11.84 International drug regulation was initially directed towards narcotics, starting with the *International Opium Convention, 1912*. Over the course of the 20th Century, regulatory controls extended to cannabis, hallucinogens, stimulants and sedatives, leading ultimately to the three international drug control conventions in operation today: the *Single Convention on Narcotic Drugs, 1961 (Narcotics Convention)*; the *Convention on Psychotropic Substances, 1971 (Psychotropic Substances Convention)*; and the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988 (Illicit Trafficking Convention)*. The conventions are discussed in more detail below.
- 11.85 The first two United Nations General Assembly Special Sessions on drugs, held in 1990 and 1998, expressed commitment to securing a *'drug-free world'* by 2008 and reinforced a global policy of prohibition including the criminalisation of types of drug offences.¹⁰³ However, at least as early as 2011, the Global Commission on Drug Policy reported that *'[t]he global war on drugs has failed, with devastating consequences for individuals and societies around the world'*, and that *'fundamental reforms in national and global drug control policies are urgently needed'*.¹⁰⁴ The Global Commission called for an end to the criminalisation, marginalisation and stigmatisation of people who use drugs but do no harm to others, and encouraged governments to experiment with *'models of legal regulation of drugs to undermine the power of organized crime and safeguard the health and security of their citizens'*.¹⁰⁵

- 11.86 In 2016, the Global Commission on Drug Policy published its report *'Advancing Drug Policy Reform: A New Approach to Decriminalization'*, in which it advocated for the removal of any penalty for *'low-level possession and/or consumption offences'*, and called on states to adopt a policy model whereby no sanctions – criminal or civil – are levied against people who use drugs.¹⁰⁶
- 11.87 In 2017, 12 United Nations agencies released a *'Joint United Nations statement on ending discrimination in healthcare settings'*, in which it called on stakeholders to support states in *'[r]eviewing and repealing punitive laws that have been proven to have negative health outcomes and that counter established public health evidence ... [including] laws that criminalise or otherwise prohibit ... drug use or possession of drugs for personal use ...'*¹⁰⁷
- 11.88 The United Nations System Chief Executives Board for Coordination (UNCEB) also supports alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use. In January 2019, the UNCEB released a summary of deliberations on its second regular session of 2018, in which members unanimously supported and adopted the *'United Nations system common position supporting the implementation of the international drug control policy through effective interagency collaboration'* (United Nations System Common Position) and committed to stepping up their joint efforts and supporting each other to:¹⁰⁸
- *'call for changes in laws, policies and practices that threaten the health and human rights of people'*
 - *'promote measures aimed at reducing stigma ...'*
 - *'to promote alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use, and to promote the principle of proportionality ...'*
- 11.89 The UNCEB's membership includes the chief executives of all United Nations agencies, including the World Health Organization and the United Nations Office on Drugs and Crime (UNODC), the United Nations agency mandated to assist member states in their struggle against illicit drugs, crime and terrorism. Notably, the UNODC has responsibility for leading the *'UN system coordination Task Team on the Implementation of the United Nations System Common Position on drug-related matters'*, an interagency team tasked with identifying actions to translate the UN System Common Position into practice.¹⁰⁹
- 11.90 In March 2019, the UN System Task Team published a briefing paper, *'What we have learned over the last ten years: A summary of knowledge acquired and produced by the United Nations system on drug-related matters'*. It reported that:
- 'The Committee on Economic, Social and Cultural Rights, the Special Rapporteurs on the right to health; on freedom from torture and other ill-treatment; and on extrajudicial, summary or arbitrary executions; the Committee on the Rights of the Child; and the Office of the United Nations High Commissioner for Human Rights have recommended the decriminalization of drug use and possession for personal use as an important step towards fulfilling the rights to health and towards protecting the safety and wellbeing of communities. Twelve UN agencies have jointly recommended reviewing and repealing laws criminalizing drug use and the possession of drugs for personal use. The World Health Organization has recommended that countries work towards the decriminalization of drug use as a strategy to reduce incarceration and support access to HIV-related services for people who use drugs.'*¹¹⁰
- 11.91 The Inquiry recognises that the unanimous views of those at the highest level of global drug policy support decriminalisation of low-level personal drug use offences.

- 11.92 By 2016, many countries had decriminalised simple possession offences in some form, as shown in Table 11.1.¹¹¹

Table 11.1: Countries that have decriminalised simple possession offences in some form

Argentina	Denmark	Paraguay
Armenia	Ecuador	Peru
Australia (ACT, SA, NT and NSW)	Estonia	Poland
Austria	France	Portugal
Belgium	Germany	Russia
Brazil	India	Spain
Chile	Italy	Switzerland
Colombia	Jamaica	United States (11 states)
Costa Rica	Mexico	Uruguay
Croatia	Netherlands	
Czech Republic	Norway	

- 11.93 There have been proposals to decriminalise simple possession in South Africa, Ireland and Malaysia,¹¹² and there have been calls to decriminalise drug use in Ghana.¹¹³

National drug policy

- 11.94 As discussed in Chapter 4, since its endorsement of the National Drug Strategy in 1985, Australia has expressed a commitment to harm minimisation as the overarching, national AOD strategy.
- 11.95 The stated goal of harm minimisation, as exemplified in the National Drug Strategy, is to prevent and minimise drug-related health, social, cultural and economic harms among individuals, families and communities.¹¹⁴ To achieve this goal, the National Drug Strategy stipulates a balanced approach to harm minimisation across the three pillars of supply reduction, demand reduction and harm reduction. The success of the National Drug Strategy is measured by the five headline indicators: increase in the average age of uptake of drugs; reduction in the recent use of drugs; reduction in arrestees' illicit drug use in the month before committing an offence for which charged; reduction in the number of victims of drug-related incidents and reduction in the drug-related burden of disease, including mortality.
- 11.96 As noted earlier in this chapter and in Chapter 7, recent national wastewater data indicate that consumption of methamphetamine is increasing.¹¹⁵ The most recent report of Drug Use Monitoring in Australia (one of the baseline measures of success in the National Drug Strategy) reports that in 2015–16, 75% of detainees who provided urine samples tested positive to at least one drug type, which represents a continuing increase in the use of drugs by detainees since 2011–12. The most commonly detected drug was amphetamines (50%).¹¹⁶

- 11.97 Numerous submissions received by the Inquiry suggest that NSW's policy of prohibition is not achieving the goals of the National Drug Strategy. For example, the NSW Bar Association submitted that current policy has not proved effective at minimising the harms associated with drug use and that it may cause harm to individuals who use drugs and to the community more generally.¹¹⁷ The Centre for Social Research in Health, UNSW Sydney, raised concerns about the extent to which drug laws conflict with the principle of harm minimisation, which underpins the National Drug Strategy, and submitted that reforming drug laws can reduce the harms associated with prohibited drug use and better direct resources.¹¹⁸ The Centre for Social Research in Health's submission also noted:

*'There is now global recognition of the need for a more public health-oriented approach to drug laws, offering a more proportionate response to drugs by focusing on activities which cause the most harm (e.g. high-level trafficking) and reducing unintended negative impacts for people who use drugs.'*¹¹⁹

- 11.98 In expressing support for the continuing criminalisation of simple possession, the Australian Criminal Intelligence Commission (ACIC) and the Department of Home Affairs submitted that an holistic, coordinated response aligned to a unified national approach would be the most effective approach to reduce harms to people who use drugs and the community.¹²⁰ The ACIC submitted that:

*'Australian drug policy and the [National Drug Strategy] is predicated on the assumption that the Commonwealth, states and territories will collaborate to reduce drug harms to users and the community.'*¹²¹

*'The National Drug Strategy (NDS) recognises that supply reduction is one of the three pillars of the strategy. Accordingly, the criminal prohibition of methylamphetamine and MDMA is entirely consistent with the NDS and in fact, a failure to maintain the criminal prohibition of both these substances would undermine both the supply reduction and the harm reduction pillars of the NDS.'*¹²²

- 11.99 The Inquiry is not persuaded that the continuing criminalisation of simple possession is consistent with the National Drug Strategy. On the contrary, the Inquiry is satisfied that prohibition has not been effective to reduce supply or demand and that it causes harm. In this regard the continuing criminalisation of simple possession is not cogently aligned with the goal of the National Drug Strategy.
- 11.100 Although a national, holistic, coordinated approach may have the benefit of consistency across the states in a federation, consistency in itself is no substitute for good policy based on compelling evidence and the clear emergence of a new paradigm of international best practice.
- 11.101 The Inquiry is satisfied that an effective and appropriate response to personal drug use recognises it as a health issue with complex social determinants and requires reform of NSW's current legislative framework.

Existing Australian approaches to decriminalisation

11.102 Despite the prohibitionist philosophy that underpins the criminal law in every Australian state and territory, each jurisdiction has decriminalised simple possession for cannabis to some degree, and most states and territories have decriminalised simple possession of other illicit drugs. Table 11.2 sets out the various models of decriminalisation in Australia for people over the age of 18 by state/territory, drug type, program type and the basis of decriminalisation (*de jure* or *de facto*). Professor Ritter, DPMP, has identified NSW and Queensland as the states with the lowest level of decriminalisation of simple possession offences, and has described NSW as ‘a laggard state’ in this regard.¹²³

Table 11.2: Models of decriminalisation in Australia¹²⁴

State	Drug Type	Type of Program	Legal Basis
NSW	Cannabis	Caution with referral to education <i>Cannabis Cautioning Scheme</i>	<i>De facto</i>
	Other illicit drugs	Expiation on payment of fine <i>Criminal Infringement Notice Scheme</i>	<i>De jure</i>
QLD	Cannabis	Caution with referral to education and assessment program <i>Police Drug Diversion Program</i>	<i>De jure</i>
VIC	Cannabis	Caution and referral to education <i>Cannabis Caution Program</i>	<i>De facto</i>
	Other illicit drugs	Diversion and referral to assessment and treatment <i>Illicit Drug Diversion Program</i>	<i>De facto</i>
SA	Cannabis	Expiation on payment of fine <i>Cannabis Expiation Scheme</i>	<i>De jure</i>
	Other illicit drugs	Diversion and referral for health assessment, brief intervention and or treatment <i>Police Drug Diversion Initiative</i>	<i>De jure</i>
WA	Cannabis	Diversion to therapeutic intervention <i>Cannabis Intervention Requirement Scheme</i>	<i>De jure</i>
	Other Illicit Drugs	Diversion to AOD treatment <i>Other Drug Intervention Requirement</i>	<i>De facto</i>
TAS	All illicit drugs	Level 1: caution (1st cannabis offence) Level 2: Diversion to brief intervention (2nd cannabis offence) Level 3: Diversion, assessment, intervention and treatment (3rd cannabis and all other drug offences) <i>Illicit Drug Diversion Initiative</i>	<i>De facto</i>
ACT	Cannabis	Decriminalisation by operation of s171A <i>Drugs of Dependence Act</i>	<i>De jure</i>
	Other illicit drugs	Diversion with referral for assessment, education counselling or other treatment <i>Illicit Drug Diversion</i>	<i>De facto</i>
NT	Cannabis	Expiation on payment of fine <i>Cannabis Expiation Notice Scheme</i>	<i>De jure</i>

The elements of decriminalisation

11.103 Designing a model of decriminalisation that addresses both the harms identified with problematic drug and the harms associated with the arrest and charge of people for simple possession requires thoughtful consideration of the many constituent elements of such a model.

11.104 In its submission, the DPMP observed:

*'Designing a fit-for-purpose decriminalisation model for NSW is not easy. The design considerations are complex and include the threshold quantities, the nature of sanctions (fines or other), whether a therapeutic response (ranging from education to treatment) is included and the eligibility criteria.'*¹²⁵

11.105 Professor Geoff Gallop, AC, Commissioner, the Global Commission on Drug Policy, remarked at the Decriminalisation Roundtable, *'[t]he details become everything in a sense – just as important as the philosophy'*.¹²⁶

Elements of a decriminalisation scheme

The principal elements of a decriminalisation scheme require consideration of:

- The method of reform – by law or policy.
- Whether criminal penalty provisions are removed and if so, should civil sanctions apply?
- If civil sanctions are included, how is secondary offending (e.g. non-payment of a civil fine) to be dealt with?
- The appropriate response to detection – for example education, health or psychosocial treatment?
- If education or health or psychosocial treatment is the appropriate response, should it be mandatory and what are the consequences of non-compliance?
- What are the eligibility criteria?
 - relevant threshold quantity of drugs
 - is it necessary for the person to admit the conduct
 - should there be a limit on the number of times a person may be detected in possession of drugs and dealt with under the scheme, or referred to treatment
 - prior criminal history/other offending
- Managing risks:
 - net-widening
 - net-deepening
 - inequity of access for particular cohorts, especially Aboriginal people and regional, rural and remote communities.

11.106 Most participants at the Decriminalisation Roundtable considered that any scheme should apply to all illicit drugs.¹²⁷ Professor Ritter, DPMP, noted that while the law should be the same for all prohibited drugs, a different response to possession of different types of drug may be warranted. For example: *'[H]aving decriminalised both drugs [methamphetamine and MDMA], you might want to preference caution and an educational response for MDMA, and preference health and social responses ... for ATS.'*¹²⁸

The basis of reform – law or policy

11.107 A fundamental consideration in drug law reform is whether reform is to be by law (*de jure*) or by policy (*de facto*). *De jure* reform is achieved by amending legislation or by binding judicial ruling. *De facto* reform involves executive action, achieved by amending or introducing policies, including departmental procedures and guidelines.

11.108 In the case of drug law reform and the decriminalisation of simple possession, *de jure* decriminalisation may involve the removal of simple possession offences from the criminal law (with or without the introduction of civil sanctions) whereas *de facto* decriminalisation involves 'lessening' criminal penalties in practice by introducing guidelines to police to not enforce the law.¹²⁹

11.109 *De jure* decriminalisation can be achieved by:¹³⁰

- removing criminal offences altogether
- replacing criminal penalties with civil penalties (such as a fine)
- replacing criminal penalties with administrative penalties (such as placing restrictions on attending certain places).

11.110 *De facto* decriminalisation can be achieved by:¹³¹

- non-enforcement of the law (through the exercise of police discretion or prosecutorial guidelines)
- diversion of offenders away from the criminal justice system.

11.111 According to Dr Hughes, Professor Ritter and others:

*'[D]e facto reforms tend to rely on the application of police/judicial discretion. This creates higher risk of inequity in terms of who avoids criminal sanctions: such as exclusion of disadvantaged and minority groups or geographic differences in policing. There is much less risk of inequity in de jure reforms, although any reform (whether de jure or de facto) that uses criteria to target particular groups of people or drug types risks inequitable outcomes.'*¹³²

11.112 Hughes et al. note that all *de facto* decriminalisation schemes in Australia have eligibility requirements that limit who can access the scheme, and that such restrictions can exclude those most marginalised and/or those most in need of diversion into treatment and rehabilitation.¹³³ The authors identified that *de jure* decriminalisation schemes have fewer eligibility restrictions, which increases program access and equity.¹³⁴

11.113 Concern was expressed in many submissions and in evidence before the Inquiry about police having discretion over whether to divert someone from the criminal justice system.

11.114 In its submission to the Inquiry, ACON referred to bias in the exercise of police discretion to issue cautions under the Cannabis Cautioning Scheme, particularly in relation to marginalised communities.¹³⁵ Annie Madden, founding member of Harm Reduction Australia and former CEO of the Australian Injecting and Illicit Drug Users League, also expressed concern about any decriminalisation model that relies on police discretion, particularly in relation to people who use drugs, informing the Inquiry that *'there are big risks, I think, in police discretion for such a highly stigmatised and marginalised community'*.¹³⁶ Cr Lloyd, Lismore City Council, indicated that discretionary diversion does not benefit the Aboriginal community. However, Cr Lloyd also noted that the limited benefit of discretionary diversion to Aboriginal people is also partially attributable to the threshold limits that apply to the Cannabis Cautioning Scheme and the prevalence of concomitant offending.¹³⁷

11.115 Dr Weatherburn, University of Sydney Law School, expressed the view that discretion carries with it the risk of corruption.¹³⁸ Andrew Scipione, Former Commissioner, NSW Police, informed the Decriminalisation Roundtable that police *'don't have a problem exercising discretion but they need to have very clear guidelines. They don't like confusion because that's when it all goes wrong'*.¹³⁹

- 11.116 It is apparent that even in the presence of clear guidelines, such as those pertaining to the Cannabis Cautioning Scheme, there are still concerns about differential application between police commands and in marginalised populations. A variation of cautioning rates between police local area commands (LACs) was identified in 2011 by the Auditor-General in his review of the Cannabis Cautioning Scheme.¹⁴⁰ The Auditor-General reported that, in 2009–10, the rates of adult cautioning varied from 6.49% in the Manning/Great Lakes LAC to 74.32% in the Eastern Suburbs LAC.¹⁴¹
- 11.117 The Auditor-General reported that the variation in cautioning rates was explained by police as being due to targeted operations involving drug dogs and different demographics in different LACs that render some people ineligible for a caution. The Auditor-General observed *'[a]lthough these factors affect cautioning rates, they alone cannot explain the large variation between LACs'*.¹⁴²
- 11.118 Dr Hughes, Flinders University, indicated in evidence to the Inquiry that legislated diversionary schemes are associated with higher rates of diversion and may be one means to reduce differentials in diversion between LACs.¹⁴³
- 11.119 Disparities such as those identified by the Auditor-General will only be avoided by the removal of police discretion and the introduction of a scheme that applies in all cases of simple possession. The Inquiry finds that this will be best achieved by legislation that mandates police diversion.

Removal or retention of criminal offences

- 11.120 The Global Commission argues that a punitive approach to drug control fundamentally undermines the relationship between the individual and the state, including because it fails to address the harms to which it is directed, and in fact causes harms.¹⁴⁴
- 11.121 The removal of criminal sanctions, with no other systemic changes, is associated with reduced burdens on the criminal justice system and reductions in drug-related harm.¹⁴⁵ The Inquiry notes that the removal of criminal offences for simple possession would eliminate the prospect of conviction, thereby addressing the consequences of a criminal record discussed earlier in this chapter and in Chapter 1.
- 11.122 In circumstances where criminalising simple possession has failed to reduce supply or demand, and has increased harm, the retention of criminal offences for simple possession appears to be wholly inconsistent with the National Drug Strategy. Criminalising simple possession is not only ineffective but counter-productive to harm minimisation. The removal of these offences would also be more consistent with principles of criminal law jurisprudence.
- 11.123 Apart from a small number of submissions which advocated for the retention of criminal offences and/or sanctions for simple possession offences, including those received from the ACIC¹⁴⁶ and the Department of Home Affairs,¹⁴⁷ most submissions received by the Inquiry supported the removal of criminal sanctions for simple possession, while maintaining the criminal status of the offences of supply and manufacture.¹⁴⁸ Most participants of the Decriminalisation Roundtable also supported the removal of criminal offences for simple possession.
- 11.124 The Inquiry notes that the Commissioner of the NSW Police Force submitted that he does not support the removal of criminal offences for simple possession; apart from submitting that those offences should remain criminal offences under the *DMT Act*, the Commissioner did not provide reasons for his position.¹⁴⁹

- 11.125 Having considered the substantial body of evidence before the Inquiry on the issue of stigma (see Chapter 9), including many submissions received by the Inquiry, the testimony of leading academics in drug policy and senior clinicians as well as compelling evidence from many witnesses with lived experience of drug use and dependence, the Inquiry is satisfied that the issue of stigma will not be adequately addressed by an approach that does not remove criminal sanctions, and that this is a necessary first step to address stigma.¹⁵⁰

Civil sanctions

*'It is important that any model that imposes civil instead of criminal responses should be grounded in human rights and dignity for the person. Coercive and punitive regimes founded in the civil law can cause as much damage as criminalisation.'*¹⁵¹

- 11.126 Some models of decriminalisation employ civil sanctions, either as an alternative to the imposition of criminal sanctions or to enforce compliance with an administrative response. The NSW Criminal Infringement Notice Scheme is an example of the former; the powers of Portugal's Commission of Dissuasion are an example of the latter.
- 11.127 Governments use a broad range of different civil sanctions in conjunction with decriminalisation, including warnings,¹⁵² fines,¹⁵³ suspension of driver's licences,¹⁵⁴ suspension of firearms licences,¹⁵⁵ and community service orders.¹⁵⁶ In some jurisdictions, civil sanctions may include restrictions on residency (for non-citizens),¹⁵⁷ restrictions on international travel,¹⁵⁸ restrictions on whom a person may associate with¹⁵⁹ or restrictions on practising in a profession or occupation that is subject to licensing requirements.¹⁶⁰
- 11.128 The civil sanction most commonly used in jurisdictions that have decriminalised drug offences is a monetary penalty or fine, which is a conventional method by which governments seek to regulate social conduct. However, it is well recognised that monetary penalties frequently operate in a discriminatory fashion. As noted above, the ALS submission describes how the imposition of fines can work to the detriment of Aboriginal people by significantly increasing their interactions with the criminal justice system.¹⁶¹
- 11.129 The imposition of fines is also associated with 'net-widening' and 'net-deepening'.¹⁶² Net-widening occurs where there is an increase in the number of people who experience some form of criminal justice intervention. Net-deepening occurs when people are subjected to more severe penalties for their failure to pay a fine than they would have received for the original offence.
- 11.130 Net-widening and net-deepening were both observed following the implementation of a decriminalisation model in SA, the Cannabis Expiation Notice (CEN) scheme. There was a 2.5-fold increase in the number of cannabis possession detections in SA, which was attributed to the ease with which a CEN could be issued, in contrast to arrest and charge procedures (net-widening).¹⁶³ There was also an increase in the number of people imprisoned for not paying fines issued under the CEN scheme (net-deepening).¹⁶⁴
- 11.131 The statistics on the current outcomes for people who are charged with simple possession offences are relevant to assessing the risk that imposing civil sanctions in NSW could lead to net-widening or net-deepening. Judicial Information Research System sentencing statistics indicate that, in the case of simple possession offences (as the principal offence) between 24 September 2018 and March 2019, the NSW Local Court:¹⁶⁵

- did not convict the person in 10% of cases involving amphetamines (excluding MDMA) and in 72.9% of cases involving MDMA
 - convicted the person (with conditional release or no other penalty) in 11.4% of cases involving amphetamines (excluding MDMA) and in 2.8% of cases involving MDMA
 - imposed a fine in 63.3% of cases involving amphetamines (excluding MDMA) and in 23.1% of cases involving MDMA.
- 11.132 If a model is adopted whereby a person receives an on-the-spot fine, the result may be that a significant number of people will be treated more punitively, albeit without the harms associated with the imposition of a criminal charge and conviction. In this respect, the Inquiry notes that of the people dealt with by NSW Local Courts for simple possession of MDMA, only 27.1% were convicted.¹⁶⁶ The Inquiry further notes that these statistics only capture those cases where the person is dealt with by the court; it does not capture the data for people detected but not charged, where charges were withdrawn or the court found the person not guilty.
- 11.133 Fines are also associated with the risk of secondary offending, which occurs when people who do not or cannot afford to pay a fine automatically have their licence suspended and are then sanctioned for driving while their licence is suspended, in some cases leading to imprisonment.¹⁶⁷
- 11.134 Fines may also have a harsh and disproportionate impact on vulnerable people who do not have the capacity to pay.¹⁶⁸
- 11.135 The Inquiry has received evidence that CINs have a disproportionate impact on Aboriginal people. For example, the NSW Ombudsman's 2009 review of the impact of CINs on Aboriginal communities reported that 89% of CINs issued to Aboriginal people between 2002 and 2008 were not paid on time and were referred for enforcement action, and only 0.6% were written off or withdrawn. In contrast, of all the CINs issued in that period, 48% were referred for enforcement and 2.9% were written off or withdrawn.¹⁶⁹ While 71.7% of all the CINs issued had been paid by January 2009, only about 29% of those issued to Aboriginal people had been paid.¹⁷⁰
- 11.136 The ALS submitted that the extension of the NSW CIN scheme to cover simple possession offences would significantly increase the interaction of Aboriginal people with the criminal justice system.¹⁷¹
- 11.137 The Inquiry notes that the *Fines Act 1996* (NSW) includes a fine mitigation scheme through the making of 'work and development orders',¹⁷² discussed further below.
- 11.138 Most participants of the Decriminalisation Roundtable were not in favour of the use of fines either on detection or to enforce compliance with an education or health/social response.¹⁷³ While Dr Weatherburn, University of Sydney Law School, did not wish to rule out the use of a fine so as to retain an incentive for people detected to enter treatment,¹⁷⁴ he outlined the reasons for his reluctance about the use of fines generally as follows:
- '[T]here's a long history in this state and other states of seeing people turn up in prison for, first, not paying their fines; second, having their licence disqualified and then being picked up for driving while disqualified. So, I think if you were going to go for a less punitive approach, it would be better to go down the caution track than the fines track, for that reason.'*¹⁷⁵
- 11.139 The Global Commission on Drugs strongly advocates against retaining any civil sanctions for simple possession offences (either on detection or to encourage compliance), arguing that any civil sanction is disproportionate to the conduct.¹⁷⁶

- 11.140 The Inquiry notes that the Commissioner of the NSW Police Force submitted that he does not support '*regulatory expansion of currently illicit substances*', as he is of the view '*it will lead to a 'soft' decriminalisation of illicit drug use*'.¹⁷⁷ However, the Commissioner does support the use of Drug CINs.¹⁷⁸

Capacity to pay fine and Work and Development Orders

- 11.141 Participants of the Decriminalisation Roundtable agreed that if fines were used as a civil sanction in a model of decriminalisation, a system of fines that could be adjusted for the income of the person detected should be implemented.¹⁷⁹ The literature and previous research conducted in NSW supports this proposal.
- 11.142 Penalty notices tend to require the payment of a fixed amount.¹⁸⁰ Fixed penalty notice schemes are inflexible, in that the fine cannot be adjusted to reflect the offender's capacity to pay the fine and the circumstances of the offending.¹⁸¹
- 11.143 In certain circumstances, a Work and Development Order (WDO) may be made to allow a person to satisfy a fine (in part or full) by carrying out an activity specified in the order.¹⁸² The eligible circumstances in which a WDO may be made are set out in the *Fines Act 1996* (NSW) and include that the person is experiencing acute economic hardship, or the person has a '*serious addiction to drugs, alcohol or volatile substances*'.¹⁸³
- 11.144 The activities that may be specified in the order include that the person undertake unpaid work for an approved organisation, undertake a course, undergo financial or other counselling or undergo some kind of treatment (including drug treatment).¹⁸⁴ If the person is only eligible because they have a '*serious addiction to drugs, alcohol or volatile substances*', the only activities that may be specified in the WDO are counselling and drug or alcohol treatment.¹⁸⁵
- 11.145 The NSW Young Lawyers Criminal Committee (NSW Young Lawyers) and ALS, in their submissions to the Inquiry, regard WDOs as an effective way to encourage rehabilitation and engage people in treatment and/or counselling.¹⁸⁶ The NSW Young Lawyers noted that WDOs have a positive impact on the community.¹⁸⁷
- 11.146 However, the ALS raised concerns about the availability of WDOs, submitting that availability depends on the presence of a sponsor agency with capacity, and that sponsor agencies are not funded by the NSW Government to support the WDO scheme.¹⁸⁸ The ALS also noted that '*there is a serious lack of [treatment and counselling] services, particularly culturally specific services for Aboriginal people*'.¹⁸⁹ This indicates that if someone is only eligible for the WDO scheme because they have a serious dependence on drugs, then the lack of services would present a barrier to accessing the scheme.

A therapeutic response to detection – general considerations

- 11.147 Evidence and submissions received by the Inquiry suggest that a therapeutic response (education, health or social or a combination of these) could be used when someone is detected with simple possession.¹⁹⁰ In particular, the Inquiry has heard evidence and received submissions about whether the provision of educational material, referral to voluntary treatment or the requirement to engage in mandatory treatment are suitable responses. Such interventions are expressly permitted by the international drug control conventions that apply to ATS¹⁹¹ (as discussed later in this chapter) and used in various models of decriminalisation discussed in the evidence.¹⁹²

- 11.148 A significant disadvantage of a model that does not offer any therapeutic response is that access to services is not directly facilitated, which may affect the potential gains of the model.¹⁹³ Another disadvantage (where simple possession offences are retained) is that such a model may be regarded as giving offenders a ‘free go’ and be less supported by police, which could lead to differential application.¹⁹⁴
- 11.149 Dr Hughes, Flinders University, pointed out the distinction between traditional ‘non-intervention’ responses and contemporary therapeutic program responses, which refer people to education, treatment or social supports. She said the former saves costs to the criminal justice system; the latter provides an opportunity to address the offender’s underlying drug treatment or health needs.¹⁹⁵
- 11.150 Dr Hughes expressed the view that, if a therapeutic response is incorporated in a model of decriminalisation, it is important that the response is proportionate to the offence and recognises that not all people who use drugs are dependent or engage in problematic use.¹⁹⁶ Professor Ritter, DPMP, noted that illicit drug use occurs across a range of different situations, and an appropriate response in one set of circumstances will not necessarily be appropriate for another.¹⁹⁷ (Different types of ATS use are discussed in Chapter 5.)
- 11.151 The desirability of an appropriately tailored response is apparent when considering the different harm and dependence profiles of different drugs. For example, a therapeutic response is not generally required for possession of MDMA the risk of becoming dependent on MDMA is minimal, in contrast to the highly addictive properties of methamphetamine.¹⁹⁸
- 11.152 To ensure that the response is relevant, proportionate and effective to address the individual needs of a person detected with simple possession, it is important to recognise that not all drug use will cause harm and that not all people who use drugs are dependent. It is also important to avoid stigmatising people who use drugs.

Education

- 11.153 Many domestic and international decriminalisation models refer people to drug education. Approaches in other jurisdictions include referral to educational material and or assistance with identifying and contacting appropriate services.¹⁹⁹
- 11.154 There was support at the Decriminalisation Roundtable for providing online information or education as a response to simple possession.²⁰⁰ Dr Hughes, Flinders University, said:
- ‘[T]here may be a means to use more modern technology as a very quick sort of assessment potential referral mechanism, such as using apps or online mechanisms, so that people can very quickly receive some sort of – basically, a caution, they can do an online education system, about amphetamine-type substances ...’*²⁰¹
- 11.155 Under the NSW Cannabis Cautioning Scheme, there is a mandatory requirement to receive education via the Alcohol and Drug Information Service in cases of second or subsequent offences for simple possession. However, Detective Acting Superintendent Cook, NSW Police Force, indicated that he was not aware of what action, if any, is taken for non-compliance. Evidence before the Inquiry indicates that the compliance rate for mandatory education under the scheme is only 38%.²⁰²
- 11.156 In relation to the current NSW trial of Drug CINs for possession of a small quantity of any illicit drug (apart from cannabis), Detective Acting Superintendent Cook, agreed that imposing sanctions for non-compliance, including non-compliance with any educational requirement, should be carefully thought through.²⁰³

- 11.157 Decriminalisation Roundtable participants did not express support for mandatory participation in education.²⁰⁴

Health/social response

- 11.158 Research into patterns of drug use and the factors that prompt people to reduce their use indicates that interaction with law enforcement is one of the main reasons people with dependent patterns of use are motivated to enter treatment.²⁰⁵ A therapeutic response would provide an opportunity for a person found in simple possession of prohibited drugs to access a health or social response and so may help address the underlying issues related to their drug use.
- 11.159 Decriminalisation Roundtable participants expressed support for referring people to a health response, such as assessment and/or treatment by a GP or AOD counsellor – provided participation is voluntary.²⁰⁶ Dr Hughes cautioned that the involvement of trained clinicians is important to ensure that any therapeutic health or psychosocial response is appropriate and effective.²⁰⁷
- 11.160 The Inquiry has heard compelling evidence, and it accepts, that it is vital to the implementation of any therapeutic response that there be adequate and effective resourcing.²⁰⁸ The Inquiry notes that law reform to decriminalise simple possession was only one part of Portugal's National Strategy for the Fight Against Drugs: Portugal also extended its healthcare services network and syringe exchange program, increased its scientific research into AOD issues and specialist AOD training, and significantly increased funding to these initiatives.²⁰⁹ The success of Portugal's reform is discussed later in this chapter from paragraph 11.274.

Mandatory treatment

- 11.161 Discussion of models of decriminalisation often includes consideration of whether civil sanctions should be employed as a 'carrot' to encourage people into treatment or as a 'stick' to punish people for not participating in a therapeutic response.
- 11.162 In its submission to the Inquiry, MindM8 suggested that people detected in possession of illicit drugs could be offered the choice between paying a fine or participating in a health intervention, or that fines could be discounted or waived as an incentive to engage in treatment, whereas failure to engage results in paying the full fine.²¹⁰ Similar models operate in numerous international jurisdictions, including Latvia and Lithuania, where a person detected in possession of illegal narcotics or psychotropics is exempt from paying a fine if the person voluntarily undergoes treatment.²¹¹ In Portugal, a person who is dependent on drugs may avoid sanction by participating in treatment.²¹² The Inquiry notes that a person issued a fine in NSW and certain other jurisdictions may be eligible for a WDO that allows an offender to participate in drug and alcohol treatment instead of paying the fine.²¹³
- 11.163 In any discussion of mandated treatment, it is important to recognise first, the importance of readiness to change and voluntary self-motivated participation to successfully address drug dependence,²¹⁴ and second, that there is little evidence that compulsory drug treatment is effective.²¹⁵ The Inquiry heard evidence that the only effective treatment programs available for ATS dependence are psychosocial therapies, most notably cognitive behavioural therapies (CBT), and that readiness to change is a precondition to successful engagement in CBT.²¹⁶
- 11.164 The 'Stages of Change' model, which divides the process of addressing drug dependence into five sequential stages, emphasises the importance of intrinsic motivation to treatment success. Those stages are:
1. Pre-contemplation: The individual has little to no interest in changing their substance use and associated behaviours

2. Contemplation: The individual engages in a risk-reward analysis of their behaviour
3. Preparation: The individual plans and commits to changing their behaviour
4. Action: The individual takes specific steps to implement their change plan
5. Maintenance: The new behaviour changes become normative.²¹⁷

11.165 Dr Shalini Arunogiri, consultant addiction psychiatrist, reported to the Inquiry that there is a lack of evidence supporting involuntary treatment for substance use disorders in general, and ATS-related use disorders specifically.²¹⁸ Dr Arunogiri gave evidence that:

*'[B]est practice treatment for ATS-related use disorder (and substance use disorders more broadly) involves a voluntary framework based on behaviour change principles, enhancement of motivation and readiness to change. This framework is underpinned by promoting intrinsic motivation.'*²¹⁹

- 11.166 The use of civil sanctions coerces a person into treatment and thereby removes or diminishes the voluntary nature of their participation in treatment. Such an approach is at odds with the recognition that successful drug treatment is generally voluntary.
- 11.167 As noted above and discussed in Chapter 5, not all people who use drugs are dependent, nor do they all engage in harmful use or need treatment.²²⁰ It is well recognised that people who use MDMA generally do not need drug treatment,²²¹ and to require them to attend mandatory counselling is a waste of resources.²²² The Inquiry also heard evidence that, while there is not yet a direct estimate of the proportion of people who use crystal methamphetamine that become dependent, the figures for cocaine and opiates could assist as a comparator.²²³ Academic literature indicates that the proportion of people who use cocaine and heroin that become dependent are 15% and 23% respectively.²²⁴
- 11.168 The Portuguese experience with decriminalisation demonstrates that most people detected in possession of drugs for personal use do not need treatment. The substantial majority of people referred to Portugal's Commission of Dissuasion are assessed to be not dependent on drugs and their proceedings are suspended with no further action taken.²²⁵
- 11.169 The evidence received at the Decriminalisation Roundtable was strongly against implementation of a mandatory health or social response as part of a decriminalisation model, with participants advocating for a targeted approach '*so not everyone has to go to the treatment system or social support system*'.²²⁶

Decriminalisation Roundtable participants observed that:

- Not all people who use or are found in possession of drugs need treatment.²²⁷
- Mandating people to attend treatment is not effective²²⁸ and there are human rights implications for such an approach.²²⁹
- Coercing people into treatment uses funds that could be better invested in assisting those who are ready for treatment.²³⁰
- There are currently not enough services for people who wish to attend voluntarily.²³¹
- Careful consideration needs to be given to the implications of relying on fines to coerce people into treatment, including the risk of net-deepening and/or secondary offending.²³²

Professor Ritter, DPMP, observed:

*'I think all of it should be voluntary. We have mandatory mechanisms for drug courts, for people with drug offending and serious offending. We have a prison-based mandatory program in the [Compulsory Drug Treatment Correctional Centre]. We have a civil commitment program – the [Involuntary Drug and Alcohol Treatment]. Those mandatory mechanisms are available for people who are either at risk of harm to self or others or engaged in serious offending. They work well. We don't need that in the context of simple use/possess. What we need is voluntary options and good triage.'*²³³

- 11.170 In its submission to the Inquiry, the DPMP also expressed concern about mandated treatment in a context where existing treatment services are inadequate to meet demand. The DPMP observed that a model that refers people to health and social services may increase the burden on treatment systems, particularly if compulsory referral models are employed.²³⁴

Conclusion: an appropriately tailored education, health or social intervention

- 11.171 The Inquiry notes the tension between recognising that most people detected in possession of prohibited drugs do not require drug treatment services, the desirability of encouraging into treatment those whose use is harmful and concern with coercive models of treatment. The evidence supports the provision of an appropriately tailored education, health or social intervention at or close to the point of detection.
- 11.172 For the reasons canvassed above, referral to any form of treatment should be voluntary and the level of treatment, if any, dictated by the participant's drug treatment needs.

The role of police in diversion

- 11.173 Many models recognise that as frontline responders, and to avoid the resource implications of unnecessary contact with authorities, police are best placed to coordinate the initial referral of people to the appropriate education or health/social response. SA and Tasmania, for instance, both employ models of diversion that rely on police as the first point of contact for the referral to an intervention.
- 11.174 SA's Police Drug Diversion Initiative (PDDI) is a diversionary scheme implemented by police at the point of detection. If a person is alleged to have committed a simple possession offence, a police officer must refer the person to a nominated assessment service and give the person a notice that sets out particulars of the date, place and time at which the person must attend the service.²³⁵ The assessment service may require the person to enter an undertaking in relation to treatment, program participation or other matters the service considers will assist the person to overcome personal problems that may have led or lead to drug use.²³⁶ On expiry of those undertakings (a period which must be no more than six months), the person is immune from prosecution for the simple possession offence.²³⁷ The person may, however, be prosecuted for the offence if he or she fails to cooperate with the assessment, fails to give an undertaking, or for a number of other related reasons.²³⁸

- 11.175 The PDDI scheme is associated with very high rate of treatment referrals and compliance and evidence of reduction in drug-related harms.²³⁹ A 10-year review of the scheme, considering data from 1 September 2001 to 31 August 2011, indicated that:
- 13,627 individuals were diverted a total of 19,717 times.
 - Amphetamines were the most common drug diverted (47%).
 - The overall compliance rate was 81%.
 - Only 25% of people were diverted more than once, with 15% diverted twice, 5% diverted three times and 4% diverted four or more times (the maximum number of diversions one person received was 32).²⁴⁰
- 11.176 Tasmania's Illicit Drug Diversion Initiative (IDDI), which provides multiple models in one program,²⁴¹ is available where the police officer is satisfied drugs are in a person's possession for personal use only. It is a three-tiered police diversion model. The first time a person is detected with cannabis, they may be cautioned. The second time a person is detected with cannabis, they may be diverted to a brief intervention, where they are required to attend a face-to-face session with a health professional. The third time a person is detected with cannabis, or the first time the person is detected in possession of any other illicit drug, the person may be diverted to an assessment and treatment intervention, in which the person must contact an AOD service to arrange an assessment and must then comply with a treatment plan to avoid prosecution.²⁴²
- 11.177 Detective Acting Superintendent Cook, NSW Police Force, expressed a preference for policy-based interventions over legislated diversion, because in his view policy-based diversion allows a broader diversion program to be managed²⁴³ and is more flexible because changes can be implemented more quickly to better achieve program goals.²⁴⁴ However, Detective Acting Superintendent Cook could not advise what would need to be built into a policy to achieve a very high level of diversion,²⁴⁵ and accepted that if diversion were based on statutory criteria rather than police discretion, a more consistent application of such a scheme would be expected across LACs.²⁴⁶
- 11.178 Clearly, the success of a model that incorporates a therapeutic response is contingent upon the adequate resourcing of assessment and treatment services. If an educational or health/social response is implemented, adequate and effective resourcing is vital.²⁴⁷
- 11.179 The Commissioner of the NSW Police Force supports responses (in addition to the continuing criminalisation of simple possession or use of the current Drug CIN scheme) *'that promote harm minimisation and have appropriate support services, such as education and health, connected to them'*.²⁴⁸

Eligibility criteria and barriers to diversion

- 11.180 To enhance the potential for any decriminalisation model to attain optimal results, it is necessary to address barriers to diversion that may arise from the design of the model.
- 11.181 The DPMP submitted that strict eligibility requirements limit access to diversionary programs.²⁴⁹ A 2019 review by the DPMP of diversionary programs authored by Hughes et al. (2019 DPMP Diversionary Program Review) indicated that narrow eligibility criteria may exclude many offenders of simple possession offences, and identified that the key criteria limiting access are:
- threshold quantities on the amount of drugs that can be processed
 - limits on the number of times people can enter programs
 - requirements placed on offenders to admit offences
 - *'priors'*/rules around concurrent offences.²⁵⁰

- 11.182 At the Diversionary Programs Hearing, Dr Hughes, lead author of the 2019 DPMP Diversionary Program Review, gave evidence consistent with those findings:

'[W]hen we look at the NSW context, one of the biggest reasons for the low rates of diversion there has been the traditional absence of police diversion for use and possession of drugs other than cannabis, as well as the requirements in the NSW context for people to admit an offence if they are to receive a diversionary option, which we were told is a particular barrier to people who are indigenous. And the third factor of note is about the threshold limits and where they are set.

*... [T]he fourth factor is that NSW, the Cannabis Cautioning Scheme has not been based in law, which means there's more option for discretion about the use, and when you look at the evaluations that have been conducted into the NSW Cannabis Cautioning Scheme, such as the one by the NSW Auditor-General, you would've noted there's a very high difference in the uptake of or provision of diversion across the local area commands, and this is where many of the stakeholders that we spoke to suggested that there's, you know – not only is there a need for more breadth of diversion programs, so ensuring that there are options for diversion for use and possession for all illicit drugs, but also that there is potential merit in either a legislated or hybrid legislated approach so that it sends a very strong signal, makes it very clear to police but also to all people who use or possess drugs, what will happen if you are detected.'*²⁵¹

- 11.183 The importance of addressing these barriers to diversion is evident from recent research that indicates rates of diversion across Australia are in decline. The 2019 DPMP Diversionary Program Review found that the proportion of people detected for simple possession diverted by police away from the criminal justice system across Australia declined from 59.1% in 2010–11 to 51.2% in 2014–15.²⁵² The authors note that the universal view among experts was *'that there needs to be more diversion for possession for personal use in Australia, including to counter the recent national trend of reducing rates of drug diversion'*.²⁵³

Threshold quantities

- 11.184 Some diversionary schemes only allow people to access the scheme where the drugs found in their possession do not exceed a prescribed quantity of a drug,²⁵⁴ commonly referred to as 'threshold quantities'.
- 11.185 Threshold quantities for the purpose of qualifying for diversion are distinguishable from the threshold quantities that 'deem' a person to be in possession of drugs for the purpose of supply (deemed supply threshold(s)).²⁵⁵ When a person is detected in possession of an amount of drugs that exceeds a deemed supply threshold, there is a rebuttable presumption that the person is in possession of those drugs for the purposes of supplying those drugs to others, and they may be charged with an offence of supply. In the event the person satisfies the court that they did not have the drugs for the purpose of supply, under the current law they may be convicted of possession.
- 11.186 All countries and states that have decriminalised simple possession offences prescribe thresholds to determine whether the amount of drugs detected is consistent with personal use. The thresholds may be a fixed quantitative amount specifying the weight of a particular drug, or they may be descriptive, such as an amount for personal consumption.²⁵⁶ For example:

- Uruguay, which has decriminalised the personal use of all illicit drugs, defines the relevant amount as '*a reasonable quantity intended exclusively for [his or her] personal use*'.²⁵⁷
 - Portugal, which has decriminalised the personal use of all illicit drugs, defines possession for personal use as an amount that does not exceed '*the quantity required for an average individual consumption during a period of 10 days*'.²⁵⁸
 - The NSW Criminal Infringement Notice Scheme sets the threshold at 0.75g of MDMA (0.25g if in capsule form) and 1g of methamphetamine.²⁵⁹
 - The NSW Cannabis Cautioning Scheme sets a threshold at 15g of dried cannabis leaf.²⁶⁰
 - The ACT, in relation to cannabis, sets the threshold quantity at 50g of cannabis.²⁶¹
- 11.187 The threshold quantities selected for a decriminalisation model can be critically important to its success. Jurisdictions where possession thresholds are so low that the system is effectively unenforceable and most people who use drugs are still criminalised are described in the literature as '*hollow examples of decriminalisation*'.²⁶² Participants at the Decriminalisation Roundtable discussed the importance of any decriminalisation model adopting threshold quantities of drugs that reflect the reality of how people purchase and consume drugs in today's market.²⁶³
- 11.188 The evidence before the Inquiry is that the amounts currently prescribed for threshold quantities in NSW are not evidence based, do not reflect consumption patterns and do not reflect purchasing behaviours.²⁶⁴ Professor Ritter, DPMP, said setting a single prescribed quantity for a particular drug is problematic, and that there ought to be a range of threshold quantities '*because drug consumption patterns differ, they change over time, and because of social supply or supplying friends or purchasing enough for one's own supply over a weekend ... So I think it is complicated to come down to ... a single number or single figure for any one drug*'.²⁶⁵ The evidence and literature before the Inquiry is that schemes that set low threshold quantities limit the number of people who are diverted by restricting access to the schemes.²⁶⁶
- 11.189 Dr Hughes, Flinders University, noted that NSW's Drug CIN scheme has a very low threshold limit on the maximum amount of MDMA that can be possessed.²⁶⁷
- 'This is lower than most other Australian drug diversion programs: 1 to 10 grams MDMA, and lower than typical quantities consumed by MDMA users in Australia. For example, the Ecstasy and related Drugs reporting System notes that regular Australian ecstasy users report consuming a median of two capsules or pills or up to three caps or pills in a typical session (approximately 0.58 - 0.87 grams), while a national evaluation of Australian drug trafficking threshold laws found that in 2014 most irregular MDMA users reported consuming 0.58 to 0.73 grams, and that MDMA users in NSW reported consuming up to 3.5 grams or 6.7 grams in a typical or heavy session respectively. Measures to expand access to other settings and increase threshold limits for MDMA are thus recommended.'*²⁶⁸

A requirement to admit the offence

- 11.190 People are often required to admit the offence to be eligible for decriminalisation schemes in Australia. A requirement to admit an offence is generally used in pre-charge diversion schemes, where a failure to admit the offence precludes police from diverting an offender, and the person is charged with the simple possession offence.

- 11.191 The Inquiry heard that the requirement to admit an offence can reduce the effectiveness of the scheme by leading to reduced rates of diversion, particularly for the Aboriginal population. For instance, in the case of the NSW Cannabis Cautioning Scheme, the requirement to admit an offence has created a barrier to diversion. Former NSW Police Commissioner Andrew Scipione noted at the Decriminalisation Roundtable that people were getting legal advice that *'No matter what you've done, you never admit the offence'*, which precluded them from receiving a caution, resulting in a criminal record.²⁶⁹ Evidence before the Inquiry suggested that about 90% of people who proceed to court ultimately plead guilty, demonstrating the adverse effect of a requirement to admit guilt before caution.²⁷⁰
- 11.192 Detective Acting Superintendent Cook, NSW Police Force, gave evidence that removing the requirement to admit an offence as an eligibility criterion from the Cannabis Cautioning Scheme would allow more people to be diverted and would remain consistent with the aims of the scheme.²⁷¹
- 11.193 ACON submitted that in communities where relationships with the police are not positive, people may be advised not to admit the offence for fear of being charged without a caution, which prevents police from exercising their discretionary power to issue a caution.²⁷² Dr Hughes also made this observation in relation to Aboriginal people due to their historically lower levels of trust in police.²⁷³ Aboriginal people may also be unwilling or reluctant to admit the offence for cultural reasons.²⁷⁴ Cr Lloyd, Lismore City Council, informed the Inquiry that in the Lismore region there is *'quite a bit division between the police and the Aboriginal community'*, which affects the willingness of Aboriginal people to admit offences.²⁷⁵
- 11.194 Dr Hughes noted that some states and territories have removed the requirement to admit an offence from their diversionary schemes to increase access.²⁷⁶ The Inquiry notes that SA does not require people detected of simple possession to admit an offence to be eligible for their PDDI scheme or their CEN scheme,²⁷⁷ discussed from paragraphs 11.174 and 11.263 respectively.
- 11.195 There does not appear to be a compelling argument in support of a requirement to admit the conduct, given it is not necessary to achieve any of the objectives of decriminalisation, namely to ensure that people are not criminalised for simple possession offences, to save the resources of the criminal justice system and to increase access to drug treatment for those who need it.

Number of diversions

- 11.196 The more opportunities a person who is dependent on drugs has to enter treatment, the more likely they are to address their dependence. The Inquiry heard evidence that to achieve optimal results, a diversionary program should not set any cap on the number of times a person may be diverted. Successful drug treatment often involves multiple attempts at rehabilitation and best practice involves maximising the opportunities for people to enter treatment.²⁷⁸ Referring people to an appropriately tailored education or health/social response on their first detection facilitates early intervention for those who need it.²⁷⁹
- 11.197 Dr Hughes gave evidence that it is best practice not to limit the number of times a person can be diverted.

*'[I]f the goal is to ... treat drug use as more of a health and social issue, then the optimal program wouldn't actually set limits. So, the South Australian PDDI program, it's traditionally operated on that basis of not having limits. So it really is about maximising referrals ... so that would be sort of the program that we would support as kind of the best practice.'*²⁸⁰

- 11.198 Data from between 2010–11 and 2014–15 regarding people detected of simple possession in Australia showed that only 10.3% were detected on a second occasion, and 3.6% were detected on three or more occasions.²⁸¹
- 11.199 Dr Hughes gave evidence that in SA, there are very few ‘*frequent flyers*’, that is people who are referred on multiple occasions.²⁸² The Inquiry notes that the SA PDDI scheme was amended to introduce a limit of two diversions in a four-year period, effective from 1 April 2019.²⁸³
- 11.200 Waiting for a second or subsequent detection before referral is not consistent with the objective of increasing access to an appropriate intervention.
- 11.201 The Inquiry notes the view of the NSW Police Force with respect to limiting the number of times a person may be diverted from the criminal justice system. In evidence to the Inquiry, Detective Acting Superintendent Cook suggested that one of the aims of the Cannabis Cautioning Scheme is to change behaviour, and that limiting the number of diversions recognises that the caution is not having the desired effect on the person concerned.²⁸⁴
- 11.202 There are two difficulties with this argument. Firstly, this argument views drug use as a criminal issue and assumes that the threat or imposition of criminal sanctions is an effective deterrent to drug use. However, as noted above:
- An effective response to prohibited drugs recognises that drug use is a health and social issue, not a criminal issue that warrants punishment.²⁸⁵
 - Criminal sanctions are not effective to reduce drug use, particularly for people who are dependent on drugs.²⁸⁶
- 11.203 Secondly, the primary goal of diversion is to divert people away from the criminal justice system and into some kind of therapeutic program or response. Setting a cap on the number of diversions inevitably reduces a person’s access to therapeutic programs. The significance of this is most readily apparent in light of the evidence that people who use drugs may require many attempts and interventions to address their drug use. For instance, at the Decriminalisation Roundtable, Professor Ritter observed: ‘*[W]e know, with quitting any addictive behaviour, it takes many, many go’s and you never know the moment that it’s going to be the right time for that person.*’²⁸⁷
- 11.204 Lived experience witness Andrew House gave evidence at the Broken Hill Hearing that he needed eight admissions into treatment before he overcame his drug dependence, and that each intervention was a significant part of his recovery.²⁸⁸

Prior offences/other offending

- 11.205 Some models of decriminalisation restrict access to diversionary programs on the basis of prior convictions. Most of the police drug diversion programs in Australia exclude people on the basis of prior convictions and/or concurrent offending.²⁸⁹ For example, in NSW, a person is ineligible for the Cannabis Cautioning Scheme if they have a concurrent offence for which a brief of evidence is required, or a prior conviction for a drug offence, sexual offence or offence involving violence (unless the prior conviction is spent).²⁹⁰
- 11.206 Excluding people from the Cannabis Cautioning Scheme on the basis of criminal history has a significant impact on rates of diversion under that scheme. Detective Acting Superintendent Cook gave evidence that, according to police data: ‘*[O]f the 64 to 70% of people that didn’t [get a caution], about 49% of those didn’t qualify because of their previous offending.*’²⁹¹

- 11.207 The South Australian CEN and PDDI schemes and the Tasmanian IDDI scheme do not restrict access to diversion on the basis of concurrent or prior offending.²⁹²
- 11.208 A 2008 review of police drug diversion across Australia reported that, in NSW, only 13% of the people diverted under the Cannabis Cautioning Scheme had offended in the previous 18 months, the lowest rate in Australia; whereas 44% and 48% of people diverted in SA and Tasmania, respectively, had offended prior to diversion. The authors attributed this to program eligibility, noting that SA and Tasmania diversion is open to more offenders, and that offenders can be diverted more than once.²⁹³ The SA and Tasmanian drug diversion schemes are discussed further paragraph 11.173 of this chapter.
- 11.209 The Inquiry heard evidence that restricting access to diversion on the basis of prior convictions has a significant impact on the rates of diversion for Aboriginal people. In the context of the Cannabis Cautioning Scheme, Detective Acting Superintendent Cook acknowledged there was a difference in the rates of diversion of Aboriginal people, which he attributed primarily to prior offending.²⁹⁴ This is consistent with various reports on diversion before the Inquiry.²⁹⁵
- 11.210 No Decriminalisation Roundtable participants voiced support for the exclusion of people from a diversionary scheme on the basis of prior convictions.²⁹⁶

Inequity of access for Aboriginal people and rural and regional NSW

- 11.211 The evidence and submissions received by the Inquiry and discussed below indicate that models of decriminalisation that involve diversion to a health/social response can operate unfairly due to inequity of access and inconsistent program implementation, particularly for Aboriginal people and for people living in remote, rural and regional NSW.
- 11.212 In Australia, access to diversionary programs nationally is an issue for Aboriginal people. Despite higher rates of contact with the criminal justice system, they are less likely to be diverted at certain points of the process than non-Aboriginal Australians.²⁹⁷ Aboriginal people are less likely to receive a warning or a caution or bail without conditions if they are arrested and charged than non-Aboriginal offenders, which continues the cycle of their over-representation in the criminal justice system.²⁹⁸
- 11.213 The Inquiry received a range of evidence about lack of access to diversionary programs, especially in regional and remote areas.
- 11.214 The Penington Institute supported investment in diversionary programs but noted the lack of treatment and support in rural and regional Australia.
- ‘Too often there is nowhere for rural and regional based authorities to refer people experiencing problems with drug use. Suitable services are often not available or within easy access for people in need who live in regional and rural communities. The current state of alcohol and drug (AOD) services means that referral and follow-up is not immediate and when referral eventually occurs, people are referred away from their community.’²⁹⁹*
- 11.215 Mission Australia observed there is a shortage of diversionary services for people who are dependent on crystal methamphetamine despite the increasing need for services to break the cycle of crime.³⁰⁰

- 11.216 Moree Plains Shire Council argued that the lack of viable and sustainable diversionary programs in rural areas is the biggest barrier to access.³⁰¹

*'Rural and remote areas of NSW would greatly benefit from new and additional diversionary programs and the funding and resources to enable these to be viable. Smaller regional towns like Moree, which has a high level of drug issues, could benefit rather than taking it to the rural centres like Tamworth and Armidale, due to tyranny of distance, cost inhibiting factors for clients to access.'*³⁰²

- 11.217 The ALS submitted that Aboriginal people face particular challenges accessing diversionary programs in rural, regional and remote areas of NSW:

*'One key issue identified by many participants was the lack of local youth diversion programs in regional, rural and remote areas of NSW. The lack of available services in these areas means that many young people have to travel outside of their communities, away from family and support networks.'*³⁰³

*'The biggest barrier to accessing diversionary programs is the limited availability of the programs themselves, as well as the critical lack of rehabilitation services, particularly in regional NSW.'*³⁰⁴

- 11.218 The Inquiry considers the evidence discussed in Chapter 16 regarding the lack of culturally appropriate AOD services is also relevant to the barriers faced by Aboriginal people in accessing diversionary programs.
- 11.219 At the Decriminalisation Roundtable, Cr Lloyd, Lismore City Council, identified not only a lack of treatment facilities in the Lismore region, but a lack of culturally appropriate ways to deliver justice.³⁰⁵
- 11.220 Aboriginal people and people living in rural, regional and remote Australia should be priority populations in any response of the NSW Government to crystal methamphetamine and ATS, as discussed in Chapter 8. Dr Hughes, Flinders University, observed it is *'incredibly important to good program design'* to ensure target populations are not deterred from accessing the programs.³⁰⁶
- 11.221 In the Inquiry's view, it is essential that any diversionary programs are accompanied by an increase in culturally appropriate AOD services in regional, rural and remote NSW.

Models of decriminalisation

- 11.222 The Inquiry heard a substantial amount of evidence about legislative models and drug policy responses implemented in other jurisdictions, both domestically and internationally.³⁰⁷
- 11.223 At least 26 countries, including two federations, the United States (11 states) and every state in Australia have policies decriminalising simple drug possession in some form (see paragraph 11.92 of this chapter).³⁰⁸
- 11.224 In a report prepared in September 2018 for the Irish Department of Justice and Equality and the Department of Health by Dr Caitlin Hughes and Shann Hulme of the National Drug and Alcohol Research Centre (NDARC) and Professor Alex Stevens and Dr Rebecca Cassidy of the University of Kent ('the Irish Review'),³⁰⁹ the authors reviewed and analysed the approaches of nine jurisdictions to simple possession offences.

- 11.225 The Irish Review identified the various approaches to decriminalisation reasonably available in the Irish context and their relative advantages and disadvantages. Different approaches were distinguished by reference to whether they were effected by law or by policy, provided a pathway to intervention and/or imposed a civil penalty.
- 11.226 The authors concluded that of the combinations theoretically available, six models exist in practice:
- depenalisation (police discretion) – a *de facto* model with no pathway to intervention or civil or administrative penalty
 - police diversion (*de facto*) – a *de facto* model with a pathway to intervention and no civil or administrative penalty
 - police diversion (*de jure*) – a *de jure* model with a pathway to intervention and no civil or administrative penalty
 - decriminalisation with no sanctions – a *de jure* model with no pathway to intervention or civil or administrative penalty
 - decriminalisation with civil or administrative sanctions – a *de jure* model with a civil or administrative penalty but no pathway to intervention
 - decriminalisation with targeted diversion to health/social services – a *de jure* model with a pathway to intervention and a civil or administrative penalty.³¹⁰
- 11.227 Each of these models falls within the scope of ‘decriminalisation’ as defined from paragraph 11.1 for the purposes of this report. Table 11.3 extracted from the Irish Review, sets out further information in relation to each model.

Table 11.3: Models of decriminalisation³¹¹

Type	Legal basis	Pathways to education / therapy / social services	Administrative / civic sanction	Examples
Depenalisation (police discretion)	<i>De facto</i>	No	No	Netherlands Gedoogbeleid ‘tolerance policy’ (cannabis only), US police ‘deprioritisation’, UK cannabis and khat warnings, Denmark warnings
Police diversion (<i>de facto</i>)	<i>De facto</i>	Yes	No	Police diversion schemes in seven Australian states, Netherlands diversion (hard drugs only), English police diversion schemes in Durham, West Midlands and Avon, US LEAD Programme, Baltimore pre-booking scheme
Police diversion (<i>de jure</i>)	<i>De jure</i>	Yes	No	South Australian Police Drug Diversion Initiative and Queensland Police Drug Diversion Program (police mandated by law to offer diversion to treatment)
Decriminalisation with no sanctions attached	<i>De jure</i>	No	No	Germany (by virtue of Constitutional ruling) and Vermont USA (since 2018)
Decriminalisation with civil or administrative sanctions	<i>De jure</i>	No	Yes	Czech Republic, Jamaica, Cannabis Expiation Notice schemes in three Australian states (ACT, SA, NT), many US states (e.g. Ohio, Mississippi, Massachusetts, Rhode Island)
Decriminalisation with targeted diversion to health / social services	<i>De jure</i>	Yes	Yes	Portugal and several US states (Maryland, Connecticut & Nebraska)

Models of decriminalisation as identified in the Irish Review

Depenalisation (police discretion)

- 11.228 Depenalisation (police discretion) is a *de facto* model that involves a minimal police response (such as issuing a warning) or no police response to simple possession. Under depenalisation (police discretion), the goal is to avoid criminalising people and save police time. Implicit in this model is the belief that people detected for simple possession do not warrant criminal sanction, or any other type of sanction.³¹² The particular depenalisation policy implemented will set out the circumstances in which a person detected with simple possession may be eligible to either have no action taken or to be issued a caution or warning, such as the drug type or quantity in possession.³¹³ Because the model is implemented *de facto*, police retain a discretion to charge the person with simple possession.
- 11.229 The outcomes of depenalisation (police discretion) include reduced consequences of convictions, reduced burdens on the criminal justice system, increased policing of serious crime and increased voluntary treatment uptake. However, the Irish Review identified a risk of net-widening and differential application.³¹⁴
- 11.230 The advantages and disadvantages of depenalisation (police discretion) identified in the Irish Review are set out in Table 11.4.

Table 11.4: Depenalisation (police discretion)

Advantages	Disadvantages
<ul style="list-style-type: none"> • Simple to achieve and few implementation costs • Reduces convictions of people who use drugs • Reduces demands on and costs to the criminal justice system (unless net-widening) • May reduce other more serious crimes • Avoids over-burdening other services 	<ul style="list-style-type: none"> • Risk of net-widening • Risk of a sense of impunity • Risk of increasing drug use • Risk of differential application/justice by geography

Police diversion

- 11.231 Both models of police diversion (*de facto* and *de jure*) involve police referring people in possession of drugs to a health/social response instead of arresting and charging them. Police diversion reflects an acceptance that drug use is more often a health or social issue than a criminal justice issue and so a criminal law response is not appropriate. People in possession of drugs come into contact with police so it is appropriate that police play a role in fostering early intervention by referring offenders to services they might otherwise not access.³¹⁵ This model is associated with reduced collateral consequences of convictions, reduced burden on the criminal justice system and costs, increased knowledge/skills among people who use drugs and reduced drug-related harms. *De jure* police diversion, in contrast to *de facto* police diversion, ensures an equitable response to all people who use drugs.

De facto police diversion

- 11.232 An example of *de facto* police diversion by policy in NSW is the NSW Cannabis Cautioning Scheme, discussed in detail below. The advantages and disadvantages of *de facto* police diversion schemes identified in the Irish Review are set out in Table 11.5

Table 11.5: Police diversion schemes (*de facto*)

Advantages	Disadvantages
<ul style="list-style-type: none"> • Reduces convictions of people who use drugs • Increases access of offenders to treatment/mental health/social services • Assessment and early intervention • Addresses offender needs e.g. access to AOD treatment, employment or legal (dependent on model) • Reduces costs of criminal justice • Reduces drug-related harms e.g. high frequency use • Reduces recidivism 	<ul style="list-style-type: none"> • May be resource intensive (in short term) for police/justice system • Increases costs for other services • Given this is discretionary there may be specific groups of offenders who 'miss out' e.g. people of minority backgrounds • Access may vary by region e.g. regional versus metropolitan areas

NSW Cannabis Cautioning Scheme

- 11.233 The NSW Cannabis Cautioning Scheme gives police the discretion to formally caution adults detected for minor cannabis offences rather than charge them. Cautioned first-time offenders are provided with information about the consequences of cannabis use and encouraged to call the Alcohol and Drug Information Service.³¹⁶ An education session with the service is mandatory if a person is cautioned on a second occasion.³¹⁷
- 11.234 A person can only be cautioned under the scheme if they meet specific eligibility criteria: they can only be in possession of 15g or less of dried cannabis leaf (one of the lowest thresholds in Australia) and must admit to the offence.³¹⁸ They cannot have prior offences involving drugs, violence or sexual assault.³¹⁹ A person is also ineligible if they have been cautioned twice under the scheme previously.
- 11.235 Despite low uptake of the education response (1.6% overall, with 0.2% for first caution, and 38% for the second),³²⁰ evidence before the Inquiry indicates that the scheme is widely regarded as successful in diverting people away from the criminal justice system, saving court costs and reducing the likelihood of re-offending.³²¹
- 11.236 A 2011 report by the NSW Auditor-General examined police responses to minor cannabis offences over the previous 10 years and found that NSW Police had diverted more than 39,000 offenders from the courts, saving at least \$20 million in court costs.³²² The Auditor-General found that people cautioned for minor cannabis offences are less likely to reoffend than those dealt with by the courts. However, the report also found very few people followed up with the drug helpline (1.6%, as already noted).³²³ It further found that cautioning rates varied significantly between LACs.³²⁴
- 11.237 An earlier evaluation concluded the scheme was successful in diverting minor cannabis offenders from the court system, producing substantial time and cost efficiencies for both the police and the local courts. However, it was unclear whether the scheme has been successful in assisting offenders to consider the legal and health ramifications of their cannabis use. The evaluation found the scheme had produced unintended outcomes, including a degree of net-widening, and was less effective for Aboriginal people.³²⁵
- 11.238 Detective Acting Superintendent Cook told the Inquiry it was the view of the NSW Police Force that, for this level of offending, the caution and a possible referral to a health service is an adequate and proportionate response to the possession of cannabis for personal use.³²⁶
- 11.239 Dr Hughes, Flinders University, drew attention to two concerns noted in the 2011 NSW Auditor-General's report: the low rate of people calling the drug helpline and the major variation in cautioning rates between LACs (39 to 73%).³²⁷

- 11.240 The Inquiry's Diversionary Programs Hearing canvassed the issue of the limit of two cautions under the NSW Cannabis Cautioning Scheme, noting that similar schemes in other jurisdictions do not have a limit on cautions.³²⁸ See also the discussion from paragraph 11.197 of this chapter.
- 11.241 The DPMP noted that both the NSW Cannabis Cautioning Scheme and the new Drug CINs are discretionary – police can choose whether to apply it or not – and this can lead to discrimination and variance in application across LACs.³²⁹

***De jure* police diversion**

- 11.242 *De jure* police diversion, in contrast to *de facto* police diversion, ensures an equitable response to all people who use drugs. The advantages and disadvantages of *de jure* police diversion schemes identified in the Irish Review are set out in Table 11.6.

Table 11.6: Police diversion schemes (de jure)

Advantages	Disadvantages
<ul style="list-style-type: none"> • Reduces convictions of people who use drugs • Removes discretion that may limit access in <i>de facto</i> approaches • Increases access to all offenders to treatment/mental health/social services • Address offender needs e.g. access to AOD treatment • Reduces costs of criminal justice • Reduces drug-related harms • Reduces recidivism 	<ul style="list-style-type: none"> • May be resource intensive for police/justice system • Increases costs for treatment services • May lead to “frequent fliers” entering the programme on repeated occasions

Decriminalisation with no sanctions

- 11.243 Decriminalisation with no sanctions is a model where criminal penalties are removed by legislation. The rationale underpinning this model is that simple possession should not be a crime and that rather than setting up any alternate system or merely depenalising the offence, the best response is to remove the offence from the law.³³⁰ The outcomes associated with this model include the elimination of collateral consequences of convictions, reduced burden on the criminal justice system and costs, increased policing of serious crime, reduced stigma and increased voluntary treatment uptake. The Irish Review identifies benefits in reducing demands on the criminal justice system and reducing drug-related harms via reducing barriers to treatment seeking and humanising people who use drugs.³³¹ The advantages and disadvantages of decriminalisation with no sanctions as identified in the Irish Review are set out in Table 11.7.
- 11.244 There are no examples of this model in Australia. Internationally, this model has been implemented in Germany, by virtue of a constitutional court ruling in 1994, and in Vermont, United States.³³² In Germany, there has been an increase in the number of people accepting or undergoing inpatient treatment and a decline in drug-related harms. However, the proportion of German youth who reported using cannabis at least once in their life almost doubled from 16.3% in 1993 to 31.3% by 2004 following the constitutional ruling, eventually stabilising at 25% in 2015.³³³

Table 11.7: Decriminalisation with no sanctions

Advantages	Disadvantages
<ul style="list-style-type: none"> • Eliminates convictions for possession alone • Reduces stigma of people who use drugs • Reduces costs of criminal justice • Reduces barriers to harm reduction and treatment seeking • Reduces drug-related harms e.g. high frequency use • Simple to achieve and few set-up costs, albeit more complex than depenalisation (police discretion) 	<ul style="list-style-type: none"> • Little evidence of effect on prevalence and frequency of drug use • Reduces legal possibility to intervene in problematic drug use

Decriminalisation with civil or administrative sanctions

- 11.245 Decriminalisation with civil or administrative sanctions involves legislative change to introduce new civil/administrative laws so that police impose civil/administrative sanctions, such as a fine, rather than arresting and charging offenders. The rationale for this approach is that drug possession should not be a crime, but it should not be ignored.³³⁴ The Inquiry notes that such a model does not require the criminal offences for simple possession to be repealed, although it is conceivable that a model could be implemented that does involve the repeal of those offences. If the criminal offences are not repealed, the prospect of arrest and conviction remains a possibility.
- 11.246 The outcomes associated with this model include reduced collateral consequences of convictions, reduced burden on the criminal justice system and costs, increased policing of serious crime, reduced stigma (while sending a message that it is a sanctionable offence) and increased revenue.
- 11.247 The most well-known example of this model in Australia is the South Australian CEN Scheme.³³⁵ Another example is the NSW Drug CIN scheme.
- 11.248 The Irish Review notes that such a model saves police time, reduces the burden on the criminal justice system, provides social benefits due to the removal of convictions (including in relation to employment prospects and housing stability), and that the reduction of stigma may facilitate the provision of harm reduction and treatment services and reduce drug-related harms.³³⁶ However, while in most cases drug use trends remained stable or reduced, outcomes have been less positive in some contexts. For example, the authors refer to research that reports youth living in decriminalised states in the United States were 2% more likely to use cannabis, states that ruled out all forms of imprisonment were associated with a higher prevalence of use, and some recent US studies noted increases in drug driving in states with decriminalisation with civil penalties.³³⁷
- 11.249 The Irish Review authors also noted that many states that have decriminalised actually have higher rates of arrests for low-level drug offences than states that have not decriminalised, and also that expiation schemes are associated with net-deepening, suggesting that it is important to consider the impacts of such schemes on people in financial difficulty.³³⁸
- 11.250 The advantages and disadvantages of decriminalisation with civil or administrative sanctions as identified in the Irish Review are set out in Table 11.8.

Table 11.8: Decriminalisation with civil or administrative sanctions

Advantages	Disadvantages
<ul style="list-style-type: none"> • Reduce convictions for people who use drugs • Faster for police • Very cheap to run (particularly with new revenue) • Social benefits for offenders from reducing conviction e.g. increased employment prospects 	<ul style="list-style-type: none"> • Need a civil/administrative system • Need a system for payment • May not be fair for all i.e. advantages wealthy people • Risk of net-widening as “easy” for police • Risk of increased drug use and driving

NSW Criminal Infringement Notice Scheme

- 11.251 Criminal Infringement Notices (CIN) are on-the-spot fines for certain offences and are an example of a scheme of decriminalisation with sanctions that operates in NSW. Since January 2019, NSW police officers have had the discretion to issue a CIN for possession or use of a small quantity of a prohibited drug other than cannabis without the need for court proceedings (Drug CIN).³³⁹
- 11.252 Although possession of a prohibited drug remains a criminal offence, the issuing of a Drug CIN is an alternative legal process. As the offence is still a criminal offence, it will appear on a person's bail report.³⁴⁰ However, a Drug CIN will only appear on a person's criminal history if the person elects to go to court and is subsequently convicted. If the person pays the penalty notice, it will not appear on a person's criminal history.³⁴¹
- 11.253 To be eligible for a Drug CIN, a person must admit the offence, and must not have previously received two Drug CINs – there is no entitlement to a third Drug CIN. Police may only issue one Drug CIN on any one occasion. This does not preclude police issuing other CINs or penalty notices. However, the combined maximum number of penalty notices (including CINs) may not exceed four per person at any one time.³⁴²
- 11.254 Although the CIN provisions of the *Criminal Procedure Act 1986* (NSW) in relation to simple possession of prohibited drugs (other than cannabis) are of general application, the Drug CIN scheme is currently geographically limited to music festivals. It started on 25 January 2019 and has been extended indefinitely to cover the 2019–20 music festival season.³⁴³ The pilot was introduced following recommendations from an Expert Panel to deter drug use at music festivals by issuing on-the-spot fines instead of Court Attendance Notices for drug possession offences at music festivals.³⁴⁴ Detective Acting Superintendent Cook, NSW Police Force, stated that there may be justification for expanding the program beyond dance festivals, pending evaluation of the initial pilot.³⁴⁵
- 11.255 Detective Acting Superintendent Cook told the Inquiry that almost 90% of the Drug CIN fines have been or will be paid, which is an indication of the program's success.³⁴⁶
- 11.256 As of 1 July 2019, a total of 303 Drug CINs had been issued at music festivals for drug possession. No Drug CINs have been issued to those identifying as Aboriginal or Torres Strait Islander.³⁴⁷

- 11.257 Dr Hughes, Flinders University, noted that the Drug CIN scheme has the potential to bring health, social and criminal justice system gains and to fill some gaps in the current NSW drug diversionary response.³⁴⁸ However, Dr Hughes outlined two restrictive features of the Drug CIN scheme that should be reconsidered. The first is that it only applies to festival settings, which limits access to diversionary programs for people who use or possess ATS in other settings.³⁴⁹ Also, the scheme employs a very low threshold limit on the maximum amount of MDMA that can be possessed.³⁵⁰ Dr Hughes gave evidence that *'[a]s the first such scheme targeting use/possession of drugs other than cannabis this is a sound and evidence-informed step forward. The scheme remains however under evaluation, and there are questions about whether and how it could be extended to non-festival settings'*.³⁵¹
- 11.258 The DPMP submitted that the discretionary nature of Drug CINs is problematic as it can lead to discrimination and variance in application across LACs.³⁵²
- 11.259 The Inquiry notes that the legislation does not restrict Drug CINs to music festivals,³⁵³ they may be issued anywhere in NSW. Detective Acting Superintendent Cook gave evidence that police were only issuing Drug CINs at music festivals because the trial arose out of the recommendations of the Keeping People Safe at Music Festivals Expert Panel. He anticipated any decision to issue Drug CINs more broadly would be made following a review of the trial.³⁵⁴
- 11.260 Detective Acting Superintendent Cook said it is envisaged that the trial of the Drug CIN scheme could be strengthened by exploring the feasibility of having a health and/or education intervention attached to the Drug CIN process, but this has not been progressed and may form part of the review of the trial.³⁵⁵
- 11.261 Detective Acting Superintendent Cook stated that the \$400 fine may have a broader impact on Aboriginal communities and may need to be reviewed.³⁵⁶ He also noted there is a need to consider the consequences for non-compliance due to the risk of 'secondary offending', where the non-payment of fines can result in the cancellation of driver's licences or the cancellation of vehicle registrations, which can be a particular issue in rural communities.³⁵⁷
- 11.262 The Commissioner of the NSW Police Force advocates for the use of Drug CINs as a mechanism to reduce harm, and submitted that to date the trial of Drug CINs has been an effective harm reduction measure. The Commissioner further submitted that there has been good compliance with the Drug CINs that have been issued, which indicates they are being well received by young people and the community. He supports the addition of an educational and/or support component to Drug CINs to enhance their overall effect on drug use in the community.³⁵⁸

SA's Cannabis Expiation Notice (CEN) scheme

- 11.263 South Australia's CEN scheme covers minor offences of cannabis cultivation, possession and consumption (simple cannabis offences). If an adult is alleged to have committed a simple cannabis offence,³⁵⁹ police must give them an expiation notice before a prosecution is commenced.³⁶⁰ If the prescribed expiation fee is paid, the person is not liable to prosecution for that offence.³⁶¹
- 11.264 The Irish Review authors regard the CEN scheme, introduced in 1987, as more cost-effective than prosecuting simple cannabis offences³⁶² and associated with significant social benefits, including fewer negative employment problems and less relationship disruption.

- 11.265 The Irish Review noted that in the early years of the CEN scheme, two perverse effects were observed:³⁶³
- net-widening as evidenced by a 2.5-fold increase in expiable cannabis offences: from 6,231 in 1987 to over 17,170 in 1996
 - low rates of compliance in paying the expiation notices (45%).
- 11.266 Net-widening was attributed to the ease with which a CEN could be issued (in contrast with arrest and charge procedures). Low compliance was attributed to ignorance of the law and financial difficulty experienced by a substantial proportion of those detected for minor cannabis offences. This led to more people who use cannabis being incarcerated for non-payment of fines (net-deepening).³⁶⁴
- 11.267 In 1996, new payment options were introduced (including payment by instalments and substitution of community service for fines) and education about the reform increased. The Irish Review suggests that these measures led to a reduction in net-widening and increased rates of payment.³⁶⁵ The Inquiry notes that these amendments would appear to increase compliance and so reduce the number of people incarcerated for non-payment of the fine, and therefore reduce net-deepening.
- 11.268 As noted above, the CEN scheme illustrates how decriminalisation schemes (including diversion) can lead to net-widening and net-deepening. It also shows how models may be designed to reduce the risk of net-deepening.

Decriminalisation with targeted diversion to health/social response

- 11.269 Decriminalisation with targeted diversion to health/social services involves offenders at a low risk of harmful drug use receiving a non-criminal response (civil penalties or suspended sanctions), while offenders with a higher risk of harmful drug use are referred to AOD assessment and treatment.
- 11.270 The rationale for this model is that it recognises that most people use drugs in non-problematic ways, but a minority may need therapeutic responses.³⁶⁶
- 11.271 This model provides an holistic response associated with increased access to AOD and other services by offenders, avoidance of the collateral consequences of convictions, improved social integration, reduced drug dependence, reduced drug-related harms and reduced cost and reduced burdens on the criminal justice system.³⁶⁷ The advantages and disadvantages of this model are set out in Table 11.9.
- 11.272 The authors of the Irish Review identified the Portuguese model as the clearest example of decriminalisation with targeted diversion to health/social services (see below).
- 11.273 The report indicates that this model is associated with lower rates of regular or problematic drug use, significant reductions in drug-related harms including opiate-related deaths and infectious diseases, increases in drug treatment engagement and a decrease in drug injection and HIV infection rates, a reduced burden on the criminal justice system, reduced rates of arrest and increased access to specialised services for high-risk offenders. The report emphasises the importance of considering the contribution that changes to welfare and the health care system make to these improvements.³⁶⁸

Table 11.9: Decriminalisation with targeted diversion to health/social services

Advantages	Disadvantages
<ul style="list-style-type: none"> • Holistic response system based on need: “low” versus “high-risk” • Increases access of high-risk offenders to treatment/mental health/social services • Reduces problematic drug use • Reduces drug-related harms e.g. overdose, HIV and hepatitis C • Reduces burden on the criminal justice system • Reduces costs • Increases social reintegration 	<ul style="list-style-type: none"> • Requires new infrastructure including new administrative and/or legal basis and new referral pathways • Some increased costs for other services but much lower than in police diversion (<i>de jure</i>)

The Portuguese model

11.274 In 2001, Portugal removed simple possession offences from the criminal law and classified them as administrative violations³⁶⁹ to be dealt with by the ‘Commission for Dissuasion of Drug Addicts’ (CDT), comprised of three people: two with relevant medical or therapeutic expertise (physicians, psychologists or social workers) and one with a legal background.³⁷⁰ The policy aims to rehabilitate rather than punish offenders.³⁷¹

11.275 A person detected in possession of illicit drugs is referred by police to the CDT. If the person is found to possess more drugs than an average individual would consume in a 10-day period, they are prosecuted in the criminal justice system for presumed supply. In all other cases the CDT will inquire into the nature, context and circumstances of the person’s drug use and determine whether the person is dependent on the drug(s).³⁷²

- If the person is not dependent, or the person is dependent but agrees to undergo treatment, proceedings are suspended. The proceedings will be re-opened if the person is detected on a subsequent occasion or if treatment is ‘unduly’ interrupted.³⁷³
- If the person is dependent and does not agree to undergo treatment, or if suspended proceedings are re-opened, the CDT may impose a range of administrative penalties, including fines, suspension of firearms licence, and placing restrictions on international travel.³⁷⁴

11.276 The context in which reform occurred in Portugal differs from the current situation in NSW in the following respects:

- Lifetime prevalence of illicit drug use in Portugal was relatively low (only 7.8% of people aged 15 to 64 had ever used an illicit drug compared to 43% of all people in Australia as at 2016^{375,376}
- Decriminalisation was only one aspect of Portugal’s National Strategy for the Fight Against Drugs. Other measures included an extension of the healthcare services network and the needle and syringe exchange program, an increase in scientific research and specialist training and a significant increase in government spending to support the scheme³⁷⁷
- Portugal’s drug policy was not as punitive as many Western states before the new legal framework was introduced. Portugal resisted the prohibitionist movement and illicit drug use was criminalised for the first time in 1970; between 1975 and 1982 drug consumption was increasingly reconceptualised as a disease, and during the 1980s and 1990s drug consumption was primarily considered a health-related problem.³⁷⁸ Less than 1% of those incarcerated for a drug offence were in prison for drug possession in the year before the law enacting decriminalisation started.³⁷⁹

11.277 The Inquiry received several submissions that referred to the Portuguese decriminalisation model.³⁸⁰ The overwhelming majority of these were supportive of decriminalisation and discussed the success of the Portuguese reform.

11.278 However, the ACIC submitted:

*'The impact of this legislative change has been debated for the best part of the past two decades because law enforcement and health indicators have varied over time and by drug. What is clear is that overall drug use has not significantly increased or declined in Portugal, drugs are readily available to motivated users in the country, criminals and organised crime groups continue to supply drugs in and through Portugal and to be arrested for such activity, and drugs from Portugal are exported to countries as far away as Australia.'*³⁸¹

11.279 The Inquiry considers that the ACIC submission overlooks the nuanced evidence of the benefits of decriminalisation to various health, social and legal systems in Portugal.

11.280 A paper by Dr Caitlin Hughes and Professor Alex Stevens published in 2010 found that in Portugal since 2001 there has been:³⁸²

- small increases in illicit drug use among adults
- reduced illicit drug use among people with problematic drug use and adolescents, at least since 2003
- reduced burden of drug offenders on the criminal justice system
- increased uptake of drug treatment
- reduction in opiate-related deaths and infectious diseases
- increases in the amounts of drugs seized by the authorities
- reductions in the retail prices of drugs.

11.281 Although some of these trends were seen as reflecting European regional developments, some effects appear to be attributable to the Portuguese model; such as the reduction in the number of people with drug dependence and reduction in burden of drug offenders on the criminal justice system.³⁸³

11.282 Research published in 2015 analysed the social costs of illicit drug use in Portugal following the approval of the Portuguese National Strategy for the Fight Against Drugs in 1999. It found that between 2000 and 2004, there was a 12% reduction in the social cost of drugs. From 2000 to 2010, the social cost (average) reduction was more significant (18%). Not only did indirect health costs decrease, but there was also a significant reduction in costs not related to health, namely direct legal system costs associated with criminal proceedings and indirect costs associated with lost income and lost production of individuals imprisoned for drug offences.³⁸⁴

11.283 The Global Commission on Drugs describes the impact of decriminalisation in Portugal as follows:

*'Since 2001, the country has experienced a number of positive health outcomes including: a reduction in drug use among certain vulnerable populations; increases in the numbers accessing treatment services; significant decreases in HIV transmission rates and new cases of AIDS among people who use drugs (85% and 91% respectively over a 13-year period); and a significant reduction in drug-related deaths. The current president of the International Narcotics Control Board in 2015 described Portugal's policy as "a model of best practices" in light of these achievements.'*³⁸⁵

Discussion of the various models

11.284 According to Dr Weatherburn, University of Sydney Law School, one of the biggest problems with prohibition is the expense of enforcing it.³⁸⁶ As at 2014, Australia spent between \$432 million and \$707 million annually on drug law enforcement, and yet one in 10 Australians over the age of 14 uses illicit drugs at least once a year and 40% of Australians try an illicit drug at some stage in their lives.³⁸⁷ The costs of law enforcement are discussed further in Chapter 6.

11.285 The Irish Review identifies reduced burdens on the criminal justice system and reduced costs as a known outcome common to all six models of decriminalisation,³⁸⁸ although there are increased costs incurred with diversion to a health/social response.³⁸⁹

11.286 Dr Hughes, lead author of the Irish Review, gave the following evidence to the Inquiry:

*'In terms of decriminalisation, which ... was the preferred option [in Ireland], the two best models, based on our review are either decriminalisation with no sanctions and where you're expanding resources for treatment, social services and the like concomitant with any reform, but it becomes entirely voluntary for people to go and access services. And the other – the other model is the decriminalisation with targeted referrals ... the Portuguese-type approach.'*³⁹⁰

11.287 Dr Hughes also suggested that there was benefit in considering a legislative or hybrid legislative requirement for police to offer diversion, similar to the schemes adopted by Tasmania and recommended by the *Victorian Parliamentary Inquiry into Drug Law Reform* for codification of drug diversionary programs.³⁹¹ The main concern with a 'legislative' requirement that entrenches diversion in law is that it could 'lock the program in' and make it harder to adjust. A hybrid system, which legislates the requirement to divert but uses policy to govern the operation of diversion programs, could retain some flexibility while ensuring police are required to divert eligible offenders.³⁹²

11.288 Most participants at the Inquiry's Decriminalisation Roundtable supported the removal of criminal sanctions (i.e. true decriminalisation) over 'depenalisation' (i.e. retention of criminal sanctions with the introduction of administrative or civil sanctions) for simple possession offences.

11.289 Several participants at the Decriminalisation Roundtable stated that they did not support depenalisation. Cr Lloyd, Lismore City Council, stated:

*'I'm not a supporter of depenalisation. For Aboriginal people, that does lead to secondary offending, where they are unable to pay a fine; this leads to suspension of licence. They often don't get the letter in the mail, because they live transient lives, they don't have stable housing. So, then they're brought before the court for drive whilst disqualified. And that leads to, for many of them, incarceration.'*³⁹³

11.290 Ms Madden, Harm Reduction Australia, stated that while she does not oppose depenalisation, she believes it to be the least amount of reform possible. She also noted the harms associated with depenalisation, in particular, the use of fines and concerns in regard to police discretion, particularly when people who use drugs are 'such a highly stigmatised and marginalised community'.³⁹⁴

- 11.291 The only participants of the Decriminalisation Roundtable who did not support removal of criminal sanctions were Dr Weatherburn, University of Sydney Law School, and Mr Scipione, Former Commissioner, NSW Police. Dr Weatherburn expressed concern that it could lead to an increase in aggregate consumption, and that such a result could increase harm.³⁹⁵ In response, Dr Hughes referred to research across 38 countries on the decriminalisation of cannabis that showed it did not lead to a significant difference in rates of lifetime use and use in the previous 12 months.³⁹⁶
- 11.292 Mr Scipione expressed concern that removing criminal sanctions may be inconsistent with Australia's international obligations and expressed a preference for the retention of police discretion in any scheme.³⁹⁷ International law is discussed later in this chapter. The evidence received by the Inquiry in relation to issues with retaining police discretion in diversion schemes is discussed above, including under from paragraph 11.107.
- 11.293 As discussed earlier in this chapter, the Commissioner of the NSW Police Force does not support the removal of criminal offences for use and possession, or their replacement with civil sanctions. However, he does support police diversion with an education and/or health component and the use of Drug CINs with appropriately resourced support services. He submitted that he is working with the Department of Communities and Justice to investigate alternative police diversion models for drugs other than cannabis, and that if police drug diversion was expanded, depending on the model, additional resources may be required.³⁹⁸
- 11.294 One of the key concerns raised about decriminalisation is whether the removal of criminal sanctions will lead to greater consumption of previously prohibited drugs. A substantial body of evidence indicates that decriminalisation, regardless of the model adopted, does not result in an increase in consumption. The DPMP and NDARC rely on the Irish Review to argue that there is no evidence of a significant increase in prevalence of use following decriminalisation. Rather there have been many positive consequences, including reductions in drug-related harms, reductions in the burden on the criminal justice system and improved employment and economic outcomes.³⁹⁹ The authors of *A Quiet Revolution: Drug Decriminalisation Across the Globe* note:

*'In light of the differing decriminalisation models in practice today, it is certainly difficult to make sweeping assessments of decriminalisation's impact on various metrics such as criminal justice savings, drug-related deaths, and the spread of infectious diseases. However, one conclusion that can be drawn is that the doomsday predictions are simply wrong, and removing criminal sanctions for possession and use of drugs does not lead to skyrocketing prevalence rates.'*⁴⁰⁰

Decriminalisation as part of broader policy reform

- 11.295 It is important that there are realistic expectations about outcomes that can be achieved through decriminalisation. Many people charged with possession of ATS are simultaneously, or on another occasion, charged with other crimes. Decriminalisation of simple possession will not remove all people who would otherwise be charged with such a crime from the criminal justice system.

- 11.296 It is also important to acknowledge that decriminalisation alone is not enough to effectively reduce the harms of problematic drug use. At the Decriminalisation Roundtable, Mr Scipione stated:

*'[I]f we look at this more as a health problem, then we need to make sure that we have additional investment in health, and social services, because without it, this will be an unmitigated catastrophe – in my mind at least. With nowhere to refer somebody to, it becomes nightmarish, for the officer that has to deal with the case, for the person that's in the grip of a terrible situation.'*⁴⁰¹

- 11.297 In addition, according to Ms Madden, Harm Reduction Australia:

*'[I]f we were to go down a decriminalisation pathway, then I think stigma reduction/elimination has to be part of any approach. And that's with police, with health services, and also with the general community, frankly, because just because you decriminalise things, it's not magically going to take away stigma and discrimination overnight. We've spent a long time building that story. So, it's going to take some deconstruction.'*⁴⁰²

- 11.298 Any changes to the legal framework must be accompanied by an increase in education, treatment and social services together with a concerted effort to address the stigmatisation of ATS use.

- 11.299 One of the criticisms of the decriminalisation of simple possession offences is that, because it does not go so far as to legalise and regulate illicit drugs, people will still have to buy their drugs in a black market where drugs are of unknown purity and content and are potentially sold in unsafe environments.⁴⁰³ The Inquiry acknowledges and accepts that decriminalisation will not address this concern.

- 11.300 Dr Manuel Cardoso, Deputy Director of the Portuguese General-Directorate for Intervention on Addictive Behaviours and Dependencies, has warned that drug law reform in isolation is not a solution, noting that Portugal also implemented social support for people who use drugs: *'We created a treatment network, educational framework and look at social problems that need to be treated. We try to solve the problem looking at each person, we try to solve all the problems – not just drug use.'*⁴⁰⁴

- 11.301 The NSW Council of Social Service submitted that the 2015 National Ice Taskforce identified the need to consider the broader social determinants that contribute to substance use.⁴⁰⁵ The Inquiry notes the commentary in the 2015 National Ice Taskforce final report:

'Prevention strategies must take into account the reasons why people use drugs in the first place. This includes the social determinants of drug use and risk factors that contribute to the development of problems across the lifespan.'

*There is a well-established relationship between social determinants and problematic drug use. Drug use is strongly associated with several social and economic factors, including poverty, unemployment, culture and community and family disadvantage. Marginalised youth in disadvantaged communities with little or no family support and limited access to education are especially vulnerable.'*⁴⁰⁶

- 11.302 Although the 2017 *Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice)* did not reach a concluded view about the appropriateness of decriminalising methamphetamine or a broader range of illicit drugs in Australia, the Committee acknowledged the need for an holistic approach to drug treatment and an increase in investment in treatment services.

*'While decriminalised drug policies are demonstrated to have a positive impact on health outcomes for drug users, decriminalisation is not a "silver bullet". Reform to decriminalise drug use must occur in conjunction with investment in treatment services to ensure drug users are able to transition into treatment services without delay. The Committee agrees with analyses that attribute the success of Portugal's approach to this combination of drug law reform and investment in treatment services.'*⁴⁰⁷

- 11.303 The Global Commission on Drugs reports that while decriminalisation is the first step, a public health approach must recognise the social, economic and environmental conditions that are often underlying drivers of problematic drug use,⁴⁰⁸ and that it is only with substantial investments in harm reduction and treatment services that the health problems primarily associated with problematic use can be mitigated.⁴⁰⁹

International law

- 11.304 As noted in Chapter 2, Australia is party to two international conventions that deal with ATS – the 1971 *Convention on Psychotropic Substances (Psychotropic Substances Convention)* and the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (Illicit Traffic Convention)*.⁴¹⁰ Although it is the Commonwealth Government rather than NSW that is signatory to the conventions, it is pertinent to consider their operation in the context of reform to the law and policy concerning simple possession.
- 11.305 The *Psychotropic Substances Convention* requires party states to 'prohibit all use' of, among other things, ATS, except for scientific and very limited medical purposes and to 'treat as a punishable offence' any action contrary to a law adopted in pursuance of its obligations under the Convention.⁴¹¹ The *Illicit Traffic Convention* requires that party states 'shall adopt such measures as may be necessary to establish as a criminal offence ... the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption'.⁴¹² Notwithstanding these provisions, the conventions allow alternatives to conviction or punishment for personal consumption offences in 'appropriate cases of a minor nature' – including the provision of treatment, education, after care, rehabilitation or social reintegration.⁴¹³
- 11.306 Opinions are mixed as to what models of decriminalisation are consistent with the conventions. The Inquiry understands that there is an ongoing debate among scholars about whether, and the extent to which, the conventions require parties to criminalise or otherwise prohibit simple possession offences.⁴¹⁴ The United Nations Chief Executives Board and the Global Commission on Drugs, along with the majority of submissions to this Inquiry that discussed international law, contend that some level of decriminalisation is permitted under the conventions.⁴¹⁵ The Department of Home Affairs, in contrast, expressed the view that state decriminalisation or legalisation of use and possession would cause Australia to be non-compliant with its international obligations.⁴¹⁶

- 11.307 As discussed in ‘International Drug Policy’ from paragraph 11.83, global drug policy is shifting away from criminalisation for simple possession and towards a more compassionate, health-oriented response to drug use. The recently adopted United Nations’ system common position on drug policy is to promote alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use.⁴¹⁷ The UN system coordination Task Team (tasked with implementing the UN system common position on drug-related matters) stated that international drug control conventions do not require parties to criminalise drug use for non-medical or non-scientific purposes.⁴¹⁸ It is also relevant to note that a significant number of countries have already decriminalised simple possession in various manners.⁴¹⁹
- 11.308 The consistency of depenalisation and diversionary schemes with the conventions is uncontroversial – decriminalisation by those mechanisms is permitted⁴²⁰ and statements from the UN unambiguously endorse such schemes.⁴²¹ Although there is an argument that a model of decriminalisation that repeals criminal offences for simple possession is inconsistent with the Convention requirement to ‘*prohibit*’ and ‘*treat as a punishable offence*’ and ‘*establish possession of ATS as a criminal offence under its domestic law*’, the UN bodies referred to above contend that the conventions are not offended where people detected with simple possession are diverted to treatment, education, after care, rehabilitation or social reintegration programs.
- 11.309 In light of the views expressed by the various UN bodies, the Inquiry is of the view that a model of decriminalisation of simple possession that removes the criminal offence and makes provision for voluntary participation in treatment and/or education as part of a health or social intervention is not inconsistent with the requirements of the conventions.

Consistency with Australia’s legal framework

Laws of the Commonwealth

- 11.310 The ACIC and the Department of Home Affairs submitted that decriminalising simple possession offences could be inconsistent with Commonwealth legislation, and present difficulties with intercepting drugs at Australia’s border. The Department of Home Affairs submitted that established illicit drug supply chains would be likely to benefit from any legislative gaps created by inconsistency between Commonwealth legislation controlling ATS and any decriminalisation or legalisation initiatives by state or territory jurisdictions.⁴²² It raised concerns about the potential for transnational, serious and organised crime groups to exploit and capitalise on any ambiguity or gaps in legislative frameworks and challenge the investigation and prosecution of the criminal law.⁴²³
- 11.311 Neither the ACIC nor the Department of Home Affairs described how inconsistency with Commonwealth legislation would arise, and it is not clear to the Inquiry how decriminalisation of simple possession would give rise to any such inconsistency.
- 11.312 The Inquiry does not accept that the decriminalisation of simple possession in NSW could compromise the integrity of Australia’s border controls or lead to the outcomes suggested by the ACIC and the Department of Home Affairs. The Inquiry notes that decriminalisation of simple possession leaves as criminal offences the manufacture, production and supply of prohibited drugs. These offences would continue to be investigated and prosecuted in NSW.

Laws of other states and territories

The Department of Home Affairs also submitted that state decriminalisation or legalisation:⁴²⁴

- would create legal ambiguity between the legal frameworks of NSW, Commonwealth legislation and other jurisdictions
- would create uncertainty for all law enforcement at the border and across Australia
- may lead to cross-border diversion and drug tourism, which may increase supply in other jurisdictions
- may drive demand
- may lead to perverse legal outcomes
- may compromise the integrity of Australia's border controls.

In raising these issues, the Department of Home Affairs conflates legalisation and decriminalisation. None of these concerns has merit:

- Decriminalisation would not create 'legal ambiguity'. It would be merely another example of state law that differs from Commonwealth law
- This is a matter that may be addressed by appropriate training of law enforcement officers
- There is no evidence to support the suggestion of cross-border diversion and drug tourism
- There is no evidence that decriminalisation significantly increases demand, indeed the international experience is to the contrary
- The proper application of state and Commonwealth laws will not lead to perverse legal outcomes
- There is no basis for the suggestion that decriminalisation of simple possession would compromise the integrity of Australia's border controls. Supply, manufacture and importation of prohibited would remain offences.

11.313 The ACIC submitted that:

*'[I]t is important that legislation at all levels of government is consistent and effectively hardens the environment against transnational and serious and organised crime groups and their domestic counterparts. The supply side of the methylamphetamine and MDMA markets involves a wide and varied number of participants who operate at very different levels of sophistication. This argues for certainty and consistency in drug legislation across Australia.'*⁴²⁵

11.314 The Inquiry agrees that consistency of approach is beneficial. However, there is no principled basis for claiming that the decriminalisation of simple possession offences would result in uncertainty or inconsistency in legislation directed to supply interdiction.

11.315 Finally, the Inquiry notes that a range of different decriminalisation models operate across Australia. NSW appears to have one of the most conservative and prohibitionist policies in the federation. There is no evidence that discrepancies in the approaches taken to simple possession between neighbouring states and territories have caused any problems in targeting supply and tackling organised crime.

11.316 The Inquiry is of the view that, to the extent a model of decriminalisation implemented by NSW will establish a legal or policy regime that differs from that of other Australian states and territories, it will not impede law enforcement efforts directed to reducing supply or result in any of the concerns raised by Home Affairs.

Findings of past inquiries that have considered decriminalisation

11.317 A number of past inquiries (discussed more broadly in Chapter 4) have considered and made findings or recommendations in relation to the issue of decriminalisation. Several made findings and recommendations that drug use is a health issue,⁴²⁶ and that use and possession should be treated as a health issue⁴²⁷ or a health and social issue⁴²⁸ rather than a criminal justice issue. Although the inquiries reported that decriminalisation can work effectively in practice⁴²⁹ and have a positive impact on health outcomes for people who use drugs,⁴³⁰ only WA recommended a model of decriminalisation be implemented.

- The 2018 *Victorian Parliamentary Inquiry into Drug Law Reform* considered the potential for ‘unintended consequences [such as] increased drug use’, and recommended Victoria ‘[explore] alternative models for the treatment of these offences, such as the Portuguese model of reform’ and ‘[remove] the discretion involved with current Victoria Police drug diversion processes by codifying them’.⁴³¹
- The 2017 *Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice)* was ‘cognisant of the jurisdictional challenges that arise in a federated system and the legal complexity and ambiguity that might be created if the Commonwealth and states and territories take different approaches’,⁴³² and noted that ‘a substantial increase in the capacity and availability of treatment services would be necessary if Australia transitioned to a decriminalised model such as Portugal’s’.⁴³³
- The 2019 *WA Parliamentary Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community* reported that it ‘heard that WA requires much more in terms of treatment, support, prevention and harm reduction before implementing decriminalisation’, and recommended that ‘[t]he Western Australian Government increase funding for drug services in line with [projected demand]’,⁴³⁴ and that ‘the Mental Health Commission and Western Australia Police Force work together to investigate, develop and implement either ... an expanded Police Drug Diversion Program [or] ... an administrative decision-making body and associated process for dealing with drug use and possession [and that] particular consideration [be given] to ensuring that people in regional and remote areas can receive equitable access’.⁴³⁵

Findings of the NSW Coronial Inquest into Music Festival Deaths

11.318 The Terms of Reference of this Inquiry require consideration to be given to any drug-related recommendations from any NSW inquest held during the course of the Inquiry. On 8 November 2019, Deputy State Coroner, Magistrate Harriet Grahame, published her findings in the inquest into the deaths of six patrons of NSW music festivals. Relevant to this discussion, Deputy State Coroner Grahame found:

‘541. ‘There is a need to closely examine decriminalising the personal use of drugs as a mechanism to reduce harm. The evidence revealed the many contradictions in our current limited approach. The NSW [Police] Commissioner, for example, supports the use of the Drug Criminal Infringement Notice (CIN) system at music festivals as a harm reduction measure. This allows for on-the-spot fines for small quantities of drugs, which may divert young people from the criminal justice system. At the same time the Commissioner also supports an approach which mandates large numbers of young people being inspected by dogs, strip searched and questioned for a possible transgression which, even if confirmed, can be treated less seriously than some minor traffic offences. This is just one of the contradictions of the current partial approach.’

*542. There is a wealth of evidence that demonstrates the benefits of alternatives to arrest for use and possession offences. NSW already has a number of existing forms of decriminalisation. This includes de facto decriminalisation of use and possession of cannabis through the police cannabis programs, available in certain limited circumstances and a new de jure decriminalisation scheme, for the use and possession of other drugs. However, these diversion programs, like the scheme operating at music festivals, are piecemeal and partial. They often have strict eligibility requirements and other barriers to participation. What is required is a more holistic approach. Clearly designing an overall decriminalisation model for NSW is not easy, but significant work has been done by eminent experts and it is worthy of consideration.'*⁴³⁶

11.319 These findings are consistent with the evidence before this Inquiry.

Conclusion

11.320 Once it is accepted that drug use may be harmful to the health of the person who uses drugs and that drug dependence is a medical condition – propositions that the Inquiry regards as uncontroversial – a health response is more appropriate than a criminal response.

11.321 Having examined and considered closely all the evidence before the Inquiry relevant to the issue, the Inquiry is satisfied that decriminalisation of the use and possession for personal use of prohibited drugs is a fundamental and necessary reform. In the Inquiry's view, true decriminalisation by removing criminal sanctions would be the most effective option. An alternative, less effective option – decriminalisation by depenalisation – would be the very minimum reform required.

Recommendation 11:

That in conjunction with increased resourcing for specialist drug assessment and treatment services, the NSW Government implement a model for the decriminalisation of the use and possession for personal use of prohibited drugs, which includes the following elements:

- removal of the criminal offences of use and possession for personal use of prohibited drugs
- at the point of detection, prohibited drugs to be confiscated and a referral made to an appropriately tailored voluntary health/social and/or education intervention
- no limit on the number of referrals a person may receive
- no civil sanctions for non-compliance.

Recommendation 12:

In the alternative to Recommendation 11, in conjunction with increased resourcing for specialist drug assessment and treatment services, that the NSW Government introduce a legislated police diversion scheme for use and possession for personal use of prohibited drugs with the following elements:

- mandatory referral by police of people detected in possession of a prohibited drug to an appropriately tailored health/social and/or education intervention
- a maximum of three times that a person may be diverted
- threshold quantities that do not unduly limit access to diversion
- no requirement to admit guilt.

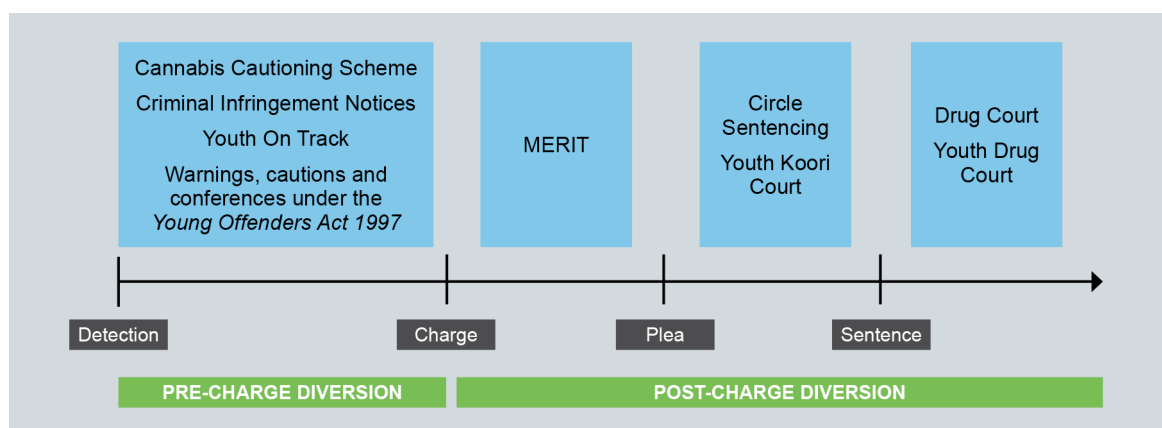
Diversion

- 11.322 In 2015, possession of prohibited drugs ('possession') was the most common proven principal offence and the most common proven offence in the Local Court of NSW. In at least 33.5% of cases, offenders were found guilty of possession and other concurrent offences.⁴³⁷ Of those found guilty of a principal offence of possession, 2.1% received a sentence of imprisonment. People found guilty of possession as a secondary offence were much more likely to receive a sentence of imprisonment for possession; when secondary offences are taken into account, the rate of imprisonment for possession offences in the Local Court in 2015 increased to 5.3%.⁴³⁸
- 11.323 The Inquiry does not have data on the proportion of offenders that are detected with possession who are imprisoned for concurrent offences. However, a report on sentencing trends by the Judicial Commission based on 2015 data indicates that, of those found guilty of possession in the Local Court, 29% of people were found guilty of possession as a secondary offence; 10,414 offenders were sentenced for possession as a principal offence and 4,333 offenders were sentenced for possession as a secondary offence.⁴³⁹
- 11.324 In relation to criminal offending more broadly, 79% of eligible police detainees who participated in the 2018 Drug Use Monitoring in Australia survey tested positive for at least one drug in urine samples submitted for testing; 54% of detainees tested positive to amphetamines.⁴⁴⁰ Thirty per cent of detainees attributed illicit drug use as the reason for their detention.⁴⁴¹ Moreover, as discussed in Chapter 20, 31% of inmates who entered custody in 2019 self-reported methamphetamine use in the four weeks before incarceration, 57% of whom reported using methamphetamines daily.⁴⁴²
- 11.325 Even in the absence of precise details about the proportion of people entering the criminal justice system due to their drug use, or the proportion that are dependent on drugs, the data suggest that the numbers are significant. Therefore, it is important that there are opportunities to divert people to a health or social or education response, including treatment, at all stages of a person's journey along the criminal justice continuum, even if possession is not decriminalised.
- 11.326 The balance of this chapter considers diversionary programs that improve outcomes for people who use drugs, by providing opportunities after they have been charged with an offence for them to address their drug-taking behaviours, including by entering treatment.

What is diversion?

- 11.327 ‘Diversion’ refers to a variety of programs that move people who use alcohol and other drugs away from the traditional criminal justice system and towards education and treatment.⁴⁴³ Diversion includes a very broad range of responses, which may operate at many different points in a person’s journey through the criminal justice system. It ranges from pre-charge diversion, that diverts a person before they are charged, to post-sentence diversion, which may require that during their sentence, a person engages in a therapeutic program to address their drug use.⁴⁴⁴

Figure 11.1: Diversion along the criminal justice process



- 11.328 Traditional approaches to diversion direct offenders away from the criminal justice system with no treatment or follow-up.⁴⁴⁵ Contemporary or therapeutic approaches to diversion seek to address the underlying causes of the offending behaviour by channelling people into education and/or treatment programs that address their drug and alcohol use along with other needs.⁴⁴⁶
- 11.329 Dr Hughes, Flinders University, told the Inquiry that traditional ‘non-intervention’ diversion reduces costs to the criminal justice system, including police, courts and prisons, as well as reducing the costs of a criminal conviction for individuals, but does not address underlying needs.⁴⁴⁷ Therapeutic diversionary programs have the advantage of providing the opportunity to address a person’s underlying needs, such as drug dependence or mental health issues.⁴⁴⁸

History of diversion in Australia

- 11.330 Diversion for drug-related offending has been a recognised component of Australia’s criminal justice system since the mid-1980s, although it has only become a common feature in the past 20 years.⁴⁴⁹ In 1984, SA introduced Drug Assessment and Aid Panels, one of the first formal diversionary programs for people who use illicit drugs to receive treatment before court sentencing.⁴⁵⁰ A few years later a fines scheme was introduced as an alternative to court prosecution for minor cannabis offences.⁴⁵¹ There was a significant expansion of diversionary programs from 2000. By July 2007, all states and territories in Australia had adopted various diversionary programs ranging from police diversion programs to specialist drug courts.⁴⁵²
- 11.331 The establishment of diversionary programs corresponded to the introduction of harm reduction approaches following the 1985 National Campaign Against Drug Abuse,⁴⁵³ which aimed to minimise harm to people who use drugs, reflecting the growing understanding of drug dependence as a health issue and the broader social context of drug use.⁴⁵⁴ It also reflected a move to focusing criminal justice interventions on drug traffickers rather than people who use drugs.⁴⁵⁵ The growth in diversionary programs was initially slow with only seven drug diversionary programs operating nationally by 1999.⁴⁵⁶

- 11.332 The introduction of the Council of Australian Governments Illicit Drug Diversion Initiative in 1999 led to a rapid growth in diversionary programs.⁴⁵⁷ The initiative aimed to divert people who used illicit drugs away from the criminal justice system to education or assessment with a view to treatment.⁴⁵⁸ A national framework and best practice principles for diversion were developed. The framework was supported by federal funding, which led to the development and expansion of various diversionary programs at the state and territory level.⁴⁵⁹
- 11.333 NSW pioneered the establishment of Australia's first drug court in 1999. Since then, successive NSW governments have implemented a range of drug diversionary programs across the continuum of responses and diversionary programs are now a well-established feature of Australia's criminal justice system.⁴⁶⁰

Why diversion is needed

- 11.334 The number of people coming into contact with the criminal justice system has continued to increase over the past 30 years, despite falling crime rates in NSW.⁴⁶¹ Diversionary programs aim to address the offenders' multiple health and social needs, such as mental illness or unemployment, which may have led or contributed to the original offence. They are an effective way to address the underlying causes of offending behaviour⁴⁶² and can help to interrupt the cycle of crime, imprisonment and re-offending that characterises the lives of so many offenders, particularly for over-represented groups such as Aboriginal people and young people.
- 11.335 The National Drug Strategy 2017–2026 prioritises the diversion of offenders into health interventions to reduce the adverse health, social and economic consequences of drug problems.⁴⁶³
- 11.336 Successful diversion avoids the negative effects of imprisonment discussed above, such as stigma and increased risk of re-offending.⁴⁶⁴ Providing people with tailored education, treatment and support programs can prevent drug use, reduce escalation to harmful drug use and treat established harmful drug use.
- 11.337 The high rates of recidivism in NSW highlight the need to deal more effectively with the underlying causes of offending.⁴⁶⁵ A 2015 BOCSAR report shows that almost 60% of offenders were convicted of another offence within 10 years. For illicit drug offenders, around two-thirds (63% of adults and 71% of juveniles) were re-convicted of another offence within 10 years.⁴⁶⁶ The high rate of recidivism obviously has significant social and economic costs for individuals, their families and society.⁴⁶⁷
- 11.338 In its submission to the Inquiry, the NSW branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted the benefits of diversion.

*'Diverting drug offenders into treatment is an effective and less expensive option that offers the best chance of recovery when compared to the expensive option of incarceration, which does little to help the offenders' substance use problems and/or reduce drug use in the wider community. In our opinion, there should be greater utilisation of treatment and rehabilitation programs for offenders with drug-related crime.'*⁴⁶⁸

Best practice for diversionary programs

- 11.339 Best-practice diversion should involve the provision of a wide range of programs with different levels of intervention and access to all offenders irrespective of age, gender, ethnicity or substance used. The program aims, eligibility criteria and procedures should be clearly defined.⁴⁶⁹

11.340 In 1999, the United Nations International Drug Court Control Programme (UNDCP) Expert Working Group outlined best practice principles for diversionary programs.⁴⁷⁰

- a shared understanding of the program philosophy
- defined eligibility criteria
- access for diverse groups of offenders
- participation based on informed consent
- compliance monitoring and review
- case management and social support for participants
- training for program providers
- documented policies and procedures
- partnerships across health and criminal justice
- supporting legislation
- discrete ongoing funding.

11.341 These principles are still recognised as a guide to the development of best-practice diversion programs, however additional principles have been recognised in recent years. One of these is the need for culturally appropriate diversion programs. Jared Sharp, a Churchill Fellow with more than 10 years' experience working for the North Australian Aboriginal Justice Agency, told the Inquiry that culturally appropriate diversionary programs increase effectiveness. In particular, Mr Sharpe stated that successful diversionary programs are run with cultural integrity and recognise the unique backgrounds of the program participants.⁴⁷¹

11.342 Moree Plains Shire Council informed the Inquiry that:

*'Culturally specific programs for those who identify as Aboriginal or Torres Strait Islanders do need the programs to have the cultural sensitivity needed, especially where mental health issues are also impacting on persons. With persons with mental health needs along with ATS use, the issue for worker, community and self-safety will need to be the core of the program.'*⁴⁷²

11.343 Mr Sharp also emphasised the need for culturally appropriate diversion programs for Aboriginal and Torres Strait Islander people, noting that:

*'[G]iven the high number of Aboriginal and Torres Strait Islander people in custody there is a need for greater use of culturally appropriate diversionary programs for Aboriginal young people and adults. As mentioned above, these should be designed and implemented by local Aboriginal communities and Aboriginal community-controlled organisations to ensure cultural safety and effectiveness for program participants.'*⁴⁷³

Outcomes of diversionary programs in Australia

11.344 Drug diversionary programs in Australia are proven to reduce recidivism, reduce the burden on police and courts, increase treatment uptake and improve social outcomes.⁴⁷⁴ They also increase the efficiency and cost-effectiveness of the criminal justice system through reduced re-offending, increased time to re-offending and decreased likelihood of imprisonment.⁴⁷⁵ Diversion is proven to lead to improved outcomes for offenders, through reduced drug use and criminal behaviour, and improved physical health, mental health and relationships with significant others.⁴⁷⁶

- 11.345 The DPMP outlined the benefits of alternatives to arrest for use and possession offences.

*'[O]ur evaluations found drug diversion is a cost-effective response to use and possession that significantly reduces the number of people who are arrested and sent to court for this offence alone and thereby improves a number of outcomes for the individual and reduces substantially the costs borne by the state. Programs like drug diversion are not associated with an increase in drug use or offending.'*⁴⁷⁷

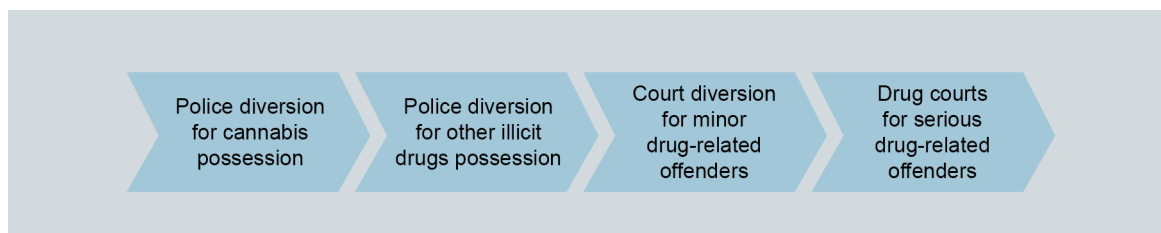
- 11.346 At the request of the Commonwealth Department of Health, Hughes et al. recently conducted the first Australian national evaluation of the reach of Australian drug diversionary programs for use or possess offenders. The analysis drew on Australian Bureau of Statistics data and consultation with police, health and non-government stakeholders from across Australia to 'assess the scale of criminal justice responses to use/possession in Australia between 2010–11 and 2014–15, including the number of people detected, prosecuted and/or sentenced for use/possession, the number of people diverted away from criminal justice proceedings, and the populations that are most and least likely to receive a drug diversion by state/territory and demographic factors'.⁴⁷⁸
- 11.347 Hughes et al. found that over the period 2010–11 to 2014–15, there was a decline in police diversion for the principal offence of possession across Australia, from 59.1% to 51.2%.⁴⁷⁹ The average rate of police diversion in NSW over that time was 46.8%, less than all states and territories except WA and Queensland.⁴⁸⁰ The key barriers to diversion identified in the report were the absence of a full spectrum of programs across all drug types, changes in drug trends and policing of drug offenders (with more detections of methamphetamine and cocaine and fewer for cannabis), narrow eligibility criteria, lack of treatment access and cultural resistance among individual police officers and LACs.⁴⁸¹
- 11.348 One of the challenges in assessing the effectiveness of diversionary programs is the diversity of program design, operation, target group and locations. Nevertheless, recent meta-analysis and systematic reviews over the past decade have strongly substantiated the effectiveness of diversionary programs.⁴⁸²
- 11.349 Although most research on drug diversionary programs points to positive outcomes, research has also found that police fines and cautioning schemes have been associated with net-widening and net-deepening.⁴⁸³ As discussed earlier in this chapter, net-widening refers to increasing the number of people who have contact with the criminal justice system,⁴⁸⁴ and net-deepening refers to increasing the severity of punishment experienced by an individual.⁴⁸⁵
- 11.350 The 2018 *Victorian Parliamentary Inquiry into Drug Law Reform* recommended removing the discretion involved with current Victoria Police drug diversion processes by codifying them.⁴⁸⁶

Types of diversion in Australia

- 11.351 Diversionary programs for drug and drug-related offences are available at different points of a person's journey through the criminal justice system, from pre-arrest diversion by police to pre-trial (bail), pre-sentencing and post-sentencing by the courts, through to custodial diversion programs in correctional centres.⁴⁸⁷ There are five main types of diversion programs in Australia:⁴⁸⁸
1. police diversion for use and possession of cannabis only
 2. police diversion for use and possession of other illicit drugs
 3. police diversion for young people
 4. court diversion for minor drug-related offenders
 5. court diversion for serious drug-related offenders.

11.352 The continuum of drug diversion responses is shown in Figure 11.2.

Figure 11.2: Continuum of drug diversion responses⁴⁸⁹



11.353 A 2007 summary of drug and drug-related diversionary programs in Australia identified 51 programs.⁴⁹⁰ Of these programs, 31% were police diversion, 22% were court diversion, and 18% were drug courts, with 29% having multiple sources of referral (e.g. by police, court or the person charged).⁴⁹¹ Police diversion programs and court diversion programs are discussed in this chapter. Custodial diversion, including the NSW Compulsory Drug Treatment Correctional Centre, is discussed in Chapter 20.

11.354 In 2014–15, 22% of people captured by the Alcohol and Other Drug Treatment National Minimum Data Set who had been diverted from the criminal justice system into drug and alcohol treatment identified amphetamines as their principal drug of concern.⁴⁹² The Inquiry notes it is likely that the proportion of people accessing diversion programs who identify amphetamines as their principal drug of concern is likely to have risen since 2015. For example, in 2017, people who principally used stimulants accounted for 49% of NSW MERIT (Magistrates Early Referral Into Treatment) participants.⁴⁹³

Police diversion (pre-charge)

11.355 As discussed above in the context of decriminalisation, police diversionary programs offer options such as cautions, warnings, fines, case conferences, information and referral to education instead of arrest or charge.⁴⁹⁴ These programs are generally targeted at minor drug offences involving possession or use of small quantities of illicit drugs.⁴⁹⁵ They do not apply to non-drug offences even if they are related to the person's drug use. Some programs allow for police discretion in determining when and to whom the measures are applied within prescribed guidelines.⁴⁹⁶

11.356 The NSW Cannabis Cautioning Scheme and the CIN scheme, both examples of pre-charge diversion by police, have been examined in the discussion of decriminalisation earlier in this chapter.

11.357 Evaluations of cannabis caution schemes in Australia have found they are more cost-effective than traditional responses. While they achieve positive social outcomes for participants, they do not reduce drug use and re-offending. People diverted through a cannabis scheme achieved a similar reduction in their level of offending and drug use compared to the charge group. However, the average cost for cautioned offenders was significantly less at \$388 compared to \$733 for arrested offenders. Diverted offenders had more positive outcomes in terms of their employment prospects and relationships.⁴⁹⁷

Court diversion (post-charge)

11.358 Court diversionary programs range from referral by local or district courts to drug assessment and treatment through to specialist problem-solving courts such as drug courts.⁴⁹⁸ Programs generally involve assessment, case planning and management, referral to services, drug treatment and supervision.⁴⁹⁹ Successful completion may result in the offender avoiding incarceration or receiving a reduced sentence. Court diversionary programs target both minor and more serious drug-related offenders depending on the nature of the program. The MERIT program, for instance, provides the opportunity for adult defendants before NSW Local Courts who are experiencing drug dependence to focus on drug and/or alcohol treatment before they enter their plea, with court matters adjourned while treatment and case management services are provided over a 12-week period.⁵⁰⁰

Drug and problem-solving courts (post-charge)

11.359 Drug courts are a type of 'problem-solving court' that are different to mainstream courts in that they address the issues underlying the legal problem, such as the offenders' health or social needs. Problem-solving courts usually involve judicial case management, a multidisciplinary court team and a collaborative approach with participants. Types of problem-solving courts include adult and juvenile drug courts, family drug treatment courts, domestic violence courts, mental health courts and community courts.⁵⁰¹

11.360 Internationally, the first drug court was established in 1989 in Florida, United States, in response to growing use of crack cocaine and the perceived failure of the traditional court system to deter drug use and offending.⁵⁰² Drug courts now operate in the United States⁵⁰³ as well as in Australia, Canada, the United Kingdom, New Zealand, South Africa, Bermuda and Jamaica.⁵⁰⁴ As of 2018, there were more than 3,100 drug courts across the US.⁵⁰⁵

11.361 Australia's first drug court opened in NSW in 1999, and drug courts now operate in SA, WA, Victoria and, since 2011, as a program of the ACT's Children's Court.⁵⁰⁶

11.362 An extensive evaluation of adult treatment drug court programs in the United States was undertaken in the late 2000s.⁵⁰⁷ This five-year study found participants reported less criminal activity (13%), had fewer re-arrests (10%) and reported less drug use (20%) than comparable offenders. While overall program costs were higher than traditional responses, drug courts saved an average of US\$5,680 to US\$6,208 per offender overall due to reduced recidivism.⁵⁰⁸

11.363 Research shows that drug courts are effective regardless of the offender's drug of choice.⁵⁰⁹ Several studies have found drug courts have a similar impact on reducing recidivism of people who use methamphetamine and people who use other drugs.⁵¹⁰ This finding is significant given the debate about whether people who use methamphetamine are as likely to complete treatment programs and therefore comply with drug court requirements.⁵¹¹ Crystal methamphetamine accounts for about 75% of the illicit drug use seen at the Drug Court of NSW.⁵¹²

Diversionary programs in NSW

11.364 Five adult diversionary programs currently operate in NSW:

- Cannabis Cautioning Scheme
- Magistrates Early Referral into Treatment (MERIT)
- NSW Drug Court
- Circle Sentencing
- Drug Criminal Infringement Notices (Drug CINs) pilot.

11.365 NSW has three main diversionary programs that target young people:

- Youth on Track
- the *Young Offenders Act 1997* (NSW)
- the Youth Koori Court

Diversionary programs that operate in NSW are set out in Table 11.10.

Table 11.10: Diversionary programs in NSW⁵¹³

Name of program	Legal basis	Type of program	Target group	Target drugs
Cannabis Cautioning Scheme^a	<i>De facto</i>	Caution with optional / compulsory referral to telephone education	Adults only	Cannabis
Magistrates Early Referral into Treatment (MERIT)^b	<i>De facto</i>	Treatment program	Adults charged with an offence suspected of using drugs or have a history of drug use. Not necessarily drug dependent	Usually illicit drugs, but alcohol at some courts
Drug Court of NSW^c	<i>De jure</i>	A 12-month program of intensive judicial supervision, treatment, and case management	Adults with a dependence on drugs who have been charged with non-violent offences and who reside in specified areas	All illicit drugs
Circle Sentencing^d	<i>De jure</i>	An alternative sentencing court	Adult Aboriginal offenders found guilty of an offence deal with summarily in the Local Court	All illicit drugs
Drug Criminal Infringement Notices^e	<i>De jure</i>	On-the-spot fine as an alternative to prosecution, issued at the discretion of police	Adults in the vicinity of a music festival	All illicit drugs except cannabis
Youth on Track^f	<i>De facto</i>	One-on-one case management and evidence-informed interventions to address the underlying causes of the young person's involvement in crime	Young people aged 10 to 17 who have a high likelihood of re-offending, and have had at least one contact with police in the form of cautions, conferences or charges and possibly other risk factors for offending	The program is not targeted to drugs specifically, but does not exclude any particular type of drug
<i>Young Offenders Act 1997</i>^g	<i>De jure</i>	Alternative processes to court proceedings, including the use of warnings, cautions and youth justice conferences	Young people aged 10 to 17 who commit certain offences, including the use or possession of small quantities of illicit drugs	The program is not targeted to drugs specifically, but does not exclude any particular type of drug
Youth Koori Court^h	<i>De facto</i>	Culturally based court diversion program involving the deferral of sentencing for 6 to 12 months to enable the young person's needs to be identified and addressed through an 'Action and Support plan'	Young people aged 10 to 17 of Aboriginal and Torres Strait Islander background who have pleaded guilty or been found guilty of a serious criminal offence	The program is not targeted to drugs specifically, but does not exclude any particular type of drug

The MERIT program in the NSW Local Court

- 11.366 The Magistrates Early Referral into Treatment (MERIT) is a voluntary pre-plea diversion program for adult defendants with ‘a *demonstrable illicit drug problem*’.⁵¹⁴ The program enables defendants to engage in drug treatment and rehabilitation as part of the bail process, with the aim of removing or substantially alleviating drug dependence and reducing drug-related crime.⁵¹⁵
- 11.367 MERIT was established in 2000 as a pilot program in the NSW North Coast region after the 1999 Drug Summit.⁵¹⁶ Since then, the program has been progressively expanded and is available in 62 Local Courts in NSW and covers about 80% of charged defendants.⁵¹⁷ The Department of Communities and Justice (DCJ) is the lead agency, with services primarily provided by NSW Health⁵¹⁸ or contracted non-government organisations.
- 11.368 Defendants may only be accepted into the program if they are charged with an offence that is not strictly indictable and they are eligible for bail.⁵¹⁹ If accepted into the program, a MERIT team works with the defendant to develop an individual treatment plan and provide case management over a 12-week period.⁵²⁰ Treatment plans vary but may include detoxification, residential rehabilitation, medication treatment, counselling and case management.⁵²¹
- 11.369 Participants are required to comply with all conditions of bail and the MERIT treatment plan. If they do not comply, participants may be removed from the program and proceed to hearing. Non-compliance does not result in punitive measures or additional penalties for the original offence.⁵²² The magistrate receives regular reports throughout the program, and considers the defendant's treatment progress as part of final sentencing.⁵²³

MERIT barriers and limitations

- 11.370 The Inquiry received evidence about limitations of the MERIT program that focused on three key issues: inadequate funding and resourcing of MERIT, which limits implementation in existing sites;⁵²⁴ inequity of access because MERIT is not available in all Local Courts;⁵²⁵ and that young people are not eligible for the program (discussed from paragraph 11.464).
- 11.371 The Inquiry heard evidence that the MERIT program struggles to meet demand, with some MERIT locations suspending their operation at various times due to resourcing limitations.⁵²⁶ The 2017 MERIT Annual Report indicates that the ability of MERIT teams to meet service demands across the state (as indicated by the average number of days a MERIT service has been suspended) was significantly reduced from 2016 to 2017. In 2017, the state-wide average number of days a MERIT service was suspended was 23, a 53% increase on the 2016 figure of 15 days. The report notes that MERIT teams may suspend taking new referrals due to factors such as sudden staff absences, increases in referrals and increased client complexity levels requiring more intensive case management.⁵²⁷
- 11.372 At the Lismore hearing, Robert Lendrum, Acting Senior Manager for MERIT in the Northern NSW Local Health District and a member of MERIT's Program Advisory Committee, gave evidence of the need for increased staffing levels across the district, and suggested that the majority of MERIT areas were similarly stressed.⁵²⁸
- 11.373 Various submissions and witnesses emphasised the lack of MERIT programs in regional areas.⁵²⁹ Melissa McInnes, Drug and Alcohol Clinical Nurse Consultant, Far West Local Health District, described the difficulty in accessing a case worker in remote locations. ‘*The Wilcannia community is 195km away from Broken Hill. MERIT holds clinic on one day per week, which can limit the client's availability to see the MERIT case worker outside these times.*’⁵³⁰

11.374 MERIT clients often rely on public transport⁵³¹ and witnesses identified that a lack of public transport in rural and remote areas is often a barrier to accessing treatment⁵³² and attending appointments.⁵³³ The Inquiry heard that greater flexibility in program delivery, such as additional staff who could travel and collect clients for appointments, would help to overcome this issue.⁵³⁴

11.375 Another barrier is the inadequacy of residential rehabilitation availability across the state. Ms McInnes noted that there are no local residential rehabilitation facilities in Broken Hill:

*'The closest residential rehabilitation facilities are located in Brewarrina and near Wentworth, which are both more than 200km from Broken Hill and are predominantly only available to Aboriginal males. Female clients and clients who have children and want to take their children with them are harder to get into rehabilitation within a suitable time frame.'*⁵³⁵

11.376 Ruth Power, Nurse Manager, Shoalhaven Drug and Alcohol Service, stated that the waiting period for a MERIT rehabilitation bed can be eight to 10 weeks.⁵³⁶ Ms McInnes, Far West Local Health District, said clients *'give up waiting and sometimes relapse'*. With no local residential rehabilitation facility, some clients agree to travel but would prefer to be close to home.⁵³⁷

11.377 Referrals have exceeded acceptances to MERIT every year of its operation. The number of referrals to MERIT have grown significantly since the program began in 2000, with the highest number of referrals (approximately 4,500) in 2016.⁵³⁸ NSW Health reported to the Inquiry on the temporary suspension of new client referrals, which occurs when MERIT team capacity limits are reached and/or the team does not have the resources to take on new clients. NSW Health reported that temporary suspensions are primarily caused by workforce challenges in the AOD sector in both government and non-government service providers rather than being a MERIT-specific issue. NSW Health also noted other factors can affect service capacity, including increased client complexity requiring more intensive case management, and increases in referral numbers.⁵³⁹

11.378 Witnesses in both the Lismore and Dubbo Hearings supported the idea of reserve MERIT workers who could be deployed to understaffed offices as needed.⁵⁴⁰ Steven Childs, Psychologist and Manager, Drug and Alcohol Service and HIV and Related Programs – Central Coast Local Health District, told the Diversionary Programs Hearing about his team's approach to understaffing.

*'First aspect is, each MERIT team can probably does do things to try not – not suspend. I certainly know, in my own service, is that we will bring in, sometimes, where we can, the resources. So we might get one of the counsellors from our counsellor team to do some of the counselling, when we're really short-staffed, to stop the suspension. So there are some things you can do as part of integrated service that can try and avoid ... suspension.'*⁵⁴¹

11.379 The NSW Police Force provided the Inquiry with information about their funding received for MERIT. Historically, the NSW Police Force received funding as part of the National Illicit Drug Strategy and the National Partnership Agreement between NSW Health and the Commonwealth Department of Health. Since 2016–17, this funding has been through the NSW Police Force base budget,⁵⁴² and has been used to employ a Senior Policy Officer in the Drug and Alcohol Coordination Unit. The functions of this position do not appear specific to the MERIT program but include policy advice, development and delivery of training to NSW Police officers, resource development, stakeholder engagement and NSW Police Force representation on relevant committees.⁵⁴³

11.380 The Inquiry heard evidence that police only account for 6% of referrals to MERIT,⁵⁴⁴ pointing to the need to educate police about the program.⁵⁴⁵ Detective Acting Superintendent Cook told the Inquiry that focus groups with police around the state suggest that the reasons for low referrals include that police believe they are not the appropriate point of referral;⁵⁴⁶ that MERIT is a ‘soft option’ for offenders;⁵⁴⁷ and that the police environment and point-of-arrest conditions are not conducive to making referrals.⁵⁴⁸ It appears to the Inquiry that increased education of police about the MERIT program would be helpful.

MERIT outcomes

11.381 The Inquiry received a range of evidence supporting MERIT and calling for the program to be expanded.⁵⁴⁹ Legal Aid NSW submitted that MERIT is highly effective for several reasons, including that it is much easier for a person of limited means to get a place at a residential rehabilitation through MERIT than by themselves. Also, MERIT’s vetting process means people are more likely to access higher quality treatment.⁵⁵⁰ The Law Society of NSW said it had long supported MERIT as an effective pre-sentence diversionary program.⁵⁵¹

11.382 Detective Acting Superintendent Cook, NSW Police Force, told the Inquiry: ‘*We see positive outcomes coming out of MERIT, and I think it’s the view of the NSW Police that we would like to see the program expanded.*’⁵⁵²

11.383 The Shopfront Youth Legal Centre described MERIT as an effective intervention that often succeeds after other attempts at rehabilitation have failed.⁵⁵³ The Centre stated that because MERIT is available early in criminal proceedings, without the need to enter a plea, it can be an opportune moment for the defendant to address their drug-related problem.⁵⁵⁴

11.384 Evaluations of the MERIT program have found it reduces recidivism and drug use and improves defendants’ health and wellbeing outcomes.⁵⁵⁵ MERIT program participants who complete the program achieve a 12 to 30% decrease in recidivism.⁵⁵⁶ The program is cost-effective, with savings of \$2.98 for every \$1 invested. These savings were attributed to reduced costs of police investigations, hospitalisations, prison and probation-related costs.⁵⁵⁷ The MERIT 2016 Annual Report notes participants had reductions in both the frequency and intensity of all forms of self-reported substance use at program exit compared to program entry.⁵⁵⁸

11.385 There has been a significant increase in MERIT participants reporting ATS as their principal drug of concern, from 18% in 2010 to 52% in 2018. Participants with ATS as their principal drug of concern have a lower completion rate compared to other participants.⁵⁵⁹ In 2018, one-third of participants reporting principal use of ATS did not complete the program due to non-compliance with program conditions, which was greater than all other principal drug types.⁵⁶⁰

11.386 A 2006 study of Aboriginal participation in the MERIT program found Aboriginal defendants were significantly less likely to be accepted into, or successfully complete, the program.⁵⁶¹ In response, NSW Health funded the ‘Improving Aboriginal participation in MERIT’ program, which aimed to improve the cultural appropriateness of the program.⁵⁶² No current data are available about the outcomes of this initiative.

11.387 The 2017 MERIT Annual Report states that women and Aboriginal people and people with ‘*stimulant concerns*’ have lower referral, acceptance and completion rates than other MERIT participants. Consequently, these three groups are identified as key focus populations for the program.⁵⁶³ Details have been provided by NSW Health for the number and location of NSW Health-funded residential rehabilitation beds for women and Aboriginal participants in the MERIT program. See Table 11.11.

- 11.388 Despite being identified as a focus population, the number of MERIT beds for women and Aboriginal people appear to have not increased since 2014, as shown in Table 11.11.

Table 11.11: NSW Health-funded residential rehabilitation beds for women and Aboriginal participants in the MERIT program⁵⁶⁴

	2014–15	2015–16	2016–17	2017–18	2018–19
NSW Health funded residential rehabilitation beds specifically for women participants					
Kamira (Wyong, Central Coast LHD)	2	2	2	2	2
Jarrah House (Little Bay, South East Sydney LHD)	2	2	2	2	2
WHOs New Beginnings (Rozelle, Sydney LHD)	1	1	1	1	1
NSW Health funded residential rehabilitation beds for Aboriginal participants					
Benelong's Haven (Kinchela, Mid North Coast LHD)	4	4	4	4	0
Namatjira Haven (Alstonville, Northern NSW LHD)	2	2	2	2	2
Oolong House (Nowra, Illawarra Shoalhaven LHD)	2	2	2	2	2
The Glen Chittaway Point, Central Coast LHD)	2	2	2	2	2
Weigelli Centre (Woodstock, Western NSW LHD)	1	1	1	1	1

Note: Benelong's Haven was located in the Mid North Coast Local Health District prior to closing in June 2018;⁵⁶⁵ the four funded beds were equally redistributed to The Salvation Army Dooralong Transformation Centre in the Central Coast Local Health District and Adele House in the Mid North Coast Local Health District.

Improving MERIT

- 11.389 MERIT has a great deal of support from a broad range of stakeholders in the community. The Inquiry received numerous submissions praising the program and advocating for its expansion.⁵⁶⁶
- 11.390 A number of witnesses and submissions suggested that the nature of ATS use, withdrawal and treatment warrants consideration of a program that is longer than 12 weeks. Ms McInnes, Far West Local Health District, noted that because of the prolonged withdrawal phase of ATS, three months was not long enough for clients to get the benefit or support from the program's counselling. She suggested that six months would be more useful.⁵⁶⁷ Ms McInnes also noted that resources are needed for a short-stay facility for people who use ATS to have a 24-hour supported care during the initial withdrawal stage and for the following weeks. She suggested MERIT could be improved by resourcing face-to-face access to an addiction medicine specialist for client assessment and review.⁵⁶⁸
- 11.391 Currently, MERIT is not available in 76 courts in NSW, mostly in regional areas.⁵⁶⁹ The Inquiry heard evidence that MERIT should be expanded to all defendants regardless of their location.⁵⁷⁰ The ALS submitted that MERIT should be expanded to all regional courts: *The current patchy provision of service means that the most isolated and disadvantaged Aboriginal people in places such as Walgett and Tumut are unable to access this basic service.*⁵⁷¹

11.392 The NSW Government submitted to the Inquiry that increasing capacity of the MERIT program to extend coverage and expanding access to young people would enhance the impact of the program.⁵⁷² Expansion of access to young people is discussed below from paragraph 11.464.

11.393 The Inquiry also received evidence that access to MERIT should be expanded to offenders whose primary drug of concern is alcohol.⁵⁷³ Lismore City Council, quoting a solicitor from the Aboriginal Legal Service, submitted:

*'Many of our Aboriginal clients have grown up in communities where alcohol use disorder and violence sadly go hand in hand. Our clients are not given the opportunity to do the MERIT program because their substance use disorder involves alcohol. This is a great shame given MERIT can assist them not only to rehabilitate but to engage in courses to address violent behaviours and forge a new path in life. The gap in this service means many reoffend and end up in custody and the cycle continues.'*⁵⁷⁴

11.394 Robert Lendrum, Senior Manager, MERIT, Northern NSW Local Health District, noted that more resources are required to *'maintain and deliver against quality standards set and achieve positive treatment outcomes of the client'*.⁵⁷⁵

11.395 The Inquiry received evidence about ways to strengthen local implementation at existing sites. One suggestion was to increase residential rehabilitation accessibility, with closer, easier and quicker access for MERIT clients. Ms McInnes, Far West Local Health District, noted that MERIT-allocated beds that are available in some rehabilitation facilities are not always available for MERIT clients and that there should be a focus on increasing residential rehabilitation accessibility.⁵⁷⁶

11.396 This was also supported by the 2017 *NSW Parliamentary inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales*, which recommended that the NSW Government conduct a review of the MERIT program, including the feasibility of establishing MERIT in additional regional areas.⁵⁷⁷ According to DCJ, sites already identified as possible expansion locations by the Ministry of Health are Taree, Moree, Bourke, Albury, Batemans Bay, Windsor and Goulburn.⁵⁷⁸

11.397 The NSW DCJ reported to the Inquiry the Government had not committed funds to expand the program,⁵⁷⁹ and that the MERIT program requires rehabilitation infrastructure to provide the wraparound support system, which is the reason MERIT is not provided in all court locations.⁵⁸⁰ Given this, special attention needs to be given to the issue of the adequacy of resourcing and funding not only for the MERIT program, but also for wraparound support services.

11.398 The Inquiry is deeply concerned in finding that, despite its proven success, insufficient funding causes the MERIT program to be suspended from time to time in various locations. This, together with the fact that the program is not available in more locations, including in some areas of disadvantage that would benefit from access to MERIT, creates inequities of access to this important diversionary opportunity.

Recommendation 13:

That the NSW Government adequately resource the MERIT program to ensure access for all eligible defendants across NSW.

Drug courts

- 11.399 Drug court programs commonly involve a six to 24-month regime of drug treatment, compliance monitoring (including drug testing), case management and rehabilitation programs.⁵⁸¹ Although there is no single drug court model,⁵⁸² there are key features, guiding principles and standards that guide best practice:⁵⁸³
1. Alcohol and other drug treatment is integrated into case processing
 2. A non-adversarial approach that promotes public safety while protecting participants' due process rights
 3. Timely identification and program entry for eligible participants
 4. Access to a continuum of alcohol, drug and other related treatment and rehabilitation services
 5. Frequent drug testing
 6. Codified guidelines on court responses to participants' compliance and non-compliance
 7. Ongoing judicial supervision and interaction with participants
 8. Regular monitoring and evaluation of program goals and effectiveness
 9. Ongoing interdisciplinary education for drug court leaders and managers
 10. Partnerships between drug courts, public agencies and community-based organisations.⁵⁸⁴
- 11.400 These components are reflected to varying degrees in contemporary drug courts,⁵⁸⁵ including Australian drug courts.⁵⁸⁶
- 11.401 As drug courts for adult offenders have become more established and accepted, other types of problem-solving courts for drug offenders have developed. These include juvenile drug courts targeting young people who use illicit drugs and alcohol and Family Drug Treatment Courts for people with children in out-of-home care primarily due to parental substance use concerns (discussed further in Chapter 18).
- 11.402 A large number of robust international and national studies on drug court outcomes have been published in the past 15 years.⁵⁸⁷ Studies have found that drug courts reduce recidivism by 8 to 14%,⁵⁸⁸ with the best-performing courts achieving reductions of between 35 and 80 per cent.⁵⁸⁹ Drug courts are also cost-effective, with average returns on investment of USD \$2 to \$4 for every USD \$1 invested.⁵⁹⁰ These cost-savings are greater when wider health and socioeconomic benefits are taken into consideration.⁵⁹¹

The Drug Court of NSW

- 11.403 The Drug Court of NSW (NSW Drug Court) is a collaborative program between the DCJ agencies and NSW Health, established in 1999 to deal with non-violent criminal matters committed by offenders who are dependent on drugs.⁵⁹² It aims to address underlying drug dependence that has resulted in criminal offending.⁵⁹³ The court sits in Parramatta, Toronto and Sydney.⁵⁹⁴
- 11.404 Non-government residential rehabilitation services also provide treatment for NSW Drug Court participants. There is no specific funding for the NSW Drug Court; it is funded by Treasury as part of the Courts.⁵⁹⁵ The supporting services provided by NSW Health and non-government organisations are funded separately.⁵⁹⁶
- 11.405 To be eligible for the NSW Drug Court, offenders must be aged 18 or over, highly likely to be sentenced to full-time imprisonment, live within specified areas⁵⁹⁷ and be dependent on illicit drugs. Violent or sex offenders are ineligible for the program.⁵⁹⁸ Participation in the program is voluntary. Once an offender is accepted into the program, they are provided with intensive judicial supervision, treatment and individual case management over 12 months.⁵⁹⁹

- 11.406 Participants must regularly appear before the court, travel to pharmacotherapy sessions and attend educational facilities and programs to address offence-related issues. Participants receive rewards and sanctions depending on whether they comply with the requirements.⁶⁰⁰ At the end of the program, participants who have substantially complied with the program may have their initial sentence reconsidered by the court and instead receive a non-custodial sentence. A participant who does not complete the program will not have their initial sentence increased for non-completion.⁶⁰¹
- 11.407 The Senior Judge of the NSW Drug Court, Judge Roger Dive, described the program as *'well entrenched within the criminal justice system and the treatment community'*.⁶⁰² His Honour described how the NSW Drug Court works:

*'A common scenario is for a participant to begin their program at residential rehabilitation, which is partly funded by the Drug Court program. We then work closely with the rehabs, and in fact having the backing of the Drug Court is very effective at the rehab end – so it is a symbiotic relationship. After a period in rehab, the participant may then be able to move back to be with family and return to work, now trustworthy enough to be allowed into the house, or to be with children.'*⁶⁰³

Outcomes of the Drug Court of NSW

- 11.408 BOCSAR has evaluated the NSW Drug Court on a number of occasions.⁶⁰⁴ These evaluations found the NSW Drug Court reduced the risk of recidivism among drug-related offenders and was more cost-effective than prison.⁶⁰⁵ The 2008 evaluation found large differences in outcomes between program completers and non-completers. This is significant given more than half (56%) of those in the program did not complete it at the time of the study.⁶⁰⁶ The 2008 evaluation also recommended expanding its reach given its apparent success.⁶⁰⁷
- 11.409 A 2008 evaluation by Stephen Goodall et al concluded that the NSW Drug Court is cheaper and produces better outcomes than the alternative, leading to significant reductions and delay in recidivism and saving 'considerable resource use as a result of reduced incarceration'.⁶⁰⁸
- 11.410 All NSW Drug Court participants (completers and non-completers) were 17% less likely to be re-convicted for any offence and 37% less likely to be re-convicted for a drug offence compared to a comparison group.⁶⁰⁹ These outcomes improved significantly for Drug Court completers, who were 37% less likely to be re-convicted for any offence and 58% less likely to be re-convicted for a drug offence compared to a comparison group. The cost assessment found the NSW Drug Court produced a net saving of \$1.758 million per annum when considering the costs saved from the reduction in future re-offending.⁶¹⁰
- 11.411 Although these evaluations indicate that the effectiveness of the court was limited by the number of participants who did not complete the program, court outcomes have improved significantly in recent years. Data from 2013 to 2017 show a sustained improvement in terms of sentenced program completers and graduates, along with the number of graduates not required to be returned to custody at the end of their program.⁶¹¹ In 2017, 96% of participants completed the program (up from 74% in 2013) and 29% fully graduated from the program (compared to 10% in 2013).⁶¹²
- 11.412 It is pertinent to note that the success of the NSW Drug Court is consistent with interstate experience. A 2014 evaluation of the Drug Court of Victoria found it was more cost-effective than imprisonment. The reduction in the frequency and severity of offending achieved by the Drug Court cohort was estimated to have resulted in 4,492 fewer days of imprisonment (6,125 versus 10,617) over two years, at a reduced cost of more than \$1.2 million.⁶¹³

Barriers to the Drug Court of NSW

11.413 For many years, demand for the NSW Drug Court program has outstripped supply, with more eligible applicants than available program places.⁶¹⁴ A weekly random ballot is held to determine program entry. In 2017, almost one-quarter of eligible offenders placed in the Parramatta drug court ballot were unsuccessful in securing a place on the program.⁶¹⁵ The increasing demand for the NSW Drug Court has been in part attributed to the increasing number of people who use ATS before the courts.⁶¹⁶

11.414 Judge Dive noted the lack of program capacity leads to an inequity of sentencing outcomes, where people who are unsuccessful in securing a place on the program are sentenced to a jail term, while others who are charged with a similar offence have the opportunity to receive treatment and support.⁶¹⁷

*'At the moment many residents in Sydney can be excluded from a Drug Court opportunity, and will therefore go to jail on a full-time basis, because they live on the wrong side of the street (and therefore live in a Local Government Area which is not within the catchment of the Drug Court). Others are denied an opportunity simply through a lack of places on the program, and being referred to the program on an unfortunately busy week.'*⁶¹⁸

11.415 The Office of the Director of Public Prosecutions (ODPP), which provides staff for the team that manages the NSW Drug Court, noted that although the data strongly suggest that drug courts help participants achieve sustained recovery from dependent drug use, the eligibility criteria and the geographical location of the courts provide an enormous barrier to accessing the Drug Court.⁶¹⁹

11.416 For example, an applicant needs to show, among other criteria, that their usual place of residence is in one of a limited number of Local Government Areas and the court referring that person needs to be in one of a limited number of specified Local and District Courts.⁶²⁰

11.417 The ODPP submitted:

*'In addition, even if an applicant is successful in satisfying these threshold matters, the limited number of places available at each of the three Drug Court venues means that otherwise-eligible participants will be routinely rejected when they are not successful in a random ballot for the few places available ... This creates a significant degree of inequity and means that a person who lives at the "right" address may be given the opportunity to remain out of custody and have assistance in getting their life "on track" – whilst one who does not will simply go to gaol.'*⁶²¹

Expanding access and improving funding for the Drug Court

11.418 The Inquiry received numerous submissions calling for the expansion of the Drug Court of NSW, including from the ALS,⁶²² Legal Aid NSW,⁶²³ the ODPP,⁶²⁴ the Shopfront Youth Legal Centre,⁶²⁵ the NSW branch of the Royal Australian and New Zealand College of Psychiatrists,⁶²⁶ the Law Society of NSW⁶²⁷ and the Public Defenders.⁶²⁸

11.419 The Inquiry notes that the authors of the 2008 NSW Drug Court evaluation supported the need to consider expanding the Drug Court given its apparent success.⁶²⁹

- 11.420 Judge Dive called for the Drug Court to be expanded to cover all of the Sydney metropolitan area, Illawarra, Dubbo, the Central Coast, Northern Rivers and Lismore as priorities.⁶³⁰ He recommended the expansion should take into account the ability to provide the services required, such as counsellors, psychiatric services and medication treatment.⁶³¹
- 11.421 The 2017 *NSW Parliamentary inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales* recorded widespread community support for the NSW Drug Court. It recommended that the NSW Government conduct a review of the Drug Court, including the feasibility of establishing it in additional regional areas, along with piloting a Drug Court in Dubbo in parallel with an increase in rehabilitation services for the area.⁶³²
- 11.422 The NSW Government has recognised the role of court diversionary programs in reducing drug and alcohol harms.⁶³³ It supported the recommendation in principle, stating it would consider expansion of the Drug Court to regional areas, including Dubbo, and noting that any expansion of the Drug Court would require a commensurate increase in treatment services.⁶³⁴
- 11.423 Detective Acting Superintendent Cook, NSW Police Force, stated:
- 'Reviews of the success of the drug courts have shown that they are effective in reducing the amount of re-offending. Anything that reduces re-offending would be strongly supported by the New South Wales Police.'*⁶³⁵
- 11.424 Dr Weatherburn, University of Sydney Law School, noted that one of the difficulties in expanding the reach of the NSW Drug Court to regional areas is the uneven distribution of the resources required for it to operate effectively.⁶³⁶ Research evidence cautions that drug courts cannot operate effectively in isolation; they must be part of an integrative approach to reducing drug and alcohol use and reducing crime.⁶³⁷
- 11.425 The Inquiry is satisfied that there is ample evidence to support a recommendation for the expansion of the NSW Drug Court and for a commensurate increase in funding necessary to support its operation. The Inquiry is particularly concerned at the significant inequity of access to the Drug Court across most of NSW, which creates unfairness and unequal justice, determined by postcode and ballot.

Recommendation 14:

That the NSW Government expand and adequately resource the Drug Court of NSW to meet demand at existing locations and to progressively expand the Court to priority regional areas, together with appropriate support for local services.

Compulsory Drug Treatment Correctional Centre

- 11.426 The Compulsory Drug Treatment Correctional Centre (CDTCC) is a therapeutic community facility that houses participants who have been sentenced to a compulsory drug treatment order by the NSW Drug Court. The CDTCC program is a five-stage program⁶³⁸ that has four eligibility and suitability criteria for admission.⁶³⁹ Currently, there is one location operating at Parklea, with the CDTCC only available to male offenders.⁶⁴⁰

- 11.427 Although the program started in 2006 and was intended to be extended to female inmates after two years of successful performance,⁶⁴¹ this is yet to occur. Linda Smith, Director of the CDTCC, told the Inquiry that offering this program to women would be the next step for the CDTCC and that there has been some lobbying in relation to a female equivalent of the program.⁶⁴²
- 11.428 The ODPP submitted the CDTCC had some '*impressive successes*' and supported expanding the CDTCC to women and to offenders who did not qualify due to residence requirements '*[i]n the interests of the equitable administration of justice in this state*'.⁶⁴³ The ODPP also supported education for lawyers and judicial officers about the opportunity of referring appropriate convicted offenders for assessment for the CDTCC, as well as an overall increase in the number of available places in the program.⁶⁴⁴
- 11.429 BOCSAR evaluated the CDTCC in 2012, and the Inquiry understands that a further evaluation by Dr Sharon Casey was being finalised during the Inquiry.⁶⁴⁵

Recommendation 15:

That further to the expansion of the Drug Court of NSW, Corrective Services NSW be resourced to expand the operation and availability of the Compulsory Drug Treatment Correctional Centre, including to make it available to women and in additional locations.

Circle Sentencing Program

- 11.430 The NSW Circle Sentencing Program is an alternative sentencing court for adult Aboriginal offenders who are found guilty of an offence dealt with summarily in the Local Court. Offenders facing serious indictable charges such as murder or sexual assault are ineligible. The Local Court refers offenders to the program. The offender must enter into an agreement to participate in the program.
- 11.431 A Circle Sentencing Group meets to determine an appropriate plan for the treatment or rehabilitation of a referred offender, provide support to the offender in completing the intervention plan, and a recommended sentence. The Circle Sentencing group includes at least three respected Aboriginal community members, the local magistrate, the prosecutor, the offender's legal representative, the offender and a program officer. The victim and other support people may also participate.⁶⁴⁶ The program is active in Bourke, Dubbo, Kempsey, Mt Druitt, Nambucca Valley, Nowra, Lismore and Walgett.⁶⁴⁷
- 11.432 The Inquiry notes there is widespread support for Circle Sentencing, which is often discussed in the context of diversionary programs. However, the Inquiry considers that the program does not fall within its Terms of Reference.

Youth diversion in NSW

- 11.433 Adolescent years are a crucial period in relation to the development of substance use behaviours.⁶⁴⁸ The availability of youth diversionary programs to intervene early and prevent young offenders from becoming entrenched in the juvenile justice system is desirable.⁶⁴⁹
- 11.434 Research has found that, despite poor retention of young people who had been diverted to drug treatment, those who stay in treatment have much better outcomes in relation to their drug use, offending risk factors and social functioning.⁶⁵⁰

- 11.435 NSW has three main diversionary programs that target young people: Youth on Track; diversion via the *Young Offenders Act 1997* (NSW); and the Youth Koori Court (which is discussed in Chapter 16). The former Youth Drug and Alcohol Court was closed in 2012.
- 11.436 In 2017–18, half of all juvenile offenders (50.4%) were diverted in NSW.⁶⁵¹ Data are not available on how many young people were diverted for ATS-related offences.
- 11.437 There were significant differences in the proportion of Aboriginal and Torres Strait Islander young people diverted compared to non-Aboriginal and Torres Strait Islander young people. Less than one-quarter (23.8%) of Aboriginal and Torres Strait Islander young offenders were diverted in 2017–18, compared to 58.7% of non-Aboriginal and Torres Strait Islander young offenders who were diverted in the same period.⁶⁵²
- 11.438 The Productivity Commission cautions that care needs to be taken in interpreting the data due to reporting issues associated with the identification of Indigenous status.⁶⁵³ However, as discussed in Chapter 16, research shows Aboriginal people are less likely to be diverted than non-Aboriginal people despite higher rates of contact with the criminal justice system.⁶⁵⁴
- 11.439 At a public hearing and a roundtable into Youth Diversionary Programs, the Inquiry examined programs in NSW that divert young offenders with a history of ATS use and/or related offending from the criminal justice system.
- 11.440 The Inquiry received submissions supporting the need to expand diversionary programs for young people.⁶⁵⁵ The ALS commented on the lack of local youth diversionary programs in regional, rural and remote areas of NSW, noting that many young people have to travel outside of their communities, away from the support of families and networks to access programs.⁶⁵⁶
- 11.441 The Law Society of NSW stated that diversion options for young people are limited and there is a gap in pre-sentence programs that focus on treating drug and alcohol issues.⁶⁵⁷ The Royal Australasian and New Zealand College of Psychiatrists (RANZCP) argued for the police and courts to continue making use of the range of diversionary powers available to them to reduce young offenders' adverse contact with the juvenile justice system.⁶⁵⁸
- 11.442 The Children's Court of NSW stated that diversion from the court system is an effective way to deal with relatively minor infringements of the law as most young offenders do not engage in criminal behaviour after adolescence.⁶⁵⁹ Conversely, interactions with the court system may increase the likelihood of a young person re-offending, particularly where a young person is detained, either on remand or following sentence.⁶⁶⁰

Youth on Track

- 11.443 The NSW Government introduced the Youth on Track program in 2013-14 in response to a gap in diversionary responses for young people at risk of long-term involvement in the criminal justice system.⁶⁶¹ The program targets young people aged 10 to 17 who have a high likelihood of re-offending, with at least one contact with police in the form of cautions, conferences or charges and possibly other risk factors for offending behaviour,⁶⁶² such as substance use. NSW Police or the Department of Education can refer a young person to the program without requiring a court order, but their participation is voluntary.

- 11.444 DCJ funds non-government organisations to provide coordinated one-on-one case management and evidence-informed interventions to address the underlying causes of the young person's involvement in crime. Providers work with the young person on their behaviour and attitudes, school engagement, alcohol and other drug issues, social network and family support. The scheme operates at seven sites: Blacktown, Hunter, Mid North Coast, Central West, Coffs Harbour, New England and Riverina.⁶⁶³

Outcomes and improvements

- 11.445 Initial evaluation outcomes from the scheme are positive. Monitoring shows that more than two-thirds (72%) of participants reduced or stabilised their contact with police after involvement with Youth on Track.⁶⁶⁴ BOCSAR is conducting a randomised controlled trial to assess re-offending, which is due to finish in 2020. The NSW Government has stated that the study results will inform funding decisions regarding future state-wide expansion.⁶⁶⁵
- 11.446 Legal Aid NSW submitted that Youth on Track should be expanded as it had achieved '*amazing results*' for at-risk young people. The submission highlighted the program's success in Coffs Harbour and Grafton, which are areas that have high rates of arrests of young people.⁶⁶⁶ Similarly, the ALS noted that Aboriginal communities had identified Youth on Track as operating effectively.⁶⁶⁷
- 11.447 The *Legislative Assembly Committee on Law and Safety Inquiry into the adequacy of youth diversionary programs in NSW* recommended that the NSW Government should expand Youth on Track so that it is available across NSW, subject to the results of the forthcoming BOCSAR evaluation in 2020.⁶⁶⁸ The Committee also found DCJ should consider additional referral pathways for Youth on Track.⁶⁶⁹ The NSW Government did not specifically address the Inquiry's recommendations in its response.
- 11.448 This Inquiry heard how Youth on Track could be improved. Nada Nasser, State Director NSW/ACT/VIC, Mission Australia, said there is a case for Youth on Track to be used as an early intervention option, long before a young person has contact with the criminal justice system, such as a program to identify risk in schools.⁶⁷⁰ She said the program must also sit within an holistic system and ensure follow-up in that system.⁶⁷¹
- 'Youth on Track, as a program, needs to sit within a system where we have got really good mental health support, we've got access to affordable housing, where we have got good legal advice for young people, where there's, you know, a whole range of community networks and support around young people. You know, otherwise – a Youth on Track program won't work without that system around it.'*⁶⁷²
- 11.449 Karly Warner, CEO, ALS, noted that solicitors often identify young people who would benefit greatly from Youth on Track but are not able to refer to the program. She also emphasised the need for culturally appropriate programs that are designed and delivered by Aboriginal community-controlled organisations.⁶⁷³

Young Offenders Act 1997

- 11.450 The *Young Offenders Act 1997 (NSW)* (the Act) is the main youth diversion mechanism in NSW. The Act establishes a scheme that provides an alternative process to court proceedings for dealing with children aged between 10 and 17 who commit certain offences, including the use or possession of small quantities of illicit drugs.⁶⁷⁴ Alternative processes are generally discretionary and non-therapeutic and include the use of warnings, cautions and youth justice conferences.⁶⁷⁵ Court is the last resort.

- 11.451 Warnings may be given for a summary offence covered by the Act, other than a graffiti offence or other offences prescribed by the regulations. A child is not entitled to a warning if the circumstances of the offence involve violence or if it is more appropriate to deal with the offence by another means in the interests of justice. The investigating official must explain the purpose, nature and effect of the warning to the young person. No conditions or additional sanctions can be imposed.⁶⁷⁶
- 11.452 Police, specialist youth officers authorised by the Commissioner of the NSW Police Force, and the courts may issue cautions for offences covered under the Act other than offences prescribed by the regulations; but only a court may issue a caution for a graffiti offence. Respected members of the community may also give the caution at the request of a police or specialist youth officer if considered appropriate. The child must admit to the offence and consent to the caution. A child is not entitled to be dealt with by caution in relation to an offence if the child has been dealt with by caution on three or more occasions.⁶⁷⁷
- 11.453 As with warnings, a child is not entitled to be issued a caution if it is more appropriate to use another means in the interests of justice. In determining whether it is appropriate to deal with the matter by issuing a caution, police must consider the seriousness of the offence, the degree of violence involved, the harm caused to any victim, the number and nature of any offences committed by the child and any other appropriate matters.⁶⁷⁸
- 11.454 A person, when issuing the caution, must give the child prior written notice outlining the offence, the purpose, nature and effect of the caution, when the caution will be given, consequences of failing to attend the giving of the caution, and their rights. A caution notice is then given and signed by the child after the caution is issued.⁶⁷⁹
- 11.455 Youth Justice Conferences can be initiated by police or the courts when a child has admitted to an eligible offence that is too serious for a warning or caution, or, they have exceeded the maximum number of cautions available to them. These conferences bring young offenders and their families face-to-face with victims, their supporters and police to discuss the crime and its effects on people. Participants agree on an outcome plan that can include an apology, reasonable reparation to victims, education or counselling. If the plan is completed, no further criminal action is taken.⁶⁸⁰

Outcomes and improvements

- 11.456 Evaluations of the *Young Offenders Act 1997* (NSW) report varied results. A 2012 BOCSAR study found Youth Justice Conferences under the Act were no more effective than the NSW Children's Court in reducing juvenile recidivism.⁶⁸¹ However, another study suggested the Act had been effective in diverting young people from custody, including Aboriginal and Torres Strait Islander young people, reducing the likelihood of entering custody, and increasing the time taken to receive a custodial order after the first proven court appearance.⁶⁸²
- 11.457 Legal Aid NSW submitted it would prefer a stronger focus on diversion and rehabilitation for young people charged with drug offences, including removing or winding back the exclusions for serious drug offences under the Act.⁶⁸³

11.458 The *Legislative Assembly Committee on Law and Safety Inquiry into the adequacy of youth diversionary programs in NSW* made several recommendations in relation to the Act.⁶⁸⁴ These include reviewing:

- the number of cautions that Police and Courts can give under the Act
- whether a young person should be required to give an admission of guilt before they can be dealt with by caution or youth justice conference
- whether offences covered by the Act remain appropriate or additional offences should be included.

11.459 That Inquiry also recommended that:⁶⁸⁵

- the NSW Police Force change policies and procedures regarding electronically recorded interviews
- training is provided for the NSW Police Force and magistrates about the diversionary options available under the Act
- Youth Justice (formerly Juvenile Justice NSW) ensure fully trained Youth Justice Conference convenors are available in every area of the state.

11.460 In its response to the Committee's report, the NSW Government committed to reviewing the Act in line with the Inquiry's recommendations.⁶⁸⁶ The NSW Government also noted that Youth Justice had subsequently completed significant work to enhance the operation of Youth Justice Conferences, including a bulk recruitment of convenors and development of a convenor training and assessment package.⁶⁸⁷

11.461 The RANZCP submitted that police across all LACs need to apply diversionary powers consistently to ensure young offenders are treated in an equitable and non-discriminatory manner.⁶⁸⁸

11.462 At the Youth Diversion Roundtable, Jacki Maxton, Senior Solicitor, Shopfront Youth Legal Centre, said there was a rationale to include offences of drug supply when considering eligibility for the Young Offenders Act.

*'[C]urrently ... the Act doesn't cover supply and that this means that there – again, you've got young people missing out and that, perhaps, it would be a simple amendment, to expand it, so that they can get the benefits of the Young Offenders Act.'*⁶⁸⁹

11.463 Judge Peter Johnstone, President of the Children's Court of NSW, noted the need for greater use of community members such as respected Elders in issuing warnings and cautions in relation to the Act. He said there is a provision in the current legislation that is not used very much.⁶⁹⁰

MERIT for young offenders

11.464 The 2015 Young People in Custody Health Survey found that 91.2% of young people surveyed in detention in NSW reported having used an illicit substance in the 12 months before entering custody.⁶⁹¹

11.465 As noted earlier, MERIT is a voluntary pre-plea diversion program for adult defendants with substance abuse problems.⁶⁹² While not currently available to people under the age of 18 years, the Inquiry received submissions from a number of sources, including the NSW Government,⁶⁹³ that expanding the MERIT program to young people would enhance its impact.

- 11.466 The Shopfront Youth Legal Centre,⁶⁹⁴ Law Society of NSW⁶⁹⁵ and Legal Aid NSW⁶⁹⁶ submitted to the Inquiry that MERIT was an effective program and consideration should be given to expanding coverage to young people in the Children's Court to support them to address their drug issues. Judge Johnstone, Children's Court of NSW, expressed strong support for the expansion of the MERIT to the Children's Court.⁶⁹⁷
- 11.467 The Inquiry heard that one of the great benefits of MERIT for young people is that it is a pre-plea program, providing immediate assistance to young people rather than waiting for months before a plea is entered.⁶⁹⁸
- 11.468 The Law Society of NSW noted the gap in the provision to young people of pre-sentence programs such as MERIT that focus on treating drug and alcohol issues.⁶⁹⁹ It stated that MERIT is an effective pre-sentencing program that often sets young adults with complex issues on a path to recovery, and that it may provide an opportunity to address underlying issues such as trauma or mental health problems.⁷⁰⁰
- 11.469 The Inquiry received evidence of the need to adapt MERIT to the needs of young offenders, for example, some children may need more than 12 weeks with a case worker.⁷⁰¹ The Law Society of NSW stated that the program could link young people to community programs and refer them to appropriate services at the completion of MERIT that could provide long-term care.⁷⁰² The Inquiry heard that another way to customise MERIT for young people would be to broaden services to incorporate assistance with education and housing.⁷⁰³

Recommendation 16:

That the NSW Government appropriately adapt and resource the MERIT program for young people and make it available across NSW.

Youth Drug and Alcohol Court

- 11.470 The NSW Youth Drug and Alcohol Court (YDAC) was established as a pilot program in 2000⁷⁰⁴ and closed by the NSW Government in 2012. The YDAC program aimed to reduce offending and drug use among young people aged between 14 and 18 years who had an alcohol or other drug problem and who were ineligible for a caution or Youth Justice Conference. To be eligible, young people were required to plead guilty or be found guilty of the offence and live within the YDAC jurisdiction.⁷⁰⁵
- 11.471 Juvenile Justice conducted an initial screen to confirm a substance use problem and to assess the young person's immediate needs for a possible bail hearing and development of a potential program plan. YDAC participants had their matter adjourned for six months under a 'Griffith remand'⁷⁰⁶ while they completed their individual program plan.⁷⁰⁷
- 11.472 YDAC participants received intensive case management from a YDAC Juvenile Justice case manager, with support from an allocated non-government organisation Support Worker and Justice Health Registered Nurse. YDAC participants also had access to a six-bed residential induction unit to assist in detoxification.
- 11.473 Paul McKnight, Executive Director, Policy and Reform (former) Department of Justice, told the *Legislative Assembly Committee on Law and Safety Inquiry into the adequacy of youth diversionary programs in NSW* that the YDAC was disbanded because it was not considered cost-effective. The NSW Government has previously stated that internal reviews of the Court did not demonstrate sufficiently positive outcomes in reducing re-offending to justify its continued operation.⁷⁰⁸

11.474 The Inquiry received submissions from numerous stakeholders calling for the former YDAC to be re-instated. For example, RANZCP suggested the expansion of specialist courts, such as YDAC.⁷⁰⁹ The Children's Court of NSW,⁷¹⁰ Law Society of NSW⁷¹¹ and Legal Aid NSW⁷¹² also supported the re-implementation of an alternative model, such as the former YDAC. However, they recommended it should be a post-sentencing court like the adult drug court.

11.475 The Inquiry also heard there were reasons not to reinstate the YDAC. Ron Frankham, Solicitor in Charge, Children's Legal Service, Legal Aid NSW, noted that the YDAC's lack of indicative sentences was a drawback for many young people, and some participants felt they were punished for not finishing the program.⁷¹³

*'[T]here were examples of many young people who were charged with very similar offences with very similar backgrounds, young people that were dealt with in the regular court being given lesser sentences than those that went through the Drug Court program but failed to graduate.'*⁷¹⁴

11.476 Judge Johnstone noted that an extended MERIT program for young people would help address the need for more rehabilitation beds for young people.⁷¹⁵ Ms Maxton, The Shopfront Youth Legal Centre, stated that funding would be better used providing beds via an extended MERIT program than for a model resembling the YDAC.⁷¹⁶

Youth drug and alcohol rehabilitation services

11.477 The *Legislative Assembly Committee on Law and Safety Inquiry into the adequacy of youth diversionary programs in NSW* also received a number of calls for the YDAC to be reinstated but noted that a YDAC would be of limited use if there was a lack of adolescent AOD services in the community.⁷¹⁷ It considered that rather than reinstating the YDAC, finite resources should be applied to increasing the number of adolescent AOD services across the state.⁷¹⁸

11.478 The Inquiry also heard of the need for youth-specific AOD rehabilitation services. Andrew Johnson, NSW Advocate for Children and Young People, said a lot of AOD facilities or mental health facilities, particularly in regional NSW, are not set up for young people and may be turning young people away.⁷¹⁹

Transitional accommodation for young people leaving Juvenile Justice

11.479 The Inquiry received evidence from several witnesses regarding the challenges for young people released from juvenile justice without access to stable and secure housing after release. Ms Nasser, Mission Australia, told the Inquiry young people need safe housing to be able to address alcohol and drugs issues.⁷²⁰

11.480 Jamie Duggan, Case Worker at Cobham Youth Justice Centre, gave evidence to the Inquiry that drugs and alcohol are the biggest challenge to young people who lack stable accommodation. This is in part due to returning to a family environment of drug and alcohol use, a lack of community-based supports and difficulties transitioning from a structured custodial setting to an unstructured environment.⁷²¹ Ms Duggan noted that it can be difficult to get young people accepted in youth refuges, particularly for clients with drug and alcohol issues and/or mental health issues.⁷²² She emphasised the need for low or no barrier transitional housing that combines case work and support with accommodation.⁷²³

11.481 The Inquiry heard about the Ryde Project, which is being trialled in NSW schools and identifies young people at risk of homelessness,⁷²⁴ and examples of specialist homelessness services for young people with AOD and complex mental health issues.⁷²⁵

Legislative Assembly Committee on Law and Safety Inquiry into the adequacy of youth diversionary programs in NSW and NSW Government Response

11.482 As noted above, in September 2017, the Legislative Assembly Committee on Law and Safety established an *Inquiry into the adequacy of youth diversionary programs in NSW* to deter juvenile offenders from long-term involvement with the criminal justice system (Youth Diversion Inquiry).

11.483 The Youth Diversion Inquiry considered all offences, not only drug and drug-related offending. The Committee's final report was published in September 2018. The Committee considered diversionary options at every stage of a young person's life: early intervention options; pre-court diversion options; pre-sentence diversion; and post-conviction diversion.

11.484 The Committee made 60 recommendations to the NSW Government to improve the adequacy of options to prevent young people from entering and being detained in the criminal justice system.⁷²⁶

11.485 The Inquiry supports some of the recommendations of the Youth Diversion Inquiry, some of which have been the subject of the NSW Government response.⁷²⁷

11.486 The evidence heard by this Inquiry suggests that the following recommendations of the Youth Diversion Inquiry should be supported:

1. *That the NSW Government review whether the number of cautions that Police and the Courts can give under the Young Offenders Act 1997 should be increased, or limits removed.*
2. *That the NSW Government review whether a young person should be required to make an admission before he or she can be dealt with by way of caution or youth justice conference under the Young Offenders Act 1997.*
4. *That the NSW Government review the Young Offenders Act 1997 to determine:*
 - *whether the offences covered by the Act remain appropriate;*
 - *whether any additional offences should be able to be dealt with under the Act in appropriate cases; and*
 - *whether Police should be able to issue warnings and cautions and refer young people to youth justice conferences for additional offences in appropriate cases.*

11.487 The Inquiry heard evidence that a review of the *Young Offenders Act 1997* (NSW) is currently under way,⁷²⁸ including in relation to the number of cautions available, the requirement for admission of guilt, and the range of eligible offences. The Inquiry has also heard that there would be benefit in extending the application of the *Young Offenders Act 1997* (NSW) to offences of supply prohibited drug.⁷²⁹ In relation to this, Judge Johnstone told the Inquiry:

*'[W]e need to remove the need for admissions before the Young Offenders Act can be applied. And what we're advocating is adoption of the New Zealand system of 'not deny'. Secondly, as I said in relation to a range of offences, like drug offences, the range of offences to which the Young Offenders Act applies could be considerably increased, including not just drug offences but family violence offences, often which are associated with drug issues. And a number of other aspects of what we might call the less serious types of offences. ... [T]hey're the things we're asking for.'*⁷³⁰

- 11.488 With respect to removal of the number of cautions allowable for the *Young Offenders Act 1997* (NSW), Mr Johnson, NSW Advocate for Children and Young People, stated: *'I just think the police do this very well and why limit their discretion'*.⁷³¹
- 11.489 The Inquiry is of the view that the NSW Government should consider including offences of supply prohibited drug in the category of offences for which a caution may be issued, and if necessary expand the terms of reference of the review to undertake that consideration.
- 11.490 The Inquiry notes and supports the following findings of the Youth Diversion Inquiry:
- '7. The NSW Government should expand Youth on Track so that it is available across NSW should the results of the evaluation by the BOCSAR, due to report in 2020, be positive.*
- 8. The Department of Justice NSW should consider additional referral pathways for Youth on Track.*
- 11.491 The Inquiry also notes and supports the following recommendations of the Youth Diversionary Inquiry:
- 23. That the NSW Government review the currently available youth diversionary programs and efforts, within custody and the community, in consultation with girls and young women to assess whether they are suitable; any areas for improvement; and where more gender-sensitive options may be needed. In doing so, particular regard should be paid to the needs of Aboriginal girls and young women.*
- 51. That the NSW Government further expand the Youth Koori Court, particularly to regional areas of NSW.'*
- 11.492 In relation to the Inquiry's support for recommendation 51 of the Youth Diversion Inquiry, see Chapter 16.

Recommendation 17:

- A. That the NSW Government implement the following recommendations and findings of the *Inquiry into the adequacy of youth diversionary programs in NSW*:
- Recommendations 1, 2 and 4
 - Findings 7 and 8
 - Recommendation 23
 - Recommendation 51.
- B. That the NSW Government review the *Young Offenders Act 1997* (NSW) to consider whether offences involving the supply of drugs should continue to be excluded from the operation of the provisions of that Act.

NSW diversion strategy

- 11.493 Inquiry evidence has highlighted the need for diversionary programs to be appropriately targeted and funded to provide equity of access across the state and to use local collaborations to achieve holistic outcomes. Diversionary programs and the wraparound services required to support them in NSW make up a complex system such that a state-wide strategy for the distribution of funding may be warranted.

11.494 In the absence of such a strategy, the scope and reach of programs may remain piecemeal and fragmented. In practice this means there is unequal and limited access to programs for some offenders, particularly those in rural and regional areas.

11.495 The Inquiry heard that funding local collaborations would be likely to improve capacity of diversionary programs. Katie Acheson, Youth Action NSW, supported local collaborations like the Maranguka Project (see Chapter 12), which is achieving good outcomes.

*'If there was ability to bring the right people in every town or at least region to come together and have localised solutions, because there are already things that are working. ... What exactly do they need? That collaboration and coordination in money and resources is often the thing that makes the difference when it comes to local responses. And I think just reimbursing the Maranguka Project particularly is exceptional evidence of what can be done if you just put a little bit of money into resourcing collaboration.'*⁷³²

11.496 Other examples of local collective collaboration include the Geelong Project⁷³³ and the collective impact approach in Claymore.⁷³⁴

11.497 Evidence suggests there is also a need to ensure that there is a sufficient allocation of resources across programs. For example, the success of MERIT is dependent on the availability of both wraparound services and aftercare services. It was noted that when a MERIT program does not offer its own after care, the program relies on the local health district or NGOs to provide it,⁷³⁵ and the availability of, or lack of, such services influences government decisions about if and where the MERIT program is rolled out.⁷³⁶ This suggests that a state-wide strategy that allocates resources across single programs in different locations, as well as across different programs, may help to ensure equitable access to diversion programs across the state.

11.498 In relation to equity of access, a diversity of diversionary programs can facilitate access by a broader range of people although it can make the system more complex and costly.⁷³⁷ However, without a planned, systematic approach to diversion, there will be gaps in the system and people will miss out.⁷³⁸

11.499 A 2014 evaluation of the ACT's drug diversion program noted the complex and interconnected nature of diversionary programs in the criminal justice system. It recommended the development of a comprehensive AOD diversion strategy to provide vision and direction for the diversion system to operate more effectively.⁷³⁹

11.500 Dr Hughes, Flinders University, told the Inquiry diversionary programs have many objectives and it is necessary to establish which set of objectives is being pursued in a government strategy for diversionary programs. Dr Hughes noted one objective should be that the intervention is proportional to the offence.

*'So if someone is detected – they're a young person – for their first offence involving, say methamphetamine, then sending someone to 12 months drug court program would clearly be disproportionate [and] in all likelihood, would not be an effective use of resources.'*⁷⁴⁰

11.501 Another objective is to reduce the use of criminal justice system resources. Dr Hughes stated that police drug diversionary programs, such as the Cannabis Cautioning Scheme in NSW, tend mainly to accrue benefits relating to *'reducing cost to the criminal justice system and improving employment prospects for the people who receive a caution rather than a charge, as well as improving social benefits'*.⁷⁴¹

- 11.502 In contrast, Dr Hughes noted that more intensive programs, such as the Drug Court, offer many additional benefits in terms of reducing harmful drug use, including reducing the frequency of drug use, reducing or eliminating dependence, improving mental health, improving stability of housing and getting people back into the job market.⁷⁴²

The Victorian Family Drug Treatment Court

- 11.503 As noted earlier, the Victorian Family Drug Treatment Court (FDTCT) is an alternative model that seeks to engage parents whose children have been taken into care due to parental substance misuse.⁷⁴³ The FDTCT aims to:⁷⁴⁴
- provide a court-coordinated response to family fragmentation by assisting parents to overcome their substance use issues and create a safe and stable environment for family reunification
 - minimise the time to achieve permanent, stable and safe placements for children in out-of-home care.
- 11.504 The Inquiry recommends the introduction of an FDTCT in NSW. The FDTCT is discussed in Chapter 18.

Other reforms

Criminal records and spent convictions

- 11.505 When a person is convicted of use or possession of a prohibited drug, that conviction appears on their criminal record, which may be accessed by a range of law enforcement agencies and others.
- 11.506 However, where a person has a criminal record for any offence (other than a sexual offence or a conviction for which a prison sentence of more than six months has been imposed),⁷⁴⁵ the *Criminal Records Act 1991* (NSW) operates to limit the effect of the conviction if the person completes a period of 10 years crime free after the date of the person's conviction (three years in the case of a child or young person).⁷⁴⁶ On completion of the period, the conviction is to be regarded as 'spent' and, subject to some exceptions, is not to form part of the person's criminal history.⁷⁴⁷
- 11.507 In cases where the court finds that an offence has been proved or that a person is guilty of an offence, without proceeding to a conviction, the conviction is spent immediately after the finding is made, with some limited exceptions.⁷⁴⁸
- 11.508 If a conviction is spent, the person is not required to disclose to any other person for any purpose information concerning the spent conviction, other than in proceedings before a court or in the event that they apply for employment in a number of specified fields, or for clearance under the *Child Protection (Working with Children) Act 2012* (NSW), the *National Disability Insurance Scheme (Worker Checks) Act 2018* (NSW).⁷⁴⁹ Importantly, a question concerning the person's criminal history is taken to refer only to any convictions of the person that are not spent.⁷⁵⁰ However, the spent conviction legislation does not affect provisions of the *Local Government Act 1993* (NSW) that render a person disqualified from holding civic office.⁷⁵¹ Records relating to spent convictions are not destroyed,⁷⁵² and continue to be accessible to certain persons and bodies, including law enforcement agencies.⁷⁵³

11.509 The Inquiry heard evidence about the impact that having a criminal record has on prospects of employment. Witnesses with lived experience gave evidence about fear of not getting employment,⁷⁵⁴ and the difficulties in setting up their own business.⁷⁵⁵ One witness gave evidence they had observed some people start using drugs again after graduating from a rehabilitation program because they could not find employment due to having a criminal record.⁷⁵⁶

11.510 Patricia Forbes, Manager of Rosa Coordinated Care (a support service for women returning to the Shoalhaven area after leaving prison or an AOD rehabilitation service), confirmed that even in circumstances where someone does not need to disclose their criminal record, women have reported that their criminal record operates as a barrier to employment.⁷⁵⁷

11.511 Ms Forbes also gave evidence that a criminal record operates as a perceived barrier to obtaining housing.

*'Women have told us – and we have actually witnesses – when we have gone to or supported them to go for housing viewings for rental – that they feel totally like, well, what's the point in even putting an application. There are, you know, 20 people looking at this house. They're dressed like this. They're in – you know, they've got employment. I've got a criminal record. Now, they don't necessarily have to disclose that, but they feel that it's written all over them.'*⁷⁵⁸

11.512 People with a criminal record are routinely searched by the Australian Border Force when re-entering Australia after travelling overseas. One witness said that this serves as a constant reminder that makes it difficult to *'move on and forget'*.⁷⁵⁹

11.513 The Inquiry received submissions consistent with the evidence discussed above that highlighted the significance of a criminal conviction. Harm Reduction Australia submitted that a criminal conviction for drug use can *'leave ongoing and permanent stains on people's lives'*, end career prospects and severely restrict overseas travel, and that arresting and convicting (and in some cases incarcerating) people who use drugs can cause long-term health, financial and social harm.⁷⁶⁰ The Penington Institute submitted that criminal convictions, and possibly incarceration, are likely to exacerbate the significant challenges already faced by people who are dependent on methamphetamine.⁷⁶¹ NDARC submitted that convictions, or even police encounters, can have lasting adverse effects for young people, such as increasing risky drug consumption and reducing employment opportunities.⁷⁶² The Public Defenders submitted that a conviction for a drug offence, even a very minor one, can have a lifelong impact.⁷⁶³

11.514 In his address at the 68th World Health Assembly in Geneva, on 19 May 2015, Commissioner and former UN General Secretary Kofi Annan said:

*'I believe that drugs have destroyed many lives, but wrong government policies have destroyed many more. A criminal record for a young person for a minor drug offence can be a far greater threat to their wellbeing than occasional drug use.'*⁷⁶⁴

11.515 The evidence before the Inquiry supports a finding that a criminal record causes harm to people who are convicted for simple possession and that the negative consequences of having a criminal record are completely disproportionate to the underlying conduct. The spent conviction legislation is a helpful way for people to overcome the stigma and negative consequences of having a criminal conviction. However, in the context of simple possession offences, a period of 10 years is disproportionate.

- 11.516 For this reason, the Inquiry recommends that the period of time required to be passed before a conviction is spent for simple possession offences be reduced to two years for adults and one year for children and young people.

Recommendation 18:

That for the purposes of the *Criminal Records Act 1991* (NSW), the period of time before which a conviction for use or possession of a prohibited drug may be spent is reduced from 10 years to two years, or in the case of a child or young person, from three years to one year.

Section 25C *Crimes Act 1900*

- 11.517 Section 25C *Crimes Act 1900* was introduced into the *Crimes Act* in November 2018, in response to recommendations of an Expert Panel comprised of Mick Fuller APM, Commissioner, NSW Police Force, Dr Kerry Chant, Chief Health Officer, NSW Ministry of Health and Philip Crawford, Chair, Independent Liquor and Gaming Authority titled '*Keeping People Safe at Music Festivals*'.⁷⁶⁵
- 11.518 The section introduces a new offence of supply prohibited drug causing death, that carries a maximum penalty of imprisonment for 20 years.
- 11.519 The Inquiry considers that there are significant problems with s 25C and that it should be referred to the NSW Law Reform Commission for consideration.

The legislation

Section 25C provides:

25C Supply of drugs causing death

- (1) A person is guilty of an offence under this section if:
 - (a) the person supplies a prohibited drug to another person for financial or material gain, and
 - (b) the drug is self-administered by another person (whether or not the person to whom the drug was supplied), and
 - (c) the self-administration of the drug causes or substantially causes the death of that other person.

Maximum penalty: Imprisonment for 20 years.

- (2) In proceedings for an offence under this section, it is necessary to prove that the accused knew, or ought reasonably to have known, that supplying the prohibited drug would expose another person (whether or not the person to whom the drug was supplied) to a significant risk of death as a result of the self-administration of the drug.
- (3) A person does not commit an offence under this section for supplying a prohibited drug if the person is authorised to supply the drug under the *Poisons and Therapeutic Goods Act 1966*.
- (4) Proceedings for an offence under this section may only be instituted by or with the approval of the Director of Public Prosecutions.

(5) Section 18 does not apply to an offence under this section.

In this section: **prohibited drug** means any substance specified in Schedule 1 to the *Drug Misuse and Trafficking Act 1985* (NSW), but does not include a prohibited plant within the meaning of that Act.

11.520 Relevantly, the *Drug Misuse and Trafficking Act 1985* (NSW) (DMT Act) provides:

- Section 3: **‘Prohibited drug means any substance, other than a prohibited plant, specified in Schedule 1’**
- Section 4: **‘In this Act, a reference to a prohibited drug includes a reference to any preparation, admixture, extract or other substance containing any proportion of the prohibited drug.’** (the admixture provision).

11.521 Schedule 1 to the *DMT Act* comprises a list of drugs and includes ATS.

Background to the introduction of s 25C

11.522 The *Keeping People Safe at Music Festivals* report states:

‘6.2 A new offence of drug supply causing death

Recommendation 7: Investigate introducing a new offence for those who supply illegal drugs, for financial or material gain, to people who then self-administer the drugs and die as a result.

Key elements of the offence:

- Supply of a prohibited drug (other than a prohibited plant i.e. cannabis, specified in Schedule 1 of the *DMT Act*).
- The person to whom the prohibited drug was supplied died and the death was caused, or substantially caused by, the prohibited drug.
- The supply was for the purpose of financial or material gain.

In considering this new offence the Panel recommends the Government should have regard to limiting the offence to those who supplied the drug for financial or material gain. In other words, the offence should be targeted towards drug dealers rather than the ‘young friends’ scenario (in this scenario, one friend is tasked with obtaining or sourcing drugs for a group of friends, and is then reimbursed, rather than seeking profit).

To ensure that any new offence of supplying a drug causing death is effective in practice, detailed consultation and careful drafting will be required to address the issues in relation to causation and intent. In this regard the Panel has not made a recommendation on the maximum penalty for this proposed new offence.

The Panel was concerned by anecdotes of the increased risk associated with drug taking at music festivals. For instance, anecdotes of users purchasing drugs from unknown drug dealers at music festivals, and subsequently having even less certainty about what they are purchasing. Other potential increased risk factors included users taking high drug dosages and taking multiple drugs in order to maintain the drug effects for the period of the festival. Added to this the potential for increased peer pressure and dealers specifically targeting music festivals for profit.

*The Panel has stopped short of recommending consideration be given to creating an aggravated drug supply at music festivals offence. The proposed new regulatory scheme will provide for better data collection which could provide information as to the increased vulnerability of drug users at music festivals and the aggravating nature of drug-dealing in these settings.*⁷⁶⁶

11.523 The Amending Act contains the following explanatory note:

‘Explanatory note. *The proposed amendment makes it an offence, punishable by imprisonment for 20 years, to supply a prohibited drug for financial or material gain if the self-administration of the drug by another person causes or substantially causes that other person’s death. It will be necessary to prove that the person supplying the prohibited drug knew, or ought reasonably to have known, that the supply would expose a person to a significant risk of death.*⁷⁶⁷

11.524 The Inquiry notes that the expert panel advised that ‘*more analysis and consultation*’ was needed before its recommendation was acted on due to the short timeframe in which the report was prepared and that this was the case particularly ‘*given the legal complexities*’ involved.⁷⁶⁸ Despite this, the relevant Bill was introduced in Parliament 20 days after publication of the report and the legislation assented to after a further 15 days. The speed of the introduction of the Bill necessarily means that any analysis and consultation concerning the legal complexities mentioned by the expert panel must have been severely limited.

Some aspects of s 25C

11.525 Section 25C marks a significant departure from established principles of the criminal law. First, the section appears to be a response to decisions in manslaughter prosecutions that have found that the chain of causation is broken by the voluntary self-administration of a prohibited drug by an informed adult, so that the accused cannot be held to have ‘caused’ the relevant death: see *Burns v the Queen* (2012) 246 CLR 33 (*Burns*).

11.526 For the purposes of manslaughter, a dangerous act is one that ‘*a reasonable person would realise exposes another to an appreciable risk of serious injury*’ and ‘*[t]he quality of dangerousness inheres in the unlawful act. The unlawful act must be the cause of death*’.⁷⁶⁹

11.527 In *Burns*, the deceased was found to have toxic, but non-lethal, levels of both olanzapine and methadone in his system. There was evidence that the combination of the two drugs was potentially fatal. The High Court considered whether the supply of methadone could be an unlawful and dangerous act for the purposes of manslaughter, where the deceased (was taken to have) self-administered the methadone and subsequently died.

11.528 At [76] the majority observed: ‘*To supply drugs to another may be an unlawful act but it is not in itself a dangerous act. Any danger lies in ingesting what is supplied.*’

11.529 The majority in *Burns* considered the law of causation and held that ‘*the voluntary and informed act of an adult negatives causal connection*’ (at [81]). Their Honours observed, ‘*[a] foolish decision to take a prohibited drug not knowing its likely effects is nonetheless the drug-taker’s voluntary and informed decision*’ (at [87]).

- 11.530 In contrast, s 25C seeks to attribute criminal liability to the supplier for the death by drug toxicity of any person who may consume the drug. In this regard, the mental element required by s 25C, that is, knowledge of a significant risk of death as a result of a further, voluntary act of the victim, represents a significant shift in principles of criminal responsibility.*
- 11.531 The second point to note is that the offence is extremely broad in its potential application. The putative victim of the offence is any person who self-administers the drug (whether or not the person to whom the drug was supplied) (s 25(2)). Subject to evidentiary issues, there is no reason an initial supplier could not be prosecuted for the death of any person who self-administered the drugs, even though there may be multiple intervening acts of supply. Indeed, all suppliers in the supply chain might be liable to be prosecuted under the section.

Section 25C *Crimes Act 1900* may not apply to contaminants

- 11.532 Section 25C is unlikely to apply in circumstances where the victim dies as a result of ingesting a contaminant in a prohibited drug supplied, where the contaminant is not listed in Schedule 1 to the *DMT Act*. Given the rapidity at which new psychoactive substances enter the drug market, and their toxicity, this is a significant shortcoming in the legislation.
- 11.533 As noted above, Schedule 1 *DMT Act* comprises a list of drugs that, on inclusion in the schedule, are classified as '*prohibited*'.
- 11.534 The language of s 25C confines '*prohibited drugs*' to the substances listed in Schedule 1 *DMT Act*. The provision is specific in its application, rather than using a formulation such as '*prohibited drug within the meaning of the DMT Act*'.
- 11.535 The Inquiry considers that there is no basis to read into s 25C a reference to the admixture provision in s 4 *DMT Act* as there is no ambiguity in the language of s 25C, nor does a literal interpretation of the section lead to a result that is absurd.⁷⁷⁰
- 11.536 On this assumption, a prosecution could not succeed where the substance causing death was a substance other than one listed in Schedule 1, even though it formed part of a mixture containing a substance listed in Schedule 1. This is because the terms of sub-s 25C(1)(c) could never be met, as the prohibited drug would not have '*caused or substantially caused*' the death. This would be the case regardless of the state of knowledge of the accused as to the contaminant.
- 11.537 The Inquiry notes that if the definition of 'prohibited drug' in s 25C was amended to provide that '*prohibited drug has the same meaning as is used in the Drug Misuse and Trafficking Act 1985*', this would pick up the 'admixture' provision of s 4 of the *DMT Act* so that a person who supplied for financial or material gain a substance containing any proportion of a prohibited drug that was self-administered by another person and the self-administration of the substance caused or substantially caused the death of that person may be criminally liable under ss 25C.

The mental element required to be proved under s 25C

- 11.538 Section 25C contains two alternative mental elements – one subjective (actual knowledge), the other objective (ought reasonably to have known). The matter about which the accused must have the requisite knowledge involves a conditional standard, that is the significant risk of death of the person who ultimately self-administers the drugs.

* In the limited time available when the proposed offence provision was introduced into Parliament, the NSW Bar Association and Law Society of NSW raised their strenuous objection to it on this basis.

- 11.539 Actual knowledge requires that the accused had an awareness of the consequences of his or her act, namely that supplying the drugs would expose another person to a significant risk of death as a result of the self-administration of the drug. Knowledge may be inferred from the surrounding circumstances of the offence, provided that it is the only rational inference available: *Pereira v DPP* (1988) 82 ALR 217 at 220.
- 11.540 In the alternative, an objective test will satisfy the mental element. In the second reading speech of the Bill introducing that provision, the Attorney-General observed:
- 'The "ought reasonably to have known" aspect of new section 25C (2) in the new offence imports a reasonable person test. For example, this test would not allow a finder of fact to consider an accused person's self-induced intoxication and transitory emotional states.'*⁷⁷¹
- 11.541 The alternative mental element in s 25C is similar to that required for manslaughter by unlawful and dangerous act, where the reasonable person is placed in the accused's physical situation but does not share their idiosyncrasies (*Lane v R* [2013] NSWCCA 317 at [57]; *Burns v The Queen* (2012) 246 CLR 334 at [75]).
- 11.542 The relevant knowledge for s 25C is that the act of supply would expose the person 'to a significant risk of death'. This may be contrasted with the mental element required for unlawful and dangerous act manslaughter, which involves a lower standard, namely that the act is one that a reasonable person in the position of the accused would have realised carried with it an appreciable risk of serious injury (*Lane v R* [2013] NSWCCA 317 at [57]).
- 11.543 Given that people's responses to drugs, and in particular MDMA, can vary greatly between individuals and in light of the fact that s 25C extends liability to the death of any person who ingests the drug supplied, it could be argued that a person supplying drugs ought reasonably to know that every act of supply carries with it a significant risk of death. If such a construction was adopted, the offence would operate in practice to impose strict liability, a remarkable extension of the criminal law.

Limitation of the offence to a person who supplies for material gain as opposed to a person who provides the drug for no gain

- 11.544 The Expert Panel stated as follows:⁷⁷²

'In considering this new offence the Panel recommends the Government should have regard to limiting the offence to those who supplied the drug for financial or material gain. In other words, the offence should be targeted towards drug dealers rather than the 'young friends' scenario (in this scenario, one friend is tasked with obtaining or sourcing drugs for a group of friends, and is then reimbursed, rather than seeking profit).' (Emphasis added)

- 11.545 While not stating the rationale for limiting the offence to supply for material gain, it appears to be related to a concern as to the role of profit-motivated suppliers at music festivals:

*'The Panel was concerned by anecdotes of the increased risk associated with drug taking at music festivals. For instance, anecdotes of users purchasing drugs from unknown drug dealers at music festivals, and subsequently having even less certainty about what they are purchasing. Other potential increased risk factors included users taking high drug dosages and taking multiple drugs in order to maintain the drug effects for the period of the festival. Added to this the potential for increased peer pressure and dealers specifically targeting music festivals for profit.'*⁷⁷³

- 11.546 Even if it is accepted that some greater risk is associated with drugs supplied by drug ‘dealers’ at such events, it is a reasonable assumption that where drugs are provided by ‘young friends’ for no gain, presumably the drugs have been purchased at some point from a ‘drug dealer’. Drugs consumed in those circumstances are also likely to be dangerous, and the rationale explained by the Expert Panel report does not support the restriction of the section to supply for material gain.
- 11.547 A distinction could potentially be justified on the basis that it may be thought that there is less moral blameworthiness associated with the motive behind the supply in the latter case. However, no such rationale has been expressed.
- 11.548 It is also pertinent to note that although the section is directed to ‘*supply for material gain*’ it is not limited to supply at music festivals.

Supply causing injury

- 11.549 Finally, s 25C is confined to instances of supply that cause death. There is no equivalent offence where the victim is injured. If liability is sought to be imposed on people who supply prohibited drugs that are then self-administered and cause death, there is no principled reason why liability should not be imposed where serious injury is caused or substantially caused by the self-administration of the drug.
- 11.550 The Inquiry considers that the problems inherent in s 25C are likely the result of hurried drafting and a lack of consultation and that the section should be referred to the NSW Law Reform Commission for consideration.

Recommendation 19:

That consideration of section 25C *Crimes Act 1900* (NSW) be referred to the NSW Law Reform Commission.

References

- ¹ *Drug Misuse and Trafficking Act 1985* (NSW) s 12.
- ² *Drug Misuse and Trafficking Act 1985* (NSW) s 10.
- ³ Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 1. See also, in relation to calls to decriminalise all drugs, Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4018.19-20 (Professor Gallop), 4035.14-16 (Odgers SC), 4042.40-42 (Professor Ritter), 4045.6-13 (Odgers SC, Madden), 4046.35-43 (Professor Hughes); Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 7-9; Centre for Social Research in Health, Submission No 65 (7 May 2019) 6; NSW Bar Association, Submission No 97 (7 May 2019) 1-2. See also, in relation to calls to respond to all drugs, Royal Australasian College of Physicians, Submission No 47 (May 2019) 4. See also, in relation to issues for consideration where targeting particular drugs, Standing Committee on Family and Community Affairs, House of Representatives, *Road to Recovery: Report on the inquiry into substance abuse in Australian communities* (Report, 2006) 206[8.13].
- ⁴ Cf Australian Criminal Intelligence Commission, Submission No 149 (7 June 2019) 23.
- ⁵ See, for example, Caitlin Hughes et al, 'Decriminalisation of drug use and possession in Australia – A briefing note' (Drug Policy Modelling Program, February 2016) 2.
- ⁶ *Criminal Procedure Amendment (Penalty Notices for Drug Possession) Regulation 2019* (NSW) cl 3, amending *Criminal Procedure Regulation 2017* (NSW) sch 4.
- ⁷ Konstantinos Alexandris Polomarkakis, 'Drug Law Enforcement Revisited: The "War" Against the War on Drugs' (2017) 47(3) *Journal of Drug Issues* 396, 398-99; Dan Werb, 'Post-war prevention: Emerging frameworks to prevent drug use after the War on Drugs' (2018) 51 *International Journal of Drug Policy* 160, 160.
- ⁸ See, for example, Andrew Ashworth, *Principles of Criminal Law* (Oxford University Press, 8th ed, 2016) 74, quoting J Feinberg *Harm to Others* (1984) 26. See also H L A Hart, *Law Liberty and Morality* (Oxford University Press, London 1963) cited in Mark Findlay, Stephen Odgers and Stanley Yeo, *Australian Criminal Justice* (Oxford University Press, 5th ed, 2014) 9.
- ⁹ See Nicola Lacey, 'The Traditional Justifications', *State Punishment: Political Principle and Community Values* (Routledge, London, 1988c) 16, cited in Mark Findlay, Stephen Odgers and Stanley Yeo, *Australian Criminal Justice* (Oxford University Press, 5th ed, 2014) 9-10.
- ¹⁰ Joel Feinberg, *Harm to others* (Oxford University Press, 1984) 26. See also John Stuart Mill, *On Liberty* (1859) (Batoche Books, 2001) 69.
- ¹¹ See Andrew Ashworth, *Principles of Criminal Law* (Oxford University Press, 8th ed, 2016) 74, citing D Husak, *Overcriminalization: The Limits of the Criminal Law* (2008) and D Husak, *Drugs and Rights* (1992).
- ¹² Darryl Robinson, *The Identity Crisis of International Criminal Law* (2008) 21(4) *Leiden Journal of International Law* 925, 926.
- ¹³ Typified by Lord Devlin, see P Devlin *The Enforcement of Morals* (Oxford University Press, London, 1965) cited in Mark Findlay, Stephen Odgers and Stanley Yeo, *Australian Criminal Justice* (Oxford University Press, 5th ed, 2014) 8; see also J Finnis, *Natural Law and Natural Rights* (1980) cited in Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (LBC Information Services, 2001) 53.
- ¹⁴ See John Stuart Mill, *On Liberty* (1859) (Batoche Books, 2001) ch 4, especially 70.
- ¹⁵ Andrew Ashworth, *Principles of Criminal Law* (Oxford University Press, 8th ed, 2016) 69, citing R Dworkin, *Taking Rights Seriously* (1977) chapter 10.
- ¹⁶ The key proponent of this theory was Immanuel Kant – see Jens David Ohlin, *Criminal law: Doctrine, application, and practice* (Wolters Kluwer, 2018) chapter 2.
- ¹⁷ See A von Hirsch A, 'Harm and wrongdoing in criminalisation theory' (2012) 8(1) *Criminal Law and Philosophy* 245, 245-256; Simester and von Hirsch, *Crimes, Harms and Wrongs* (Hart Publishing, 2011) ch 2. See also Joel Feinberg, *Harm to Others* (Oxford University Press, 1984) 26.
- ¹⁸ Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (LBC Information Services, 2001) 57.
- ¹⁹ See Joel Feinberg, *Harm to Others* (Oxford University Press, 1984) 26.
- ²⁰ See also Jeremy Bentham, *Introduction to the Principles of Morals and Legislation* (1789) (Oxford University Press, 1907) ch 13.
- ²¹ See, eg, Jeremy Bentham, *Introduction to the Principles of Morals and Legislation* (1789) (Oxford University Press, 1907) ch 13; Andrew Ashworth, *Principles of Criminal Law* (Oxford University Press, 8th ed, 2016) 74, quoting Joel Feinberg *Harm to Others* (Oxford University Press, 1984) 26.
- ²² Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (LBC Information Services, 2001) 12, citing Andrew Ashworth, *Principles of Criminal Law* (Oxford University Press, 3rd ed, 1999) 32-37.
- ²³ *Universal Declaration of Human Rights*, GA Res 217A (III) (10 December 1948) art 29.
- ²⁴ Don Weatherburn, 'The Pros and Cons of prohibiting drugs' (2014) 47(2) *Australian & New Zealand Journal of Criminology* 176, 178.
- ²⁵ New South Wales Crime Commission, *Annual Report 2016-2017* (Report, October 2017) 21.
- ²⁶ New South Wales Crime Commission, *Annual Report 2017-2018* (Report, October 2018) 25; Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2017-2018* (Report, July 2019) 30.
- ²⁷ Council of Australian Governments, Department of the Prime Minister and Cabinet, *National Ice Action Strategy 2015* (Strategy, 2015) 18.
- ²⁸ Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2017-2018* (July 2019) 18.
- ²⁹ NSW Bureau of Crime Statistics and Research, *New South Wales Recorded Crime Statistics – Quarterly Update December 2018* (Report, December 2018) 18.
- ³⁰ NSW Bureau of Crime Statistics and Research, *New South Wales Recorded Crime Statistics – Quarterly Update June 2019* (Report, June 2019) 18.
- ³¹ New South Wales Crime Commission, *Annual Report 2015-2016* (October 2016) 18.
- ³² NSW Crime Commission, Submission No 107 (2019) 1.
- ³³ Australia21, 'Can Australia respond to drugs more effectively and safely' (Roundtable report, November 2016) 44 (Former NSW Police Commissioner, Ken Moroney). See also, 'The war on drugs is a losing battle', *The Age* (Online, 9 July 2016) <<https://www.theage.com.au/national/victoria/the-war-on-drugs-is-a-losing-battle-20160707-gq0m5f.html>> (Former Chief Commissioner of Victoria Police, Ken Lay); 'Former top cops want 'white market' in illicit drugs, decriminalisation, more injecting

- rooms', *ABC News* (Online, 20 March 2017) <<https://www.abc.net.au/news/2017-03-20/former-top-cops-want-white-market-in-illicit-drugs/8369102>> (Former Australian Federal Police Commissioner, Mick Palmer).
- 34 NSW Bar Association, Submission No 97 (7 May 2019) 6.
- 35 Niamh Eastwood, Edward Fox and Ari Rosmarin, Release, *A quiet revolution: drug decriminalisation across the globe* (Report, March 2016) 17.
- 36 "Deterrence" is the principle that criminal sanctions will deter the offender (specific deterrence) and others (general deterrence) from engaging in criminal behaviour. 'Specific or personal deterrence' is a sentencing concept that refers to the extent to which a person punished for an offence will be deterred from committing that offence again.
- 37 Criminal Law Committee, New South Wales Bar Association, *Drug Law Reform* (Discussion Paper, November 2014) 14. See also NSW Bar Association, Submission No 97 (7 May 2019) 6.
- 38 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4055.31-5 (Lloyd).
- 39 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4057.11-13 (Dr Wodak).
- 40 Penington Institute, Submission No 56 (May 2019) 4. See also NSW Bar Association, Submission No 97 (7 May 2019) 5.
- 41 Joint United Nations Programme on HIV/AIDS (UNAIDS), *Health, Rights and Drugs: Harm reduction, decriminalization and zero discrimination for people who use drugs* (Report, 13 March 2019) 9. See also Rolles et al, Transform Drug Policy Foundation, *The War on Drugs: Wasting billions and undermining economies* (Briefing Paper, 2020) 3, 4. See, in relation to prevalence globally, United Nations Office on Drugs and Crime, *World Drug Report 2019* (Publication, 26 June 2019) bk 1, 7, bk 2, 9.
- 42 Global Commission on Drug Policy, *Regulation: The Responsible Control of Drugs* (Report, 2018) 5.
- 43 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 7, 11, 17.
- 44 Joint United Nations Programme on HIV/AIDS (UNAIDS), *Health, Rights and Drugs: Harm reduction, decriminalization and zero discrimination for people who use drugs* (Report, 13 March 2019) 5.
- 45 Centre for Social Research in Health, UNSW, Submission No 65 (7 May 2019) 5.
- 46 Centre for Social Research in Health, UNSW, Submission No 65 (7 May 2019) 6, quoting Csete et al, 'Public health and international drug policy' (2016) 387(10026) *The Lancet* 1427, 1429.
- 47 Criminal Law Committee, New South Wales Bar Association, *Drug Law Reform* (Discussion Paper, November 2014) 13.
- 48 Criminal Law Committee, New South Wales Bar Association, *Drug Law Reform* (Discussion Paper, November 2014) 15-16.
- 49 Niamh Eastwood, Edward Fox and Ari Rosmarin, 'A Quiet Revolution: Drug Decriminalisation Across the Globe' (Report, 2nd ed, March 2016) 17.
- 50 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3971.5-11 (Cr Lloyd); Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 17.
- 51 Bryan Stevenson, *Drug Policy, Criminal Justice and Mass Imprisonment* (Working Paper, Global Commission on Drug Policy, January 2011) 2, 5.
- 52 Norval Morris and Gordon Hawkins, *An honest politician's guide to crime control* (Sun Books, 1971) 9.
- 53 Lismore Hearing, Lismore, 15 May 2019, TS 812.44-13.1 (Crayden).
- 54 Penington Institute, Submission No 56 (May 2019) 5-6.
- 55 New South Wales Law Reform Commission, *Sentencing* (Report 139, July 2013) 9 [1.44], 33 [2.98].
- 56 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 16.
- 57 Nowra Hearing (Private), Nowra, 29 May 2019, TS 889.42-5 (Name Withheld). See also, Susan D Phillips and Trevor Gates, 'A conceptual framework for understanding the stigmatization of children of incarcerated parents' (2011) 20(3) *Journal of Child and Families Studies* 286, 290.
- 58 See also, Charlie Lloyd, 'The stigmatization of problem drug users: A narrative literature review' (2013) 20(2) *Drugs: Education, Prevention and Policy* 85, 89; Kari Lancaster, Kate Seear and Alison Ritter, National Drug & Alcohol Research Centre, *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use* (Report, DPMP Monograph series No 26, April 2017) 62-63.
- 59 Shirley J Semple, Igor Grant and Thomas L Patterson, 'Utilization of drug treatment programs by methamphetamine users: the role of social stigma' (2005) 14(4) *American Journal of Addiction* 367, 368; Jennifer Ahern, Jennifer Stuber, Sandro Galea, 'Stigma, discrimination and the health of illicit drug users' (2007) 88(2-3) *Drug and Alcohol Dependence* 188, 188-89.
- 60 National Drug and Alcohol Research Centre, Submission No 81 (7 May 2019) 2, 3; Positive Life NSW and HIV/AIDS Legal Centre, Submission No 82 (7 May 2019) 3.
- 61 Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 12.
- 62 Moree Plains Shire Council, Submission No 72 (May 2019) 2; Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4006.16-18 (Professor Ritter).
- 63 James D. Livingston et al, 'The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review' (2012) 107(1) *Addiction* 39, 40; Kate Seear, Kari Lancaster and Alison Ritter, 'A new framework for evaluating the potential for drug law to produce stigma: insights from an Australian study' (2017) 45(4) *Journal of Law, Medicine and Ethics* 596, 597-99.
- 64 The Public Defenders, Submission No 12 (29 April 2019) 4.
- 65 Positive Life NSW and HIV/AIDS Legal Centre, Submission No 82 (7 May 2019) 3; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 8.
- 66 Positive Life NSW and HIV/AIDS Legal Centre, Submission No 82 (7 May 2019) 3.
- 67 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3970.1-2 (Dr Weatherburn).
- 68 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4004.7-10 (Professor Seear).
- 69 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4006.20-8 (Professor Ritter).
- 70 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4006.37-40 (Dr Hughes).
- 71 New South Wales Crime Commission, *Annual Report 2015-2016* (October 2016) 18.
- 72 New South Wales Crime Commission, *Annual Report 2015-16* (October 2016) 18. See also Penington Institute, Submission No 56 (May 2019) 5.
- 73 New South Wales Crime Commission, *Annual Report 2017-2018* (Report, October 2018) 25, 31.
- 74 Criminal Law Committee, New South Wales Bar Association, *Drug Law Reform* (Discussion Paper, November 2014) 15.
- 75 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3970.32-8, 3971.33-7 (Lloyd); Aboriginal Legal Service, Submission No 116 (9 May 2019) 3; Legal Aid NSW, Submission No 136 (May 2019) 21.

- 76 See Joanne Baker and Derek Goh, *'The cannabis cautioning scheme three years on: an implementation and outcome evaluation'* (NSW Bureau of Crime Statistics and Research, 2004) 33. See also Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4931.20-32 (Dr Hughes); Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4628.20-34 (Acting Superintendent Cook).
- 77 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 46, Response of Department of Communities and Justice dated 30 August 2019, to Request for Information dated 23 July 2019, 1; Tab 56, Excel Spreadsheet of Court Data, Slide 21A. See also Judicial Commission of New South Wales, *'Drug Misuse and Trafficking Act 1985 (NSW) – s 10(1) possess prohibited drug (amphetamine) – NSW Local Court – Sentences from 24 Sep 2018 to Mar 2019'* (Judicial Information Research System Statistics, November 2019).
- 78 Aboriginal Legal Service, Submission No 116 (9 May 2019) 3. See also Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4933.12-24 (Dr Hughes).
- 79 Aboriginal Legal Service, Submission No 116 (9 May 2019) 3. See also Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3971.33-7 (Lloyd).
- 80 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4643.34-38 (Acting Superintendent Cook).
- 81 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 6, Statement of Jared Sharp dated 18 September 2019, [22]; Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4931.29-32 (Dr Hughes).
- 82 Joanne Baker and Derek Goh, *'The cannabis cautioning scheme three years on: an implementation and outcome evaluation'* (NSW Bureau of Crime Statistics and Research, 2004) 33.
- 83 Aboriginal Legal Service, Submission No 116 (9 May 2019) 6 [or 4]; Lucy Snowball, 'Diversion of Indigenous juvenile offenders' (Trends & Issues in Crime and Criminal Justice No 355, Bureau of Crime Statistics and Research, June 2008) 1-2, 5.
- 84 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3971.37-41 (Lloyd); Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4628.20-40 (Acting Superintendent Cook).
- 85 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4034.8-11 (Lloyd).
- 86 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3996.20-21, 4034.4-8 (Lloyd).
- 87 See Australian Institute of Health and Welfare, *Australia's Health 2018* (Australia's Health Series No. 16, 2018) 208; Commonwealth of Australia, Department of Health, *National Drug Strategy 2017–2026* (2017) 4-5; United Nations Office on Drugs and Crime, *World Drug Report 2015* (Publication, May 2015) 18-20, 32, 34; UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, *What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters* (Briefing Paper, March 2019) 7.
- 88 Aboriginal Legal Service, Submission No 116 (9 May 2019) 1; Legal Aid NSW, Submission No 136 (May 2019) 6; Positive Life NSW and HIV/AIDS Legal Centre, Submission No 82 (7 May 2019) 6; Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 9. See also NSW Bar Association, Submission No 97 (7 May 2019) 7; Justice Action, Submission No 100 (7 May 2019) 4.
- 89 See The Royal Australasian College of Physicians, Submission No 47 (May 2019) 4, 5, 9; NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 21; NSW Council of Social Service, Submission No 54 (7 May 2019) 4-5; Nicholas Cowdery AO, QC, Submission (19 August 2019) 1; National Drug Research Institute, Submission No 48 (May 2019) 7; Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3970.25-40 (Lloyd).
- 90 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 4.
- 91 Dr Thalia Anthony, Submission No 156 (18 July 2019) 1.
- 92 Dr Thalia Anthony, Submission No 156 (18 July 2019) 1-2.
- 93 Dr Thalia Anthony, Submission No 156 (18 July 2019) 2.
- 94 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 21; NSW Council of Social Service, Submission No 54 (7 May 2019) 4; Nicholas Cowdery AO, QC, Submission 159 (19 August 2019) 1.
- 95 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 7.
- 96 NSW Bar Association, Submission No 97 (7 May 2019) 7.
- 97 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3979.36-7 (Dr Wodak).
- 98 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3967.40-7 (Professor Ritter).
- 99 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3971.23-8 (Lloyd).
- 100 Australia21, 'Can Australia respond to drugs more effectively and safely' (Roundtable Report, November 2016) 2.
- 101 Steve Bolt, 'Drugs and the law' (Hot Topics 59, Legal Information Access Centre, 2006) 1.
- 102 See Steve Bolt, 'Drugs and the law' (Hot Topics 59, Legal Information Access Centre, 2006) 1.
- 103 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (2016) 9.
- 104 Global Commission on Drug Policy, *War on Drugs: Report of the Global Commission on Drug Policy* (June 2011) 2.
- 105 Global Commission on Drug Policy, *War on Drugs: Report of the Global Commission on Drug Policy* (June 2011) 2.
- 106 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (2016) 7, 17.
- 107 Joint United Nations Programme on HIV/AIDS (UNAIDS) et al, *Joint United Nations statement on ending discrimination in health care settings* (Joint Statement, United Nations, 27 June 2017) 3.
- 108 United Nations System Chief Executives Board for Coordination, *Summary of deliberations: Chief Executives Board for Coordination, 2nd regular session of 2018, New York, 7 and 8 November 2018* (Report, 18 January 2019) 4, 14.
- 109 United Nations System Chief Executives Board for Coordination, *Summary of deliberations: Chief Executives Board for Coordination, 2nd regular session of 2018, New York, 7 and 8 November 2018* (Report, 18 January 2019) 4.
- 110 UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, *What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters* (Briefing Paper, March 2019) 41-42.
- 111 Caitlin Hughes et al, (Drug Policy Modelling Program), 'Decriminalisation of drug use and possession in Australia – A briefing note' (February 2016) 4; Niamh Eastwood, Edward Fox and Ari Rosmarin, 'A Quiet Revolution: Drug Decriminalisation Across the Globe' (Report, 2nd ed, March 2016) 13-37; Rebecca Flood, 'Norway becomes first Scandinavian country to decriminalise drugs in historic vote', *Independent* (online, 15 December 2017) <<https://www.independent.co.uk/news/health/norway-parliament-drugs-decriminalise-recreational-cocaine-heroin-marijuana-a8111761.html>>.
- 112 See The Law Library of Congress, 'Decriminalisation of narcotics' (Report, July 2016) 79ff.; Alex Stevens and Caitlin Hughes 'Drug laws on possession: several countries are revisiting them and these are their options', *The Conversation* (online, 2 August 2019) <<https://theconversation.com/drug-laws-on-possession-several-countries-are-revisiting-them-and-these-are-their-options-121221>>; 'Malaysia to decriminalise drug use, says health minister', *Al Jazeera* (online, 28 June 2019) <<https://www.aljazeera.com/news/2019/06/malaysia-decriminalise-drug-health-minister-190628060223845.html>>.

- 113 'CSOs calling for decriminalisation of drug use in Ghana' *Whatsup News* (online, 8 August 2019)
<<https://idpc.net/alerts/2019/08/csos-calling-for-decriminalization-of-drug-use-in-ghana>>.
- 114 Commonwealth of Australia, Department of Health, *National Drug Strategy 2017–2026* (Report, 2017) 1.
- 115 Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2017-2018* (July 2019) 18, 30. See also New South Wales Crime Commission, *Annual Report 2017-2018* (October 2018) 25.
- 116 Eileen Patterson et al, 'Drug use monitoring in Australia: 2015 and 2016 report on drug use among police detainees' (Statistical Report No 4, (Australian Institute of Criminology), 2018) 10.
- 117 NSW Bar Association, Submission No 97 (7 May 2019) 7.
- 118 Centre for Social Research in Health, UNSW, Submission No 65 (7 May 2019) 5.
- 119 Centre for Social Research in Health, UNSW, Submission No 65 (7 May 2019) 5.
- 120 Commonwealth Department of Home Affairs, Submission No 141 (June 2019) 5; Australian Criminal Intelligence Commission, Submission No 149 (June 2019) 22.
- 121 Australian Criminal Intelligence Commission, Submission No 149 (7 June 2019) 21.
- 122 Australian Criminal Intelligence Commission, Submission No 149 (7 June 2019) 25.
- 123 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3968.6-11 (Professor Ritter).
- 124 NSW: Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 25, Confidential Exhibit; *Criminal Procedure Amendment (Penalty Notices for Drug Possession) Regulation 2019* (NSW) cl 3, amending *Criminal Procedure Regulation 2017* (NSW) sch 4. The use to Drug CINs is currently limited by policy to music festivals: Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 21, Confidential Exhibit.
- Queensland: *Police Powers and Responsibilities Act 2000* (QLD) s 379.
- Victoria: Department of Health & Human Services, State Government of Victoria, 'Diversion programs', *Forensic Services* (Web Page) <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/forensic-aod-services#p-h-3>>.
- SA: *Controlled Substances Act 1984* (SA) s 45A; *Controlled Substances Act 1984* (SA) ss 36-40.
- WA: *Misuse of Drugs Act 1981* (WA) pt 3A; Mental Health Commission, Government of Western Australia, *Other Drug Intervention Requirement (ODIR)* (Web Page) <<https://www.mhc.wa.gov.au/getting-help/diversion-support-programs/other-drug-intervention-requirement-odir/>>.
- Tasmania: As per the Tasmania Police Illicit Drug Diversion Initiative (IDDI) Protocol, referred to in the *Tasmania Police Manual* (Manual, 18 December 2018) 120[2.7.10] <<https://www.police.tas.gov.au/uploads/TPM-RTI-18-December-2018.pdf>>. See Jason Payne, Max Kwiatkowski and Joy Wundersitz, 'Police drug diversion: a study of criminal offending outcomes' (Research and Public Policy Series No 97, Australian Institute of Criminology, October 2008) 7-8.
- ACT: *Drugs of Dependence Act 1989* (ACT) s 171A; ACT Policing, Australian Federal Police, 'Illicit Drug Diversion Program', *Youth Alcohol and Drug Diversion Programs* (Web page) <<https://police.act.gov.au/about-us/programs-and-partners/youth-alcohol-and-drug-diversion-programs>>.
- NT: *Misuse of Drugs Act 2017* (NT) pt 2B.
- 125 Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 8.
- 126 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4017.38 (Professor Gallop).
- 127 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4018.19-20 (Professor Gallop), 4035.14-16 (Odgers SC), 4042.40-42 (Professor Ritter), 4045.6-13 (Odgers SC, Madden), 4046.38-41 (Dr Hughes).
- 128 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4042.46-43.2 (Professor Ritter).
- 129 Caitlin Hughes et al, Drug Policy Modelling Program, *Decriminalisation of drug use and possession in Australia* (Briefing Note, February 2016). 2.
- 130 Caitlin Hughes et al, Drug Policy Modelling Program, *Decriminalisation of drug use and possession in Australia* (Briefing Note, February 2016). 2.
- 131 Caitlin Hughes et al, Drug Policy Modelling Program, *Decriminalisation of drug use and possession in Australia* (Briefing Note, February 2016). 2.
- 132 Caitlin Hughes et al, Drug Policy Modelling Program, *Decriminalisation of drug use and possession in Australia* (Briefing Note, February 2016). 4.
- 133 Caitlin Hughes et al, Drug Policy Modelling Program, *Decriminalisation of drug use and possession in Australia* (Briefing Note, February 2016). 5-6.
- 134 Caitlin Hughes et al, Drug Policy Modelling Program, *Decriminalisation of drug use and possession in Australia* (Briefing Note, February 2016). 6.
- 135 ACON, Submission No 77 (May 2019) 13-14.
- 136 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3973.9-10 (Madden).
- 137 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3996.18-24 (Lloyd).
- 138 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3983.18-21 (Dr Weatherburn).
- 139 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4024.17-18 (Scipione).
- 140 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 14.
- 141 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 24.
- 142 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 14.
- 143 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4026.20-29 (Dr Hughes).
- 144 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 5, 7, 13, 29.
- 145 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018). 65.
- 146 Australian Criminal Intelligence Commission, Submission No 149 (7 June 2019) 21-26.
- 147 Commonwealth Department of Home Affairs, Submission No 141 (June 2019) 4-6.
- 148 The Public Defenders, Submission No 12 (29 April 2019) 3-5; Harm Reduction Australia, Submission No 37 (5 May 2019) 2; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 7-8; Centre for Social Research in Health, UNSW Sydney, Submission No 65 (7 May 2019) 6; Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received

- 10 May 2019) 14; Legal Aid NSW, Submission No 136 (May 2019) 6-7. See also NSW Bar Association, Submission No 97 (7 May 2019) 1-4; National Drug and Alcohol Research Centre, Submission No 81 (7 May 2019) 12; NSW Council of Civil Liberties, Submission No 70 (7 May 2019) 5.
- 149 Closing Submissions on behalf of NSW Police Force (11 November 2019), 7.
- 150 See Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3970.1-2 (Dr Weatherburn), 3971.5-11 (Lloyd), 4004.7-10 (Professor Seear).
- 151 Niamh Eastwood, Edward Fox and Ari Rosmarin, *'A Quiet Revolution: Drug Decriminalisation Across the Globe'* (Report, 2nd ed, March 2016) 9.
- 152 Administrative Violations Code (Latvia) s 46 [tr Valsts valodas centrs (State Language Centre)]; Decree No. 309 of 9 October 1990 (Italy), s 75(2) [tr United Nations]; Law No 30/2000 of 29 November (Portugal) art 18 [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 153 Administrative Violations Code (Latvia), s 46 [tr Valsts valodas centrs (State Language Centre)]; Drug Dependence (Treatment not Imprisonment) Act, 2014 (Malta) art 4; Law No 30/2000 of 29 November (Portugal) arts 15(1), 16. See, also, the discussion of the NSW Drug CIN scheme and the SA CEN scheme later in this chapter.
- 154 Decree No. 309 of 9 October 1990 (Italy), s 75(1) [tr United Nations].
- 155 Law No 30/2000 of 29 November (Portugal) art 2(f) [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 156 Law No 30/2000 of 29 November (Portugal) art 17(3) [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 157 Decree No. 309 of 9 October 1990 (Italy), s 75(1) [tr United Nations].
- 158 Decree No. 309 of 9 October 1990 (Italy), s 75(1) [tr United Nations]; Law No 30/2000 of 29 November (Portugal) art 17(2)(d) [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 159 Law No 30/2000 of 29 November (Portugal) art 17(2)(c) [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 160 Law No 30/2000 of 29 November (Portugal) art 17(2)(a) [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 161 Aboriginal Legal Service, Submission No 116 (9 May 2019) 2, 3.
- 162 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4933.14-34 (Dr Hughes).
- 163 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018). 47.
- 164 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4933.19-32 (Dr Hughes).
- 165 Judicial Commission of New South Wales, *'Drug Misuse and Trafficking Act 1985 (NSW) – s 10(1) possess prohibited drug (amphetamine) – NSW Local Court – Sentences from 24 Sep 2018 to Mar 2019'* (Judicial Information Research System Statistics, November 2019); Judicial Commission of New South Wales, *'Drug Misuse and Trafficking Act 1985 (NSW) – s 10(1) possess prohibited drug (ecstasy) – NSW Local Court – Sentences from 24 Sep 2018 to Mar 2019'* (Judicial Information Research System Statistics, November 2019).
- 166 See Judicial Commission of New South Wales, *'Drug Misuse and Trafficking Act 1985 (NSW) – s 10(1) possess prohibited drug (ecstasy) – NSW Local Court – Sentences from 24 Sep 2018 to Mar 2019'* (Judicial Information Research System Statistics, November 2019).
- 167 Aboriginal Legal Service, Submission No 116 (9 May 2019) 3; Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3969.32-7 (Dr Weatherburn), 4076.38-39 (Professor Seear). See also Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 8.
- 168 Aboriginal Legal Service, Submission No 116 (9 May 2019) 3. See also Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4076.3-39 (Professor Seear).
- 169 NSW Ombudsman, *Review of the impact of Criminal Infringement Notices on Aboriginal communities* (Report, August 2009) 91-5.
- 170 NSW Ombudsman, *Review of the impact of Criminal Infringement Notices on Aboriginal communities* (Report, August 2009) 98.
- 171 Aboriginal Legal Service, Submission No 116 (9 May 2019) 2.
- 172 See *Fines Act 1996* (NSW) pt 4 div 8 sub-div 1.
- 173 See Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3969.32-7, 3970.10-13 (Dr Weatherburn), 3971.32-7 (Cr Lloyd), 3973.6-9 (Madden), 4042.45-43.6 (Professor Ritter, Dr Weatherburn), 4068.35ff (Professor Ritter, Odgers SC, Dr Weatherburn, Madden, Professor Seear). Note: Mr Odgers SC and Dr Weatherburn were in favour of retaining the possibility of imposing a fine for non-compliance.
- 174 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4061.3-7 (Dr Weatherburn).
- 175 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3969.33-7 (Dr Weatherburn).
- 176 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 11.
- 177 Closing Submissions on behalf of NSW Police Force, (11 November 2019), 7.
- 178 Closing Submissions on behalf of NSW Police Force, (11 November 2019), 7-8.
- 179 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4070.5-30 (Dr Wodak, Dr Weatherburn, Odgers SC).
- 180 See, for example, *Criminal Procedure Regulation 2017* (NSW) sch 4; *Road Transport (General) Regulation 2013* (NSW) cl 123, sch 5.
- 181 David Brown, Chris Cunneen, Sophie Russel, "It's all about the Benjamins": Infringement notices and young people in New South Wales' (2017) 42(4) *Alternative Law Journal* 253, 254; NSW Ombudsman, *On the Spot Justice? The Trial of Criminal Infringement Notices by NSW Police* (April 2005) 130.
- 182 Fine enforcement orders may be made by a court or the Commissioner of Fines Administration in certain circumstances if the fine is not paid by the due date: see *Fines Act 1996* (NSW) pt 2 div 3, pt 3 div 4.
- 183 *Fines Act 1996* (NSW) s 99B(1).
- 184 *Fines Act 1996* (NSW) s 99A.
- 185 *Fines Act 1996* (NSW) s 99B(2A).
- 186 NSW Young Lawyers Criminal Committee, Submission No 124 (12 May 2019) 4; Aboriginal Legal Service, Submission No 116 (9 May 2019) 10.
- 187 NSW Young Lawyers Criminal Committee, Submission No 124 (12 May 2019) 4.
- 188 Aboriginal Legal Service, Submission No 116 (9 May 2019) 4.
- 189 Aboriginal Legal Service, Submission No 116 (9 May 2019) 4.

- 190 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 68; Caitlin Hughes et al, Drug Policy Modelling Program, *Decriminalisation of drug use and possession in Australia* (Briefing Note, February 2016) 2; National Drug and Alcohol Research Centre, Submission No 81 (7 May 2019) 12; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 8.
- 191 *Convention on Psychotropic Substances* (1971) art 22(1)(b); *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) art 3(4)(d).
- 192 For example, Portugal's Commission of Dissuasion of Drug Addiction considers the circumstances of a person's drug use to inform its decisions about an appropriate response: Law No 30/2000 of 29 November (Portugal) art 10 [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 193 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 65.
- 194 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 65.
- 195 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4920.19-4921.9 (Dr Hughes).
- 196 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4921.11-40 (Dr Hughes).
- 197 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4163.33-41 (Professor Ritter).
- 198 See Sydney General Hearing, Sydney, 9 May 2019, TS 239.18-35, 243.8-10 (Dr Brett).
- 199 See, for example, Department of Health & Human Services, State Government of Victoria, 'Diversion programs – Cannabis cautioning', *Forensic Services* (Web Page) <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/forensic-aod-services/#ip-h-3>>; Police Powers and Responsibilities Act 2000 (QLD) s 379; Queensland Police Service, *Police drug diversion program* (Web Page) <<https://www.police.qld.gov.au/drugs-and-alcohol/police-drug-diversion-program>>; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 25, Confidential Exhibit. See, in relation to international examples, Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 28, 51.
- 200 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4060.16-21 (Dr Hughes), 4071.36-8 (Professor Ritter).
- 201 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4060.17-21 (Dr Hughes).
- 202 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4636.40-4637.35 (Acting Superintendent Cook).
- 203 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4643.40-4 (Acting Superintendent Cook).
- 204 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4071.36-72.26 (Professor Ritter), 4080.24-4081.19 (Professor Weatherburn, Dr Hughes, Professor Ritter, Professor Seear).
- 205 Bluemoon Research and Planning, 'Patterns of use and harms associated with specific populations of methamphetamine users in Australia – Exploratory research' (February 2008) 76.
- 206 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4011.7-19 (Dr Weatherburn), 4058.45-7 (Dr Hughes), 4080.9-10 (Professor Ritter), 4080.24-4081.19 (Professor Weatherburn, Dr Hughes, Professor Ritter, Professor Seear).
- 207 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4928.36-44 (Dr Hughes).
- 208 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4829.1-4 (Dr Hughes); Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3966.25-30 (Scipione). See also Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 3, 69; Legal Aid NSW, Submission No 136 (May 2019) 7.
- 209 Ricardo Gonçalves, Ana Lourenço and Sofia Nogueira da Silva, 'A social cost perspective in the wake of the Portuguese strategy for a fight against drugs' (2015) 26(2) *International Journal of Drug Policy* 199, 200-201.
- 210 MindM8 Ventures, Submission No 93 (undated, received 7 May 2019) 1.
- 211 Administrative Violations Code (Latvia), s 46 [tr Valsts valodas centrs (State Language Centre)]; Code of Administrative Offences 1985 (Lithuania) art 44 [tr Redagavo Aušrinė Trapinskienė].
- 212 Law no 30/2000 of 29 November (Portugal) arts 12, 13 [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 213 NSW's Work Development Order scheme is discussed later in this chapter. See also, for example, *Fines Enforcement and Debt Recovery Act 2017* (SA) subs 20(6)(g), (8), (14); *Fines Reform Act 2014* (Vic) s 218.
- 214 Custodial Hearing, Sydney, 4 September 2019, TS 3517.43-18.10 ("PG"), TS 3597.6-29 (Dr Gray). See Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Expert Report of Shalini Arunogiri dated September 2019, Appendix 1: Manning et al, Turning Point, *Rapid Review – the evidence for compulsory treatment* (Report, September 2018) 20.
- 215 Dan Werb et al, 'The effectiveness of compulsory drug treatment: a systematic review' (2016) 28 *International Journal of Drug Policy* 1, 7.
- 216 Custodial Hearing, Sydney, 4 September 2019, TS 3597.6-29 (Dr Gray); Sydney (General) Hearing, Sydney, 9 May 2019, TS 273.38-274.19 (Dr Brett). See also Harm Reduction Hearing, Sydney, 23 September 2019, TS 4209.46-4210.11 (Associate Professor McKetin); Harm Reduction Hearing, Sydney, 24 September 2019, TS 4286.41-4287.2 (Professor Ezard).
- 217 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Expert Report of Shalini Arunogiri dated September 2019, Appendix 1: Manning et al, Turning Point, 'Rapid Review – the evidence for compulsory treatment' (Report, September 2018) 20.
- 218 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Expert Report of Shalini Arunogiri dated September 2019, 31.
- 219 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Expert Report of Shalini Arunogiri dated September 2019, 31.
- 220 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4921.11-17 (Dr Hughes); Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4034.31-4 (Lloyd). See also Australasian Chapter of Addiction Medicine of the Royal Australasian College of Physicians, Preliminary Submission No 85 (31 January 2019) 3; Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: Detailed Findings* (2017) 67; Gary CK Chan et al, 'Longitudinal patterns of amphetamine use from adolescence to adulthood: A latent class analysis of a 20-years prospective study of Australians' (2019) 194 *Drug and Alcohol Dependence* 121, 125; Andrew Smirnov et al, 'Young Adults' Trajectories of Ecstasy Use: A Population Based Study' (2013) 38(11) *Addictive Behaviours* 2667, 2673.
- 221 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4009.34-6 (Professor Ritter); Sydney (General) Hearing, Sydney, 9 May 2019, TS 243.8-10 (Dr Brett); Harm Reduction Hearing, Sydney, 23 September 2019, TS 4177.9-13 (Professor Ritter). See Harm Reduction Hearing, Sydney, 24 September 2019, TS 4326.6-12 (van der Gouwe); James Shearer, Linda Gowing, 'Chapter 8: Pharmacological interventions' in Amanda Baker, Nichole Lee, Linda Jenner (eds), *Models of intervention and care for psychostimulant users* (Australian Government Department of Health and Ageing, National Drug Strategy Monograph Series No. 51, 2nd ed, 2004) Ecstasy; Libby Topp, Wayne Hall and Julie Hando, *Is there a syndrome for ecstasy?* (NDARC Technical Report

- No 51, 1997) 27-8; Louisa Degenhardt, Raimondo Bruno and Linda Topp, 'Is ecstasy a drug of dependence?' (2010) 107(1) *Drug and Alcohol Dependence* 1 Cf Jerrold Meyer, '3,4-methylenedioxyamphetamine (MDMA): current perspectives' (2013) 4 *Substance Abuse and Rehabilitation* 83, 93-94.
- 222 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4177.7-26 (Professor Ritter).
- 223 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4045.45-46.5 (Professor Ritter).
- 224 Wayne Hall et al, 'How many dependent opioid users are there in Australia?' (Monograph No 44, [NDARC UNSW Sydney], 2000) 1, citing Anthony et al, 'Comparative epidemiology of dependence on tobacco, alcohol, controlled substances and inhalants: Basic findings from the National Comorbidity Survey' (1994) *Experimental and Clinical Psychopharmacology* 2, 244-268.
- 225 In 2013, 70% of people who came before the CDT were assessed to be non-dependent users and received a suspended sentence with no further intervention: see Ana Sofia Santos and Óscar Duarte, Reitox National Focal Point, 2014 *National Report (2013 data) to the EMCDDA – Portugal – New Developments, Trends* (Annual Report, General-Directorate for Intervention on Addictive Behaviours and Dependencies, 2015) 105.
- 226 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4046.45-6 (Dr Hughes). See also Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4080.24-4081.19 (Dr Weatherburn, Professor Ritter, Professor Seear, Dr Hughes).
- 227 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4010.1-2 (Professor Ritter). See also Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3997.47-98.1 (Madden), 3998.33-4 (Professor Weatherburn), 4009.34-5 (Professor Ritter), 4034.32-33 (Cr Lloyd), 4938.33-6 (Professor Seear).
- 228 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3997.39-40 (Madden), 4010.9-35 (Professor Ritter).
- 229 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3977.27-36 (Professor Seear).
- 230 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4011.7-19 (Professor Weatherburn).
- 231 See Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3979.37-8 (Dr Wodak), 3984.40-85.4 (Scipione, Professor Weatherburn), 3998.36-46 (Professor Weatherburn), 4009.13-21 (Professor Ritter), 4011.7-19, 4038.9-10 (Professor Weatherburn).
- 232 See Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3969.32-7, 3970.10-13 (Professor Weatherburn), 3971.32-7 (Cr Lloyd), 3973.6-8 (Madden), 4042.45-43.6 (Professor Ritter, Professor Weatherburn), 4068.35ff (Professor Ritter, Odgers SC, Professor Weatherburn, Madden, Professor Seear, Lloyd).
- 233 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4072.27-34 (Professor Ritter).
- 234 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 8. See Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 63-64.
- 235 *Controlled Substances Act 1984* (SA) s 36(1).
- 236 *Controlled Substances Act 1984* (SA) s 38(1).
- 237 *Controlled Substances Act 1984* (SA) ss 38(4), 40(4).
- 238 *Controlled Substances Act 1984* (SA) ss 37-40.
- 239 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 63.
- 240 Melanie Millstead, Office of Crime Statistics and Research, 'Ten Years of the South Australian Police Drug Diversion Initiative' (Data Analysis Report, May 2012) 1-3.
- 241 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 71.
- 242 Jason Payne, Max Kwiatkowski and Joy Wundersitz, Australian Institute of Criminology, *Police drug diversion: a study of criminal offending outcomes* (Research and Public Policy Series No 97, , October 2008) 7-8.
- 243 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4639.36-46 (Acting Superintendent Cook).
- 244 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4648.37-49.4 (Acting Superintendent Cook).
- 245 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4650.1-6 (Acting Superintendent Cook).
- 246 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4649.13-38 (Acting Superintendent Cook).
- 247 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4929.1-4 (Dr Hughes); Legal Aid NSW, Submission No 136 (May 2019) 7; NSW Bar Association, Submission No 97 (7 May 2019) 4.
- 248 Closing Submissions on behalf of NSW Police Force, (11 November 2019), 7.
- 249 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 7.
- 250 Caitlin Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion*, (Monograph No. 27, May 2019) 6.
- 251 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4939.20-32 (Dr Hughes).
- 252 Caitlin Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion*, (Monograph No. 27, May 2019) 4.
- 253 Caitlin Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion*, (Monograph No. 27, May 2019) 5, 46.
- 254 For example, the NSW Criminal Infringement Notice Scheme – see *Criminal Procedure Regulation 2017* (NSW), sch. 4; Offences under *Drug Misuse and Trafficking Act 1985*; and the NSW Cannabis Cautioning Scheme which sets a threshold at 15g of dried cannabis leaf.
- 255 *Drug Misuse and Trafficking Act 1985* (NSW) s 29.
- 256 For a range of threshold limits that apply internationally, see <http://www.emcdda.europa.eu/publications/topic-overviews/threshold-quantities-for-drug-offences/html_en>.
- 257 Decree Law 14294 of 1974 (Uruguay) art 31 [tr United Nations Office on Drugs and Crime].
- 258 Law No 30/2000 of 29 November (Portugal) art 2(2) [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 259 *Criminal Procedure Regulation 2017* (NSW) sch 4; *Drug Misuse and Trafficking Act 1985* (NSW) sch 1.
- 260 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 25, Confidential Exhibit.
- 261 *Drugs of Dependence Act 1989* (ACT) s 171A(7)(b).

- 262 Niamh Eastwood, Edward Fox and Ari Rosmarin, *'A Quiet Revolution: Drug Decriminalisation Across the Globe'* (Report, 2nd ed, March 2016) 7, 8.
- 263 Decriminalisation Roundtable, Sydney, 18 December 2019, TS 3973.15-18 (Madden), 4034.21-29 (Cr Lloyd), 4059.8-30, 4060.8-14 (Dr Hughes), 4063.1-6 (Professor Ritter).
- 264 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 9. See also National Drug and Alcohol Research Centre, Submission No 81 (7 May 2019) 13; Justice Action, Submission No 100 (7 May 2019) 21.
- 265 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4063.1-6 (Professor Ritter).
- 266 Caitlin Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph No. 27, May 2019) 50, 55; See also Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes dated 13 September 2019, 14[29(a)]; Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4060.12-14 (Dr Hughes).
- 267 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes dated 13 September 2019, 14[29(a)]. For thresholds, see *Criminal Procedure Regulation 2017* (NSW) sch 4; *Drug Misuse and Trafficking Act 1985* (NSW) sch 1.
- 268 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes dated 13 September 2019, 14[29(a)].
- 269 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3983.47-84.7 (Scipione).
- 270 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3984.9-12 (Professor Weatherburn, Scipione).
- 271 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4627.11-21 (Acting Superintendent Cook).
- 272 ACON, Submission No 77 (May 2019) 13.
- 273 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4939.44-4940.3 (Dr Hughes). See also Caitlin Hughes et al, *'Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion'* (Monograph No. 27, [Drug Policy Modelling Program], May 2019) 50.
- 274 Caitlin Hughes et al, *'Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion'* (Monograph No. 27, Drug Policy Modelling Program, May 2019) 50.
- 275 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4034.7-11 (Lloyd).
- 276 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4940.5-10 (Dr Hughes).
- 277 Caitlin Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph No. 27, May 2019) 24.
- 278 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4074.26-4076.1 (Lloyd); Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4941.13-18 (Dr Hughes).
- 279 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4014.11-27 (Professor Weatherburn).
- 280 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4941.13-18 (Professor Hughes).
- 281 Caitlin Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph No. 27, May 2019) 29.
- 282 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4077.16-19 (Dr Hughes).
- 283 Statutes Amendment (Drug Offences) Act 2018 (SA) s 24. The amendments were passed on 21 November 2018, and commenced on 1 April 2019 by proclamation.
- 284 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4627.38-4628.5 (Acting Superintendent Cook).
- 285 See Global Commission on Drug Policy, *Regulation: The Responsible Control of Drugs* (Report, 2018) 5; Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (2016) 5-7, 15; Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3967.40-47 (Professor Ritter), 3971.23-8 (Lloyd), 3979.36-7 (Dr Wodak); Australia21, 'Can Australia respond to drugs more effectively and safely' (Roundtable report, November 2016) 2.
- 286 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (2016) 5, 11. See also, in relation to the impact of criminalisation relative to the purpose of drug policy and in relation to access to treatment and harm reduction, Joint United Nations Programme on HIV/AIDS (UNAIDS), *Health, Rights and Drugs: Harm reduction, decriminalization and zero discrimination for people who use drugs* (13 March 2019) 5, 33-5; United Nations system coordination Task Team on the Implementation of the United Nations System Common Position on drug-related matters, *What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters* (Brief, March 2019) 11, 41. See Criminal Law Committee, New South Wales Bar Association, *Drug Law Reform* (Discussion Paper, November 2014) 14; NSW Bar Association, Submission No 97 (7 May 2019) 6. See also NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 7.
- 287 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4074.2-4 (Professor Ritter).
- 288 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 41, Statement of Andrew House dated 4 July 2019, [14], [17]; Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2515.29-37, 2517.26-2518.5 (House).
- 289 See Caitlin Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph No. 2, May 2019) 23-27.
- 290 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 25, Confidential Exhibit.
- 291 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4628.31-4 (Acting Superintendent Cook).
- 292 See Caitlin Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph No. 27, May 2019) 24-25.
- 293 Jason Payne, Max Kwiatkowski and Joy Wundersitz, Australian Institute of Criminology, *Police drug diversion: a study of criminal offending outcomes* (Research and Public Policy Series No 97, , October 2008) 23.
- 294 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4628.7-26 (Acting Superintendent Cook).
- 295 Hughes et al, Drug Policy Modelling Program, *Criminal justice responses relating to personal use and possession of illicit drugs: the reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph 27, UNSW Sydney, May 2019) 48; Australian Institute of Health and Welfare, *The effectiveness of the illicit drug diversion initiative in rural and remote Australia* (Drug Statistic Series Number 19, Canberra, April 2008) 20.
- 296 See Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4081.39-82.21 (Professor Seear, Madden, Professor Weatherburn, Lloyd), 4082.35-41 (Professor Seear).

- 297 Troy Allard et al, Australian Institute of Criminology, *Police diversion of young offenders and Indigenous over-representation* (Trends & issues in crime and criminal justice No. 390, March 2010) 1, 4.
- 298 Laura Brown, 'The criminalisation of conduct: Indigenous youth in the criminal justice system' (2012) 7(28) *Indigenous Law Bulletin* 8, 8.
- 299 Penington Institute, Submission No 56 (May 2019) 18.
- 300 Mission Australia, Submission No 66 (2019) 5.
- 301 Moree Plains Shire Council, Submission No 72 (May 2019) 10 [2.4.11].
- 302 Moree Plains Shire Council, Submission No 72 (May 2019) 10 [2.4.14].
- 303 Aboriginal Legal Service, Submission No 116 (7 May 2019) 7.
- 304 Aboriginal Legal Service, Submission No 116 (7 May 2019) 7.
- 305 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3970.38-40 (Lloyd).
- 306 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4940.19-27 (Dr Hughes).
- 307 See, for example, Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 7-8; National Drug and Alcohol Research Centre, Submission No 81 (7 May 2019) 11-12; NSW Bar Association, Submission No 97 (7 May 2019) 3-4; Justice Action, Submission No 100 (7 May 2019) 4-12; Caitlin Hughes and Alison Ritter, Drug Policy Modelling Program, *A summary of diversion programs for drug and drug-related offences* (Monograph No. 16, February 2008); Caitlin Hughes et al, UNSW Australia and University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, 2018).
- 308 Caitlin Hughes et al, Drug Policy Modelling Program, *Decriminalisation of drug use and possession in Australia – A briefing note* (February 2016) 4; Commonwealth Parliamentary Joint Committee on Law Enforcement, *Final report: Inquiry into crystal methamphetamine* (Report, 27 March 2018) 130-131.
- 309 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018).
- 310 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 57.
- 311 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 57.
- 312 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 58.
- 313 See, for example, Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 27-28, 34, 36, 50.
- 314 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 59.
- 315 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 60.
- 316 Joanne Baker, Derek Goh, NSW Bureau of Crime Statistics and Research *The cannabis cautioning scheme three years on: an implementation and outcome evaluation* (Report, 23 September 2004) 4.
- 317 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 19; Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes dated 13 September 2019, [23].
- 318 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 2.
- 319 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 2, 10.
- 320 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 19; Diversionary Programs Hearing, Sydney, Diversionary Programs Exhibit A, Tab 5 Statement of Caitlin Hughes, 13 September 2019, 10[23].
- 321 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 12, 15. See also, in relation to benefits of diversion generally, Diversionary Program Hearing, Sydney, 1 October 2019, TS 4650.8-26 (Acting Superintendent Cook).
- 322 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 12.
- 323 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 15, 19.
- 324 NSW Auditor-General, Audit Office of New South Wales, *The effectiveness of cautioning for minor cannabis offences: NSW Police Force, NSW Health* (Performance Audit, April 2011) 14.
- 325 Joanne Baker, Derek Goh, 'The cannabis cautioning scheme three years on: an implementation and outcome evaluation' (NSW Bureau of Crime Statistics and Research, 2004) 25, 29, 31-37.
- 326 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4626.30-4 (Acting Superintendent Cook).
- 327 Diversionary Programs Hearing, Sydney, Diversionary Programs Exhibit A, Tab 5 Statement of Caitlin Hughes, 13 September 2019, 10[23].
- 328 See Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4941.5ff (Dr Hughes); 1 October 2019, TS 4627.28ff (Acting Superintendent Cook).
- 329 Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 7.
- 330 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 64.
- 331 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 65.
- 332 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 38, 57, 64.
- 333 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 39.
- 334 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 65.

- 335 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 45.
- 336 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 66.
- 337 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 67.
- 338 Caitlin Hughes et al, UNSW Australia, University of Kent, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, September 2018) 67.
- 339 *Criminal Procedure Amendment (Penalty Notices for Drug Possession) Regulation 2019* (NSW) cl 3; *Criminal Procedure Regulation 2017* (NSW) sch 4.
- 340 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 35, Response of NSW Police Force dated 7 August 2019, to Request for Information dated 2 July 2019, 11.
- 341 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 35, Response of NSW Police Force dated 7 August 2019, to Request for Information dated 2 July 2019, 11.
- 342 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 21, Confidential Exhibit, Tab 22, Confidential Exhibit.
- 343 Sydney (General) Hearing, Sydney, 7 May 2019, TS 107.11-24 (Acting Superintendent Cook); Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4632.8-12 (Acting Superintendent Cook).
- 344 Tom Gotsis, NSW Parliamentary Research Service, 'Drug use at music festivals' (e-brief Issue No 3/2018, December 2019) 4.
- 345 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4632.5-12 (Acting Superintendent Cook).
- 346 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4632.1-5 (Acting Superintendent Cook). See also Mick Fuller, Kerry Chant and Philip Crawford, NSW Government, *Keeping People Safe at Music Festivals: Expert Panel Report* (October 2018) 2.
- 347 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 35, Response of Natalie Marsic, NSW Police Force dated 7 August 2019, to Request for Information dated 2 July 2019, 9-11.
- 348 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes dated 13 September 2019, 13-14.
- 349 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes dated 13 September 2019, 14.
- 350 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes dated 13 September 2019, 14.
- 351 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes, 13 September 2019, 8[18].
- 352 Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 7.
- 353 *Criminal Procedure Regulation 2017* (NSW) sch 4.
- 354 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4632.1-40 (Acting Superintendent Cook).
- 355 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4631.12-18 (Acting Superintendent Cook).
- 356 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4643.16-19 (Acting Superintendent Cook).
- 357 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4643.29-44 (Acting Superintendent Cook).
- 358 Closing Submissions on behalf of the NSW Police Force, 11 November 2019, 7-8.
- 359 Including possession within a prescribed amount and consumption not in a public or other restricted place: *Controlled Substances Act 1984* (SA) ss 33L(2), 45A(8)(b)-(c).
- 360 *Controlled Substances Act 1984* (SA) s 45A(2).
- 361 *Expiation Offences Act 1996* (SA) s 15.
- 362 Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, [UNSW Australia and University of Kent], 2018) 47.
- 363 Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, UNSW Australia and University of Kent, 2018) 47.
- 364 Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, UNSW Australia and University of Kent, 2018) 47.
- 365 Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, UNSW Australia and University of Kent, 2018) 47.
- 366 See Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, UNSW Australia and University of Kent, 2018) 68.
- 367 Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, UNSW Australia and University of Kent, 2018) 69.
- 368 Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, UNSW Australia and University of Kent, 2018) 69-70.
- 369 Law no. 30/2000, of 29 November (Portugal) art 2(1) [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 370 Law no. 30/2000, of 29 November (Portugal) arts 5, 7 [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 371 Caroline Sapp, 'Rehabilitate or incarcerate? A comparative analysis of the United States' sentencing laws on low-level drug offenders and Portugal's decriminalization of low-level drug offenses' (2014) 23 *Cardozo Journal of International and Comparative Law* 63, 68, 86.
- 372 See Law no. 30/2000, of 29 November (Portugal) arts 2(2), 4, 5, 10 [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 373 See Law no. 30/2000, of 29 November (Portugal) arts 11, 13, 14 [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 374 See Law no. 30/2000, of 29 November (Portugal) arts 15, 16, 17 [tr General-Directorate for Intervention on Addictive Behaviours and Dependencies Ministry of Health – Portugal].
- 375 Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: Detailed findings* (Drug Statistics Series No 31, 2017) 51, 53.
- 376 Caitlin Hughes and Alex Stevens, 'What can we learn from the Portuguese Decriminalization of Illicit Drugs? (2010) 50 *British Journal of Criminology* 999, 1001.
- 377 Ricardo Gonçalves, Ana Lourenço and Sofia Nogueira da Silva, 'A social cost perspective in the wake of the Portuguese strategy for a fight against drugs' (2015) 26(2) *International Journal of Drug Policy* 199, 200-201.

- 378 Ricardo Gonçalves, Ana Lourenço and Sofia Nogueira da Silva, 'A social cost perspective in the wake of the Portuguese strategy for a fight against drugs' (2015) 26(2) *International Journal of Drug Policy* 199, 200.
- 379 Hannah Lacquer, 'Uses and Abuses of Drug Decriminalization in Portugal' (2015) 40(3) *Law & Social Inquiry* 746, 748.
- 380 Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 7-8; National Drug and Alcohol Research Centre, Submission No 81 (7 May 2019) 12; NSW Bar Association, Submission No 97 (7 May 2019) 3-4; Justice Action, Submission No 100 (7 May 2019) 4-7.
- 381 Australian Criminal Intelligence Commission, Submission No 149 (7 June 2019) 22.
- 382 Caitlin Hughes and Alex Stevens, 'What can we learn from the Portuguese Decriminalization of Illicit Drugs?' (2010) 50 *British Journal of Criminology* 999, 1017.
- 383 Caitlin Hughes and Alex Stevens, 'What can we learn from the Portuguese Decriminalization of Illicit Drugs?' (2010) 50 *British Journal of Criminology* 999, 1017.
- 384 Ricardo Gonçalves, Ana Lourenço and Sofia Nogueira da Silva, 'A social cost perspective in the wake of the Portuguese strategy for a fight against drugs' (2015) 26(2) *International Journal of Drug Policy* 199, 207.
- 385 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 20.
- 386 Don Weatherburn, 'The pros and cons of prohibiting drugs' (2014) 47(2) *Australian & New Zealand Journal of Criminology* 176, 177.
- 387 Don Weatherburn, 'The pros and cons of prohibiting drugs' (2014) 47(2) *Australian & New Zealand Journal of Criminology* 176, 177.
- 388 Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, UNSW Australia and University of Kent, 2018) 59, 61, 63, 64, 66, 69. See also Legal Aid NSW, Submission No 136 (May 2019) 7; Criminal Law Committee, New South Wales Bar Association, *Drug Law Reform* (Discussion Paper, November 2014) 5, 18-19. Cf costs of prohibition discussed in Criminal Law Committee, New South Wales Bar Association, *Drug Law Reform* (Discussion Paper, November 2014) 15-16.
- 389 Caitlin Hughes et al, 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' (Report, UNSW Australia and University of Kent, 2018) 63, 70. See also Criminal Law Committee, New South Wales Bar Association, *Drug Law Reform* (Discussion Paper, November 2014) 5.
- 390 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4061.28-34 (Dr Hughes).
- 391 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes, 13 September 2019, 15; Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4924.8-14, 4939.20-32 (Dr Hughes).
- 392 Caitlin Hughes et al, 'Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion' (Monograph No 27, Drug Policy Modelling Program, May 2019) 8.
- 393 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3971.33-37 (Lloyd).
- 394 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3973.4-10 (Madden).
- 395 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3991.35-44, 4005.35-38 (Professor Weatherburn); Alex Stevens, 'Is policy 'liberalization' associated with high odds of adolescent cannabis use? A re-analysis of data from 38 countries' (2019) 66 *International Journal of Drug Policy* 94.
- 396 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3993.21-28 (Dr Hughes).
- 397 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4028.10-21, 4029.15-30 (Scipione).
- 398 Closing Submissions on behalf of the NSW Police Force, 11 November 2019, 7-8.
- 399 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 8; National Drug and Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 12.
- 400 Niamh Eastwood, Edward Fox and Ari Rosmarin, 'A Quiet Revolution: Drug Decriminalisation Across the Globe' (Report, 2nd ed, March 2016) 7.
- 401 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3966.25-30 (Scipione).
- 402 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3973.42-47 (Madden).
- 403 Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3974.3-5 (Madden), TS 3990.16-43, 4054.5-38 (Dr Wodak); Nicholas Cowdery QC, Submission No 159 (19 August 2019) 2, 3; Penington Institute, Submission No 56 (May 2019) 6; Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 27.
- 404 Rawsthorne, 'Global expert calls for drug decriminalisation in Australia', *The Sydney Morning Herald* (online, 8 June 2019) <<https://www.smh.com.au/national/global-expert-calls-for-drug-decriminalisation-in-australia-20180607-p4zk42.html>>.
- 405 NSW Council of Social Service, Submission No 54 (7 May 2019) 5.
- 406 Department of the Prime Minister and Cabinet, Commonwealth, *Final Report of the National Ice Taskforce* (Report, 2015) 112.
- 407 Parliamentary Joint Committee on Law Enforcement, Commonwealth, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) 166[6.92].
- 408 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 15.
- 409 Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 20.
- 410 The Inquiry notes that submissions and literature discuss a third international drug convention – the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol (*Narcotics Convention*). However, the *Narcotics Convention* does not apply to ATS.
- 411 *Convention on Psychotropic Substances* (1971) art 7(a), 22(1)(a).
- 412 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) art 3(2).
- 413 *Convention on Psychotropic Substances* (1971) art 22(1)(b); *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) art 3(4)(d).
- 414 See Law Reform, Road and Community Safety Committee, Parliament of Victoria, *Inquiry into drug law reform* (Final Report, March 2018) 47.
- 415 See United Nations System Chief Executives Board for Coordination, *Summary of deliberations: Chief Executives Board for Coordination, 2nd regular session of 2018, New York, 7 and 8 November 2018* (Report, 18 January 2019) 4, 14; Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016); The Public Defenders, Submission No 12 (29 April 2019) 3; NSW Bar Association, Submission No 97 (7 May 2019) 7; Legal Aid NSW, Submission No 136 (May 2019) 7-8.
- 416 Commonwealth Department of Home Affairs, Submission No 141 (June 2019) 5.

- 417 United Nations System Chief Executives Board for Coordination, *Summary of deliberations: Chief Executives Board for Coordination, 2nd regular session of 2018, New York, 7 and 8 November 2018* (Report, 18 January 2019) 4, 14.
- 418 UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, *What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters* (Briefing Paper, March 2019) 25.
- 419 Caitlin Hughes et al, 'Decriminalisation of drug use and possession in Australia – A briefing note' (Drug Policy Modelling Program, February 2016) 4; Niamh Eastwood, Edward Fox and Ari Rosmarin, 'A Quiet Revolution: Drug Decriminalisation Across the Globe' (Report, 2nd ed, March 2016) 13-37.
- 420 *Convention on Psychotropic Substances* (1971) art 22(1)(b); *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) art 3(4)(d).
- 421 See United Nations System Chief Executives Board for Coordination, *Summary of deliberations: Chief Executives Board for Coordination, 2nd regular session of 2018, New York, 7 and 8 November 2018* (Report, 18 January 2019) 4, 14; The Commission on Narcotic Drugs, *Supporting the collaboration of public health and justice authorities in pursuing alternative measures to conviction or punishment for appropriate drug related offences of a minor nature* (Resolution 58/5) <https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_58/2015_Resolutions/Resolution_58_5.pdf>. See also United Nations Office on Drugs and Crime and World Health Organization, *Treatment and care for people with drug use disorders in contact with the criminal justice system – alternatives to conviction or punishment* (March 2018) 18, 21ff; UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, *What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters* (Briefing paper, March 2019) 28.
- 422 Commonwealth Department of Home Affairs, Submission No 141 (June 2019) 6.
- 423 Commonwealth Department of Home Affairs, Submission No 141 (June 2019) 5.
- 424 Commonwealth Department of Home Affairs, Submission No 141 (June 2019) 4-6.
- 425 Australian Criminal Intelligence Commission, Submission No 149 (7 June 2019) 21.
- 426 Law Reform, Road and Community Safety Committee, Victorian Parliament, *Inquiry into drug law reform* (Final Report, March 2018) 190; Western Australia Legislative Council, *Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community* (Final Report, August 2019) 72; see also Commonwealth Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) [6.98].
- 427 Law Reform, Road and Community Safety Committee, Victorian Parliament, *Inquiry into drug law reform* (Final Report, March 2018) 193; see also Commonwealth Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) [6.98].
- 428 Western Australia Legislative Council, *Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community* (Final Report, August 2019) 74.
- 429 Law Reform, Road and Community Safety Committee, Victorian Parliament, *Inquiry into drug law reform* (Interim Report, March 2018) 190-193.
- 430 Commonwealth Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice)* (Interim Report, March 2018) [6.92].
- 431 Law Reform, Road and Community Safety Committee, Victorian Parliament, *Inquiry into drug law reform* (Final Report, March 2018) 190-193.
- 432 Commonwealth Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) [6.94].
- 433 Commonwealth Parliamentary Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) [6.93].
- 434 Western Australia Legislative Council, *Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community* (Final Report, August 2019) 85-86.
- 435 Western Australia Legislative Council, *Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community* (Final Report, August 2019) 94.
- 436 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam and Alexandra Ross-King*, (Findings of Deputy State Coroner Grahame, 8 November 2019) [541]-[542].
- 437 See Amanda Jamieson, Brandi Baylock and Patrizia Poletti, Common offences in the NSW Local Court: 2015 (Sentencing Trends and Issues, Judicial Commission of New South Wales, No 46, May 2017, 10, 35.
- 438 See Amanda Jamieson, Brandi Baylock and Patrizia Poletti, Common offences in the NSW Local Court: 2015 (Sentencing Trends and Issues, No 46, Judicial Commission of New South Wales, May 2017) 11, 35.
- 439 See Amanda Jamieson, Brandi Baylock and Patrizia Poletti, Common offences in the NSW Local Court: 2015 (Sentencing Trends and Issues, No 46, Judicial Commission of New South Wales, May 2017) 35.
- 440 Alexandra Voce and Tom Sullivan, *Drug use monitoring in Australia: Drug use among police detainees, 2018* (Statistical Report No 18, Australian Institute of Criminology Reports, (4 December 2019) 3, 5.
- 441 Alexandra Voce and Tom Sullivan, *Drug use monitoring in Australia: Drug use among police detainees, 2018* (Statistical Report No 18, Australian Institute of Criminology Reports, (4 December 2019) 10.
- 442 Custodial Hearing, Sydney, Exhibit A, Tab 26, Statement of Gary Forrest 4 July 2019, 7[37].
- 443 Caitlin Hughes et al, *Evaluation of the Australian Capital Territory Drug Diversion Programs* (Drug Policy Modelling Program, Report February 2013) 7; See also Jason Payne, Max Kwiatkowski and Joy Wundersitz, *Police drug diversion: a study of criminal offending outcomes* (Research and Public Policy Series No 97, Australian Institute of Criminology, (October 2008) 2; Australian Institute of Health and Welfare, *Alcohol and other drug treatment and diversion from the Australian criminal justice system* (Bulletin 125, October 2014) 4.
- 444 New South Wales Law Reform Commission, *Sentencing* (Report 139, July 2013) 339-340, 345.
- 445 Caitlin Hughes and Alison Ritter, 'A summary of diversion programs for drug and drug-related offences' (Monograph No. 16, Drug Policy Modelling Program, February 2008) 5.
- 446 Caitlin Hughes et al, *Evaluation of the Australian Capital Territory Drug Diversion Programs* (Drug Policy Modelling Program, February 2013) 15. See also Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 5; Randall T. Brown, 'Systematic review of the impact of adult drug-treatment courts' (2010) 155(6) *Translational Research* 263, 263.
- 447 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4921.1-6 (Dr Hughes).
- 448 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4921.6-9 (Dr Hughes).

- 449 Jason Payne, Max Kwiatkowski and Joy Wundersitz, *Police drug diversion: a study of criminal offending outcomes* Research and Public Policy Series No 97, Australian Institute of Criminology, (October 2008) 2-3; Australian Institute of Health and Welfare, *Alcohol and other drug treatment and diversion from the Australian criminal justice system* (Bulletin No 125, October 2014) 4.
- 450 Jason Payne, Max Kwiatkowski and Joy Wundersitz, *Police drug diversion: a study of criminal offending outcomes* (Research and Public Policy Series No 97, Australian Institute of Criminology, October 2008) 2.
- 451 Jason Payne, Max Kwiatkowski and Joy Wundersitz, *Police drug diversion: a study of criminal offending outcomes* Research and Public Policy Series No 97, Australian Institute of Criminology, (October 2008) 2; Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No. 16, Drug Policy Modelling Program, February 2008) 4.
- 452 See Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 2, 11, 13-14.
- 453 See Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 4.
- 454 See Ministerial Council on Drug Strategy, Commonwealth, *National Drug Strategic Framework 1998–1999 to 2002–2003: Building Partnerships* (Strategy, November 1998) 6-7, 15.
- 455 Caitlin Hughes and Alison Ritter, 'A summary of diversion programs for drug and drug-related offences' (Monograph No. 16, Drug Policy Modelling Program, February 2008) 4.
- 456 Marian Shanahan, Caitlin Hughes and Tim McSweeney, *Australian police diversion for cannabis offences: Assessing program outcomes and cost-effectiveness* (Monograph Series No 66, *National Drug Law Enforcement Research Fund*, 2016) 6.
- 457 Australian Institute of Health and Welfare, Commonwealth, *Alcohol and other drug treatment and diversion from the Australian criminal justice system* (Bulletin No 125, October 2014) 4.
- 458 Jason Payne, Max Kwiatkowski and Joy Wundersitz, *Police drug diversion: a study of criminal offending outcomes* (Research and Public Policy Series No 97, Australian Institute of Criminology, October 2008) 3. See also Australian Institute of Health and Welfare, *Alcohol and other drug treatment and diversion from the Australian criminal justice system*, (Bulletin No 125, October 2014) 4, 6.
- 459 See Melissa Bull, A comparative review of best practice guidelines for the diversion of drug related offenders' (2005) 16(4) *International Journal of Drug Policy* 223, 223; Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No. 16, Drug Policy Modelling Program, February 2008) 4.
- 460 See Marian Shanahan, Caitlin Hughes and Tim McSweeney, *Australian police diversion for cannabis offences: Assessing program outcomes and cost-effectiveness* (Monograph Series No 66, *National Drug Law Enforcement Research Fund*, 2016) 6-7.
- 461 Senate Legal and Constitutional Affairs Reference Committee, *Value of a justice reinvestment approach to criminal justice in Australia* (Report, Commonwealth of Australia, June 2013) [2.1], [2.19].
- 462 See Caitlin Hughes et al, *Evaluation of the Australian Capital Territory Drug Diversion Programs* (Report, Drug Policy Modelling Program, February 2013) 15; Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No. 16, Drug Policy Modelling Program, February 2008) 5-6.
- 463 Department of Health, Commonwealth of Australia, *National Drug Strategy 2017–2026* (Report, 2017) 23.
- 464 Adam Fletcher and André Dao, *Alternatives to Imprisonment for Vulnerable Offenders – International standards and best practice* (Report for Australian Government Attorney-General's Department, July 2012) 6.
- 465 Lily Trimboli, 'NSW Court Referral of Eligible Defendants into Treatment (CREDIT) pilot program: An evaluation' (*Crime and Justice Bulletin* No. 159, NSW Bureau of Crime Statistics and Research, February 2012) 2.
- 466 Winifred Agnew-Pauley and Jessie Holmes, 'Re-offending in NSW' (*Crime and Justice Statistics Bureau Brief* No. 108, NSW Bureau of Crime Statistics and Research, August 2015) 1, 3.
- 467 See Senate Legal and Constitutional Affairs Reference Committee, *Value of a justice reinvestment approach to criminal justice in Australia* (Report, June 2013) Chapter 3.
- 468 NSW Branch of the Royal Australian and New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 15.
- 469 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 5.
- 470 Melissa Bull, 'A comparative review of best practice guidelines for the diversion of drug related offenders' (2005) 16(4) *International Journal of Drug Policy* 223, 227-232.
- 471 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 6, Statement of Jared Sharp 18 September 2019, [17], [24], [35]-[37].
- 472 Moree Plains Shire Council, Submission No 72 (May 2019) 10[2.4.16].
- 473 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 6, Statement of Jared Sharp 18 September 2019, [24].
- 474 Caitlin Hughes et al, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph No 27, Drug Policy Modelling Program, May 2019) 1.
- 475 Caitlin Hughes et al, 'Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion' (Monograph No. 27, Drug Policy Modelling Program, May 2019) 12.
- 476 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 6.
- 477 Drug Policy Modelling Program, UNSW, Submission No 57 (7 May 2019) 7.
- 478 Caitlin Hughes et al, *Criminal justice responses relating to personal use and possession of illicit drugs: the reach of Australian drug diversion programs and barriers and facilitators to expansion* (Drug Policy Modelling Program Monograph No 27, May 2019) 1.
- 479 Caitlin Hughes et al, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph No 27, Drug Policy Modelling Program, May 2019) 4.
- 480 Caitlin Hughes et al, 'Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion' (Monograph No. 27, Drug Policy Modelling Program, May 2019) 5.
- 481 Caitlin Hughes et al, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Monograph No 27, Drug Policy Modelling Program, May 2019) 6-7.
- 482 J Latimer et al, 'A Meta-Analytic Examination of Drug Treatment Courts: Do They Reduce Recidivism?' (Research and Statistics Division, Department of Justice Canada, 2006) 13-14; Gill McIvor, 'Chapter 7: Drug Courts - Lessons from the UK and Beyond' in Anthea Huckleby and Emma Wincup (eds) *Drug Interventions in Criminal Justice* (Open University Press, 2010) 135; Eric Sevigny, Brian Fuleihan and Frank Ferdik, 'Do drug courts reduce the use of incarceration?: A meta-analysis' (2013) 41(6) *Journal*

- of *Criminal Justice* 416, 416; Ojmarrh Mitchell et al, 'Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts' (2012) 40(1) *Journal of Criminal Justice* 60, 70. See also Randall T Brown, 'Systematic review of the impact of adult drug-treatment courts' (2010) 155(6) *Translational Research* 263, 263.
- 483 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 5. See Caitlin Hughes et al, *Evaluation of the Australian Capital Territory Drug Diversion Programs* (Report, Drug Policy Modelling Program, February 2013) 15.
- 484 Caitlin Hughes et al, *Decriminalisation of drug use and possession in Australia – A briefing note* (Drug Policy Modelling Program, February 2016) 1.
- 485 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4933.18-19 (Dr Hughes).
- 486 Law Reform, Road and Community Safety Committee, Parliament of Victoria, *Inquiry into drug law reform* (Final Report, March 2018) 191-193.
- 487 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 6; Jason Payne, Max Kwiatkowski and Joy Wundersitz, *Police drug diversion: a study of criminal offending outcomes* (Research and Public Policy Series No 97, Australian Institute of Criminology, October 2008) 2-3. See also Sarah Larney and Kristy A. Martire, 'Factors affecting criminal recidivism among participants in the Magistrates Early Referral Into Treatment (MERIT) program in New South Wales, Australia' (2010) 29(6) *Drug Alcohol Review* 684, 684; Marian Shanahan, Caitlin Hughes and Tim McSweeney, *Australian police diversion for cannabis offences: Assessing program outcomes and cost-effectiveness* (Monograph Series No 66, National Drug Law Enforcement Research Fund, 2016) 7.
- 488 Diversionary Programs Hearing, Sydney, 30 September 2019 TS 4925.16-19 (Dr Hughes).
- 489 Marian Shanahan, Caitlin Hughes and Tim McSweeney, *Australian police diversion for cannabis offences: Assessing program outcomes and cost-effectiveness* (Monograph Series No 66, National Drug Law Enforcement Research Fund, 2016) 7.
- 490 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 24. See also Marian Shanahan, Caitlin Hughes and Tim McSweeney, *Australian police diversion for cannabis offences: Assessing program outcomes and cost-effectiveness* (Monograph Series No 66, National Drug Law Enforcement Research Fund, 2016) 6.
- 491 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 2.
- 492 Susan Goldsmit et al, *Australian methamphetamine user outcomes* (Australian Institute of Criminology Statistical Bulletin 3, May 2017) 9.
- 493 Community Corrections, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program – 2017 Annual Report* (Annual Report, 2019) 6.
- 494 See Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No. 16, Drug Policy Modelling Program, February 2008) 17; Caitlin Hughes et al, *Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences* (Report, UNSW Australia and University of Kent, 2018) 58, 60, 62-63, 65-66, 68.
- 495 Jason Payne, Max Kwiatkowski and Joy Wundersitz, *Police drug diversion: a study of criminal offending outcomes* (Research and Public Policy Series No 97, Australian Institute of Criminology, October 2008) 3-4.
- 496 See, for example, Marian Shanahan, Caitlin Hughes and Tim McSweeney, *Australian police diversion for cannabis offences: Assessing program outcomes and cost-effectiveness* (Monograph Series No 66, National Drug Law Enforcement Research Fund, 2016) 59.
- 497 Marian Shanahan, Caitlin Hughes and Tim McSweeney, *Police diversion for cannabis offences: assessing outcomes and cost-effectiveness* (Trends and Issues in Crime and Criminal Justice, Australian Institute of Criminology No 532, June 2017) 7-8.
- 498 See Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No. 16, Drug Policy Modelling Program, February 2008) 18-23.
- 499 See Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No. 16, Drug Policy Modelling Program, February 2008) 18-23.
- 500 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 41, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program – 2017 Annual Report* (Annual Report, 2019) 3.
- 501 See The Australasian Institute of Judicial Administration (AIJA), *Problem-Solving Courts* (Web Page) <<https://aija.org.au/research/resources/problem-solving-courts/>>.
- 502 D T Driscoll, 'Solving the Problem of Problem-Solving Justice: Rebalancing Federal Court Investment in Re-entry and Pretrial Diversion Programs' (2018) 105 *Minnesota Law Review* 1384, 1386.
- 503 US Department of Justice, Office of Justice Programs, 'Drug Courts' (Fact Sheet, May 2018) 1.
- 504 Ojmarrh Mitchell et al, 'Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts' (2012) 40(1) *Journal of Criminal Justice* 60, 61; Gill McIvor, 'Chapter 7: Drug Courts - Lessons from the UK and Beyond' in Anthea Hucklesby and Emma Wincup (eds) *Drug Interventions in Criminal Justice* (Open University Press, 2010) 135, 136; NSW Bar Association, *Court structure, judges titles and order of seniority* (Report 2018) 38-39.
- 505 US Department of Justice, Office of Justice Programs, 'Drug Courts' (Fact Sheet, May 2018) 1.
- 506 Ryan Kornhauser, 'The effectiveness of Australia's drug courts' (2018) 51(1) *Australian and New Zealand Journal of Criminology* 76, 77.
- 507 US Department of Justice Office of Justice Programs, National Institute of Justice, MIJ's Multisite Adult Drug Court Evaluation (Web Page, 14 May 2019) <<https://nij.gov/topics/courts/drug-courts/pages/madce.aspx>>.
- 508 US Department of Justice, Office of Justice Programs, 'Drug Courts' (Fact sheet, May 2018) 1.
- 509 Deborah Shaffer et al, 'Outcomes among drug court participants: Does drug of choice matter?' (2011) 55(1) *International Journal of Offender Therapy and Comparative Criminology* 155, 168; Shelley Johnson Listwan, Deborah Koetzle Shaffer and Jennifer L Hartman, 'Combating Methamphetamine use in the community: The efficacy of the drug court model' (2009) 55(4) *Crime Delinquency* 627, 638.
- 510 Jeffrey A Bouffard and Katie A Richardson, 'The effectiveness of drug court programming for specific kinds of offenders: Methamphetamine and DWI offenders versus other drug-involved offenders' (2007) 18(3) *Criminal Justice Policy Review* 274, 290; Shelley Johnson Listwan, Deborah Koetzle Shaffer and Jennifer L Hartman, 'Combating methamphetamine use in the community: The efficacy of the drug court model' (2009) 55(4) *Crime Delinquency* 627, 638.
- 511 Jeffrey A Bouffard and Katie A Richardson, 'The effectiveness of drug court programming for specific kinds of offenders: Methamphetamine and DWI offenders versus other drug-involved offenders' (2007) 18(3) *Criminal Justice Policy Review* 274, 278.
- 512 His Honour Judge Roger Dive, Drug Court of New South Wales, Preliminary Submission No 13 (14 January 2019) 1.
- 513 References to Table 11.10:
- a. Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 25, Confidential Exhibit; Caitlin Hughes et al, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Drug Policy Modelling Program Monograph No 27, May 2019) 23.

- b. Caitlin Hughes et al, *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion* (Drug Policy Modelling Program Monograph No 27, May 2019) 75.
- c. *Drug Court Act 1998* (NSW).
- d. *Criminal Procedure Regulation 2017* (NSW) pt 7: See also *Criminal Procedure Act 1986* (NSW) pt 4.
- e. *Criminal Procedure Amendment (Penalty Notices for Drug Possession) Regulation 2019* (NSW) cl 3, amending *Criminal Procedure Regulation 2017* (NSW) sch 4; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 21, Confidential Exhibit, Tab 22, Confidential Exhibit.
- f. NSW Department of Communities and Justice, *Youth on Track* Factsheet (Fact Sheet, 23 August 2019).
- g. See *Young Offenders Act 1997* (NSW) pts 3, 4, 5.
- h. Children's Court of New South Wales, *Practice Note No 11: Youth Koori Court*, 5 March 2015, 1.1-1.3, 4.1, 7.1, 7.5, 9.1-9.2, 10.1-10.3; Melissa Williams et al, *Youth Koori Court – Review of Parramatta Pilot Project* (Report, 2018) 8-9, 19, 58-61, 98.
- 514 See Diversionary Programs Hearing, Sydney, Exhibit A, Tab 4, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program: Annual Report 2017* (Annual Report, June 2018) 5-6.
- 515 Law Society of NSW, Submission No 111 (9 May 2019) 5.
- 516 Rohan Lulham, 'The Magistrates Early Referral Into Treatment Program – Impact of program participation on re-offending by defendants with a drug use problem' (2009) 131 *BOCSAR Crime and Justice Bulletin* 1; NSW Health, *The Magistrates Early Referral Into Treatment (MERIT) Program: Health Outcomes* (Report, 2007) 6.
- 517 NSW Government, Submission No 143 (2019) 5.
- 518 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 4, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program: Annual Report 2017* (Annual Report, June 2018) 6.
- 519 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 4, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program: Annual Report 2017* (Annual Report, June 2018) 5, 6.
- 520 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 4, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program: Annual Report 2017* (Annual Report, June 2018) 5, 6.
- 521 NSW Department of Communities and Justice, 'The MERIT Program' (Web Page, 2019)
<<http://www.merit.justice.nsw.gov.au/Pages/merit/program.aspx>>.
- 522 NSW Department of Communities and Justice, 'The MERIT Program' (Web Page, 2019)
<<http://www.merit.justice.nsw.gov.au/Pages/merit/program.aspx>>.
- 523 Community Corrections, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program: Annual Report 2016* (Annual Report, June 2018) 6.
- 524 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes (MERIT), 21 June 2019, [12]; Nowra Hearing, Nowra, Exhibit A, Tab 21, Statement of Ruth Power, Shoalhaven AOD service, 22 May 2019, [17]; Dubbo Hearing, Dubbo, Exhibit A, Tab 16, Statement of Jenny Taylor, 15 May 2019, [22]; Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 11-12.
- 525 Aboriginal Legal Service, Submission No 116 (9 May 2019) 9; Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019, [12]; Dubbo Hearing, Dubbo, Exhibit A, Tab 16, Statement of Jenny Taylor, 15 May 2019, [21]-[23]; Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 11-12.
- 526 Lismore Hearing, Lismore, 14 May 2019 TS 618.1-10 (Cr Lloyd); Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4677.25-78.46 (Childs, Young); Diversionary Programs Hearing, Sydney, Exhibit A, Tab 24B, Response of Kerry Chant dated 30 September 2019 to Request for Information dated 16 September 2019, 3. See also Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) [11]. NB: Suspensions were noted in Western Sydney, Nepean and Northern NSW LHDs.
- 527 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 4, NSW Government, 2017 *Merit Annual Report* (Report, 2017) 5.
- 528 Lismore Hearing, Lismore, 15 May 2019, TS 842.38-43.13 (Lendrum).
- 529 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019, [12]; Nowra Hearing, Nowra, Exhibit A, Tab 21, Statement of Ruth Power, Shoalhaven AOD service, 22 May 2019, [17]; Dubbo Hearing, Dubbo, Exhibit A, Tab 16, Statement of Jenny Taylor, 15 May 2019, [22]; Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 11-12.
- 530 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019, [12].
- 531 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019 [16][c].
- 532 Lismore Hearing, Lismore, Exhibit LF, Tab 17A, Statement of Robert Lendrum, 13 May 2019, [17]; Nowra Hearing, Nowra, Exhibit A, Tab 21, Statement of Ruth Power, 22 May 2019, [22]; Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019, [16][c].
- 533 East Maitland Hearing, East Maitland, Exhibit A, Tab 14, Statement of William Robertson, 24 May 2019, [16]; Nowra Hearing, Nowra, 30 May 2019, TS 1123.23-39 (Pepper).
- 534 Lismore Hearing, Lismore, 15 May 2019, TS 843.45-844.5 (Lendrum); Dubbo Hearing, Dubbo, 5 June 2019, TS 1647.20-28 (Jenny Taylor).
- 535 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019, [15][d].
- 536 Nowra Hearing, Nowra, Exhibit A, Tab 21, Statement of Ruth Power, 22 May 2019, [17].
- 537 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019, [16][b].
- 538 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 86, Response of NSW Health dated 3 July 2019, to Request for Information dated 17 June 2019, 3.
- 539 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 86, Response of NSW dated 3 July, to Request for Information dated 17 June 2019, 3.
- 540 Lismore Hearing, Lismore, 15 May 2019, TS 847.11-39 (Lendrum); Dubbo Hearing, Dubbo, 5 June 2019, TS 1650.17 (Taylor).
- 541 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4679.8-14 (Childs).
- 542 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 78, Response of Department of Communities and Justice dated 17 October 2019, to Request for Information dated 10 October 2019, 3.
- 543 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 78, Response of Department of Communities and Justice dated 17 October 2019, to Request for Information dated 10 October 2019, 3.
- 544 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4633.41-47 (Acting Superintendent Cook).
- 545 See Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4635.1-6 (Acting Superintendent Cook).
- 546 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4633.47-34.8 (Acting Superintendent Cook).

- 547 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4634.35 (Acting Superintendent Cook).
- 548 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4634.21-27 (Acting Superintendent Cook).
- 549 Law Society of NSW, Submission No 111 (9 May 2019) 5; Legal Aid NSW, Submission No 136 (May 2019) 20, 23; Shopfront Youth Legal Centre, Submission No 92, 7 May 2019, 2; Sydney (General) Hearing, Sydney, 7 May 2019, TS 102.28-33 (Acting Superintendent Cook); East Maitland Hearing, East Maitland, 19 June 2019 TS 1947.30-45 (Superintendent Jackson).
- 550 Legal Aid NSW, Submission No 136 (May 2019) 20.
- 551 Law Society of NSW, Submission No 111 (9 May 2019) 5.
- 552 Sydney (General) Hearing, Sydney, 7 May 2019, TS 102.31-33 (Acting Superintendent Cook).
- 553 Shopfront Youth Legal Centre, Submission No 92, 7 May 2019, 5.
- 554 Shopfront Youth Legal Centre, Submission No 92, 7 May 2019, 5.
- 555 NSW Government, 'NSW Government Response to the Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales' (Government Response to Portfolio Committee No. 2 - Health and Community Services Report 49, 17 January 2019) 6; NSW Health, *The Magistrates Early Referral Into Treatment (MERIT) Program: Health Outcomes* (Report, 2007) 23-25; Sarah Larney and Kristy Martire, 'Factors affecting criminal recidivism among participants in the Magistrates Early Referral Into Treatment (MERIT) program in New South Wales, Australia' (2010) 29(6) *Drug Alcohol Review* 684; R Lulham, 'The Magistrates Early Referral Into Treatment Program – Impact of program participation on re-offending by defendants with a drug use problem' (2009) 131 *BOCSAR Crime and Justice Bulletin* 10.
- 556 R Lulham, 'The Magistrates Early Referral Into Treatment Program – Impact of program participation on re-offending by defendants with a drug use problem' (2009) 131 *BOCSAR Crime and Justice Bulletin* 1; Sarah Larney and Kristy Martire, 'Factors affecting criminal recidivism among participants in the Magistrates Early Referral Into Treatment (MERIT) program in New South Wales, Australia' (2010) 29(6) *Drug Alcohol Review* 684.
- 557 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 7.
- 558 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 41, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program – 2017 Annual Report* (Annual Report, 2019) 3.
- 559 NSW Government, Submission No 143 (12 July 2019) 5; NSW Government, 2010 *MERIT Annual Report* (2010) v.
- 560 NSW Government, Submission No 143 (12 July 2019) 5.
- 561 Michael Cain, Crime Prevention Division, NSW Attorney General's Department, *Participation of Aboriginal people in the MERIT program* (Report, December 2006) 32-33, 41-42.
- 562 NSW Health, *Improving Aboriginal Participation in the MERIT program* (Report, 2008).
- 563 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 41, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program – 2017 Annual Report* (Annual Report, 2019) 3.
- 564 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 180, Response of NSW Health dated 18 October 2019, to Request for Information dated 10 October 2019, 2.
- 565 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 24B, Response of Dr Kerry Chant PSM, NSW Health, to Request for Information dated 16 September 2019, [5].
- 566 See for example, Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 7, 11-12; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 9-10; The Buttery, Submission No 105 (undated, received 9 May 2019) 6, 9; Law Society of NSW, Submission No 111 (9 May 2019) 5; Aboriginal Legal Service, Submission No 116 (9 May 2019) 5-6; NSW Young Lawyers Criminal Committee, Submission No 124 (12 May 2019) 5; Legal Aid NSW, Submission No 136 (May 2019) 20, 23; NSW Government, Submission No 143 (12 June 2019) Attachment A – NSW strategies, services and programs, 5; The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 5-7.
- 567 Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2746.23-46 (McInnes).
- 568 Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2740.23-32, 2747.16-35 (McInnes); Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019, [17].
- 569 See Diversionary Programs Hearing, Sydney, Exhibit A, Tab 24A, Response of Lyncoln Chee, NSW Department of Communities and Justice dated 16 September 2019 to Request for Information dated 2 September 2019, [1]; Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4691.4-23 (Young).
- 570 See The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 2, 6; Aboriginal Legal Service, Submission No 116 (9 May 2019) 6; Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes, 13 September 2019, [29(b)]. See also Legal Aid NSW, Submission No 136 (May 2019) 20.
- 571 Aboriginal Legal Service (NSW/ACT) Limited, Submission No 116 (9 May 2019) 6.
- 572 NSW Government, Submission No 143 (12 June 2019) Attachment A, NSW strategies, services and programs, 5.
- 573 Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 11-12; Diversionary Programs Hearing, Sydney, Exhibit A, Tab 5, Statement of Caitlin Hughes, 13 September 2019, [29(b)].
- 574 Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 11.
- 575 Lismore Hearing, Lismore, Exhibit LF, Tab 17A, Statement of Robert Lendrum, 13 May 2019, [27].
- 576 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 15, Statement of Melissa McInnes, 21 June 2019, [17].
- 577 Portfolio Committee No 2 - Health and Community Services, NSW Legislative Council, *Provision of drug rehabilitation services in regional, rural and remote New South Wales* (Report 49, 6 August 2018) ix, 65.
- 578 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 24A, Response of NSW Department of Communities and Justice dated 16 September 2019 to Request for Information dated 2 September 2019, [2]; Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4669.17-35 (Young).
- 579 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 67, Response of NSW Department of Communities and Justice dated 16 September 2019, to Request for Information dated 2 September 2019, 2.
- 580 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 67, Response of NSW Department of Communities and Justice dated 16 September 2019, to Request for Information dated 2 September 2019, 2.
- 581 Jeff Latimer, Kelly Morton-Bourgon and Jo-Anne Chretien, Research and Statistics Division, Department of Justice Canada, *A Meta-Analytic Examination of Drug Treatment Courts: Do They Reduce Recidivism?* (Report, August 2006) 1, 6; Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No. 16, Drug Policy Modelling Program, February 2008) 21; Toni Makkai, 'The emergence of drug treatment courts in Australia' (2002) 37(12 & 13) *Substance Use & Misuse* 1567, 1578.
- 582 Melissa Bull, 'A comparative review of best practice guidelines for the diversion of drug related offenders' (2005) 16(4) *International Journal of Drug Policy* 223, 224.

- 583 Craig Jones, 'Early-Phase Outcomes from a Randomized Trial of Intensive Judicial Supervision in an Australian Drug Court' (2013) 40(4) *Criminal Justice and Behavior* 453, 454.
- 584 National Association of Drug Court Professionals, Drug Court Standards Committee, *Defining Drug Courts: The Key Components* (Drug Courts Resource Series, 1997, reprinted 2004) 1-23; Craig Jones, 'Early-Phase Outcomes from a Randomized Trial of Intensive Judicial Supervision in an Australian Drug Court' (2013) 40(4) *Criminal Justice and Behavior* 453, 454.
- 585 Jeff Latimer, Kelly Morton-Bourgon and Jo-Anne Chretien, Research and Statistics Division, Department of Justice Canada, *A Meta-Analytic Examination of Drug Treatment Courts: Do They Reduce Recidivism?* (Report, August 2006) 1; Gill McIvor, 'Chapter 7: Drug Courts - Lessons from the UK and Beyond' in Anthea Huckleby and Emma Wincup (eds) *Drug Interventions in Criminal Justice* (Open University Press, 2010) 135, 136; Ojmarrh Mitchell et al, 'Drug Courts' effects on Criminal Offending for Juveniles and Adults' (2011) 4 *Campbell Systematic Reviews* 6, 10; Douglas Marlow, National Association of Drug Court Professionals, *Research update on adult drug courts* (Report, December 2010) 3.
- 586 Toni Makkai, 'The emergence of drug treatment courts in Australia' (2002) 37(12 & 13) *Substance Use & Misuse* 1567, 1578.
- 587 See Jeff Latimer, Kelly Morton-Bourgon and Jo-Anne Chretien, Research and Statistics Division, Department of Justice Canada, *A Meta-Analytic Examination of Drug Treatment Courts: Do They Reduce Recidivism?* (Report, August 2006); Alyson Galloway and Laurie Drapela, 'Are Effective Drug Courts an Urban Phenomenon? Considering Their Impact on Recidivism Among a Nonmetropolitan Craig Jones, 'Early-Phase Outcomes from a Randomized Trial of Intensive Judicial Supervision in an Australian Drug Court' (2013) 40(4) *Criminal Justice and Behavior* 453; Gill McIvor, 'Chapter 7: Drug Courts - Lessons from the UK and Beyond' in Anthea Huckleby and Emma Wincup (eds) *Drug Interventions in Criminal Justice* (Open University Press, 2010) 135; Randall T Brown, 'Systematic review of the impact of adult drug-treatment courts' (2010) 155(6) *Translational Research* 263; Eric Sevigny, Brian Fuleihan and Frank Ferdik, 'Do drug courts reduce the use of incarceration?: A meta-analysis' (2013) 41(6) *Journal of Criminal Justice* 416; Ojmarrh Mitchell et al, 'Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts' (2012) 40(1) *Journal of Criminal Justice* 60.
- 588 Devin T Driscoll, 'Solving the Problem of Problem-Solving Justice: Rebalancing Federal Court Investment in Re-entry and Pretrial Diversion Programs' (2018) 102 *Minnesota Law Review* 1381, 1387. See also Jeff Latimer, Kelly Morton-Bourgon and Jo-Anne Chretien, Research and Statistics Division, Department of Justice Canada, *A Meta-Analytic Examination of Drug Treatment Courts: Do They Reduce Recidivism?* (Report, August 2006) iii; Eric Sevigny, Brian Fuleihan and Frank Ferdik, 'Do drug courts reduce the use of incarceration?: A meta-analysis' (2013) 41(6) *Journal of Criminal Justice* 416, 416; Ojmarrh Mitchell et al, 'Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts' (2012) 40(1) *Journal of Criminal Justice* 60, 69; Michael Rempel, Mia Green and Dana Kralstein, 'The impact of adult drug courts on crime and incarceration: findings from a multi-site quasi-experimental design' (2012) 8(2) *Journal of Experimental Criminology* 165, 185.
- 589 Devin T Driscoll, 'Solving the Problem of Problem-Solving Justice: Rebalancing Federal Court Investment in Re-entry and Pretrial Diversion Programs' (2018) 102 *Minnesota Law Review* 1381, 1387.
- 590 Devin T Driscoll, 'Solving the Problem of Problem-Solving Justice: Rebalancing Federal Court Investment in Re-entry and Pretrial Diversion Programs' (2018) 102 *Minnesota Law Review* 1381, 1387; Shelli B Rossman et al, Urban Institute Justice Policy Center, *Multi-Site Adult Drug Court Evaluation: The Impact of Drug Courts, Volume 4* (Final Report, 2011) 257.
- 591 Douglas Marlow, National Association of Drug Court Professionals, *Research update on adult drug courts* (Report, December 2010) 3.
- 592 NSW Bar Association, *Court structure, judges' titles and order of seniority* (Report, 2018) [20.1]; NSW Department of Communities and Justice, 'History', *Drug Court* (Web Page) <http://www.drugcourt.justice.nsw.gov.au/Pages/dc_aboutus/dc_history.aspx>; *Drug Court Act 1998* (NSW) s 3.
- 593 NSW Bar Association, *Court structure, judges' titles and order of seniority* (Report, 2018) [20.2].
- 594 NSW Department of Communities and Justice, 'About Us', *Drug Court* (Web Page) <http://www.drugcourt.justice.nsw.gov.au/Pages/dc_aboutus/dc_aboutus.aspx>.
- 595 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 16, Response of Department of Justice dated 1 March 2019 to Request for Information dated 7 February 2019, Attachment: Information provided by Courts Strategy, 4.
- 596 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 16, Response of Department of Justice dated 1 March 2019 to Request for Information dated 7 February 2019, Attachment: Information provided by Courts Strategy, 3.
- 597 Offenders must live in the Bayside, Burwood, Camden, Canada Bay, Canterbury-Bankstown, City of Blacktown, City of Campbelltown, City of Cessnock, City of Fairfield, City of Hawkesbury, City of Lake Macquarie, City of Liverpool, City of Maitland, City of Newcastle, City of Parramatta, City of Penrith, City of Randwick, City of Ryde, City of Sydney, City of Willoughby, Cumberland, Georges River, Hornsby, Hunter's Hill, Inner West, Ku-ring-gai, Lane Cove, Mosman, Northern Beaches, North Sydney, Port Stephens, Strathfield, Sutherland Shire, The Hills Shire, Waverly, or Woollahra Local Government Areas; or be referred from the District Court at Campbelltown, East Maitland, Liverpool, Newcastle, Parramatta, Penrith or Sydney; or be referred from the Local Court at Bankstown, Belmont, Blacktown, Burwood, Campbelltown, Central, Cessnock, Downing Centre, Fairfield, Kurri Kurri, Liverpool, Maitland, Mount Druitt, Newcastle, Newtown, Parramatta, Penrith, Raymond Terrace, Waverly and Windsor. *Drug Court Regulation 2015* (NSW) regs 4, 5, 6.
- 598 NSW Bar Association, *Court structure, judges' titles and order of seniority* (Report, 2018) [20.4].
- 599 NSW Bar Association, *Court structure, judges' titles and order of seniority* (Report 2018) [20.6].
- 600 Judge Roger Dive, Preliminary Submission No 13 (14 January 2019), Attachment B, *The Drug Court: Combining justice and treatment* (Guide, 2017) 2-3, 5-6.
- 601 Judge Roger Dive, Preliminary Submission No 13 (14 January 2019), Attachment B, *The Drug Court: Combining justice and treatment* (Guide, 2017) 3.
- 602 Judge Roger Dive, Preliminary Submission No 13 (14 January 2019) 3.
- 603 Judge Roger Dive, Preliminary Submission No 13 (14 January 2019) 3.
- 604 Drug Court, NSW Department of Communities and Justice, *BOCSAR evaluations* (Web Page, 8 March 2017) <http://www.drugcourt.justice.nsw.gov.au/Pages/dc_publications/dc_bocsar.aspx>.
- 605 Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (*Crime and Justice Bulletin No. 121*, NSW Bureau of Crime Statistics and Research, September 2008) 1, 12; Sarah Love, *A comparative assessment between the NSW Drug Court, Cape Cod, Nashville and Morgan County Drug Courts and the case for a Drug Court in Lismore* (Report, 2019) 3.
- 606 Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (*Crime and Justice Bulletin No. 121*, NSW Bureau of Crime Statistics and Research, (September 2008) 1, 10-12.
- 607 Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (*Crime and Justice Bulletin No. 121*, NSW Bureau of Crime Statistics and Research, (September 2008) 1, 13.
- 608 Stephen Goodall, Richard Norman and Marion Haas, 'The costs of NSW Drug Court' (*Crime and Justice Bulletin No. 122*, NSW Bureau of Crime Statistics and Research, (2008) 1, 14. See also Cherise Donovan, *To investigate and research effective Drug Court initiatives* (Report, The Winston Churchill Memorial Trust of Australia, 2018) 10.

- 609 Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (*Crime and Justice Bulletin No. 121*, NSW Bureau of Crime Statistics and Research, (September 2008) 1, 8; Sarah Love, *A comparative assessment between the NSW Drug Court, Cape Cod, Nashville and Morgan County Drug Courts and the case for a Drug Court in Lismore* (Report, 2019) 3.
- 610 Sarah Love, *A comparative assessment between the NSW Drug Court, Cape Cod, Nashville and Morgan County Drug Courts and the case for a Drug Court in Lismore* (Report, 2019) 3.
- 611 Drug Court of NSW, *Reflections on 2017* (Annual Report, 24 August 2018) 1.
- 612 Drug Court of NSW, *Reflections on 2017* (Annual Report, 24 August 2018) 1.
- 613 KPMG, *Evaluation of the Drug Court of Victoria* (Final Report, 18 December 2014) 6, 93.
- 614 Drug Court of NSW, *Reflections on 2017* (Annual Report, 24 August 2018) 2.
- 615 See Drug Court of NSW, *Reflections on 2017* (Annual Report, 24 August 2018) 5.
- 616 Roger Dive, *Reflections on 2017* (Annual Report, 24 August 2018) 1. See also Judge Roger Dive, Preliminary Submission No 13 (14 January 2019) 1.
- 617 Roger Dive, *Reflections on 2017* (Annual Report, 24 August 2018) 2.
- 618 Judge Roger Dive, Preliminary Submission No 13 (14 January 2019) 3.
- 619 Office of the Director of Public Prosecutions, Submission No 24 (May 2019) 3.
- 620 Office of the Director of Public Prosecutions, Submission No 24 (May 2019) 3.
- 621 Office of the Director of Public Prosecutions, Submission No 24 (May 2019) 3-4.
- 622 Aboriginal Legal Service, Submission No 116 (9 May 2019) 5-6.
- 623 Legal Aid NSW, Submission No 136 (May 2019) 19.
- 624 Office of the Director of Public Prosecutions, Submission No 24 (May 2019) 4.
- 625 The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 5-6.
- 626 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 1.
- 627 Law Society of NSW, Submission No 111 (9 May 2019) 4-5.
- 628 The Public Defenders, Submission No 12 (29 April 2019) 4.
- 629 Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (*Crime and Justice Bulletin No 121*, NSW Bureau of Crime Statistics and Research, (September 2008) 13.
- 630 Judge Roger Dive, Preliminary Submission No 13 (14 January 2019) 2; Judge Roger Dive, Submission No 101 (3 May 2019) 4.
- 631 Judge Roger Dive, Preliminary Submission No 13 (14 January 2019) 3; Judge Roger Dive, Submission No 101 (3 May 2019) 4.
- 632 Portfolio Committee No 2 - Health and Community Services, NSW Legislative Council, *Provision of drug rehabilitation services in regional, rural and remote New South Wales* (Report 49, 6 August 2018) 65.
- 633 NSW Government, 'NSW Government Response to the Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales' (Government Response to Portfolio Committee No. 2 - Health and Community Services Report 49, 17 January 2019) 6.
- 634 NSW Government, 'NSW Government Response to the Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales' (Government Response to Portfolio Committee No. 2 - Health and Community Services Report 49, 17 January 2019) 6.
- 635 Sydney (General) Hearing, Sydney, 7 May 2019, TS 103.15-17 (Acting Superintendent Cook).
- 636 Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (*Crime and Justice Bulletin No 121*, NSW Bureau of Crime Statistics and Research, September 2008) 1, 13.
- 637 Hon. Peggy Fulton Hora and Theodore Stalcup, 'Drug treatment courts in the twenty-first century: the evolution of the revolution in problem-solving courts' (2008) 42(3) *Georgia Law Review* 717, 810.
- 638 Custodial Hearing, Sydney, Exhibit A, Tab 4, Statement of Linda Smith, 19 July 2019, [14].
- 639 Custodial Hearing, Sydney, Exhibit A, Tab 4, Statement of Linda Smith, 19 July 2019, [15]-[16].
- 640 Custodial Hearing, Sydney, Exhibit A, Tab 2, Statement of Jeremy Tucker, 14 June 2019, [29], Annexure 5, 'Eligibility requirements for targeted CSNSW AOD programs', 1-2.
- 641 Custodial Hearing, Sydney, Exhibit A, Tab 4, Statement of Linda Smith, 18 July 2019, Annexure A, Astrid Birgden and Luke Grant, 'Establishing a compulsory drug treatment prison: Therapeutic policy, principles, and practices in addressing offender rights and rehabilitation' (2010) *International Journal of Correctional Staff Development* 1, 1.
- 642 Custodial Hearing, Sydney, 26 September 2019, TS 4569.19-39 (Smith).
- 643 Office of the Director of Public Prosecutions, Submission No 24 (May 2019) 5.
- 644 Office of the Director of Public Prosecutions, Submission No 24 (May 2019) 5.
- 645 Custodial Hearing, Sydney, 26 September 2019, TS 4566.44-67.3 (Smith).
- 646 *Criminal Procedure Regulation 2017* (NSW) cls 43, 44.
- 647 NSW Government, 'NSW Government Response to the Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales' (Government Response to Portfolio Committee No. 2 - Health and Community Services Report 49, 17 January 2019) 9.
- 648 Emily Stockings et al, 'Prevention, early intervention, harm reduction, and treatment of substance use in young people' (2016) 3(3) *Lancet Psychiatry* 280, 291.
- 649 Tony Eardley et al, 'Evaluation of the New South Wales Youth Drug Court Pilot Program' (Social Policy Research Centre Report No 8/04, March 2004) 5.
- 650 Rachael Green et al, *Policing and pathways to diversion and care among vulnerable young people who use alcohol and other drugs* (Monograph Series No 64, National Drug Law Enforcement Research Fund, 2016) 70.
- 651 Productivity Commission, *Report on Government Services 2019* (Report, 2019) Chapter 6 Table 6A.21.
- 652 Productivity Commission, *Report on Government Services 2019* (Report, 2019) Chapter 6 Table 6A.21.
- 653 Productivity Commission, *Report on Government Services 2019* (Report, 2019) Chapter 6 Table 6A.21.
- 654 Troy Allard et al, 'Police diversion of young offenders and Indigenous over-representation' (*Trends & issues in crime and criminal justice* No 390, Australian Institute of Criminology, March 2010) 1, 4.
- 655 Aboriginal Legal Service, Submission No 116 (9 May 2019) 1, 3, 5; Law Society of NSW, Submission No 111 (9 May 2019) 5-6; Children's Court of NSW, Submission No 63 (7 May 2019) 3, 5.
- 656 Aboriginal Legal Service, Submission No 116 (9 May 2019) 5.
- 657 Law Society of NSW, Submission No 111 (9 May 2019) 6.

- 658 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 19.
- 659 Children's Court of NSW, Submission No 63 (7 May 2019) 2.
- 660 Children's Court of NSW, Submission No 63 (7 May 2019) 2.
- 661 See Attorney General, Minister for Justice and Minister for Police and Emergency Services, 'Early intervention to keep Youth on Track' (Media Release, 27 February 2013).
- 662 Juvenile Justice, NSW Justice, 'Youth on Track Factsheet' (Fact sheet, November 2018) 1-2.
- 663 Juvenile Justice, NSW Justice, 'Youth on Track Factsheet' (Fact sheet, November 2018) 1-2; NSW Minister for Families, Communities and Disability Services, 'Youth set to get on track in the Riverina' (Media Release, 10 May 2019).
- 664 Juvenile Justice, NSW Justice, 'Youth on Track Factsheet' (Fact sheet, November 2018) 2.
- 665 Juvenile Justice, NSW Justice, 'Youth on Track Factsheet' (Fact sheet, November 2018) 2.
- 666 Legal Aid NSW, Submission No 136 (May 2019) 23.
- 667 Aboriginal Legal Service, Submission No 116 (9 May 2019) 7.
- 668 Committee on Law and Safety, Legislative Assembly of New South Wales, *The Adequacy of Youth Diversion Programs in New South Wales* (Report No 2/56, September 2018) 79.
- 669 Committee on Law and Safety, Legislative Assembly of New South Wales, *The Adequacy of Youth Diversion Programs in New South Wales* (Report No 2/56, September 2018) 81.
- 670 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4761.20-34 (Nasser).
- 671 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4766.9-15 (Nasser).
- 672 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4761.34-39 (Nasser).
- 673 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4763.28-40 (Warner).
- 674 See *Young Offenders Act 1997* (NSW) ss 3, 4, 7A, 8.
- 675 Communities and Justice, NSW Government, *Youth Justice Conferencing* (Web Page, 29 July 2019) <<http://www.juvenile.justice.nsw.gov.au/Pages/youth-justice/conferencing/conferencing.aspx>>; *Young Offenders Act 1997* (NSW) ss 13, 18, 31, 35.
- 676 *Young Offenders Act 1997* (NSW) pt 3.
- 677 *Young Offenders Act 1997* (NSW) pt 4.
- 678 *Young Offenders Act 1997* (NSW) s 20(3).
- 679 *Young Offenders Act 1997* (NSW) ss 24, 30.
- 680 *Young Offenders Act 197* (NSW) pt 5; NSW Department of Communities and Justice, *Youth Justice Conferencing* (Web Page, 29 July 2019) <<http://www.juvenile.justice.nsw.gov.au/Pages/youth-justice/conferencing/conferencing.aspx>>.
- 681 Nadine Smith and Don Weatherburn, 'Youth Justice Conferences versus Children's Court: A comparison of re-offending' (*Crime and Justice Bulletin No 160*, NSW Bureau of Crime Statistics and Research, (2012) 1.
- 682 Wai-Yin Wan, Elizabeth Moore and Steve Moffatt, 'The impact of the NSW Young Offenders Act (1997) on likelihood of custodial orders' (*Crime and Justice Bulletin No 166*, NSW Bureau of Crime Statistics and Research, (2013) 1.
- 683 Legal Aid NSW, Submission No 136 (May 2019) 23.
- 684 NSW Legislative Assembly Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report No 2/56, 2018) Recommendations 1-4, 18, 20 and 21.
- 685 NSW Legislative Assembly Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report No 2/56, 2018) Recommendations 3, 18, 20, 21.
- 686 NSW Government, *Response to Report of the Legislative Assembly Committee on Law and Safety - Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report, August 2019) 3.
- 687 NSW Government, *Response to Report of the Legislative Assembly Committee on Law and Safety - Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report, August 2019) 11.
- 688 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 19.
- 689 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019 TS 4749.14-17 (Maxton).
- 690 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4753.23-29 (Judge Johnstone).
- 691 Custodial Hearing, Sydney, Exhibit A, Tab 60 (9) Justice Health and Forensic Mental Health Network and Juvenile Justice NSW, *2015 Young People in Custody Health Survey* (Full Report, November 2017) 61.
- 692 Diversionary Programs Hearing, Sydney, Exhibit A, Tab 41, NSW Department of Justice, *Magistrates Early Referral Into Treatment (MERIT) Program – 2016 Annual Report* (Annual Report, 2019) 3.
- 693 NSW Government, Submission No 143 (12 June 2019) Attachment A, NSW strategies, services and programs, 5.
- 694 The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 2.
- 695 Law Society of NSW, Submission No 111 (9 May 2019) 5-6.
- 696 Legal Aid NSW, Submission No 136 (May 2019) 23.
- 697 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4777.36-41 (Judge Johnstone).
- 698 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4779.9-21 (Frankham).
- 699 Law Society of NSW, Submission No 111 (9 May 2019) 6.
- 700 Law Society of NSW, Submission No 111 (9 May 2019) 6.
- 701 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4778.11-39 (Judge Johnstone and Maxton).
- 702 Law Society of NSW, Submission No 111 (9 May 2019).
- 703 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4779.23-28 (Frankham), TS 4781.18-26 (Nasser).
- 704 Shelley Turner, 'The New South Wales Youth Drug and Alcohol Court Program: A Decade of Development' (2011) 37(1) *Monash University Law Review* 280, 280.
- 705 Shelley Turner, 'The New South Wales Youth Drug and Alcohol Court Program: A Decade of Development' (2011) 37(1) *Monash University Law Review* 280, 280, 282.
- 706 *Griffiths v The Queen* (1977) 137 CLR 293; *Children (Criminal Proceedings) Act 1987* (NSW) s 33(1)(c2).
- 707 Tony Eardley et al, *Evaluation of the New South Wales Youth Drug Court Pilot Program* (Final Report for the NSW Attorney-General's Department, March 2004) 29; Shelley Turner, 'The New South Wales Youth Drug and Alcohol Court Program: A Decade of Development' (2011) 37(1) *Monash University Law Review* 280, 283-4.

- 708 'Quiet death of the youth drug court', *Sydney Morning Herald* (online, 9 July 2012) <<https://www.smh.com.au/politics/federal/quiet-death-of-the-youth-drug-court-20120708-21p7h.html>>.
- 709 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 20.
- 710 Children's Court of NSW, Submission No 63 (7 May 2019) 4-5.
- 711 Law Society of NSW, Submission No 111 (9 May 2019) 6.
- 712 Legal Aid NSW, Submission No 136 (May 2019) 22.
- 713 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4789.42-90.7 (Frankham).
- 714 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4790.1-4 (Frankham).
- 715 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4790.34-44 (Judge Johnstone).
- 716 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4790.34-91.3 (Maxton).
- 717 NSW Legislative Assembly Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report No 2/56, 2018) 90, cl 3.151.
- 718 NSW Legislative Assembly Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report No 2/56, 2018) 90, cl 3.153.
- 719 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4780.18-24 (Johnson).
- 720 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4781.18-26 (Nasser).
- 721 Custodial Hearing, Sydney, Exhibit A, Tab 17, Statement of Jamie Duggan, 13 August 2019, [8]-[9].
- 722 Custodial Hearing, Sydney, Exhibit A, Tab 17, Statement of Jamie Duggan, 13 August 2019, [11].
- 723 Custodial Hearing, Sydney, Exhibit A, Tab 17, Statement of Jamie Duggan, 13 August 2019, [14].
- 724 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4772.38-45 (Acheson).
- 725 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4794.9-18 (Acheson).
- 726 NSW Legislative Assembly Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report No 2/56, 2018) 1v, ix-xvii.
- 727 See, for example, commitment to review the *Young Offenders Act 1997* (NSW): NSW Government, *Response to Report of the Legislative Assembly Committee on Law and Safety - Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report, August 2019) 3, citing NSW Legislative Assembly Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversion Programs in New South Wales* (Report No 2/56, 2018) 15.
- 728 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4750.23-25 (Judge Johnstone).
- 729 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4749.13-17 (Maxton).
- 730 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4750.43-51.4 (Judge Johnstone).
- 731 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4756.12-16 (Johnson).
- 732 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4798.13-21 (Acheson).
- 733 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4798.33-36 (Acheson).
- 734 Youth Diversionary Programs Roundtable, Sydney, 2 October 2019, TS 4798.43-47 (Nasser).
- 735 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4667.44-68.44 (Childs).
- 736 Diversionary Programs Hearing, Sydney, 1 October 2019, TS 4668.37-69.10 (Childs).
- 737 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 35.
- 738 Caitlin Hughes and Alison Ritter, *A summary of diversion programs for drug and drug-related offences* (Monograph No 16, Drug Policy Modelling Program, February 2008) 2-3.
- 739 Caitlin Hughes et al, *Evaluation of the Australian Capital Territory Drug Diversion Programs* (Report, Drug Policy Modelling Program, February 2013) 8, 89.
- 740 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4922.44-23.1 (Dr Hughes).
- 741 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4923.20-22 (Dr Hughes).
- 742 Diversionary Programs Hearing, Sydney, 30 September 2019, TS 4923. 24-31 (Dr Hughes).
- 743 Health and Human Services, Victoria State Government, *Child protection manual: Family Drug Treatment Court - advice* (Web Page, 14 November 2019) <<https://www.cpmmanual.vic.gov.au/advice-and-protocols/advice/court/family-drug-treatment-court-advice>>.
- 744 Health and Human Services, Victoria State Government, *Child protection manual: Family Drug Treatment Court - advice* (Web Page, 14 November 2019) <<https://www.cpmmanual.vic.gov.au/advice-and-protocols/advice/court/family-drug-treatment-court-advice>>.
- 745 *Criminal Records Act 1991* (NSW) s 7(1).
- 746 *Criminal Records Act 1991* (NSW) ss 7-9.
- 747 *Criminal Records Act 1991* (NSW) s 3(1).
- 748 *Criminal Records Act 1991* (NSW) s 8(2).
- 749 *Criminal Records Act 1991* (NSW) ss 12, 15, 16.
- 750 *Criminal Records Act 1991* (NSW) s 12(b).
- 751 *Criminal Records Act 1991* (NSW) s 17. NB: A person who acts in a civic office while disqualified from holding the office is guilty of an offence: *Local Government Act 1993* (NSW) s 652(1).
- 752 *Criminal Records Act 1991* (NSW) s 23.
- 753 *Criminal Records Act 1991* (NSW) sub-ss 13(2)-(4B).
- 754 Sydney (General) Hearing, Sydney, 8 May 2019, TS 194.35-37 (Tillier).
- 755 Lismore Hearing (Private), Lismore, 13 May 2019, TS 469.11-12, 477.39-43 (Lived Experience Witness, Name Withheld).
- 756 Sydney (General) Hearing, Sydney, 8 May 2019, TS 194.44-47 (Tillier).
- 757 Nowra Hearing, Nowra, 31 May 2019, TS 1275.38-39 (Forbes).
- 758 Nowra Hearing, Nowra, 31 May 2019, TS 1275.40-45 (Forbes).
- 759 Sydney (General) Hearing, Sydney, 8 May 2019, TS 194.41-42 (Tillier).
- 760 Harm Reduction Australia, Submission No 37 (5 May 2019) 1-2.
- 761 Penington Institute, Submission No 56 (May 2019) 6.

- ⁷⁶² National Drug and Alcohol Research Centre, Submission No 81 (7 May 2019) 11.
- ⁷⁶³ The Public Defenders, Submission No 12 (29 April 2019) 4.
- ⁷⁶⁴ Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization* (Report, 2016) 17.
- ⁷⁶⁵ Section 25C of the *Crimes Act 1900* was introduced into the *Crimes Act* by *Community Protection Legislation Amendment Act 2018* (NSW).
- ⁷⁶⁶ Mick Fuller, Kerry Chant, Philip Crawford, NSW Government, *Keeping people safe at music festivals - expert panel report* (Report, October 2018) 13.
- ⁷⁶⁷ *Community Protection Legislation Amendment Act 2018* (NSW) sch 2.1.
- ⁷⁶⁸ Mick Fuller, Kerry Chant and Philip Crawford, NSW Government, *Keeping people safe at music festivals - expert panel report* (Report, October 2018) 2.
- ⁷⁶⁹ *Burns v the Queen* (2012) 246 CLR 334 at [75].
- ⁷⁷⁰ See *Repatriation Commission v Vietnam Veterans' Association of Australia NSW Branch Inc and ors* [2000] NSWCA 65; (2000) 48 NSWLR 548 at [107]; *Cooper Brookes (Wollongong) Pty Limited v Federal Commissioner of Taxation* (1981) 147 CLR 297 at 320).
- ⁷⁷¹ NSW, *Parliamentary Debates*, Legislative Assembly, 13 November 2018, 51.
- ⁷⁷² Mick Fuller, Kerry Chant and Philip Crawford, NSW Government, *Keeping people safe at music festivals - expert panel report* (Report, October 2018) 13.
- ⁷⁷³ Mick Fuller, Kerry Chant and Philip Crawford, NSW Government, *Keeping people safe at music festivals - expert panel report* (Report, October 2018) 13.

Chapter 12. Prevention

Introduction

- 12.1 Initiatives to prevent or delay the start of drug use are a critical component of AOD policy. Rather than responding to AOD-related harms after they occur, prevention initiatives help people avoid using drugs in the first place or transitioning to more risky and harmful use.
- 12.2 As discussed in Chapter 3, drug use generally results from a complex interaction of individual and environmental risk factors.¹ Evidence received by the Inquiry indicates that drug use, and dependent drug use in particular, often occurs in a context of broad socioeconomic disadvantage.² The National Drug Research Institute (NDRI) submitted: *‘The most effective responses to preventing AOD use and harm should include a wide range of interventions that acknowledge the social origins of poor health, and the role social determinants play in AOD use.’*³
- 12.3 The presence of risk and protective factors can determine a person’s vulnerability to drug use.⁴ Therefore it is important that policy responses aimed at prevention recognise and address the risk factors that increase a person’s susceptibility to social, behavioural and health problems and the protective factors that can mitigate these risks.
- 12.4 Effective responses will necessarily include a particular focus on preventing or delaying the onset of drug use among children and young people, and initiatives targeting this group. Although risk factors can emerge at any stage of life, exposure to them earlier in life can have a ‘snowball’ effect with subsequent risk factors accumulating as a consequence of earlier issues.⁵
- 12.5 Evidence to the Inquiry and reviews of the recent literature make it clear that there is a need for better research into prevention, particularly in relation to ATS. Existing research frequently focuses on alcohol and tobacco and may not be readily applicable to ATS use. Further, there is limited evidence on prevention programs in non-school settings and contexts, such as the workplace, community and family. This need for research is dealt with further in Chapter 21.
- 12.6 Prevention strategies take many forms and may be led by a range of government and non-government organisations. Programs in NSW include education for the community, in school and non-school settings (addressed in Chapter 13), recreationally based interventions and whole-of-community approaches such as the Maranguka Project. Evidence to the Inquiry suggests that community-led, collective-impact approaches can be particularly effective, and that they should continue to be supported and expanded.

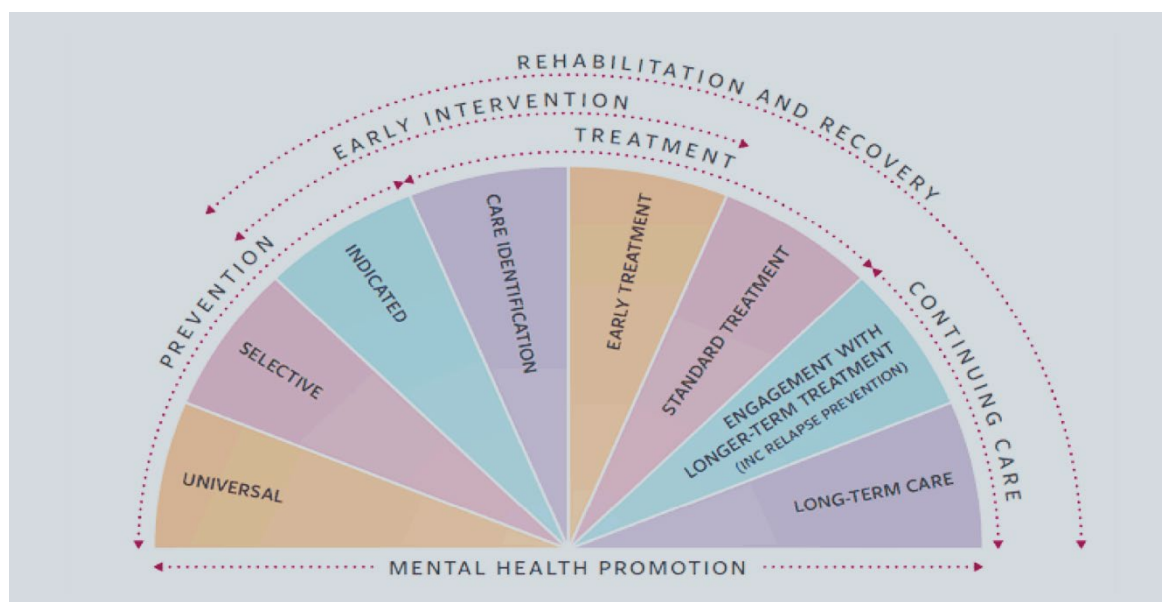
Conceptualising prevention

Prevention is an important aspect of drug policy

- 12.7 A comprehensive response to ATS in NSW must include the development and support of measures to prevent or delay the uptake of ATS. It is uncontroversial that the best way to avoid the harms of drug use is to not take drugs. Evidence to the Inquiry addressed prevention efforts, as well as the drivers and social determinants of drug use.⁶

- 12.8 The importance of prevention is recognised in the National Drug Strategy 2017–2026, the aim of which is *‘to build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities’*.⁷ The National Drug Strategy emphasises prevention as part of the demand reduction pillar, which defines demand reduction as preventing the uptake and or delaying the onset of use of alcohol, tobacco and other drugs; reducing the use of AOD in the community; and supporting people to recover from dependence through evidence-informed treatment.⁸ These pillars and the Inquiry’s recommendations in relation to them are discussed further in Chapter 10.
- 12.9 Prevention can also be seen as part of a healthcare continuum that encompasses promotion, prevention, treatment and continuing care. In NSW, this has been depicted in the Community Mental Health Strategy 2007–2012.⁹ While originally used in relation to mental health, the continuum of interventions has also been used to illustrate the continuum of care for AOD and the different interventions available for prevention.¹⁰ See Figure 12.1

Figure 12.1: The spectrum of interventions for mental health problems and disorders¹¹



- 12.10 The spectrum depicts the continuum of care as a semi-circle with each segment representing a particular intervention. The spectrum is underpinned by health promotion. This figure includes universal, selected and indicated prevention interventions; these are discussed in more detail in this chapter. Indicated interventions, care identification and early treatment make up early intervention, while care identification, early treatment and standard care comprise the treatment interventions. Continuing care encompasses engagement with longer-term treatment (including relapse prevention) and long-term care.

12.11 In its International Standards on Drug Use Prevention, the World Health Organization outlined the primary objective of AOD prevention as *‘to help people, particularly but not exclusively of a younger age, to avoid or delay the initiation of the use of psychoactive substances, or, if they have started already, to avert the development of substance use disorders’*.¹² There are a number of reasons children and young people are a focus of AOD prevention strategies:

- There are adverse and often irreversible impacts of repeated ATS use.¹³
- Drug use and heavy drug use in the early years have been associated with a range of harms, as young people may be more socially, physically and mentally vulnerable to some risks associated with drug use.¹⁴
- Drug use and mental health disorders are among the leading global causes of burden of disease in young people. Worldwide, the peak of disability occurs in those aged 15 to 24 and corresponds to the period in life in which AOD use is most likely to begin.¹⁵
- Early age of use is recognised as one the best predictors of future drug use and dependence.¹⁶
- Drug use and heavy drug use in the early years have been associated with a range of problems later in life, including continued drug use, criminal involvement, poor educational outcomes and mental health problems.¹⁷

12.12 The Inquiry recognises the importance of prevention initiatives focused on reducing supply. The Inquiry also recognises the importance of reducing harms associated with ATS use once a person has started using drugs. (Chapter 15 explores harm reduction approaches to ATS use.) This chapter focuses on demand reduction measures that aim to prevent or delay the onset of drug use, with an emphasis on children and young people.

Adopting an approach that considers risk and protective factors

12.13 As has already been identified, evidence before the Inquiry indicates that dependent drug use often occurs in a context of broad socioeconomic disadvantage.¹⁸ The Inquiry has consistently heard that while ATS are used across the spectrum of Australian society, methamphetamine use is higher in disadvantaged areas than in advantaged areas. In contrast, MDMA use is more prevalent among those living in areas of higher socioeconomic advantage.¹⁹ In Sydney and throughout regional NSW, the Inquiry also heard evidence from lived experience witnesses who spoke about a traumatic event or childhood that led to their drug use or drug dependence later in life.²⁰

12.14 The connection between a broad range of socioeconomic factors and drug use points to the need for prevention efforts to engage with these factors. Effectively preventing drug-related harms requires greater investment in strategies directed towards vulnerable people, communities and families, and recognition of the critical importance of social determinants such as school engagement and employment.

12.15 Greg Telford, founder of the Rekindling the Spirit program for Aboriginal families in Lismore, told the Inquiry there is *‘lots of talk that goes around in government about early intervention and prevention’*, but unless disadvantage and the social determinants of AOD use are addressed nothing will be achieved.

*‘The alcohol and the drugs, I see them as a symptom of other stuff. The other stuff is what we’ve got to deal with. I mean, those social determinants that I mentioned before, we have to deal with those issues ... Until we deal with those, not a lot is going to change, and we will be sitting here talking about this in another 20 years.’*²¹

- 12.16 An approach to prevention based on risk considers the range of risk and protective factors in designing prevention initiatives, complemented by a developmental approach that tailors initiatives to the life stage of the group being targeted. This approach has been recognised as best practice in the *Final Report of the National Ice Taskforce*,²² the 2014 report of WA's Methamphetamine Action Plan Taskforce²³ and the *Victorian Parliamentary Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria*.²⁴ A number of submissions to the Inquiry by organisations with significant AOD experience, including the Royal Australian and New Zealand College of Psychiatrists,²⁵ the Royal Australasian College of Physicians,²⁶ NDRI²⁷ and the NSW Council of Social Services,²⁸ also note the complex interplay between the social determinants of drug use and the need for prevention strategies to consider risk factors.
- 12.17 Such an approach emphasises that prevention should be broadly understood. Prevention measures can extend beyond those directly related to drug use and include measures that address factors affecting the likelihood of drug uptake. For example, the Inquiry heard that as engagement in education is recognised as a protective factor,²⁹ one strategy to address youth uptake of drugs is to provide and support schooling, training and employment opportunities.³⁰ Interventions are unlikely to be effective if they only address individual risk factors, such as a lack of knowledge, when environmental risk factors remain unchanged and continue to be influential.³¹ Accordingly, isolated interventions – education and/or media campaigns, for example – are unlikely to prevent drug use without support from broader prevention efforts. The role of education in an holistic drug policy is addressed in more detail in Chapter 13.

Developmental approach

- 12.18 Some researchers argue for a developmental perspective to prevention, noting the importance of environmental influences that accumulate across the course of a person's life.³² They note that different risk factors are present at different times, including in pregnancy and during exposure to drugs and drug-using social contexts in high school.³³
- 12.19 A developmental approach supports interventions that use the social environment such as the classroom or family setting as a focus,³⁴ and dovetail with the risk-based approach that addresses issues other than drug use.

Risk factors approach

- 12.20 Risk factors are predictors of negative behavioural and adverse outcomes, and can include factors in a person's environment that increase their susceptibility to social, behavioural and health problems.³⁵ Conversely, protective factors enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences due to risk factors.³⁶ They decrease a person's susceptibility to social, behavioural and health problems and enhance their ability to cope with adverse circumstances.³⁷
- 12.21 Interventions target identified risk factors for drug use and are informed by the ways these factors have been effectively addressed for the relevant groups.³⁸
- 12.22 A significant body of work on a risk-based approach to AOD prevention, particularly with young people, has been developed in the United States. Numerous risk factors have been identified and can be divided into three main categories: genetic factors; individual characteristics; and environmental and contextual factors.

12.23 Research has identified common antecedents of adolescent drug use, as listed in Table 12.1.

Table 12.1: Contextual, individual and interpersonal factors³⁹

Contextual Factors	Individual and Interpersonal Factors
Laws and norms favourable to drug use	Certain physiological characteristics
Availability of drugs	A family history of alcoholism and parental use of illegal drugs
Extreme economic deprivation (socio-economic disadvantage, poverty, overcrowding and poor housing)	Family conflict, poor family management practices and low family bonding
Neighbourhood disorganisation (high population density, physical deterioration, high rates of crime, lack of natural surveillance of public spaces, high residential mobility and low levels of neighbourhood attachment)	Early and persistent behaviour problems including aggressive behaviour in boys, other conduct problems and hyperactivity in childhood and adolescence
	Academic failure and low levels of commitment to school
	Early peer rejection, alienation and rebelliousness, association with drug-using peers, and early initiation of drug use.

12.24 This work has been further developed in the past few decades. The following table summarises risk and protective factors for AOD use as expressed by researchers at the Matilda Centre, University of Sydney.

Table 12.2: Risk and protective factors for AOD use⁴⁰

	Risk factors	Protective factors
Genetic factors	<ul style="list-style-type: none"> Up to eightfold increase in drug use disorders in close relatives Certain genes associated with AOD use Genetic vulnerability likely to overlap across different drugs 	<ul style="list-style-type: none"> Inactive ALDH2 gene related to a genetically lower risk for alcoholism
Individual factors	<ul style="list-style-type: none"> Favourable attitudes and low perceived risks of drug use Low religiosity Non-conformity to traditional values and resistance to authority Sensation seeking Early and persistent aggression Early conduct problems Low academic expectations and school engagement Delinquency 	<ul style="list-style-type: none"> Childhood temperament (easy or cautious temperament) Social and emotional competence Religious involvement Social problem-solving skills Belief in own self-efficacy Association with peers who do not use drugs
Environmental/Contextual factors	<ul style="list-style-type: none"> Peer approval and use of alcohol and drugs Truancy/school drop-out Family approval and modelling of alcohol and drug use Poor family communication Poor family bonding and attachment Family structure – living with a step parent Social disadvantage Availability of drugs Positive media portrayal of drugs Laws and norms favourable to drug use 	<ul style="list-style-type: none"> High attachment to family High parental supervision High sharing of affection and family communication Minimal parental conflict Opportunities for pro-social involvement Rewards for pro-social involvement Being born outside Australia

- 12.25 The researchers note that the applicability of these risk and protective factors to culturally and linguistically diverse communities, or across different transition points of use – such as from regular use to problematic use – is not yet clear.⁴¹
- 12.26 Research indicates that promising risk-based approaches include:⁴²
- early childhood education
 - early family support
 - parent training
 - school-based education social competence promotion
 - school-based academic competence promotion
 - school-organisational change strategies.

Other approaches to conceptualising prevention

- 12.27 A number of prevention frameworks have informed, and continue to inform, current prevention activities.

Disease progression model

- 12.28 Historically it was common to define three tiers of prevention from biomedically based categories⁴³ focused on disease and illness progression: primary prevention, which attempts to reduce the likelihood of developing an illness in the first place; secondary prevention, which aims to halt or interrupt disease progression through early intervention; and tertiary prevention, which aims to reduce the negative impacts of an established disease, such as through treatment.⁴⁴ In the context of ATS use, Allsop has noted that primary prevention aims to prevent illicit drug use, secondary prevention initiatives are aimed at *‘reducing the uptake of risky ATS use, such as preventing the transition from oral to injecting drug use’* and tertiary prevention encompasses strategies to reduce *‘behaviours or practices that lead to significant social and/or individual harms’*.⁴⁵
- 12.29 Since this framework was developed, there have been significant public health advancements in understanding the complex interplay between risk factors and health outcomes.⁴⁶ Nonetheless, this model continues to be used and adapted for the AOD sector.⁴⁷

Population-based definitions

- 12.30 A second influential framework, developed in relation to disease prevention generally but also applicable to AOD programs, categorises prevention measures by the population on which they focus: universal, selective and indicated prevention.⁴⁸
- 12.31 Universal prevention strategies target the entire population without screening for risk factors. All participants are taken as sharing the same general risk, even though risks vary greatly among individuals.⁴⁹ Selective prevention strategies target subsets of the population deemed to be at higher risk. Participants may be distinguished by age, family history or other characteristics, and activities focus on preventing the development of drug use problems.⁵⁰ Indicated prevention strategies target those at significantly higher risk and/or those already experiencing a problem. Strategies focus on preventing the development of dependence, diminishing the frequency of use and preventing harmful substance use.⁵¹

- 12.32 Due to the size of the broader population, the effect sizes for universal prevention strategies are often small, regardless of relative risk.⁵² However, in the context of delaying the initiation of drug use at a population level, research has found they are associated with significant financial savings.⁵³ Examples of successful universal public health prevention strategies include seat belts in cars and immunisation. To date most universal drug prevention programs have focused on alcohol and tobacco. Allsop noted that *'it is unclear how well these approaches might generalise across drugs, especially those with lower prevalence of use'*.⁵⁴
- 12.33 There has been debate on the benefits of targeted versus universal prevention programs, with concerns that targeted programs can be costly and may introduce stigmatisation issues.⁵⁵ However, targeted interventions have also been acknowledged as necessary to address inequities⁵⁶ when some groups disproportionately experience a range of negative outcomes as a result of structural disadvantage and those disadvantages tend to persist without intervention. In an Australian context, for example, it is recognised that universal approaches need to be complemented with culturally sensitive and appropriate approaches for Aboriginal communities.⁵⁷
- 12.34 The historical development of prevention frameworks and strategies highlights that there is no one approach to prevention.⁵⁸ To this end, the *Final Report of the 2015 National Ice Taskforce* noted the need for prevention approaches that incorporate a range of strategies, including universal and targeted interventions which *'should be complemented by broader activities that address the needs of disadvantaged and vulnerable communities, families and individuals'*.⁵⁹
- 12.35 To address multiple risk and protective factors, effective prevention strategies should be diverse in their aims and how and where they are delivered.⁶⁰ Any future NSW AOD prevention strategy should take this into consideration.

Prevention activities can occur in a variety of settings

- 12.36 Prevention activities may be implemented in a range of settings and through a variety of mechanisms, including education campaigns, school or family-based approaches, recreation or community-based approaches or workplace-based initiatives. The following section discusses settings that provide current or potential avenues for prevention efforts.
- 12.37 Prevention activities tend to be effective when employed in the domains that influence the cohort they are targeting. For example, family, school and community environments are seen as key to influencing risk and protective factors for children and young people in relation to AOD use and are commonly used as settings for prevention programs for this cohort.⁶¹
- 12.38 Classifications of different delivery settings or strategies are not mutually exclusive. There are times when recreational and leisure-based approaches may be classified as community approaches, or when a community approach includes components of some or all of the other settings. A comprehensive prevention approach is likely to involve a combination of settings and delivery mechanisms. There is emerging evidence that combining prevention strategies can *'produce greater effects than a single program delivered in isolation'*.⁶²

Information and education campaigns

- 12.39 Information and awareness-raising campaigns are important elements of many prevention strategies. However, it is important that they are not the only prevention activity undertaken.

School-based approaches

- 12.40 Research has found that drug education programs in schools, as well as broader whole-of-school approaches, can be effective in preventing, delaying and/or reducing AOD use. For these reasons they are important aspects of a comprehensive prevention approach. Chapter 13 outlines the evidence for school-based education programs and current programs in NSW schools.

Family-based approaches

- 12.41 Family organisation, relationships and parenting approaches can operate as both risk and protective factors for children and young people. The Inquiry heard a substantial amount of evidence about the risks faced by children whose parents, carers or family members use ATS. Chapter 18 outlines in detail the associations between parental or carer drug use and a child or young person being at risk of significant harm, and the responses to this by the NSW child protection system.
- 12.42 Evidence to the Inquiry noted that exposure to drug use at a young age can increase the likelihood of a child using drugs themselves.⁶³ It is important that there are initiatives to strengthen families and support parents. These can be both universal and targeted for families where risk factors are present before child protection services become formally involved. Family-based interventions can also be delivered as standalone programs or as components in interventions that are also school or community-based.
- 12.43 In the academic literature, family-based interventions tend to draw on social development models and focus on protective factors. A 2018 National Drug and Alcohol Research Centre review found *‘there is good evidence to suggest that family-based universal prevention programs are effective in delaying and reducing alcohol use, and emerging evidence to suggest that these programs are also effective in reducing illicit drug use’*.⁶⁴ The review found that programs were generally more likely to be effective if they involved children in early adolescence and active parental participation; included a psychosocial aspect; and were designed to have an impact on a range of behaviours rather than focusing exclusively on substance use.⁶⁵
- 12.44 Submissions from the Ethnic Communities’ Council of NSW and the Drug and Alcohol Multicultural Education Centre also highlighted the need for prevention programs to respond to the local cultural context. Risk factors for migrants and refugees, such as pre-migration experiences of forced displacement, torture and trauma, require culturally appropriate AOD approaches from prevention to treatment.⁶⁶ International experience provides examples of family-based programs that have successfully incorporated culturally specific factors, some examples of which are included in the boxes below. Chapter 8 explores the needs of culturally and linguistically diverse communities in more detail.

Resilient Families program

Resilient Families was a universal intervention aimed at preventing early initiation and frequent and heavy alcohol use among secondary school students in Melbourne. As part of the program, students were given social relationship education and their parents received parent education handbooks and invitations to parent events outlining strategies to encourage healthy adolescent development and reduce adolescent alcohol consumption. A two-year follow-up study found that relative to controls, students in the program showed significant reductions in alcohol use and reduced progression to frequent and heavy use.⁶⁷ Although it showed potential for family- and school-based interventions to reduce adolescent alcohol consumption, the program did not include other drugs.

The Strengthening Families program

One family-based intervention developed in the United States has shown favourable effects on cannabis and methamphetamine use. The Strengthening Families program promotes family relationships, communication, behaviour and conflict management. A trained facilitator delivers six two-hour sessions to parents and young people. These are followed by a one-hour family session in which parents and young people put the lessons into practice.

Families of sixth graders enrolled in 33 rural schools were recruited for the randomised control trial. Of the families involved, 86% were dual parent and 98% of all participants were white.⁶⁸ The program did not have content specific to the prevention of methamphetamine use. It addressed general risk and protective factors for drug use associated with family and school environments.⁶⁹

Results from two randomised studies examining the effectiveness of the program for preventing methamphetamine use suggest that, six years after the intervention, methamphetamine use reduced by around two-thirds,⁷⁰ demonstrating the potential for a universal family-based program to reduce methamphetamine use among adolescents.⁷¹ Interestingly, some adaptations of these programs in European countries have not shown similar results.⁷²

Programs for Hispanic at-risk families

The Familia Adelante program was a targeted program in California designed for at-risk young people aged 11 to 14 and their families. Youth participants were referred to the program as a result of experiencing behavioural or emotional problems. The 12-session intervention focused on enhancing communication and psychosocial coping, increasing knowledge and perceptions of harms of substance use and HIV, and improving behaviour in school.⁷³ All group sessions were held at a school location and conducted after school hours. Research showed that marijuana and other illegal drug use decreased significantly among the cohort and stayed this way at the six-month follow-up.⁷⁴ The program also reported that young people had improved communication skills with their peers and reported improved overall family attachment.⁷⁵

Familias Unidas was a Florida family-based intervention delivered to Hispanic adolescents in eighth grade. Participants with behavioural problems were recruited by a school counsellor. The intervention involved trained facilitators working with parents on parenting skills in nine one-hour group sessions. Parents then used these skills and knowledge with their children in 10 one-hour home visits, with four one-hour booster sessions at 10, 16 and 22 months.⁷⁶

Participants were assessed at baseline, six, 18 and 30 months after the program started. Relative to the control group, adolescents in the program experienced significantly less substance use at follow-up compared to baseline. In addition, there was increased condom use among young people receiving the intervention and families reported significant improvements in family functioning compared to the control group.⁷⁷

Recreational and leisure-based approaches

- 12.45 International research suggests that participation in supervised leisure time such as sports, recreational or youth activities works as a protective factor to deter drug use,⁷⁸ as these activities can act as a positive alternative to drug use and provide a sense of social connectedness.

- 12.46 An Australian review found that although the evidence base is small, preventive interventions in a sports setting have a positive impact on use.⁷⁹ Most of the positive findings were based on the Australian Good Sports program, which is outlined below. The Alcohol and Drug Foundation noted the potential reach and contextual value of the recreational setting for prevention: *‘At the core of Australian culture, sports clubs are an effective medium to educate young Australians in high-risk age groups.’*⁸⁰ It also submitted that sporting clubs *‘can play an important role in helping to prevent and reduce drug use by role-modelling positive behaviours and adopting protective policies’*.⁸¹
- 12.47 This was illustrated by information received at the Broken Hill Roundtable, where the Inquiry heard that football players in the district abstained from crystal methamphetamine use during the football season.

*‘[T]he fortunate thing is, through a football season, because there’s a zero tolerance towards drugs ... people abstain, but then you have the six months break and people go back to their normal boredom, depression, grief – they don’t have that relief and release during the season, so people then revert back to what the others have been doing.’*⁸²

- 12.48 The Inquiry heard that as a consequence of the resumption of crystal methamphetamine use during the off season, the number of football teams in the district had fallen from seven to one-and-a-half in the course of a year.⁸³

Community-based approaches

- 12.49 The premise of community-based approaches is that the community, both individuals and organisations, identifies and mobilises around an issue and participates in the planning, design and implementation of the response.⁸⁴ Community programs are typically based on theories of community organisation, mobilisation and participation, sometimes referred to as community impact and community capacity building. They are also underpinned by a risk factors approach⁸⁵ and often encompass multiple elements and aim to reach various social units from schools, families and other networks to have positive impacts on the wider community.
- 12.50 Liverpool City Council submitted that the effectiveness of community-led initiatives relies on good governance, and that community prevention programs need to:⁸⁶
- specify the partner agencies involved
 - clarify expectations and collective service planning and delivery issues
 - be adequately resourced with project staff, optimally with drugs and alcohol sector experience
 - work from a community-based, non-government organisation.
- 12.51 Community-based programs appear to have had varied results. A 2018 review found there was a lack of high-quality evidence examining community-based programs for the prevention of AOD use,⁸⁷ but a number of the studies focused on preventing alcohol consumption. Others have argued that community-led primary prevention activities have shown promise. The Alcohol and Drug Foundation observed that these approaches draw on community infrastructure and can use evidence-based approaches tailored to the community.⁸⁸

- 12.52 Some community-based initiatives for alcohol prevention have had positive effects, leading to suggestions that these approaches might be effective in preventing ATS use, although Allsop has noted there is a lack of evidence that specifically relates to their impact on methamphetamine or other ATS use.⁸⁹ However, as noted by the Alcohol and Drug Foundation, some successful community-based AOD prevention strategies have focused on reducing risk factors and strengthening protective factors internationally and in Australia. These are explored further later in this chapter.⁹⁰

Aboriginal community initiatives

- 12.53 As outlined in Chapter 8, the Inquiry has identified certain groups that have particular experiences of ATS use, including Aboriginal people and communities. There have been a number of AOD prevention initiatives targeting young Aboriginal Australians, although evidence reviews have highlighted that there is a lack of evidence regarding effective drug prevention approaches in these communities.⁹¹

- 12.54 This was noted by the NSW Aboriginal Land Council, which called on the NSW Government to provide funding to evaluate Aboriginal community-driven and community-based prevention and treatment models. It also identified the need to commit resources to gather data that distinguishes between different user groups and the best preventive/intervention strategies for each different group.⁹² The Marrin Weejali Aboriginal Corporation highlighted the practical implications of the lack of evidence.

*'Marrin Weejali aims to deliver primary interventions wherever possible but we have little access to research-based evidence in relation to how to support our community to prevent ice-related harm and to prevent ice use escalating.'*⁹³

- 12.55 Consistent themes in these reviews point to best practice principles for prevention initiatives with Aboriginal communities. Findings included that initiatives are more likely to be effective if they:

- actively involve the Aboriginal community⁹⁴
- are delivered by Aboriginal community-controlled organisations that have the support to take control in an agreed timeframe⁹⁵
- include multiple program elements,⁹⁶ such as combined educational, recreational, employment and cultural activities (incorporating cultural activities is of particular benefit in helping young people feel connected to their community, as cultural discontinuity is recognised as a risk factor)⁹⁷
- involve both local Aboriginal and non-Aboriginal staff and emphasise the need for a strong partnership between them⁹⁸
- incorporate ongoing and regular contact, as one-off and shorter-term initiatives have a less positive impact.⁹⁹

- 12.56 Some of these principles were also noted in the Aboriginal Health and Medical Research Council's submission to the Inquiry, which emphasised the importance of:¹⁰⁰

- adopting a social determinants approach that considers the continuing disadvantage that many Aboriginal people experience
- understanding the importance of culture and community to the health of Aboriginal people
- community-driven interventions involving Aboriginal communities, which are more readily accepted
- Aboriginal community ownership and control and Aboriginal Community Controlled Health Services.

- 12.57 During its hearings in regional centres and in roundtable sessions with members of Aboriginal communities, the Inquiry heard about the imperative for Aboriginal people to learn about their culture, for communities to take control of their own futures, and the impact of intergenerational trauma and its association with drug use.¹⁰¹ These issues are discussed further in Chapter 16.

Workplace-based initiatives

- 12.58 Methamphetamine use in the work environment can lead to problems including absenteeism, irritability, agitation and mood swings, difficulty concentrating and reduced performance, mental health conditions including paranoia and depression, lack of concern about otherwise serious matters, and physical health problems.¹⁰²
- 12.59 As outlined in Chapter 8, the Inquiry has identified that there is a higher prevalence of ATS use in certain sectors such as mines, hospitality workers, sex workers and long-haul truck drivers.¹⁰³ The *Final Report of the National Ice Taskforce* also identified wholesale trades, the construction industry, the mining industry and the hospitality industries as sectors that had a higher methamphetamine prevalence.¹⁰⁴ The National Centre for Education and Training on Addiction (NCETA) informed the Inquiry that young workers aged between 18 and 39 reported the highest prevalence of methamphetamine use in the past year.¹⁰⁵
- 12.60 Employers, unions and employer organisations have previously implemented initiatives to address AOD-related harm in the workplace. To date, the focus has been on developing workplace policies and providing information, education and drug testing. However, as with other prevention strategies, there is limited research regarding the effectiveness of workplace-based interventions. A recent Australian review found that evidence from the previous 10 years was insufficient to determine whether the implementation of universal prevention strategies in workplace settings have had an effect on AOD use.¹⁰⁶
- 12.61 For example, an NCETA evaluation of a three-year trial of a comprehensive alcohol harm reduction intervention in Australian manufacturing workplaces found it achieved increases in awareness of the workplace alcohol policy and employee assistance. However, the results of the trial indicated that the intervention was not effective in reducing risky alcohol use.¹⁰⁷
- 12.62 There is a range of reasons for the limited evidence base for the effectiveness of workplace-based interventions, including a lack of workplace initiatives focused on AOD; the challenge of conducting controlled investigations in the workplace;¹⁰⁸ and the fact that workplace prevention initiatives have tended to broadly encompass AOD rather than focusing on specific drugs. As such, there is limited evidence that is particular to ATS.
- 12.63 Nonetheless, researchers and NCETA maintain that the workplace is ‘a *unique and cost-effective setting to implement public health strategies to address alcohol and drug-related harm*’.¹⁰⁹ The *Final Report on the National Ice Taskforce* found that the workplace was underused as a prevention setting.¹¹⁰
- 12.64 Factors that make the workplace suitable for prevention initiatives include:¹¹¹
- Most people who use alcohol and/or drugs are employed, so the workplace provides access to people who might need but not seek assistance.
 - The substantial amount of time workers spend at the workplace maximises opportunities for exposure to prevention initiatives.
 - Employers have substantial influence over employees’ work-related behaviours, particularly when related to workplace safety and productivity.
 - Industrial relations and occupational health and safety legislation and frameworks already incorporate AOD-related issues.

- Workplace-based prevention initiatives could influence the wider community via employees' interaction with family and friends.
- 12.65 Chapter 5 discusses situational ATS use including occupational use, and the appropriate objectives of policy and service responses.
- 12.66 NCETA has developed a broad primary prevention approach and cultural model as part of its workplace AOD research program. This model recognises that working environments and work-related consumption patterns vary widely¹¹² and that working conditions and employee beliefs and behaviours interact to influence cultures of AOD use.¹¹³
- 12.67 As well as recognising the importance of workplace conditions and employee culture, NCETA researchers have identified four interrelated components that are crucial to the effectiveness of future workplace AOD interventions:¹¹⁴
- development and implementation of a formal workplace policy
 - provision of education and training
 - access to counselling and treatment
 - evaluation.

Current approaches to prevention in NSW

- 12.68 The Inquiry notes that a number of programs currently operating in NSW have prevention of drug use as an aim or outcome. Some are delivered and/or funded by the NSW Government, while others are funded by the Commonwealth. The Inquiry received evidence of highly responsive and successful programs delivered by non-government organisations and of the role that local governments can play in drug prevention. For example, Liverpool City Council submitted that the local government sector can play a key role in prevention strategies, subject to the availability of funding: *'As the closest level of government to the community, councils are well placed to understand local problems and aspirations ... reducing demand for drugs is already part of local government's role.'*¹¹⁵
- 12.69 In its submission to the Inquiry, the NSW Government identified community education and prevention programs provided in support of demand reduction, including:¹¹⁶
- drug education in schools
 - online information and resources provided by NSW Health, and the information and support provided by telephone through the Alcohol and Drug Information Service
 - Community Drug Action Teams
 - the Crystal Methamphetamine Community Education Program conducted in 2016 through community forums.

Drug education in schools and the community

- 12.70 School-based drug education is mandatory in NSW as part of the Kindergarten to Year 10 Personal Development, Health and Physical Education curriculum. Other programs address community education in non-school settings, such as the Crystal Methamphetamine Community Education Program, online information provided by NSW Health, and the Commonwealth 'Ice destroys lives' campaign. These education programs are considered in Chapter 13.

Community Drug Action Teams

- 12.71 The NSW Ministry of Health has engaged the Alcohol and Drug Foundation to deliver the state-wide Community Engagement and Action Program.¹¹⁷ The Program supports a network of Community Drug Action Teams (CDATs) across NSW to deliver programs to prevent and minimise AOD-related harms in their local communities.¹¹⁸ CDATs have operated in NSW since the 1999 Drug Summit, using groups of volunteers working in their local community to deliver AOD education, awareness and prevention activities. The Program's objectives are to:¹¹⁹
- build strong partnerships between community members, business, local service providers and government and non-government organisations by encouraging engagement and participation
 - identify legal and illegal AOD-related problems in the local community
 - increase community knowledge and awareness of legal and illegal AOD harms and related social, health and wellbeing problems
 - increase communities' capacity to develop locally based initiatives to prevent the uptake of illegal drug use, alcohol consumption and the non-prescribed use of legal drugs to reduce associated harms
 - facilitate coordinated and collaborative action between agencies and groups with common goals in addressing local AOD issues.
- 12.72 There are currently 72 active CDATs in NSW. Their activities include convening AOD forums and conferences, training workshops, festivals, community events and recreational activities. The Alcohol and Drug Foundation provides some centralised support, through a team of eight staff, including disbursement of small grants and partnership grants, and digital and print resources including a dedicated website.¹²⁰
- 12.73 Six senior community development officers are located across NSW and liaise with and advise the CDATs. A state-wide Community Engagement and Action Program Advisory Committee advises the Alcohol and Drug Foundation on the oversight of CDATs across NSW. The Alcohol and Drug Foundation informed the Inquiry that the Community Engagement and Action Program was funded until June 2019. At the time of writing, the details of any subsequent funding arrangement with the NSW Ministry of Health are unknown.
- 12.74 The role and impact of CDATs was highlighted by other submissions to the Inquiry, including by councils with programs in their area.¹²¹ These submissions stressed the benefits of CDATs being able respond to community needs. Some challenges were identified in the implementation of CDATs¹²² but the program was generally strongly supported. The NSW Government submission noted that: *'Stakeholders perceive that CDATs improve community awareness and knowledge about drug and alcohol-related harm and deliver significant community engagement and impacts.'*¹²³
- 12.75 A 2017 evaluation of the NSW Community Engagement and Action Program found:¹²⁴
- There is a perception that CDATs have helped to improve community awareness and knowledge about AOD-related harm. Almost 60% of 509 community survey respondents reported that they had gained a significant level of AOD awareness and knowledge from engaging in CDAT activities.
 - Community members do not necessarily recognise the branding of CDATs, and public awareness of CDATs is separate to increasing AOD awareness and knowledge in the community.
 - The nature, extent and/or strength of community links vary across CDATs.
 - The effectiveness of implementing successful initiatives is contingent on the skill of CDAT members, shared allocation of tasks, the strength of the pre-existing relationships between members and the nature of the activity.

- CDATs are highly diverse in terms of size, activities and capabilities and their members are a highly motivated, passionate and dedicated group of people. However, as volunteers, CDAT members are also time poor and there is a perception that the CDAT workload is not properly recognised or funded.
- Factors such as resources, time, team dynamics and capacity influence the projects regardless of the type of funding model.
- CDAT members do not necessarily have the required administrative and technical knowledge, such as understanding evidence and evaluation.

12.76 The evaluation did not assess the effectiveness of CDATs or the extent to which the Community Education Action Program prevents and reduces AOD-related harm.¹²⁵

Local Drug Action Teams

12.77 The Commonwealth Government funds Local Drug Action Teams (LDATs) through the National Ice Action Strategy. They aim to support communities to work together to reduce the harms of AOD in NSW. The LDAT Program is open to Australian community volunteers wanting to prevent and minimise AOD issues. It supports communities to work together to deliver evidence-informed activities by developing and implementing their own Community Action Plan.¹²⁶

12.78 The Moree Plains Shire Council outlined various activities organised by its CDAT and LDAT, including an LDAT program to revitalise junior touch football, incorporating healthy lifestyle programs before games.¹²⁷

*'The Community Drug Action Teams, Local Drug Action Teams, Community Health support groups [and] generalist services support groups are all leading the way in which innovative strategies are educating the community. A variety of forums have been held in the Moree Shire to engage and educate the community.'*¹²⁸

12.79 The Alcohol and Drug Foundation reviews all applications for LDAT funding and gives priority to: those that focus on preventing AOD-related problems before they occur; are community driven, with strong community consultation and engagement; demonstrate collaboration and partnerships with local community partners; and are informed by evidence and responsive to local data and need.¹²⁹

12.80 The Alcohol and Drug Foundation has also developed a practical guide to support LDATs and their partners to develop and implement their Community Action Plans. There are 70 LDATs in NSW: 33 in Sydney; 31 in inner regional areas; eight in outer regional areas; and four in remote areas. Seventy-six Community Action Plans have been completed,¹³⁰ of which 84% focus on young people and/or young adults and 86% address crystal methamphetamine.¹³¹

12.81 The Alcohol and Drug Foundation has developed a program evaluation framework to provide an objective analysis of the implementation of the LDAT program and whether short-term outcomes have been achieved. The evaluation was to be conducted before November 2019.¹³² At the time of writing, results were not publicly available.

The combined value and shared challenges of CDATs and LDATs

12.82 The Inquiry received evidence about the value of CDATs and LDATs from the local government perspective. The Northern Beaches Community Safety Committee's submission outlined the effectiveness of CDATs and LDATs. It said a higher-level Council Community Safety Committee, chaired by the Mayor, allows stakeholders such as community representatives, non-government organisations, government agencies, specialist staff and councillors *'to come together on a regular basis and discuss issues of concern to the community'*.¹³³

12.83 Some submissions also noted the challenges faced by LDATs and CDATs:

*'[T]here is always going to be a problem of limited reach and limited resource[s] for dealing with areas that have a small population within which to coordinate LDAT activities ... more needs to be done in areas where LDATs options are not viable.'*¹³⁴

12.84 Moree Plains Shire Council observed that CDATs may be run by volunteers *'who do not want to shock or upset the community'* and that a *'softly, softly' approach* may not be what is needed.¹³⁵ Liverpool City Council noted that while CDAT activities are well attended and supported by Council and other government agencies, *'a criticism of the grassroots approaches of both CDATs and LDATs is that their effectiveness appears dependent on the motivation of the agency, or motivated individual, running them'*.¹³⁶ It suggested that funded positions, attached to councils and supported by the Alcohol and Drug Foundation with access to their evidence-based resources, would provide CDATs and LDATs with continuity and consistent support.¹³⁷

12.85 State and Commonwealth-funded CDATs and LDATs both operate in NSW. The Alcohol and Drug Foundation said they have *'different aims, different roles and work on different scales'*.¹³⁸ CDATs facilitate the involvement of individual citizens in drug prevention, while LDATs are more focused on partnerships between organisations; together *'the two programs enable a greater reach of community prevention across the state'*.¹³⁹

12.86 Evidence before the Inquiry did not identify any significant concerns around the joint operation of these programs.

The role of local government

12.87 This Inquiry also received submissions from a number of local councils, several of which detailed actions that the councils had taken to contribute to prevention efforts in their local community (including council support of local agencies that address social determinants of use).¹⁴⁰ The submission made by Liverpool City Council observed the key role that the local government sector can play in prevention strategies and the potential for this role to be enhanced.¹⁴¹

12.88 The Liverpool City Council submission outlined a number of community-based initiatives that support demand reduction. With a focus on building protective factors and social engagement, improving community understanding and reducing stigma, and addressing underlying the social determinants of use, these include:¹⁴²

- providing and maintaining sporting facilities (sports fields, cycle ways and leisure centres)
- promoting social justice through its Social Justice Policy
- providing grants to organisations for projects that benefit residents, including mental health, employment and sporting programs
- delivering community education and awareness-raising activities such as by providing educational material through its website and other communication channels
- developing a Drug and Alcohol Policy.

Other councils provided information about their support for agencies and for local community-based prevention programs such as Good Sports.¹⁴³

NSW Police Force initiatives

12.89 Police Citizens Youth Clubs (PCYC) NSW were established in 1937 to reduce and prevent crime by developing partnerships between police and young community members.¹⁴⁴ PCYCs operate in 64 sport and recreational centres in NSW, undertaking work that generally could be classed as a form of primary prevention.¹⁴⁵ The Inquiry heard evidence¹⁴⁶ about the RISEUP strategy developed by the NSW Police Commissioner, a collaborative approach with PCYC NSW and industry leaders to connect disengaged young people to workplace opportunities.

12.90 Superintendent Toby Lindsay, Commander, Richmond Police District, NSW Police Force, told the Lismore hearing how the program operates in the region.

*'[It] targets at-risk youth around 10 years of age, but it can be higher and can be lower ... it's an opportunity where police identify these kids, divert them through PCYC facilities – this program, specifically. We collect them in the mornings once a week. We take them to PCYC, engage with them through fitness. We feed them breakfast, facilitate their attendance at school. Really positive outcomes. We get about 15 to 20 kids once a week at Lismore. We've also conducted outreach at Casino Public School at the request of Department of Ed which is a fantastic outcome.'*¹⁴⁷

12.91 The Inquiry heard evidence that the RISEUP program has positive effects in reducing drug-taking behaviour,¹⁴⁸ with Superintendent Lindsay describing it as 'one of the most positive prevention activities the NSW Police Force has [been] involved in, the 25 years I've been in the job'.¹⁴⁹

The Good Sports program

12.92 The Good Sports program, coordinated by the Alcohol and Drug Foundation and funded by the Commonwealth Government, is an example of a recreational and leisure-based approach delivered universally to participating sporting clubs. The Good Sports program provides clubs with resources, training and guidance to build a healthy club environment. A KPMG report about the Good Sports program found it provided a return of \$4.20 for every \$1 invested.¹⁵⁰ The Alcohol and Drug Foundation told the Inquiry:

*'By improving the governance of sporting clubs and promoting sporting participation alongside the strengthening of social bonds, Good Sports is reinforcing protective factors that are known to decrease use of alcohol and other drugs, and subsequent drug-related harm.'*¹⁵¹

12.93 The program targets determinants of risky alcohol consumption, such as alcohol availability and pricing, free alcohol promotions, drinking games, and alcohol-related sponsorship as part of a three-stage accreditation framework. Support for implementation at club level includes project officer support, printed resources and newsletters, training, and feedback from observational audits of alcohol management practices on game days.¹⁵²

12.94 A 2015 evaluation found that while only 58% of clubs that received the intervention completed the full three-stage program, those that implemented some or all elements of the program achieved an 8% reduction in risky alcohol consumption among sporting club members and a 16% reduction in alcohol-related harm. Greater impacts were found for clubs in regional and rural areas compared with metropolitan areas, for soccer and/or association football clubs compared with other football codes, and for clubs that completed all three stages of the accreditation.¹⁵³

The Tackling Illegal Drugs program

- 12.95 Building on the success of Good Sports, the Alcohol and Drug Foundation developed the Tackling Illegal Drugs program to help sporting clubs address drug-related issues through developing and implementing an illegal drugs policy.¹⁵⁴ It said sporting clubs *'can play an important role in helping to prevent and reduce drug use by role-modelling positive behaviours and adopting protective policies'*.¹⁵⁵
- 12.96 The Tackling Illegal Drugs program was piloted under Victoria's Ice Strategy in 2015 and was funded by the Commonwealth Government until December 2019.¹⁵⁶ Each club's illegal drugs policy aims to prevent illegal drug use in the club, set standards for expected behaviour to act as a positive influence on members and reinforce a positive club culture, and guide the club in effectively responding to any illegal drug issues that may arise.¹⁵⁷
- 12.97 There are 110 sporting clubs in NSW and the ACT engaged in the program and 69 have completed their illegal drugs policy.¹⁵⁸ The Inquiry was told that 14 Tackling Illegal Drugs forums and workshops have been held for sporting clubs throughout NSW including in Sydney, Newcastle, Wagga Wagga, Dubbo and the Illawarra.¹⁵⁹
- 12.98 The Alcohol and Drug Foundation is considering integrating components of its different Good Sports programs into a single model and will explore the use of digital technologies to reach rural and remote communities.¹⁶⁰

The Street University

- 12.99 The Ted Noffs Foundation's Street University program is a targeted strategy underpinned by an understanding of risk and protective factors and the social determinants of drug use, including homelessness, unemployment and contact with the criminal justice system. Focused on young people aged 12 to 25, Street Universities are centres that provide a wide range of workshops, programs and activities, including those based around the arts, life skills development and technology and design. They also deliver vocational and educational workshops, AOD programs, mentoring, and bridging programs for further education.¹⁶¹ There are two Street Universities in NSW, one in Liverpool and one in Mt Druitt.
- 12.100 The programs attract, engage and intervene with marginalised young people who may otherwise be reluctant to seek help. The primary aim of a Street University is to reconnect individuals with their community and cultivate the social inclusion of young people.¹⁶² They can be seen as a community or recreational-based prevention strategy.
- 12.101 The NSW Ministry of Health has funded an evaluation of the Street University program under its Alcohol and Other Drugs Early Intervention Innovation Fund.¹⁶³ The Centre for Social Research in Health at UNSW Sydney is working with the Ted Noffs Foundation to evaluate the program's impact on substance use, mental health and criminal activity, as well as other personal and social outcomes for the young participants. The evaluation began in 2017 and was due for completion in 2019.¹⁶⁴ At the time of writing, results were not publicly available.

The ‘Icelandic model’ – Planet Youth

12.102 The Planet Youth primary prevention program, also known as the Icelandic model, is a broad-ranging community-based approach to AOD prevention. It was developed by the Icelandic Centre for Social Research and Analysis and implemented in partnership with municipalities throughout Iceland in 1999 to arrest and reverse trends in adolescent substance use. The model is guided by the following five principles:

- Enhancing the social environment through primary prevention, including addressing the drivers of substance use, strengthening protective factors and reducing risk factors for initiation of substance use.
- Emphasising community action, with schools as natural hubs to ‘*support child and adolescent health, learning and life success*’.¹⁶⁵
- Engaging and empowering the community to make decisions using high-quality local and accessible data and analytics.
- A cooperative approach to problem solving, involving researchers, policy makers, healthcare workers or clinicians and the community.
- Matching the scope of the solution to the scope of the problem, with a focus on long-term solutions and adequate resource allocation.¹⁶⁶

12.103 The Icelandic model involves a set of implementation steps but also allows for flexibility in implementation.¹⁶⁷ One evaluation, examining 12-year changes in alcohol use and cigarette smoking, found that in communities that received the intervention compared with those that did not, parental modelling and adolescent participation in organised sports (protective factors) increased; unmonitored idle hours and attendance at unsupervised parties (risk factors) decreased; and over time alcohol use and being intoxicated during the previous 30 days decreased.¹⁶⁸

12.104 While not specifically related to ATS, the Icelandic model has seen a significant reduction in the proportion of adolescents using substances.¹⁶⁹ Elements of the Planet Youth program are continuing in Iceland; government-funded community organisations have been established to strengthen and improve the collaborative aspect of parenting at the local school and community level, and municipalities have dramatically increased funding for recreational and extracurricular activities for adolescents, available through a voucher system.¹⁷⁰

12.105 Research on the Icelandic experience suggests:

- Prevention efforts need to simultaneously mobilise the peer group, the school, the family and those who coordinate youth activities to reduce substance use.
- Social relationships, parental social support and social control in ‘*the everyday social world of adolescents*’ have enduring importance.
- Prevention efforts must begin early, around the age of 12 or 13, when intervention has the best possible chance of interrupting experimentation and stemming use.
- Reaching young people early in their school years, as well as the parents of younger adolescents, is critical to success.¹⁷¹

12.106 The Inquiry received evidence about piloting a Planet Youth approach as a part of the LDAT program.¹⁷² The Alcohol and Drug Foundation submitted that:

‘Key components of the “Icelandic model” are support for parents in forming and maintaining positive relations with children, adolescent participation in organised sport and supervised work and recreational activities with respected adult role models outside the home. The creation of social environments that are high in protective factors and low in risk factors not only reduce the likelihood of young people engaging in substance use but promote physical and mental health more generally.’¹⁷³

- 12.107 The Alcohol and Drug Foundation has announced its intention to pilot Planet Youth in three sites in NSW as part of a national trial, with a focus on localised rather than universal implementation. The locations have been chosen from communities in the LDAT program that have strong relationships with their local council and schools.¹⁷⁴ The Alcohol and Drug Foundation will meet with the LDATs regularly to help them identify the right partners and issues of focus for the pilots, and assist them to organise community consultations and develop action plans.
- 12.108 In a statement to the Inquiry, the CEO of the Alcohol and Drug Foundation, Dr Erin Lalor, anticipated challenges to implementing the Icelandic model in NSW. These include an excessive focus on the demographic differences between Australia and Iceland, rather than shared protective factors in preventing AOD use; misconceptions that education in schools is a ‘silver bullet’; media and political emphasis on AOD treatment and harms, rather than prevention; short-term thinking in preventing and delaying AOD use; and encouraging parental involvement.¹⁷⁵
- 12.109 Dr Lalor also identified opportunities to strengthen and support the pilot in NSW, including:¹⁷⁶
- funding for five-year pilots
 - guiding the pilot sites and their communities to develop community action plans with a focus on reducing risk factors and building protective factors
 - working with Planet Youth to support the analysis and reporting of data so community-based workshops understand local issues and develop evidence-based localised solutions
 - delivering an infrastructure survey to local governments in pilot sites, with reports provided to inform local government and the community on gaps in supporting prevention activities locally
 - overseeing the grants process that pilot sites can access to support the delivery of community action plans
 - providing guidance, tools and resources to implement evidence-based actions via the LDAT program.

Community-driven initiatives

- 12.110 The Inquiry heard evidence about the value of community-driven initiatives, some of which have been discussed above. Such initiatives may deliver particular benefits to Aboriginal communities. The Inquiry heard evidence about, and in support of, the Maranguka Justice Reinvestment Project (The Maranguka Project), a community-driven initiative in Bourke that applies a collective impact approach.

Collective impact

- 12.111 Collective impact has emerged in recent years as a popular framework for supporting local approaches. It is a collaboration framework that engages sectors and groups in a given community with a common interest in addressing a complex social issue.¹⁷⁷ Collective impact is based on the premise that existing approaches are ineffective for solving complex social issues and a different approach is needed.¹⁷⁸
- 12.112 The framework comprises five key elements to achieve population-level change in relation to complex social issues.¹⁷⁹
- A common agenda: participants have a shared vision, including the problem to be solved and the agreed approach to solving it.
 - A shared measurement framework: data collection and measurement of results to ensure efforts are aligned and participants held accountable.

- A shared plan of action: diverse stakeholders should undertake activities relevant to their expertise and skill set, in a way that supports and is coordinated with the actions of others.
- Continuous communication: to build and maintain trust among participants, assure mutual objectives and build motivation.
- A backbone function: dedicated staff with the specific skills to coordinate participants and otherwise plan, manage and support the initiative.¹⁸⁰

12.113 The Aboriginal Legal Service noted that a collective impact framework *'involves adopting a more holistic approach to addressing harms, and in particular, looking at the drivers into alcohol and drug use rather than only the fact and consequences of alcohol and drug use'*.¹⁸¹

Justice reinvestment

12.114 Justice reinvestment is an emerging approach to reducing crime, imprisonment and increasing public safety.¹⁸² It aims to direct resources away from the criminal justice system to address the root causes of offending in communities with high rates of contact with the criminal justice system. It involves a four-step approach of analysing criminal justice data, developing policy solutions, implementing policy in practice and measuring outcomes.¹⁸³ It is grounded in fiscally sound, data-driven policies that local communities own and implement.¹⁸⁴ This holistic approach is aligned to a risk factors-based approach to drug prevention.

12.115 Justice reinvestment initiatives in Australia have taken a different approach to those in other nations.¹⁸⁵ They are focused on community investment to reduce crime in regional Aboriginal communities, reflecting concerns about disproportionate rates of Aboriginal incarceration.¹⁸⁶ The primary justice reinvestment organisation in NSW is Just Reinvest, a coalition of 25 organisations and individuals working to address the over-representation of Aboriginal people in custody.¹⁸⁷ The Aboriginal Legal Service (NSW/ACT), one of the supporting organisations for Just Reinvest, highlights that justice reinvestment in Australia is based on four key principles:¹⁸⁸

- Community led: self-determination and cultural authority and knowledge are critical. Communities drive local responses to crime and build pathways away from the criminal justice system for children and young people. Resources are shifted into strategies identified by the community
- Place based: identifies and addresses the particular circumstances in communities that drive offending. Service providers work collaboratively to meet goals identified by communities and to co-design localised solutions
- Data driven: data analysis informs decisions at both local and state levels
- Fiscally sound: long-term investment in sustainable solutions is required to build safer and stronger communities and prevent people from coming into contact with the justice system.

The Maranguka Project

12.116 The Maranguka Project began in 2013 and was the first major justice reinvestment project in Australia. Based in the north-west NSW town of Bourke, it was established by a coalition of local Aboriginal leaders, non-government organisations and Just Reinvest NSW in response to local concerns about rising crime and the number of Aboriginal families experiencing high levels of social disadvantage.¹⁸⁹ The project is an Aboriginal-led, place-based model of justice reinvestment aimed at improving outcomes for vulnerable families and children, making the community safer and reducing offending. Maranguka (meaning 'caring for others' in Ngemba language) is a model of Aboriginal community self-governance where services are coordinated through a multidisciplinary team owned and led by the Aboriginal community, working in partnership with relevant government and non-government agencies.¹⁹⁰

- 12.117 The project involves more than 20 organisations using a collective impact approach¹⁹¹ and is based on achieving long-term systems change through the empowerment of community, self-governance, role modelling and practical action.¹⁹² Project activities focus on four domains: building momentum for change; collaboration to build new relationships; new prevention and community-building programs; and procedural changes.¹⁹³
- 12.118 The Maranguka Project includes a Tribal Council, comprised of representatives of the 27 different tribal groups living in the region, to guide the work of the project, provide a mechanism for collaboration between government and the community and enable local decision-making about the delivery of services.¹⁹⁴ Those involved in the project stress the importance of the Tribal Council¹⁹⁵ and note that, although the model is adaptable, it needs to be tailored to the individual needs of any given community.¹⁹⁶
- 12.119 The Inquiry heard that the Maranguka Project addresses risk factors throughout the different stages of people's lives, with the local community identifying *'that what was relevant to a young person's trajectory into the criminal justice system ranged from early childhood data across the whole life course'*.¹⁹⁷ Sarah Hopkins, Managing Solicitor of Justice Projects at the Aboriginal Legal Service and Chair of Just Reinvest NSW, gave evidence that the community:
- '... wanted data reflecting the full life span of a young Aboriginal person in Bourke, from prenatal to 25 – including indicators related to early childhood, education, health, employment, child safety, mental health, drugs and alcohol, as well as data surrounding a young person's involvement with the criminal justice system ... to get a better informed and complete picture of what was happening with their children and young people.'*¹⁹⁸
- 12.120 The Aboriginal Legal Service outlined some of the activities designed to drive change within the community and justice system, including: ¹⁹⁹
- Aboriginal leaders inspiring a grassroots movement for change among the local community
 - facilitating collaboration and alignment across the service system, delivery of community-based programs and service hubs
 - partnering with justice agencies such as NSW Police to develop their procedures and operations towards a proactive and reinvestment model of justice
 - a focus on supporting children, youth, adults and families to build strength and independence and to reduce contact with the criminal justice system.
- 12.121 The Maranguka Project incorporates many of the common themes identified above for successful drug prevention interventions with Aboriginal communities. Alistair Ferguson, Executive Director of Maranguka Justice Reinvestment, said the main factor in the project's success is that the Aboriginal community is *'front and centre of the decision-making'* and able to make informed decisions.²⁰⁰
- 12.122 The Inquiry also heard from Ms Hopkins, Aboriginal Legal Service, about the importance of tracking results to ensure the program's effectiveness and to try different methods.²⁰¹ She said that while outcomes can be achieved in the shorter and medium term, the project is working towards generational change.²⁰²

- 12.123 The Aboriginal Legal Service highlighted the key findings of an impact assessment of the Maranguka Project undertaken by KPMG in 2018. They include a 23% reduction in police-recorded incidence of domestic violence and comparable drops in rates of re-offending, an 18% reduction in the number of major offences reported, and a 39% decrease in the number of people proceeded against for drug offences.²⁰³ In addition, there was a 31% increase in year 12 retention rates,²⁰⁴ showing the project has had an impact on both risk and protective factors.
- 12.124 The submission also highlighted the economic value of this type of justice reinvestment, with the KPMG assessment finding that changes in Bourke after it adopted this approach resulted in a gross economic impact of \$3.1 million in 2017. About two-thirds of those savings related to the justice system and one-third to the broader economic impact on the region.²⁰⁵ *KPMG further estimated that if just half of the results achieved in 2017 were sustained, Bourke could deliver an additional economic impact of \$7 million over the next five years.*²⁰⁶
- 12.125 Mr Ferguson, Maranguka Project, gave evidence about the potential to transfer the project to other locations, as a model for place-based and community-led projects:
- 'I think the model itself – it's adoptable and transferable, but I think it needs to be certainly customised and tailored to the individual sorts of needs of that – and demands of that particular community and given the diversity and the dynamics, and all that needs to come into account.'*²⁰⁷
- 12.126 The significant successes of the Maranguka Project, discussed above, provide an example of a project with direct, significant and meaningful effects on communities. The praise for the success of the project from those involved, and the external evaluation by KPMG, provide clear evidence of the potential of this kind of community-led approach.
- 12.127 There are challenges in developing justice reinvestment models. The Maranguka Project impact assessment report cautions that justice reinvestment is not simple or easy. It requires long-term commitment, relationship building and openness to new ideas.²⁰⁸ Research similarly notes that justice reinvestment approaches are premised on years of research, conversations and multilevel stakeholder commitment.²⁰⁹ The success of justice reinvestment projects also depends on the commitment, participation and support of local communities.²¹⁰
- 12.128 The Maranguka impact assessment report notes that justice reinvestment approaches still lack an effective mechanism of reinvestment.²¹¹ It proposes two approaches that could underpin a funding approach in NSW communities: the long-term reinvestment of funding from crisis response and incarceration towards preventive community-led initiatives, and the reallocation of local service expenditure from existing programs to initiatives that align to a community-defined local plan.²¹² The report suggests these approaches need to be underpinned by flexible and collective local funding, and models that are community-led and outcomes based.²¹³
- 12.129 Noting that the NSW Government allocated \$3.8 billion over four years in the 2016–17 Budget to increase prison capacity,²¹⁴ the Aboriginal Legal Service recommended directing resources away from expanding prison infrastructure into effective justice reinvestment programs and services for communities with high numbers of offenders.²¹⁵
- 12.130 The NSW Branch of the RANZCP supported a justice reinvestment approach to reduce offending and increase community safety at a local level.²¹⁶ The NSW Aboriginal Land Council recommended that the NSW Government adopt a justice reinvestment approach to offenders using ATS.²¹⁷

- 12.131 Superintendent Peter McKenna, Commander, Orana Mid-Western Police District, NSW Police Force, told the Inquiry that aspects of the justice reinvestment model could be applied in Dubbo.²¹⁸ Lismore City Council's Social Justice and Crime Prevention Committee supports justice reinvestment initiatives such as the Maranguka Project.²¹⁹
- 12.132 The Inquiry heard that early steps have been taken towards developing justice reinvestment projects elsewhere, including in Armidale, Mt Druitt, Dubbo, Moree and Wilcannia.²²⁰

Prevention as part of future NSW policy

An evidence-based, comprehensive and resourced prevention strategy

- 12.133 As has already been identified in this chapter and Chapter 10, strategies to prevent and delay the start of drug use need to be recognised as crucial to any AOD policy and resourced accordingly.²²¹ Rather than responding to AOD issues after they occur, prevention initiatives help people avoid using drugs in the first place or transitioning to more risky or harmful use.²²² The programs outlined above are, for the most part, limited in their scale and reach. While the CDAT and LDAT programs are examples of a coordinated government approach, there is currently no overarching framework or coordination for prevention programs in NSW. Consistent with the whole-of-government approach to AOD policy recommended in Chapter 10, such coordination would be likely to assist and support prevention efforts across the state.
- 12.134 In its final report, the *2017 Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice)* said that prioritising funding for law enforcement strategies above demand and harm reduction measures runs the risk of undermining the success of the National Drug Strategy, and recommended AOD funding be rebalanced across the three pillars of harm minimisation.²²³ The NSW Government does provide and support prevention activities in various strategies, most notably through school-based drug education and CDATs. However, any future drug policy should recognise and appropriately resource prevention as a key pillar or action as part of a reconceptualisation of the current three pillars approach to harm minimisation.
- 12.135 The importance of recognising protective and risk factors is well established. The stories of the lived experience witnesses who gave evidence to the Inquiry vividly illustrate the importance of risk and protective factors in influencing drug use, as examined in the literature.²²⁴ In light of this evidence, such risk and protective factors should be recognised and addressed in drug policy. Relevant approaches to address factors such as housing and family support are addressed in more detail in this report, in Chapters 17 and 18 respectively.
- 12.136 Given the social determinants that commonly drive drug use, including ATS use, effective prevention initiatives should focus on the broader social context within which drug use occurs, such as employment, housing and family cohesion. As recognised by the European drug prevention standards, not all initiatives will be AOD-specific; they may address wider health or social issues, meaning that drug prevention might form only one part of the program, or that their effectiveness in preventing drug use may not be seen for many years.²²⁵ An effective approach to prevention needs to be supported and enhanced by a consistent, whole-of-government approach involving all relevant government departments, as well as the community more broadly.

Continuing to strengthen the support for effective community-based prevention initiatives

- 12.137 A consistent theme of the evidence before this Inquiry has been the importance of ensuring that communities affected by ATS use are centrally involved in developing responses to those issues.²²⁶ Local or community-based approaches address complex problems at a local level by strengthening the capacity of communities to take action themselves. This Inquiry received submissions advocating for community-driven approaches from a range of bodies including councils, consumer advocates and health bodies.²²⁷

Recommendation 20:

That the NSW Government support local, community-driven collective impact initiatives, including justice reinvestment initiatives, that aim to respond to the local drivers of drug use, and actively support the further expansion of such programs, in consultation with local communities.

References

- 1 Catherine Spooner and Kate Hetherington, *Social determinants of drug use* (Technical Report No 228, 2004).
- 2 See, for example, Mission Australia, Submission No 66 (2019) 2; NSW Council of Social Service, Submission No 54 (7 May 2019) 4-5.
- 3 National Drug Research Institute Curtin University, Submission No 48 (May 2019) 7.
- 4 Catherine Spooner and Kate Hetherington, *Social determinants of drug use* (Technical Report No 228, 2004).
- 5 Penny Mitchell et al, *The Role of Families in the Development, Identification, Prevention and Treatment of Illicit Drug Problems* (Report, 2001) cited in Wendy Loxley et al, *The Prevention of Substance Use, Risk and Harm in Australia: A Review of the Evidence* (Report, 2004).
- 6 See, Aboriginal Legal Service (NSW/ACT) and Just Reinvest NSW, Preliminary Submission No 61 (30 January 2019) 2; National Drug and Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 4-6, 17.
- 7 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (Report, 2017) 1.
- 8 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (Report, 2017) 6-7.
- 9 NSW Health, *NSW Community Mental Health Strategy 2007-2012: From prevention and early intervention to recovery* (Report, 2018) 4, adapted from Patricia Mrazek and Robert Haggerty (eds), *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (Institute of Medicine US Committee on Prevention of Mental Disorders Washington DC National Academics Press, 1994) Figure 2.1.
- 10 See, Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 126.
- 11 NSW Health, *NSW Community Mental Health Strategy 2007-2012: From prevention and early intervention to recovery* (Report, 2018) 4, adapted from Patricia Mrazek and Robert J Haggerty (eds), *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (Institute of Medicine US Committee on Prevention of Mental Disorders Washington DC National Academics Press, 1994) Figure 2.1.
- 12 United Nations Office on Drugs and Crime and the World Health Organisation, *International Standards on Drug Use Prevention* (2nd Report, 2018) 2.
- 13 Amy O'Donnell et al, 'Which individual, social and environmental influences shape key phases in the amphetamine type stimulant use trajectory? A systematic narrative review and thematic synthesis of the qualitative literature' (2018) 114(1) *Addiction* 24, 25.
- 14 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Perspectives on Amphetamine-Type Stimulants* (IP Communications, 2012) 173, 174.
- 15 Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee, *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 125.
- 16 Amy O'Donnell et al, 'Which individual, social and environmental influences shape key phases in the amphetamine type stimulant use trajectory? A systematic narrative review and thematic synthesis of the qualitative literature' (2018) 114(1) *Addiction* 24, 25.
- 17 Steve Allsop 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Perspectives on Amphetamine-Type Stimulants* (IP Communications, 2012) 173, 174.
- 18 See, for example, Mission Australia, Submission No 66 (2019) 2-3; NSW Council of Social Service, Submission No 54 (7 May 2019).
- 19 Australian Institute of Health and Welfare, Commonwealth, *Custom Analysis of the 2016 NDSHS* (unpublished data), Patterns of Use, 'Table 4: Proportion of people aged 14 or older who recently used ecstasy, by social characteristics, 2004 to 2016 (per cent)', (see Appendix 17).
- 20 See for example Sydney (General) Hearing, Sydney, 8 May 2019, TS 192.41-44 (Tillier); Sydney (General) Hearing, Sydney, 8 May 2019, TS 186.39-42 (Hawkins); Broken Hill Hearing, Broken Hill, Exhibit D, Tab 41, Statement of Andrew House, 4 July 2019, [3]; East Maitland Hearing (Private), East Maitland, 21 June 2019, TS 2243.30-34 (Lived Experience Witness, Lewis); Lismore Hearing (Private), Lismore, 13 May 2019, TS 487.24-488.7 (Lived Experience Witness, Name Withheld).
- 21 Lismore Roundtable (Private), Lismore, 13 May 2019, TS 562.47-563.5 (Telford).
- 22 Department of Prime Minister and Cabinet (Cth), *Final Report of the National Ice Taskforce* (Report, 2015).
- 23 Western Australia Department of Premier and Cabinet, *Methamphetamine Action Plan Taskforce Final Report* (Report, August 2018).
- 24 Law Reform, Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamines, Particularly 'Ice', in Victoria* (Final Report, September 2014).
- 25 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 3.
- 26 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 6-7.
- 27 National Drug Research Institute, Curtin University, Submission No 48 (May 2019) 7.
- 28 NSW Council of Social Service, Submission No 54 (7 May 2019) 5-6.
- 29 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 2, 10.
- 30 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 2, 10.
- 31 Catherine Spooner and Kate Hetherington, National Drug and Alcohol Research Centre, UNSW Sydney, *Social determinants of drug use* (Technical Report Number 228, 2004) 1.
- 32 Catherine Spooner and Kate Hetherington, National Drug and Alcohol Research Centre, UNSW Sydney, *Social determinants of drug use* (Technical Report Number 228, 2004) iv.
- 33 Catherine Spooner and Kate Hetherington, National Drug and Alcohol Research Centre, UNSW Sydney, *Social determinants of drug use* (Technical Report Number 228, 2004) vi.
- 34 Thomas F Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2nd ed, 2018) 126.
- 35 Commonwealth Department of Health, 'Risk and protective factors in the lives of your people', *Module 3: Young People Risk and Resilience: Learner's Workbook* (Web Page, 2004)
<<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front3-wk-toc~drugtreat-pubs-front3-wk-secb~drugtreat-pubs-front3-wk-secb-2~drugtreat-pubs-front3-wk-secb-2-2>>.
- 36 Richard Jessor, Mark Turbin and Frances Costa, 'Risk and Protection in Successful Outcomes Among Disadvantaged Adolescents' (1998) 2(4) *Applied Developmental Science* 194, 195.

- 37 Commonwealth Department of Health, 'Risk and protective factors in the lives of your people', *Module 3: Young People Risk and Resilience: Learner's Workbook* (Web Page, 2004) <<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front3-wk-toc~drugtreat-pubs-front3-wk-secb~drugtreat-pubs-front3-wk-secb-2~drugtreat-pubs-front3-wk-secb-2-2>>.
- 38 J David Hawkins, Richard Catalano and Janet Miller, 'Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention' (1992) 112(2) *Psychological Bulletin* 64, 65.
- 39 J David Hawkins, Richard Catalano and Janet Miller, 'Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention' (1992) 112(2) *Psychological Bulletin* 64, 65.
- 40 Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australia Adolescents' in Alison Ritter, Trevor King and Nicole Lee, *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 131.
- 41 Katrina Champion et al, 'Chapter 7: Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 130.
- 42 J David Hawkins, Richard Catalano and Janet Miller, 'Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention' (1992) 112(2) *Psychological Bulletin* 64, 92-6.
- 43 Thomas F Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2nd ed, 2018) 125.
- 44 Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 125-6.
- 45 Steven Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and reduced harm' in Steve Allsop and Nicole Lee (eds), *Perspectives on Amphetamine Type Stimulants* (IP Communications, 2012) 173, 174.
- 46 Patricia Mrazek and Robert J Haggerty (eds), *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (Institute of Medicine US Committee on Prevention of Mental Disorders Washington DC National Academics Press 1994).
- 47 David Hawks, Katie Scott and Nyanda McBride, *Prevention of Psychoactive Substance Use: A Selected Review of What Works in the Area of Prevention* (Report, 2002) 1.
- 48 Robert Gordon Jr, 'An operational classification of disease prevention' (1983) 98(2) *Public health reports* 107, 108.
- 49 Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 126.
- 50 Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 127.
- 51 European Monitoring Centre for Drugs and Drug Addiction, *Preventing later substance use disorders in at-risk children and adolescents: a review of the theory and evidence base of indicated prevention* (2009) 12.
- 52 Louise Mewton et al, 'Universal prevention of alcohol and other drug use: An overview of reviews in an Australian context' (2018) 27(S1) *Drug and Alcohol Review* S435.
- 53 Louise Mewton et al, 'Universal prevention of alcohol and other drug use: An overview of reviews in an Australian context' (2018) 27(S1) *Drug and Alcohol Review* S435.
- 54 Steven Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and reduced harm' in Steve Allsop and Nicole Lee (eds), *Perspectives on Amphetamine Type Stimulants* (IP Communications, 2012) 173, 174.
- 55 Louise Mewton et al, 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27 (Supplement 1) *Drug and Alcohol Review* S435, S437.
- 56 Catherine Spooner and Kate Hetherington, *Social determinants of drug use* (Technical Report Number 228, 2004) xi.
- 57 Catherine Spooner and Kate Hetherington, *Social determinants of drug use* (Technical Report Number 228, 2004).
- 58 Steven Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and reduced harm' in Steve Allsop and Nicole Lee (eds), *Perspectives on Amphetamine Type Stimulants* (IP Communications, 2012) 173, 174.
- 59 Department of Prime Minister and Cabinet (Cth), *Final Report of the National Ice Taskforce* (Report, 2015) 113.
- 60 Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 132.
- 61 See, for example, Inga Dóra Sigfúsdóttir et al (2008) 'Substance use prevention for adolescents: the Icelandic Model' (2008) 24(1) *Health Promotion International* 16, 17-19; Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed,) 124-143; Thomas F Babor, *Drug Policy and the Public Good* (Oxford University Press 2nd edition, 2018) 126-137.
- 62 Katrina Champion et al, 'Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 138.
- 63 See, The Royal Australian and New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 12; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 6; East Maitland Hearing, East Maitland, 18 June 2019, TS 1826.45-1827.4 (Connelly).
- 64 Louise Mewton et al, 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27 (Supplement 1) *Drug and Alcohol Review* S435, S437.
- 65 Louise Mewton et al 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27 (Supplement 1) *Drug and Alcohol Review* S435, S437.
- 66 See Ethnic Communities' Council of NSW, Submission No 138 (undated, received 25 May 2019); Drug and Alcohol Multicultural Education Centre, Submission No 139 (29 May 2019) 5.
- 67 John Toumbourou et al, 'Reduction of Adolescent Alcohol Use Through Family-School Intervention: A Randomised Trial' (2013) 53(5) *Journal of Adolescent Health* 778.
- 68 Richard Spoth et al, 'Long-term effects of Universal Preventive Interventions on Methamphetamine Use Among Adolescents' (2006) 160 *Archives of Pediatrics and Adolescent Medicine* 876, 877.
- 69 Richard Spoth et al, 'Long-term effects of Universal Preventive Interventions on Methamphetamine Use Among Adolescents' (2006) *Archives of Paediatrics and Adolescent Medicine* 876, 880-1.
- 70 Thomas F Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2nd ed, 2018) 130-131.
- 71 Richard Spoth et al, 'Long-term effects of Universal Preventive Interventions on Methamphetamine Use Among Adolescents' (2006) 160 *Archives of Pediatrics and Adolescent Medicine* 876, 880-1.
- 72 Thomas F Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2nd ed, 2018) 134-135.
- 73 Richard Cervantes, Jeremy Golbach and Susan Santos, 'Familia Adelante: A Multi-Risk Prevention Intervention for Latino Families' (August 2011) 32(3-4) *Journal of Primary Prevention* 225, 225.
- 74 Richard Cervantes, Jeremy Golbach and Susan Santos, 'Familia Adelante: A Multi-Risk Prevention Intervention for Latino Families' (August 2011) 32(3-4) *Journal of Primary Prevention* 225, 228-9.

- 75 Richard Cervantes, Jeremy Golbach and Susan Santos, 'Familia Adelante: A Multi-Risk Prevention Intervention for Latino Families' (August 2011) 32(3-4) *Journal of Primary Prevention* 225, 230.
- 76 Hilda Pantin et al, 'A randomized controlled trial of Familias Unidas for Hispanic adolescents with behavior problems' (2009) 71(9) *Psychosomatic Medicine* 987, 989.
- 77 Hilda Pantin et al, 'A randomized controlled trial of Familias Unidas for Hispanic adolescents with behavior problems' (2009) 71(9) *Psychosomatic Medicine* 987, 990-1.
- 78 See Inga Dóra Sigfúsdóttir et al, 'Substance use prevention for adolescents: the Icelandic Model' (2008) 24(1) *Health Promotion International* 16, 18; Alfreir Logi Kristjánsson et al, 'Adolescent substance use, parental monitoring and leisure-time activities: 12-year outcomes of primary prevention in Iceland' (2010) 51 *Preventive Medicine* 168, 170.
- 79 Louise Mewton et al 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27 (Supplement 1) *Drug and Alcohol Review* S435, S462.
- 80 Alcohol and Drug Foundation, Preliminary Submission No 29 (23 January 2019) 2.
- 81 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 11.
- 82 Broken Hill Roundtable (Private), Broken Hill, 15 July 2018, TS 2430.20-2431.43 (Doyle).
- 83 Broken Hill Roundtable (Private), Broken Hill, 15 July 2018, TS 2430.20-2431.43 (Doyle).
- 84 Emily Stockings et al, 'Whole-of-community interventions to reduce population level harms arising from alcohol and other drug use: a systematic review and meta-analysis' (2018) 113(11) *Addiction* 1984, 1984-5; Johanna Birckmayer et al, 'Prevention of Methamphetamine Abuse: Can Existing Evidence Inform Community Prevention?' (2008) 38(2) *Journal of Drug Education* 147, 147-165.
- 85 See, for example, John W Toumbourou et al, 'Community Intervention to Prevent Adolescent Health Behavior Problems: Evaluation of Communities that Care in Australia' (2019) 38(6) *Health Psychology* 536; J David Hawkins et al, 'Testing Communities That Care: The Rationale, Design and Behavioural Baseline Equivalence of the Community Youth Development Study' (2008) 9 (3) *Prevention Science* 178, 179-80; Emily Stockings et al, 'Whole-of-community interventions to reduce population level harms arising from alcohol and other drug use: a systematic review and meta-analysis' (2018) 113(11) *Addiction* 1984, 1984-5; B K Elizabeth Kim et al, 'Effects of the Communities that Care Prevention System on Youth Reports of Protective Factors' (2015) 16(5) *Prevention Science* 652, 653.
- 86 Liverpool City Council, Submission No 120 (May 2019) 8.
- 87 Louise Mewton et al, 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27 (Supplement 1) *Drug and Alcohol Review* S435, S462.
- 88 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 6.
- 89 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Perspectives on Amphetamine-Type Stimulants* (IP Communications, 2012) 173, 176.
- 90 Alcohol and Drug Foundation, Submission No. 78 (7 May 2019), 6-12.
- 91 Lynore Geia et al, 'Adolescent and young adult substance use in Australian Indigenous communities: a systematic review of demand control program outcomes' (2018) 42(3) *Australian and New Zealand Journal of Public Health* 254, 259; Louise Mewton et al, 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27(Supplement 1) *Drug and Alcohol Review* S435, S465; Kylie Lee et al, 'Pressing need for more evidence to guide efforts to address substance use among young Indigenous Australians' (2013) 24 *Health Promotion Journal of Australia* 87, 94.
- 92 NSW Aboriginal Land Council, Submission No 118 (May 2019) 1.
- 93 Marrin Weejali Aboriginal Corporation, Preliminary Submission No 24 (22 January 2018) 2.
- 94 Louise Mewton et al, 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27(S1) *Drug and Alcohol Review* S435, S464-5.
- 95 Lynore Geia et al, 'Adolescent and young adult substance use in Australian Indigenous communities: a systematic review of demand control program outcomes' (2018) 42(3) *Australian and New Zealand Journal of Public Health* 254, 259.
- 96 Louise Mewton et al, 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27(S1) *Drug and Alcohol Review* S435, S464.
- 97 Kylie Lee et al, 'Pressing need for more evidence to guide efforts to address substance use among young Indigenous Australians' (2013) 24 *Health Promotion Journal of Australia* 87, 94-5.
- 98 Louise Mewton et al, 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27(S1) *Drug and Alcohol Review* S435, S464-5.
- 99 Kylie Lee et al, 'Pressing need for more evidence to guide efforts to address substance use among young Indigenous Australians' (2013) 24 *Health Promotion Journal of Australia* 87, 94.
- 100 Aboriginal Health and Medical Research Council of NSW, Preliminary Submission No 59 (30 January 2019) 5.
- 101 Broken Hill Hearing, Broken Hill, 18 July 2019, TS 2842.18-45 (Hampton); East Maitland Roundtable (Private), East Maitland, 21 June 2019, TS 2345.39-47 (Name Withheld); Dubbo Roundtable (Private), Dubbo, 3 June 2019, TS 1364.1-5 (Name Withheld); see also Catherine Spooner and Kate Hetherington, *Social determinants of drug use* (Technical Report No 228 (2004)).
- 102 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Perspectives on Amphetamine-Type Stimulants* (IP Communications Pty Ltd, 2012) 173, 178.
- 103 Sex Workers Outreach Project, Submission No 83 (7 May 2019) 2; Dubbo Hearing, Dubbo 6 June 2019, TS 1774.7-9 (Henderson); Ann Williamson et al, *Final report of stimulant use by long distance road transport drivers project* (Report, 2006) 3; Jeremy Davey, Naomi Richards and James Freeman, 'Fatigue and beyond: Patterns of and motivations for illicit drug use among long-haul truck drivers' (2007) 8 *Traffic Injury Prevention* 253, 255-6.
- 104 Department of the Prime Minister and Cabinet (Cth), *Final Report of the National Ice Taskforce* (Report, 2015) 118.
- 105 National Centre for Education and Training on Addiction, Flinders University, Submission No 110 (9 May 2019) 2.
- 106 Louise Mewton et al, 'Universal prevention of alcohol and drug use: An overview of reviews in an Australian context' (2018) 27 (Supplement 1) *Drug and Alcohol Review* S435, S465.
- 107 Ken Pidd et al, 'Workplace alcohol harm reduction intervention in Australia: Cluster non-randomised controlled trial' (May 2018) 37(4) *Drug and Alcohol Review* 502, 510-1.
- 108 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Perspectives on Amphetamine-Type Stimulants* (IP Communications, 2012) 173, 179.
- 109 Ken Pidd and Ann Roche, 'Workplace alcohol and other drug programs: What is good practice?' (Report, 1 July 2013) 2.
- 110 Commonwealth of Australia, Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce* (2015) 119, 166.
- 111 Ken Pidd and Ann Roche, 'Workplace alcohol and other drug programs: What is good practice?' (Report, 1 July 2013) 2.
- 112 Ken Pidd and Ann Roche, 'Workplace alcohol and other drug programs: What is good practice?' (Report, 1 July 2013) 8.

- 113 National Centre for Education and Training on Addiction, Submission No 110 (May 2019) 3.
- 114 Ken Pidd and Ann Roche, 'Workplace alcohol and other drug programs: What is good practice?' (Report, 1 July 2013) 5-6.
- 115 Liverpool City Council, Submission No 120 (May 2019) 5.
- 116 NSW Government, Submission 143 (2019) 13.
- 117 'Prevention, brief and early intervention and harm minimisation', *NSW Ministry of Health* (Web Page) <<https://www.health.nsw.gov.au/aod/programs/Pages/prevention.aspx>>.
- 118 'Prevention, brief and early intervention and harm minimisation', *NSW Ministry of Health* (Web Page) <<https://www.health.nsw.gov.au/aod/programs/Pages/prevention.aspx>>.
- 119 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 14.
- 120 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 14.
- 121 Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 3-4; Tweed Shire Council, Submission 75 (7 May 2019) 4.
- 122 See, for example, Liverpool City Council, Submission No 120 (May 2019) 9.
- 123 NSW Government, Submission No 143 (2019) 13.
- 124 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 643, Communio, *Evaluation of the NSW Community Engagement and Action Program (CEAP) for NSW Ministry of Health* (Final Report, 7 July 2017).
- 125 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 643, Communio, *Evaluation of the NSW Community Engagement and Action Program (CEAP) for NSW Ministry of Health* (Final Report, 7 July 2017).
- 126 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 12.
- 127 Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 4.
- 128 Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21.
- 129 Is it right for us?', *Alcohol and Drug Foundation Community Hub* (Web Page, 2018) <https://community.adf.org.au/join-program/it-right-us/>.
- 130 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 13.
- 131 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 13.
- 132 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 13.
- 133 Northern Beaches Council, Submission No 53 (undated, received 7 May 2019) 4.
- 134 MindM8 Ventures, Submission No 93 (undated, received 7 May 2019) 1.
- 135 Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 3.
- 136 Liverpool City Council, Submission No 120 (May 2019) 11.
- 137 Liverpool City Council, Submission No 120 (May 2019) 11.
- 138 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 16.
- 139 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 16.
- 140 Tweed Shire Council, Submission 75 (7 May 2019); Moree Plains Shire Council, Submission 72 (undated); Liverpool City Council, Submission 120 (May 2019).
- 141 Liverpool City Council, Submission No 120 (May 2019) 8.
- 142 Liverpool City Council, Submission 120 (May 2019), 4-5.
- 143 Tweed Shire Council, Submission 75 (7 May 2019) 5.
- 144 'Our Vision', *Police Citizens Youth Clubs NSW* (Web Page) <https://www.pcycnsw.org.au/>.
- 145 Philip Birch and Tim Prenzler, 'Community-based prevention' in Tim Prenzler (ed), *Understanding Crime Prevention: The Case Study Approach* (2017) 61, 67.
- 146 Lismore Hearing, Lismore, 14 May 2019, TS 605.29-606.11 (Superintendent Lindsay); East Maitland Hearing, East Maitland, 19 June 2019, TS 1948.1-23 (Superintendent Jackson); Moree Hearing, Moree, Exhibit A, Tab 5, Statement of Scott Tanner, 5 August 2019, [4].
- 147 Lismore Hearing, Lismore, 14 May 2019, TS 605.40-606.6 (Superintendent Lindsay).
- 148 East Maitland Hearing, East Maitland, 19 June 2019, TS 1948.1-23 (Jackson).
- 149 Lismore Hearing, Lismore, 14 May 2019, TS 606.38-39 (Superintendent Lindsay).
- 150 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 10.
- 151 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 10-11.
- 152 Melanie Kingsland et al, 'Tackling risky alcohol consumption in sport: a cluster randomised controlled trial of an alcohol management intervention with community football clubs' (2015) 69 *Journal of Epidemiological Community Health* 993, 994.
- 153 Melanie Kingsland et al, 'Tackling risky alcohol consumption in sport: a cluster randomised controlled trial of an alcohol management intervention with community football clubs' (2015) 69(10) *Journal of Epidemiological Community Health* 993, 996.
- 154 'Tackling Illegal Drugs Program', *Good Sports* (Web Page, 2016) <<https://goodsports.com.au/programs/tackling-illegal-drugs-program/>>.
- 155 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 11.
- 156 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 11.
- 157 'Tackling Illegal Drugs Program', *Good Sports* (Web Page, 2016) <<https://goodsports.com.au/programs/tackling-illegal-drugs-program/>>.
- 158 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 11.
- 159 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 11.
- 160 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 11.
- 161 'Street University', *Noffs Foundation* (Web Page) <<https://noffs.org.au/blank/street-university/>>.
- 162 'Street University', *Noffs Foundation* (Web Page) <<https://noffs.org.au/blank/street-university/>>.
- 163 'Alcohol and Other Drugs (AOD) Early Intervention Innovation Fund', *NSW Ministry of Health* (Web Page, 13 August 2018) <<https://www.health.nsw.gov.au/aod/programs/Pages/aod-innovation-fund.aspx>>.
- 164 Evaluation of the Ted Noffs Foundation Street University Program', *Centre for Social Research in Health UNSW* (Web Page) <<https://www.arts.unsw.edu.au/centre-social-research-health/our-projects/evaluation-ted-noffs-foundation-street-university/>>.
- 165 About Planet Youth, *Planet Youth* (Web Page) <<https://planetyouth.ie/about/>>.

- 166 Alfgeir Logi Kristjansson et al, 'Development and Guiding Principles of the Icelandic Model for Preventing Adolescent Substance Use' (2019) 21(1) *Health Promotion Practice* 62, 65.
- 167 Alfgeir Logi Kristjansson et al, 'Implementing the Icelandic Model for Preventing Adolescent Substance Use' (2019) 21(1) *Health Promotion Practice* 70, 79.
- 168 Alfgeir Logi Kristjansson et al, 'Adolescent substance use, parental monitoring and leisure-time activities: 12-year outcomes of primary prevention in Iceland' (2015) 51 *Preventive Medicine* 168, 169-70.
- 169 See Inga Dóra Sigfúsdóttir et al, 'Substance use prevention for adolescents: the Icelandic Model' (2009) 24(1) *Health Promotion International* 16, 19; Alfgeir Logi Kristjansson et al, 'Population trends in smoking, alcohol use and primary prevention variables among adolescents in Iceland, 1997-2014' (2016) 111(4) *Addiction* 645, 645-6.
- 170 Alfgeir Logi Kristjansson et al, 'Development and Guiding Principles of the Icelandic Model for Preventing Adolescent Substance Use' (2019) 21(1) *Health Promotion Practice* 62, 64.
- 171 Inga Dóra Sigfúsdóttir et al, 'Substance use prevention for adolescents: the Icelandic Model' (2019) 24(1) *Health Promotion International* 16, 24.
- 172 Sydney Schools (private session), Sydney, Exhibit A, Tab 9, Statement of Erin Lalor, 19 August 2019, [8].
- 173 Alcohol and Drug Foundation, Preliminary Submission No 29 (23 January 2019) 3.
- 174 Sydney Schools (private session), Sydney, Exhibit A, Tab 9, Statement of Erin Lalor, 19 August 2019, [9].
- 175 Sydney Schools (private session), Sydney, Exhibit A, Tab 9, Statement of Erin Lalor, 19 August 2019, [11].
- 176 Sydney Schools (private session), Sydney, Exhibit A, Tab 9, Statement of Erin Lalor, 19 August 2019, 12.
- 177 Collective Impact, *Social Outcomes* (Web Page) <<https://socialoutcomes.com.au/toolkit/collective-impact/>>.
- 178 Australian Institute of Family Studies, *Collective Impact: Evidence and implications for practice* (Paper No 45, 2017) 3.
- 179 Australian Institute of Family Studies, *Collective Impact: Evidence and Implications for Practice* (Paper No 45, 2017) 3; John Kania and Mark Kramer, 'Collective Impact' (2011) 9(1) *Stanford Social Innovation Review* 36, 39.
- 180 Australian Institute of Family Studies, *Collective Impact: Evidence and Implications for Practice* (Paper No 45, 2017) 3; John Kania and Mark Kramer, 'Collective Impact' (2011) 9(1) *Stanford Social Innovation Review* 36, 39.
- 181 Aboriginal Legal Service, Submission No 116 (9 May 2019) 12.
- 182 David Brown, Melanie Schwartz and Laura Boseley, 'The promise of justice reinvestment' (2012) 37(2) *Alternative Law Journal* 96, 96; David Brown et al, *Justice Reinvestment: Winding Back Imprisonment* (Palgrave Macmillan, 2016) 2-3.
- 183 'About Justice Reinvestment', Council of State Governments Justice Center (Web Page, 7 June 2019) <<https://csgjusticecenter.org/jr/about/>>.
- 184 Senate Legal and Constitutional Affairs References Committee, Parliament of Australia, *Value of a justice reinvestment approach to criminal justice in Australia* (Report, June 2013) 45; James Austin and Garry Coventry, 'A Critical Analysis of Justice Reinvestment in the United States and Australia' (2014) 9(1) *Victims & Offenders* 126, 144; David Brown, Melanie Schwartz and Laura Boseley, 'The promise of justice reinvestment' (2012) 37(2) *Alternative Law Journal* 96, 96.
- 185 David Brown et al, *Justice Reinvestment: Winding Back Imprisonment* (Palgrave Macmillan, 2016) 17.
- 186 David Brown et al, *Justice Reinvestment: Winding Back Imprisonment* (Palgrave Macmillan, 2016) 17.
- 187 Aboriginal Legal Service, Submission No 116 (9 May 2019) 8.
- 188 Aboriginal Legal Service, Submission No 116 (9 May 2019) 9.
- 189 KPMG, *Maranguka Justice Reinvestment Project: Impact Assessment* (Report, 27 November 2018) 6.
- 190 'Justice Reinvestment in Bourke', *Just Reinvest NSW* (Web Page, 6 June 2019) <<http://www.justreinvest.org.au/justice-reinvestment-in-bourke/>>.
- 191 'Justice Reinvestment in Bourke', *Just Reinvest NSW* (Web Page, 6 June 2019) <<http://www.justreinvest.org.au/justice-reinvestment-in-bourke/>>.
- 192 KPMG, *Maranguka Justice Reinvestment Project: Impact Assessment* (Report, 27 November 2018) 8.
- 193 KPMG, *Maranguka Justice Reinvestment Project: Impact Assessment* (Report, 27 November 2018) 32.
- 194 Dubbo Hearing, Dubbo, 4 June 2019, TS 1531.43-6 (Ferguson); KPMG, *Maranguka Justice Reinvestment Project: Impact Assessment* (Report, 27 November 2018) 8, 34.
- 195 Dubbo Hearing, Dubbo, 4 June 2019, TS 1531.43-5 (Ferguson); Dubbo Hearing, Dubbo, 4 June 2019, TS 1532.1-4 (Hopkins).
- 196 Dubbo Hearing, Dubbo, 4 June 2019, TS 1532.13-17 (Ferguson); Dubbo Hearing, Dubbo, 4 June 2019, TS 1532.21-9 (Hopkins).
- 197 Dubbo Hearing, Dubbo, 4 June 2019, TS 1518.30-32 (Hopkins).
- 198 Dubbo Hearing, Dubbo, Exhibit A, Tab 33, Statement of Sarah Hopkins, 31 May 2019, [8].
- 199 Aboriginal Legal Service, Submission No 116 (9 May 2019) 10.
- 200 Dubbo Hearing, Dubbo, 4 June 2019, TS 1518.3-6 (Ferguson).
- 201 Dubbo Hearing, Dubbo, 4 June 2019, TS 1532.39-43 (Hopkins).
- 202 Dubbo Hearing, Dubbo, 4 June 2019, TS 1532.33-1533.2 (Hopkins).
- 203 Aboriginal Legal Service, Submission No 116 (9 May 2019) 10.
- 204 Aboriginal Legal Service, Submission No 116 (9 May 2019) 10.
- 205 Aboriginal Legal Service, Submission No 116 (9 May 2019) 11.
- 206 Aboriginal Legal Service, Submission No 116 (9 May 2019) 11.
- 207 Dubbo Hearing, Dubbo, 4 June 2019, TS 1532.13-17 (Ferguson).
- 208 KPMG, *Maranguka Justice Reinvestment Project: Impact Assessment* (Report, 27 November 2018) 16.
- 209 Melanie Schwartz, 'Building communities, not prisons: justice reinvestment and indigenous over-imprisonment' (2010) 14(1) *Australian Indigenous Law Review* 2, 5.
- 210 Melanie Schwartz, 'Building communities, not prisons: justice reinvestment and indigenous over-imprisonment' (2010) 14(1) *Australian Indigenous Law Review* 2, 11.
- 211 KPMG, *Maranguka Justice Reinvestment Project: Impact Assessment* (Report, 27 November 2018) 32.
- 212 KPMG, *Maranguka Justice Reinvestment Project: Impact Assessment* (Report, 27 November 2018) 32.
- 213 KPMG, *Maranguka Justice Reinvestment Project: Impact Assessment* (Report, 27 November 2018) 27.
- 214 Aboriginal Legal Service, Submission No 116 (9 May 2019) 11.
- 215 Aboriginal Legal Service, Submission No 116 (9 May 2019) 11.
- 216 NSW Branch of the Royal Australian and New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 15.

- ²¹⁷ NSW Aboriginal Land Council, Submission No 118 (May 2019) 1.
- ²¹⁸ Dubbo Hearing, Dubbo, 5 June 2019, TS 1586.1-25 (Superintendent McKenna).
- ²¹⁹ Lismore Hearing, Lismore, 14 May 2019, TS 620.35-621.1 (Lloyd).
- ²²⁰ Dubbo Hearing, Dubbo, 4 June 2019, TS 1517.35-45 (Hopkins); Moree Hearing, Sydney, 30 September 2019, TS 4597.13 (Superintendent Tanner); Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2596.8-2597.15 (Superintendent Smith).
- ²²¹ See also, Mental Health Commission of NSW, Submission 119 (May 2019) 6; St Vincent's Health Australia, Submission 127 (May 2019) 27.
- ²²² Australian Drug Foundation, *Preventing alcohol and drug problems in your community* (Report, June 2014) 3.
- ²²³ Joint Committee on Law Enforcement, Parliament of Australia, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) 119.
- ²²⁴ See, for example, Sydney (General) Hearing, Sydney, 8 May 2019, TS 192-196 (Tillier); Sydney (General) Hearing, Sydney, 8 May 2019, TS 187-188 (Hawkins); Broken Hill Hearing, Broken Hill, 16 July 2019, Exhibit D, Tab 41, Statement of Andrew House, 4 July 2019, [29].
- ²²⁵ European Monitoring Centre for Drugs and Drug Addition, *European drug prevention quality standards* (Manual, 7th ed, 2011) 121.
- ²²⁶ See, for example, Dubbo Hearing, Dubbo, 4 June 2019, TS 1532.13-23 (Ferguson and Hopkins).
- ²²⁷ See, for example, NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019); St Vincent's Health Australia, Submission No 127 (14 May 2019); Mental Health Commission, Submission No 119 (May 2019).

Chapter 13. Education

Introduction

- 13.1 Drug education is an important part of an effective drug policy. Education can help delay or prevent use, and promote and support less harmful use. Taking a broader view, drug education not only provides information about drugs, it can help break down the stigma associated with use and empower people to seek help for themselves or for others. School-based drug education also aims to develop knowledge and critical thinking skills to help young people make healthier, safer choices.¹
- 13.2 The Inquiry received a number of submissions that referred to the importance of drug education. In relation to school-based drug education, the Inquiry conducted three private hearings to obtain evidence from educational bodies on drug education for school students.
- 13.3 This chapter will focus on drug education that provides information about drugs (particularly ATS), harm reduction and treatment services, and the contribution of that education to preventing the use of ATS, reducing the harms associated with ATS use and helping people access services and supports to manage ATS use. Education in the context of reducing the stigma associated with ATS use is discussed further in Chapter 9. Education for workers in health services is discussed in Chapter 14.
- 13.4 Drug education has historically focused on preventing use,² particularly through school-based education³ and mass media campaigns. However, given that drug use – including ATS use – affects all ages and demographics, a comprehensive approach to drug education should include ongoing education in the broader community. It should also include education that targets those populations whose experience of ATS use requires careful and specific consideration in the formulation of policy and treatment responses (see Chapter 8). Drug education also requires a broader focus than prevention, consistent with the National Drug Strategy's overriding objective of harm minimisation.
- 13.5 Consistent with other aspects of this Inquiry, a whole-of-government approach is needed to support drug education provided in schools, and reinforce and build on it in different settings. Any such approach should ensure consistent messaging and coordinated activity across policy areas.

Drug education is multifaceted

- 13.6 Drug education plays a role in multiple aspects of a harm minimisation approach to drug use, contributing to prevention, harm reduction and health promotion. Ensuring people have access to accurate information about ATS and other drugs can help to:
- prevent use of these drugs (and their associated harms)⁴ or delay their uptake⁵
 - empower people to make informed decisions about their drug use, including the decision not to use⁶
 - provide people with information and skills to make responsible, healthy and safe choices⁷
 - provide factual information to help people who use drugs to do so in less risky ways⁸
 - provide information and encouragement to identify when to seek help and where to access help

- improve the wellbeing of people who use drugs, encouraging them to take better care of themselves, access available services and have positive interactions with others.⁹
- 13.7 Dr Stephen Bright, Course Coordinator for Addiction Studies at Edith Cowan University and a psychologist with 15 years' experience in the AOD field, gave evidence at the *NSW Coronial Inquest into Music Festival Deaths* that:
- '[I]t is important that contemporary drug education presents a balanced picture of drug use. It should discuss both the reasons that people use drugs in addition to information about the potential harms that are presented with information about the prevalence of these harms so that the information is credible.'*¹⁰
- 13.8 As discussed in Chapter 5, effective drug policy – including education – needs to encompass appropriate responses to different types of drug use. These responses include discouraging use by people who do not use drugs; providing health and harm reduction information for people who use drugs recreationally; and supporting treatment decisions and preventing relapse among people who are dependent on drugs.
- 13.9 Drug education is often a component of prevention programs outlined in Chapter 12. Media campaigns are a common educational strategy for prevention, targeting either the community broadly or more specific audiences. Best practice principles for media campaigns are outlined later in this chapter. School-based drug education also plays a significant role in prevention efforts, although it is not the only means of providing education.
- 13.10 Education is particularly important for young people due to the harms associated with starting use of licit or illicit drugs in adolescence.¹¹ Preventing or delaying drug use for as long as possible is important because early uptake is associated with problems with use, including dependence, later in life.¹² The Inquiry heard that in NSW schools, drug education as part of the syllabus *'aims to provide students with protective strategies and the development of skills to make appropriate decisions throughout life'*.¹³
- 13.11 Drug education should, and often does, form part of harm reduction approaches for people who already use drugs. Education can help people manage their drug use to avoid mental health and physical harms, such as overdose and blood-borne viruses.¹⁴ Chapter 15 explores harm reduction strategies in more detail.
- 13.12 Further, drug education is critical to ensuring that people know how and where to access services and support if they need help to manage their own or another's drug use. This may include factual information about drugs and their effects, what services and supports are available and how to access them. A number of submissions to the Inquiry identified a need for education that reduces the stigma associated with drug use, encourages help seeking and provides information about treatment and support options, both to people who use ATS and their support networks.¹⁵ Moree Plains Shire Council submitted that: *'Information needs to be current and up to date for both the community and the ATS user to enable both demographics to be aware of choices and assistance available.'*¹⁶

- 13.13 The Inquiry received evidence from stakeholders that those with lower levels of educational attainment and literacy skills face particular difficulties navigating service systems and accessing information and support.¹⁷ Literacy for Life, an Aboriginal organisation that delivers literacy education to adults in Indigenous communities across Australia, noted in its submission that it works with a cohort of people who have *'low levels of engagement with health services about managing chronic disease and preventive health care'*.¹⁸ It is important that these hard-to-reach and often marginalised populations receive education about treatment and support options.
- 13.14 The Inquiry heard that this lack of knowledge about ATS contributes to the stigma experienced by people who use these drugs (see Chapter 9). Professor Helen Milroy, Professor of Child Psychiatry, University of Western Australia, who served as a Commissioner for the *Royal Commission into Institutional Responses to Child Sexual Abuse*, gave evidence about the importance of public education in combating stigma and giving people the confidence to seek support.
- 'I think that the more public education and awareness that we have and the more understanding that we are, people are more likely to come forward and talk about these things. The experience of the Royal Commission was that people towards the end of the five years [of the Commission] said that they felt that they were almost given permission to come and speak with us, because it was now okay to speak up ... public awareness and that sort of high-level awareness is really important in society in reducing stigma, but also just generally at the community level, as well.'*¹⁹
- 13.15 The information needs of families, friends and carers of people who use drugs, including in relation to the available support and services, is addressed in Chapter 18. The need to improve access to information about available withdrawal management and residential rehabilitation services, their entry requirements and contact details is examined further in Chapter 14.
- 13.16 Drug education can be delivered through a wide range of approaches, including:
- public education and public health campaigns
 - mass media campaigns
 - school-based education
 - tailored interventions for specific events, such as music festivals
 - tailored information for specific populations, such as the LGBTQI+ community or culturally and linguistically diverse communities.
- 13.17 Drug education can also occur at multiple points in life, such as during pregnancy, as well as in the community, workplace, outreach and treatment settings. It can be tailored to specific population groups, places or communities²⁰ and can also address specific drugs. For example, the NSW Health 'Your Room' website provides information about methamphetamine including its different forms, street names and methods of use, as well as its impacts and legal status.²¹
- 13.18 The objective of, and intended audience for, any education program should shape the education and intervention provided, whether it be preventing future drug use, reducing harms, facilitating support to stop harmful use or supporting people to recover from dependent use. For example, drug education for young people focuses on teaching generic information and skills, such as the realistic consequences of drug use, skills to resist peer pressure and education to correct adolescents' overestimates of the number of their peers who use drugs.²²

Features of effective drug education

13.19 While drug education has a variety of aims, audiences and means of communication, there are several key features associated with effective education campaigns. Although some research is available in relation to school-based drug education programs, the evidence base for other types of drug education programs is more limited. Other than a few notable exceptions referred to later in this chapter, studies of universal drug education programs have generally addressed the use of substances other than ATS, including alcohol, tobacco and cannabis. It is unclear how applicable these studies are to other drugs, especially those with lower prevalence of use.²³

13.20 The available evidence suggests the following:

- Drug education should be based on accurate and up-to-date information.²⁴
- Providing information may improve drug-related knowledge but is not enough on its own to reduce drug use.²⁵
- Drug education needs to be tailored to the social and cultural contexts and the needs of the intended audience.²⁶
- Education programs that are least effective in preventing drug use include knowledge-only approaches (that is, approaches that do not also include other support programs), fear-based approaches and standalone mass media campaigns.²⁷
- Drug education delivered by peers is able to reach marginalised populations and can be more credible than messages from health professionals.²⁸

13.21 The features listed above are consistent with, and recognised by, the National Drug Strategy, which states that *'[s]trategies are also more effective in combination than separately, and should be tailored to meet the varied needs of individuals, families, communities, and specific population groups'*.²⁹

13.22 Significantly, as mentioned above, knowledge alone does not usually translate into behaviour change. Therefore drug education and information should be part of a suite of responses and interventions that support consistent messaging and provide relevant, accurate information for different groups in the community. Research has noted that early health education campaigns:

*'... were characterised by their emphasis on the transmission of information, and were based upon a relatively simplistic understanding of the relationship between communication and behaviour change. Over time, it became apparent that campaigns which focused only on the transmission of information and failed to take account of the social and economic circumstances of individuals were not achieving the results which had been expected in terms of their impact on health behaviour.'*³⁰

13.23 Dr Craig Sadler, Addiction Medicine Specialist at the Calvary Mater Newcastle Hospital, told the Inquiry that improved knowledge would not necessarily result in more people deciding not to initiate drug use, due to the complex socioeconomic factors that often accompany use.

*'There would be some people that don't understand the risks, or don't – don't have access to education, resources, social cohesiveness, solid peer groups, community, structure and organisation in their lives. So, all of those things, in development and upbringing, are risk factors for drug use, as they are risk factors for mental health problems. So, it is quite difficult to – to tease out that, to say "yes", you know, "if they knew more about it, they wouldn't use" ... we all know that that's not the case.'*³¹

- 13.24 This point was reinforced by one lived experience witness who used crystal methamphetamine.

*'I didn't really think about the addictive properties of ice at the time. I thought heroin was the only physically addictive drug out there. Even if I had of known it was addictive I still would have tried it. It made me feel good and helped with the work I was doing with the time. It made me forget about everything.'*³²

Peer education

- 13.25 The National Drug Strategy identifies peer education as both a demand reduction and harm reduction strategy.³³ Peer education is widely used to address healthcare issues, to share information about drug-related issues and to influence attitudes, knowledge and behaviour. It involves the provision of information and education by people considered peers by the target audience due to common characteristics such as shared experiences, age, ethnicity, gender and culture.³⁴

- 13.26 Peer education models can be more cost-effective and easily accepted than other forms of education and can be used to educate populations that are hard to reach through conventional methods.³⁵ The Inquiry heard that peer-led responses have been successful in engaging people who use crystal methamphetamine *'by using lived experience to solve the problems drug use may be creating for the ... user, without challenging their use or stigmatising those who use'*.³⁶

- 13.27 Participants at the Inquiry's Youth Roundtable described challenges in accessing accurate information about drugs, and valued services such as DanceWize that provide information about how to minimise drug-related harms.³⁷ In evidence to the *NSW Coronial Inquest into Music Festival Deaths*, Erica Franklin, NSW coordinator for DanceWize, noted that peer-based strategies offer accurate, evidence-based education and facilitate the kind of open communication that cannot be achieved through channels such as security personnel, police officers, school staff, medical teams or counsellors.³⁸

*'Our membership to this community is our greatest asset. We speak the same language, and live similar lives. This allows us to have real and candid harm reduction conversations with our community and our advice is taken on board because our lived experience gives us legitimacy.'*³⁹

- 13.28 Peers are perceived as credible sources of information and positive role models, and as being more successful than professionals in disseminating information.⁴⁰ Depending on the model used and its duration, peers may also be able to reinforce education through ongoing contact.⁴¹

- 13.29 In Australia, peer education has been used for AOD prevention, harm minimisation, patient support⁴² and support to prevent relapse, such as through the NSW iCanQuit website, where former smokers share stories and tips.⁴³ Peer educators operate in a range of formal and informal settings, such as face-to-face, over the phone or on social media platforms, one-on-one or in groups.⁴⁴

- 13.30 Peer-led education has been an effective way to disseminate health-related and safer partying messages to people who use MDMA and related drugs,⁴⁵ and has been used as a harm minimisation model in recreational settings such as events, festivals and nightclubs.⁴⁶

- 13.31 There is limited research examining whether peer-based education reduces the probability of drug use and related harm.⁴⁷ Some research suggests peer-led interventions are most effective when used to enhance other approaches rather than as standalone programs.⁴⁸

- 13.32 Much of the published work on peer education provides insufficient detail on program elements and operations to enable a comparison of studies and to understand which elements – for example, the duration or mode of delivery – contribute to their efficacy.⁴⁹ However, they continue to be a feature of drug education, particularly in relation to harm minimisation at recreational events.

Case study: DanceWize

DanceWize NSW is a peer-led harm reduction service at music festivals funded by the NSW Ministry of Health.⁵⁰ DanceWize aims to increase the safety and wellbeing of festival patrons by providing crowd care services and hosting a dedicated care space, as well as providing information about safer partying. The substances discussed most frequently in DanceWize education interventions are alcohol, MDMA and LSD.⁵¹ The Inquiry heard the program has been highly successful, attending 22 regulated and three unregulated events up until May 2019, with more than 12,000 education interventions delivered to festival patrons.⁵²

Drug education needs a whole-of-government approach

- 13.33 The need for a coordinated holistic response to address ATS use has been demonstrated many times throughout the Inquiry and is discussed throughout this report. Such considerations apply with equal force to drug education.
- 13.34 The provision of drug education and information should be part of a suite of responses and interventions.⁵³ It requires more than isolated education approaches and should form part of an integrated, whole-of-government approach that reinforces key education messages across different settings and provides information relevant to people's changing needs.⁵⁴ The World Health Organization has recognised that complex health issues, particularly those with social determinants such as harmful substance use, require multisectoral government responses.⁵⁵
- 13.35 This is consistent with submissions to the Inquiry, which emphasised that a whole-of-government approach, across a variety of government portfolios, is needed to provide evidence-based interventions to people who use crystal methamphetamine.⁵⁶
- 13.36 Whole-of-government approaches can also build on, strengthen and ensure consistency in the messages provided as part of drug education in schools. This is particularly important in light of evidence to the *NSW Coronial Inquest into Music Festival Deaths* that many people do not recall the drug education they received at school.⁵⁷ Given the relatively recent increase in public awareness of ATS use and its harms (as identified in Chapter 7), it is likely that some people may not have received information at school about the risks and harms associated with ATS use.
- 13.37 Often, drug education efforts focus on school-based education and prevention of drug use. However, such approaches should not be undertaken in isolation – they should be part of a broader education strategy. Developing consistent messaging and coordinating activity across policy areas and service delivery domains helps reinforce the same key messages and reach people in various settings, supporting the drug education provided in schools.
- 13.38 Representatives of the Department of Education, Sydney Catholic Schools and the Association of Independent Schools of NSW (AISNSW) told the Inquiry that it would be beneficial if a broader, whole-of-government approach supported drug education in schools.⁵⁸

- 13.39 Andrew Sortwell, Special Projects Officer, Sydney Catholic Schools, said such an approach could encourage *'partnership with organisations in the community'* and parent support,⁵⁹ while AISNSW representatives said it could raise awareness, promote interagency conversations and enable cross-sectoral collaboration.⁶⁰ Jo McLean, Head of Professional Services at AISNSW, said: *'I think that a whole-of-government drug education strategy could be really beneficial ... It could provide a framework, additional resources for work in that area and links between school and non-school-based settings'*.⁶¹
- 13.40 The Inquiry heard that drug education in NSW government schools reflects the whole-of-government harm minimisation approach.⁶² Deborah Summerhayes, Director Secondary Education, Department of Education, said the Department has worked with the Departments of Health and Communities and Justice and the NSW Police Force on this approach, and *'that's always a good thing because that's replicated in organisations that families and students engage with in the community, and that's a similar kind of message'*.⁶³ If a young person receives the same messages about AOD from their school, family and community, they are more likely to believe them.⁶⁴
- 13.41 Ms Summerhayes said that, as with road safety and sun safety campaigns, education could be replicated and reinforced by organisations with which families and students engage in the community.⁶⁵ Ms McLean, AISNSW, told the Inquiry:
- 'I think it's all around that shared responsibility, and that's certainly critical. [It's] that old adage, it takes a village to raise a child ... Schools can't do it by themselves. Parents can't do it by themselves. Other agencies can't do it by themselves. It has to be a shared approach.'*⁶⁶
- 13.42 There is also a need for drug education for young people that is not school based, for reasons including that some children are not engaged with the education system.⁶⁷ The Inquiry heard about the need for accurate and meaningful interventions for children and young people at risk of disengaging from education due to AOD problems. Debborah Beckwith, Regional Network Specialist Facilitator, Department of Education in the Hunter New England region, told the Inquiry:
- '[T]he disengagement from education is a big issue, and the longer young people are disengaged from school, the more difficult and challenging it is to re-engage them ... that's a common factor with these young people. If we can get in early to get them back engaged in education, then they're attending; they're seen every day.'*⁶⁸
- 13.43 Whole-of-government strategies for drug education must consider the different information and communication needs of the populations affected by ATS use, as well as the importance of working with them to design programs that respond to their needs. The education, information and communication needs of identified priority populations are considered later in this chapter.

Recommendation 21:

A. That the NSW Government develop a whole-of-government education strategy that considers drug education in school and non-school-based settings, with the objectives of improving understanding across the community of:

- the harms associated with amphetamine-type stimulant use
- how to reduce the harms associated with amphetamine-type stimulant use
- how to access services and support to manage drug use.

B. That this education strategy include specific strategies and messages targeted at the priority populations identified in the AOD Policy and at different types of drug use.

- 13.44 The remainder of this chapter addresses matters identified by the Inquiry as being relevant to education programs (both existing and future) that should be considered within that whole-of-government response. Of particular relevance are opportunities to strengthen existing school-based education and the education needs of various priority populations.

School-based drug education

- 13.45 School-based drug education programs have received considerable attention both in Australia and internationally. Preventing and delaying the uptake of drug use by young people has long been a policy priority due to the range of harms associated with drug use in childhood and adolescence.⁶⁹

- 13.46 Effective school drug education focuses on skills development and provides students with the capacity to make healthier and more responsible decisions for their own and others' safety and wellbeing.⁷⁰ In primary school, drug education aims to build life skills and resilience. Drug education in secondary school aims to strengthen these skills and resilience, as well as informing and educating young people about illegal and legal drugs.⁷¹

- 13.47 The Inquiry recognises that in addition to providing direct drug education, schools are protective environments for children and young people; they promote protective factors and reduce risk factors through educational, health promotion and pastoral care programs.⁷² As noted by Ms Summerhayes, Department of Education:

*'They can play an important role in preventing substance misuse by providing a safe and supportive environment, a curriculum that engages students and is relevant to their needs, and by encouraging young people to stay at school.'*⁷³

- 13.48 The role of schools in supporting children and young people affected by ATS is covered further in Chapter 18. Prevention of drug use more generally is addressed in Chapter 12.

Elements of effective school-based drug education

- 13.49 There has been extensive research examining what makes school-based drug education effective in preventing and reducing AOD use. However, as noted above, most research relates to more prevalent drugs such as alcohol and tobacco rather than lower prevalence illicit drugs such as ATS.⁷⁴
- 13.50 The Inquiry heard that the most effective drug education programs provide accurate information about drugs, focus on social norms, and work with students to develop interpersonal skills.⁷⁵
- 13.51 School-based programs that aim to improve life and social skills are likely to be most effective in reducing initial use of drugs.⁷⁶ Skills-focused programs influence factors such as drug knowledge, decision-making, self-esteem and resisting peer pressure. In evidence to the *NSW Coronial Inquest into Music Festival Deaths*, Paul Dillon, Director and Founder of Drug and Alcohol Research and Training Australia (DARTA), noted that drug education and drug information are two different things: *'[W]e know effective drug education is more likely to be about getting them skills and peer refusal, things like that.'*⁷⁷
- 13.52 Ms Summerhayes, Department of Education, told the Inquiry:
- '[Programs] need to be teaching young people about choices and safe behaviours and how to manage peer pressure and how to navigate the world, and drugs is just one element of that ... So the work that we do in schools is a lot more holistic than just through one syllabus area'.*⁷⁸
- 13.53 The Inquiry received evidence that school-based drug education programs are most effective when implemented in late primary school and continued in early secondary school.⁷⁹ The most effective primary school programs focus on the development of positive social and peer influences.⁸⁰ Mr Dillon's evidence to the inquest was consistent with this evidence and research. He also noted that it is difficult to determine the right point in schooling to deliver drug education messages.⁸¹
- 13.54 Unless drug education provided in schools is delivered effectively, it has the potential to produce negative outcomes, including increasing the risk of use of ATS, stigmatising people who use ATS and their families, and decreasing help-seeking behaviour,⁸² particularly among young people who have already used ATS.⁸³
- 13.55 In Australia, the nationally ratified *Principles for school drug education* guide the planning, implementation and review of school drug education programs, policies and practices, which are then interpreted at local level depending on the needs and context of individual schools.⁸⁴

Principles for school drug education

School drug education should:⁸⁵

- be based on what works and be regularly evaluated
- employ a whole-school approach to health and wellbeing
- have clear educational outcomes that contribute to the overall goal of minimising drug-related harm
- promote a safe, supportive and inclusive school environment
- promote positive and collaborative relationships between students, staff, families and the broader community
- provide culturally appropriate, targeted and responsive drug education that addresses local needs, values and priorities
- acknowledge that a range of risk and protective factors affect health and education outcomes, and influence choices about drug use
- use consistent policy and practice to inform and manage responses to drug-related incidents and risks
- occur within the curriculum framework, providing timely, developmentally appropriate and ongoing drug education
- ensure teachers are resourced and supported in their central role in delivering drug education
- use student-centred, interactive strategies to develop students' knowledge, skills, attitudes and values
- provide accurate information and meaningful learning activities that dispel myths and focus on real life contexts and challenges.

13.56 As with other forms of drug education, school-based drug education programs have been found to be most effective when delivered in combination with other interventions.⁸⁶ This includes initiatives such as parent education, family intervention and support programs.⁸⁷ If drug use is influenced by availability, environmental and individual risk factors outside the reach of the education system, *'it is unlikely that a few hours of drug education will be a sufficient antidote'*.⁸⁸ Tackling drug-related issues in isolation and only in the classroom is less likely to achieve positive outcomes.⁸⁹

13.57 One educator told the Inquiry that parent education *'should go hand in hand'* with school students' education about drugs.⁹⁰ Others said parents could benefit from improved drug education⁹¹ as many are unsure about how to access information, or are not confident or comfortable enough to address drug-related issues with their own children.⁹² The importance of involving parents and families in drug education is well recognised, with parental involvement enhancing students' wellbeing and learning outcomes.⁹³ Young people are more likely to believe messages they receive from their school, family and community if those messages are consistent.⁹⁴

13.58 Support for parents to talk to children about drug use was also addressed by the *NSW Coronial Inquest into Music Festival Deaths*, which included a recommendation that:

*'B8. The Department of Health working with organisations such as Family Drug Support Australia and drug educators such as Paul Dillon of Drug and Alcohol Research and Training (DARTA), develop resources for parents about talking to their children about stimulant drugs consumed at music festivals, focused on harm prevention and reduction.'*⁹⁵

- 13.59 The evidence received by the Inquiry supports providing resources to parents. Such resources should enable parents to share information with their children that is accurate and consistent with information provided by schools and in the community. The Deputy State Coroner's recommendation complements Recommendation 21 made by this Inquiry above.

Drug education in NSW schools

- 13.60 In NSW, school-based drug education is delivered as part of the personal development, health and physical education (PDHPE) syllabus. NSW school drug education aims to increase students' knowledge of the impacts and harms of the drugs to which students are most likely to be exposed – medications, alcohol, tobacco and cannabis – and develop resilience and skills in assertive communication and good decision-making.⁹⁶ Ms Summerhayes told the Inquiry:

*'Drug education in NSW government schools reflects the whole-of-government harm minimisation approach. This approach aims to build knowledge, skills, attitude[s] and behaviours in students including building resilience to enable young people to make responsible, healthy and safe choices.'*⁹⁷

The syllabus

- 13.61 In NSW in 2018, 65.7% of students attended government schools, 19.7% attended Catholic schools and 14.6% attended independent schools.⁹⁸ The NSW Education Standards Authority (NESA) is responsible for developing the syllabus taught in all schools, regardless of sector.⁹⁹
- 13.62 Drug education in NSW schools is part of the mandatory Kindergarten to Year 10 PDHPE syllabus. PDHPE can be continued as an elective subject in Stage 6 (Years 11 and 12), with a syllabus containing further drug education. The current PDHPE Kindergarten to Year 10 syllabus was released in 2017 and incorporates most of the drug education content from the National Health and Physical Education curriculum plus additional drug education content, particularly in the high school years.¹⁰⁰ Implementation of the new syllabus started in 2019 for Years 7 and 9 and full implementation for Kindergarten to Year 10 will start from 2020.¹⁰¹
- 13.63 Drug education in NSW government schools begins in Kindergarten.¹⁰² The PDHPE syllabus outlines the drug education content for Stage 3 (Years 5 and 6), Stage 4 (Years 7 and 8) and Stage 5 (Years 9 and 10). It aims to prevent or reduce the harm associated with drug use in the broader context of personal health choices and individual and community health, and help students develop the knowledge, understanding and skills to make informed decisions about drug use.¹⁰³
- 13.64 The NSW drug education syllabus does not require students to learn about the risks and harms particular to ATS; rather, the syllabus is broadly drafted in a way that enables staff to determine what subject areas are relevant to their school cohort. The Inquiry heard that this flexibility is important because every school and cohort is different, and a mandated, prescriptive curriculum *'doesn't necessarily address the needs of the student cohort you're working with'*.¹⁰⁴ Karen Ingram, Inspector PDHPE, NESA stated that:

*'Schools are encouraged to look at the needs of their students and school community when deciding what emphasis to place on content. This includes content relating to drug education. If a school has identified an issue with a particular drug in its community, the syllabus provides flexibility for the school to deliver drug education programs relevant to this issue.'*¹⁰⁵

- 13.65 Syllabus objectives and outcomes are framed broadly so schools have the flexibility to choose drug education programs and learning activities, while the content provides a starting point for teachers to tailor the learning activities to their students' needs.¹⁰⁶
- 13.66 Decisions about course delivery are made by schools at a local level, based on students' needs, community context and resources.¹⁰⁷ Ms Summerhayes, Department of Education, told the Inquiry that local context is important because even two schools 500m apart *'will be completely different schools ... with completely different issues and completely different community context'*.¹⁰⁸
- 13.67 In the time available it was beyond the scope of the Inquiry to conduct a detailed review of the PDHPE syllabus. The current syllabus has only recently been developed and implemented, and is being considered by NESA as a part of the NSW curriculum review due to report in 2020. Accordingly, the Inquiry has not undertaken a detailed review of the drug education content in the syllabus.
- 13.68 However, the Inquiry notes that the NSW Government supports in principle the recommendation of Deputy State Coroner, Magistrate Harriet Grahame, in the *NSW Coronial Inquest into Music Festival Deaths*:
- 'That NESA commission a review from a recognised expert in drug education and harm reduction, such as Paul Dillon, Drug and Alcohol Research and Training (DARTA) to obtain advice on how best to protect young people from the potential harm posed by amphetamine-type stimulants, particularly in the music festival environment, in a way that minimises harm that would include advice on the type of education appropriate for different age groups.'*¹⁰⁹
- 13.69 In its response, the NSW Government referred to the current curriculum review, noting *'[t]he need for any further review into drug education is best assessed after this report has been delivered'*¹¹⁰ in 2020. The Inquiry also notes that in its submission, the Department of Education stated that: *'Redevelopment of Education teaching resources in drug education and PDHPE will follow the NESA curriculum review.'*¹¹¹ Such redevelopment should include consideration of the needs of young people in relation to ATS, including harm reduction messages.
- 13.70 The Inquiry recognises the importance of providing age-appropriate education for young people, including information about harm reduction. The recommendation by Deputy Coroner Grahame is consistent with Recommendation 21.

Life Ready

- 13.71 Life Ready is a 25-hour program for students in Years 11 and 12 at government schools and is mandatory for all students who do not choose to study the elective PDHPE course in their senior years. The program includes content on AOD.¹¹² It replaced the previous program, Crossroads, in 2018.

- 13.72 The Inquiry received mixed evidence about Life Ready. Witnesses representing the Department of Education highlighted the strength of its drug education component.¹¹³ In submissions (though not in evidence), the Department also sought to identify the support given to teaching staff to deliver that program.¹¹⁴ However, other witnesses raised concerns about its effectiveness in engaging students and providing relevant information.¹¹⁵ The Inquiry heard the program is less relevant to students than compulsory PDHPE and students *'do it to tick the box'*.¹¹⁶ The evidence of those witnesses was that some students do not value Life Ready because they are focused on their Higher School Certificate studies.¹¹⁷ The Inquiry heard that delivery of Life Ready is highly variable depending on how individual schools implement it, with some schools struggling to find appropriately qualified or interested staff to deliver the program.¹¹⁸
- 13.73 As noted, it was beyond the scope of the Inquiry to draw conclusions about the effectiveness of any particular program or curriculum. The Inquiry recognises that the evidence given is not a comprehensive review of the program or its implementation overall. However, it does indicate that issues have been observed in the delivery of the Life Ready program.
- 13.74 Life Ready is a new program and it does not appear to have been evaluated. As is clear from the previous discussions in this chapter, the content and delivery of school-based programs is an important aspect of responding to illicit drug use, including ATS. In light of its significance, especially as a program provided to two-thirds of NSW senior students, the Inquiry recommends the program be reviewed and evaluated.
- 13.75 The Inquiry notes that the NSW Government, in its response to the recommendations of the *NSW Coronial Inquest into Music Festival Deaths*, indicated that the Department of Education, in conjunction with NESA, will review its existing units of work in the Life Ready program.¹¹⁹ This review will be *'in the context of'* the Deputy State Coroner's recommendation:
- 'F1. That in the High School curriculum consideration be given to a learning module dedicated to deaths at music festivals with a particular focus on:*
- a. The effects of MDMA in particular of high doses.*
 - b. Other factors that can increase your risk to having an adverse reaction to MDMA including temperature, exercise, weight, prescription medication, and mixing with other drugs and alcohol.*
 - c. Having a sober friend, warning signs to look out for, and seeking medical help.'*¹²⁰
- 13.76 Unlike its predecessor, Crossroads, the Life Ready program is not available to non-government schools. Representatives of AISNSW and Sydney Catholic Schools told the Inquiry they would benefit from having the program available for use in their schools.¹²¹ Stephen Said, Head of Student Wellbeing and Pastoral Care at Sydney Catholic Schools, noted there could be some flexibility in how it was delivered, but in his opinion there should be some mandated outcomes that all three school sectors – government, Catholic and independent – were responsible for delivering.¹²² Ms McLean, AISNSW, expressed reservations about mandating the program, on the basis that the current content might not be appropriate because the program was not developed with the input of all school sectors.¹²³

Recommendation 22:

That in consultation with relevant experts and young people, the NSW Department of Education review the Life Ready program to ensure it meets the drug education needs of students, including consideration of:

- the emphasis given in the program to drug education
- the content of the program relating to drug education
- whether Life Ready should be made available to non-government schools.

Current challenges in drug education in schools

- 13.77 Evidence to the Inquiry identified broader challenges relating to what young people are taught about drugs, when and by whom. As noted above, it is beyond the scope of the Inquiry to reach any conclusions about these matters. However, those challenges are discussed here and should be considered in the future development of the curriculum and an effective whole-of-government response.

Drug education messages need to be effective

- 13.78 The Australian School Students Alcohol and Drug Survey 2017 found that 28% of respondents aged 12 to 17 did not recall receiving any drug education about illicit drugs in the previous year, with a further 35% recalling only receiving one lesson or part of a lesson.¹²⁴
- 13.79 Several young people gave evidence at the *NSW Coronial Inquest into Music Festival Deaths* that they were not aware of the potential risks of using MDMA or of combining it with alcohol. They either did not recall receiving drug education or received messages such as *‘just say no’*.¹²⁵
- 13.80 In her findings from the inquest, Deputy State Coroner Grahame said:
- ‘The evidence in this inquest also demonstrated that the production of a single message “Just Say No” is dangerous in itself ... What is needed is more nuanced messaging that provides accurate information about risk. We need to talk more openly about how to provide correct and credible information about drugs to young people.’*¹²⁶
- 13.81 In relation to drug education delivered at school, one young person told the inquest that Healthy Harold came to their primary school, with the main message of *‘Don’t do drugs, they’re bad’*. The witness could not recall anyone coming to their public high school to speak about drugs, or any AOD being delivered by teachers during physical education. They said they were not given any specific information about toxic or dangerous levels of drug use.¹²⁷
- 13.82 Evidence to the Inquiry indicates that some young people do not remember the drug education they received at school or do not consider it relevant. When participants at the Inquiry’s Youth Roundtable were asked whether they learned anything helpful about drugs at school, they replied: *‘Nothing’*, *‘Nothing whatsoever’* and *‘Nothing useful’*.¹²⁸
- 13.83 Ms Summerhayes, Department of Education, said while some former students might not remember drug education at school, that does not mean it was not provided. *‘[T]hey may remember; they may forget. Things won’t resonate, and I don’t know how you get around that.’*¹²⁹ Ms Summerhayes said students had told her about occasions when they applied the skills learned at school, *‘including [in] situations where they were offered an illicit substance’*.¹³⁰

- 13.84 In relation to school-based education programs that target alcohol use, research conducted by Associate Professor Nicole Lee and colleagues at the National Drug Research Institute concluded that existing evaluations are of only *'moderately good quality'*. They noted there is only a handful of studies in respect of each program, providing a relatively limited evidence base to evaluate the effectiveness of school-based alcohol education programs.¹³¹ They further noted *'[t]he change in relevant outcomes may not become apparent for some time after a program, yet few studies assessed longer-term outcomes. Furthermore, most research in this area has been conducted in the US, where the primary outcome measure of "success" was often abstinence, neglecting other harm reduction outcomes'*.¹³² It is unclear how well such programs might be generalised to other drugs, including ATS.

Providing drug education at the right time

- 13.85 Both the Inquiry and the *NSW Coronial Inquest into Music Festival Deaths* heard about the challenges of providing drug education at the right time. In her findings, Deputy State Coroner Grahame referred to the evidence given by drug educator Paul Dillon about the challenges of school-based drug education in relation to MDMA.

*'If it is done too early, the reality is most young people will have no experience of it. However, "if you leave it too late and you hit year 12, we then have – it's now one in six 17-year-old boys and one in 10 17-year-old girls who have tried ecstasy." The difficulties of explaining risk to a young person who has already had a positive experience of MDMA can be daunting.'*¹³³

- 13.86 As mentioned above, the Inquiry heard that drug education in NSW government schools begins in Kindergarten,¹³⁴ and that the Department of Education provides age-appropriate drug education for children as young as preschool age when required.¹³⁵ The Department said that generally, drug education should begin before children and young people are likely to face situations when they make decisions about drug use and before behavioural patterns have become established.¹³⁶ For some students, that may be in primary school. As one young person told the Inquiry: *'I took MDMA before I started high school, so I had no drug education.'*¹³⁷
- 13.87 Mr Sortwell, Sydney Catholic Schools, said children in Stage 3 (Years 5 and 6) may have been exposed to drugs, including through use by older siblings, *'and when they hit high school, there will definitely be that increase in the access of drugs. So we really need to develop their knowledge and understanding and it's not really covered from K to 6'*.¹³⁸
- 13.88 One participant at the Youth Roundtable convened by the Inquiry argued for more meaningful drug education *'from a younger age because I just feel that in Australia we do have a very big problem with binge drinking and drug-taking culture'*.¹³⁹

Teachers need support to be knowledgeable and confident when delivering drug education

- 13.89 The Inquiry heard that teachers need ongoing professional development for up-to-date drug education information and teaching strategies that are relevant, engaging and underpinned by best practice.¹⁴⁰ The Inquiry also heard that professional learning is crucial to building staff capacity to deliver sensitive content such as drug education.¹⁴¹ Mr Sortwell, Sydney Catholic Schools, said:

'[T]he curriculum is that packed, teachers are close to breaking point ... but they just need that time. I think they need that PD [professional development] to actually develop their knowledge and understanding around "what are some of those key issues that we need to be covering?"'.¹⁴²

- 13.90 Mr Said, Sydney Catholic Schools, told the Inquiry that teachers may not be aware of the current impacts and prevalence of major drugs, and may not realise how important the issue is.¹⁴³
- 13.91 The Department of Education, the AISNSW and Sydney Catholic Schools each provided a statement which identified the supports available to teachers to deliver the curriculum. In each case, the body provides some form of professional learning for their teachers to support the delivery of drug education.¹⁴⁴ Geoff Newcombe, CEO of AISNSW, said AISNSW supports schools in planning and programming for student wellbeing, safety and drug education as part of the PDHPE syllabus. This includes offering professional learning courses for teachers, in-school consultancies and directing schools to current trends, research and data.¹⁴⁵ Sydney Catholic Schools, the largest system of Catholic schools in NSW, told the Inquiry it takes a preventive approach to drug education, which informs students of the benefits of a healthy lifestyle as well as the potential harms of drug use.¹⁴⁶ It also works closely with NSW Health in the delivery of drug education.¹⁴⁷

External providers of drug education

- 13.92 Schools often use external providers to deliver components of the drug education program.¹⁴⁸ Educators highlighted the importance of external providers complementing the drug education already provided by schools.¹⁴⁹
- 13.93 Responsibility for selecting these providers rests with teaching staff or the school. The Department of Education, AISNSW, Sydney Catholic Schools and NESA do not currently recommend or endorse particular external providers.
- 13.94 AISNSW can help schools determine why external providers are sought and how they might best complement a school drug education program.¹⁵⁰ Sydney Catholic Schools said schools in its network have engaged external providers to help deliver drug education for students and parents.¹⁵¹
- 13.95 Life Education, with its giraffe mascot, Healthy Harold, is the most common external provider in government schools.¹⁵² Lynette Davis, vice-president of the NSW Primary Principals' Association, told the Inquiry that Life Education's programs do not always encompass drug education and that some families cannot afford to send their children to Life Education.¹⁵³

Challenges in engaging external providers

- 13.96 The Inquiry heard evidence about various challenges in engaging external providers to complement the drug education syllabus. Educators said it can be difficult for teachers to determine the quality of external providers and the information they provide,¹⁵⁴ with schools having to rely on a process of trial and error or word of mouth.¹⁵⁵ Further, schools are not always equipped with the skills, resources and support to identify which external providers adopt evidence-based practice,¹⁵⁶ with educators raising their concerns about the use of ineffective 'scare tactics' or programs that do not align with the NSW syllabus.¹⁵⁷

- 13.97 Ms McLean, AISNSW, said some external providers marginalise students through their use of language or by *'assuming that everybody ... in the audience is doing drugs or doing the wrong thing'*.¹⁵⁸ She observed that *'a perfect way to get students to tune out of their education around specific issues is to make assumptions about what they're doing, and if they're not doing it, then they don't pay attention to the messages that are being delivered'*.¹⁵⁹
- 13.98 The Department of Education said schools should only use visiting speakers and external providers where they add value to existing teaching and learning practice.¹⁶⁰
- 13.99 The Inquiry heard educators are concerned about schools relying entirely on external providers to provide drug education¹⁶¹ or providers teaching from a lived experience base.¹⁶² The Alcohol and Drug Foundation has warned that *'testimonial education'* from those with lived experience of drug use can be counterproductive, as it risks encouraging drug use among susceptible or vulnerable young people.¹⁶³
- 13.100 The Inquiry heard that schools could benefit from guidance on which external providers deliver programs that contain accurate and appropriate content for young people.¹⁶⁴
- 'At a time when teacher workloads continue to escalate and the curriculum becomes increasingly crowded, the ability of a specialist team to check a range of providers, content and resources and to be able to recommend these to schools would be highly beneficial'*.¹⁶⁵
- 13.101 Representatives of the Department of Education told the Inquiry about the potential to establish a centralised panel of drug education providers through a short procurement process, with the ability to share participating schools' feedback and assessment to other schools.¹⁶⁶ Such a panel is currently being developed for student welfare providers.¹⁶⁷
- 13.102 The need for support in this area is not unique to government schools. In its submission to the Inquiry, the Department of Education made no comment about whether it supported sharing this information with other school systems. The Inquiry considers there are clear potential benefits in making this resource available to all teachers in NSW.

Recommendation 23:

That the NSW Department of Education establish a panel of recommended external providers of school-based drug education programs. In establishing this panel, the Department should:

- ensure that programs are evidence based and strengths based
- ensure that programs are aligned to the objectives of the syllabus
- help schools determine which provider is best suited to their local context
- publish this panel to the non-government sector.

Beyond school: some observations on the drug education needs of young adults

- 13.103 Evidence to the Inquiry demonstrates that young adults need detailed, nuanced drug education and harm reduction information. One young adult told the Inquiry's Youth Roundtable that drug education *'is incredibly lacking'*,¹⁶⁸ and said: *'Everything says "Don't do it", your school education said, "Don't do it" – that didn't – clearly isn't stopping you.'*¹⁶⁹

- 13.104 The Inquiry heard that a ‘just say no’ or ‘drugs are bad’ approach is ineffective, particularly for the most at-risk populations.¹⁷⁰ The Shopfront Youth Legal Centre submitted:

‘Young adults who choose to take drugs are infantilised rather than being supported with information that would enable them to make rational decisions about drug use. Far preferable would be an honest discussion of the benefits and harms associated with illicit drug use.’¹⁷¹

- 13.105 The Inquiry heard evidence that young people want and need to know about drugs, and specifically about ATS, with one young person saying he wanted:

‘[J]ust commonsense information which is actually going to communicate to people and not, like, make them feel defensive about taking their drugs or what they choose to do with their lives... I wish the state could do that more, you know, and you could [depend] on them to just give you, like, information that’s in your best interests rather than scaring you away in order to moralise or control your behaviour’.¹⁷²

- 13.106 Another told the Inquiry that knowing more about safe drug use, beyond being told ‘That’s bad for your health’, could have reduced the harm she experienced from ATS.

‘I think it would have really helped if I had an interaction with someone ... who was unbiased, but – like, an expert who could tell me more information and make it a bit more real to me and relatable rather than just that, “These are really bad and they’re going to do bad things to you”.’¹⁷³

- 13.107 In evidence to the *NSW Coronial Inquest into Music Festival Deaths*, a peer of one of the deceased noted it would be useful for young people to receive information about the long-term effects of drugs, and said talking about drugs in this way would not necessarily encourage young people to use them.¹⁷⁴

- 13.108 Providing accurate information about ATS is crucial, as messages that do not sit well with an individual’s own experience may not be credible with the target audience and can potentially undermine confidence in other messages or strategies.¹⁷⁵ Education should address the benefits as well as the harms of different drugs, as information exaggerating the harms may be viewed as less credible.¹⁷⁶ This was supported by evidence at the Inquiry’s Youth Roundtable, where one participant noted they first tried drugs out of curiosity, after finding information online that contradicted the content of the school-based drug education they had received: ‘*And that’s how I got into drugs – out of curiosity – when I had read stuff that contradicted with what was at school, and I was, like “Well, that doesn’t make any sense” and I, sort of, proved it to myself.*’¹⁷⁷

- 13.109 The *NSW Coronial Inquest into Music Festival Deaths* heard evidence that some drug messaging ‘has been well intentioned but fails to reflect the lived experience of people who actually consume illicit drugs so that it can be scoffed at or considered a bit of a joke’.¹⁷⁸

- 13.110 Education programs should consider the accuracy and perceived legitimacy of messaging around complex social issues such as ATS use. Evidence provided to the Inquest highlighted that information would be seen as credible if it came from a doctor or someone with medical training, but more so, a young person, as they would be more relatable.¹⁷⁹

- 13.111 It is crucial that target audiences view drug education, and the people delivering it, as credible. Mr Dillon, DARTA, gave evidence at the inquest that messages about ecstasy and MDMA had to be developed in conjunction with young people.

*'I think certainly in terms of how the message is delivered, I think it's got to be kind of multipronged and I think we need to involve young people in that development of messages, what messages work, what messages don't ... it's incredibly important that we start thinking really carefully about who young people perceive as credible in terms of delivering messages.'*¹⁸⁰

- 13.112 Mr Dillon said research showed that young people regard those in law enforcement as being *'down the end of the line'* in terms of credibility and that they *'believe people in white coats'*.¹⁸¹

*'It doesn't matter if it's a doctor, it's a professor ... emergency department doctors, people like that who are perceived as working on the front line with, with drug users, I think, are more likely to be perceived as credible sources.'*¹⁸²

- 13.113 The Inquiry heard evidence at its Youth Roundtable that teachers are not always viewed as credible sources of information. *'But if you see someone who looks like yourself, speaks like yourself and admits maybe that they've done it, I think I would listen to that.'*¹⁸³

- 13.114 Another young person told the Inquiry that, in their opinion, fear-based campaigns are not as effective as information¹⁸⁴ and that these campaigns perpetuate stigma surrounding drug use and people who use drugs.¹⁸⁵

- 13.115 Mary Harrod, CEO of the NSW Users and AIDS Association, gave evidence to the Inquiry of the need for *'real education, not talking giraffes. You know, targeted education that teaches people how to stay safe when they're using drugs'*.¹⁸⁶

- 13.116 Providing drug education and early intervention in locations where young people use or may be considering using drugs can be an effective strategy. The Inquiry heard that DanceWize is one such initiative that helps *'to make that information more readily accessible to people who are using drugs, when they're using drugs'*.¹⁸⁷ The literature recognises that clubs and other entertainment venues can be ideal places to provide education and early interventions, as young people who may be considering using ATS for the first time may attend these venues.¹⁸⁸

- 13.117 In addition to one-on-one peer support provided by roving crews at festivals, DanceWize has an education space set up at festivals to provide *'accurate and evidence-based education'* about a range of topics, including harm reduction, drugs and the law, mental health, sexual health and the effects of polydrug combinations (particularly combinations involving prescription medication).¹⁸⁹ Further information about the provision of education via harm reduction services is in Chapter 15.

Education for the general community

- 13.118 Drug education is often part of community-level prevention and harm minimisation activities. It also provides information to the general community about interventions, warnings about the risks of drug use and advice about where to get help.¹⁹⁰

The need for general education

13.119 The need for education was consistently supported across a number of submissions.¹⁹¹ The central importance of education was summed up by one witness with lived experience of ATS use, who said: *‘It should be recognised that the only way to break the cycle of addiction and re-offending is through education, health and residential support services being on offer.’*¹⁹²

13.120 The Inquiry heard that a lack of understanding in parts of the community about the nature and effects of crystal methamphetamine may be contributing to the uptake of ATS use among some people. A number of witnesses identified the need for more education to raise awareness about the effects of crystal methamphetamine and the signs of dependence,¹⁹³ and to increase community awareness about the availability of resources and services that offer treatment and support to those negatively affected by their own or another’s drug use.¹⁹⁴

13.121 One person with personal experience of crystal methamphetamine dependence told the Inquiry they did not know much about the drug before they tried it.

*‘I was always a bit worried about meth ... because I didn’t know much about it. There was meth around in Parramatta, and I saw it being smoked. About a year after moving to Parramatta, I was on the verge of coming down one night and couldn’t get any speed. Someone offered me meth, and I smoked some. At 8 or 9 am the next day, I was still going. The comedown was awful, worse than usual but I used again the next weekend.’*¹⁹⁵

13.122 One participant at the Inquiry’s Dubbo Roundtable said that when her son first started using crystal methamphetamine at age 14, he did not know about its effects.

*‘[H]e started when he was 14, uneducated, unknowing. [At] 28, 27, he’s being educated by the local GP, at the accident and emergency at the hospital, and that’s how he’s understanding what choices he’s actually making.’*¹⁹⁶

13.123 Nicolas Parkhill, CEO of ACON, gave evidence to the Inquiry of the need for further investment in community education, saying:

*‘[E]ducation that is community-based, allowing communities who are affected to talk to their communities about what that use looks like, why that use is occurring, ways that ... the harms can be minimised is something that needs additional resources.’*¹⁹⁷

13.124 The Inquiry heard that broader-based public education about drugs, the reasons why people use drugs and the settings in which they take them would be valuable in encouraging more useful public discussion of drug-related issues.¹⁹⁸ Drug education objectives have been moving for some time from just preventing and delaying use towards giving people the skills they need to reduce the harms associated with use.¹⁹⁹ When it comes to prevention, research suggests information about drugs rather than against drugs can more effective,²⁰⁰ as discussed further in Chapter 12.

13.125 There is also a need for education to include the effectiveness of treatment options for people concerned about their use of drugs, as there is little community knowledge about treatments and where to access information and support.²⁰¹ This highlights the need for adequately resourced and accessible support services as part of an holistic response to ATS use.

Government advertising, information and media campaigns

- 13.126 Advertising, mass media and education campaigns are frequently used to convey drug-related information and education to the general public. Government advertising or mass media campaigns are widely used to reach large populations through traditional media and marketing channels such as paid advertising.²⁰²
- 13.127 These media campaigns tend to be directly or indirectly based on theories of behaviour change, which often involve varying degrees of self-efficacy and self-determination. As outlined in Chapter 3, there is a range of risk factors outside an individual's control that influence drug use. This is one reason drug education campaigns should be considered as part of a broader strategy.²⁰³

Table 13.1: Educational objectives of drug-related media campaigns²⁰⁴

Objective	Main message
Warning	<ul style="list-style-type: none"> Information about the dangers and associated risks of a range of illicit substances
Empowerment and support	<ul style="list-style-type: none"> Information about behaviours that will contribute to drug prevention Information about where and how to seek support, counselling and treatment for illicit drug use Promoting the message that change is achievable
Correct false normative beliefs	<ul style="list-style-type: none"> Challenging and/or correcting beliefs around the normalisation of drug use (e.g. a belief in exaggerated levels of drug use among peers)
Setting or clarifying social and legal norms	<ul style="list-style-type: none"> Information that deglamourises drug use and related behaviour (e.g. drug driving) and explains the rationale for community norms and legal measures to influence attitudes and decision making
Setting positive role models or social norms	<ul style="list-style-type: none"> Promoting positive lifestyle and behaviours not associated with drug use

Effectiveness of media campaigns

- 13.128 For decades, media campaigns have been used to relay a variety of public health messages, most notably about tobacco use, cancer screening, HIV/AIDS and road safety initiatives. These campaigns have the advantages of disseminating focused messages to large audiences, repeatedly, over an extended period of time and at a low cost per head.²⁰⁵
- 13.129 However, their effectiveness has been mixed due to factors including campaign messages falling short or backfiring, inadequate funding and the increasingly fractured media environment distracting from the campaign message.²⁰⁶ Campaigns may also be ineffective because the content or format is not age-appropriate or they try to address behaviours that audiences lack the resources to change.²⁰⁷ However, it should be noted that government advertising campaigns are increasingly targeting audience groups by demographics such as age, sex and cultural background. They are also becoming more sophisticated in their methods, for example by embedding messaging within entertainment and social media platforms. The Cancer Institute NSW's Aboriginal Quit Smoking mini-series, developed in partnership with the National Indigenous TV network,²⁰⁸ and its 2015 community engagement strategy, which used social media to promote the importance of cervical screening among Arabic and Chinese women,²⁰⁹ are recent examples.

- 13.130 The literature notes that a campaign might create knowledge about or interest in how to use a drug where none previously existed.²¹⁰ Balancing the risk of stigmatisation with the normalisation of potentially harmful drug use is important in this context. Data suggest that poorly conceptualised drug education programs may actually be harmful and increase levels of adolescent substance use.²¹¹
- 13.131 Research suggests drug education is ineffective at preventing or reducing drug use if it simply shows the risks associated with drug use.²¹² Mass media campaigns are more likely to succeed where they target a clearly defined audience with relevant and credible messages to which they are frequently exposed.²¹³ Well-resourced and enduring campaigns that are part of a comprehensive approach and/or multiple interventions, and are complemented by policies that support opportunities to change, are also more likely to succeed.²¹⁴

Australian ATS-specific information and campaigns

- 13.132 Several Australian states have developed and implemented education campaigns directed towards ATS. These are identified below.

Your Room

- 13.133 The Your Room website, a joint initiative of NSW Health and St Vincent's Alcohol and Drug Information Service, provides factual information and resources about AOD, including detailed information on methamphetamine and other ATS. The section on methamphetamine tells people about:
- forms of methamphetamine
 - short and long-term effects
 - mixing with other drugs
 - overdose and bad reactions
 - what to do in an emergency
 - tolerance and dependence
 - withdrawal.
- 13.134 Your Room provides comprehensive information about where to find further information, advice and support for and about methamphetamine use.²¹⁵

What are you doing on ice?

- 13.135 The 'What are you doing on ice?' campaign was developed by the Victorian Department of Health and the Penington Institute. Launched in 2014, it aims to present a realistic picture of the progression from recreational use of crystal methamphetamine to dependence, and provides information on where to go for help.²¹⁶ A survey of 150 young people found that 75% of those who had taken drugs had thought about their attitudes towards crystal methamphetamine or spoken to family and friends about the drug after seeing the campaign.²¹⁷

Drug Aware Methamphetamine Education Campaign

- 13.136 The WA Mental Health Commission's Drug Aware Methamphetamine Education Campaign began development in 2008 in partnership with Curtin University. The WA Government provided \$500,000 for the Drug Aware 'Meth Can Take Control' prevention campaign, which was launched in December 2015.²¹⁸ The campaign aims to increase knowledge of the health, social and legal consequences of methamphetamine use and increase access to support services at an early stage.²¹⁹

- 13.137 Drug Aware campaign evaluations have found consistent increases since 2014 in the numbers of people intending not to use methamphetamine, with 91% of young people surveyed in 2017 not intending to use the drug.²²⁰
- 13.138 The WA Mental Health Commission also operates the Meth Helpline, which offers free counselling and advice 24 hours a day, seven days a week.²²¹

Ice Destroys Lives campaign

- 13.139 In 2015, the Commonwealth Government launched the \$9 million 'Ice Destroys Lives' campaign, developed as part of the National Drug Campaign. The campaign tag-line was *'Ice destroys lives. Don't let it destroy yours'*. The campaign had two waves of activity, May to June 2015 and August to September 2015.
- 13.140 Both waves targeted people aged 14 to 25 and their parents. The campaign aimed to reduce the uptake of illicit drugs among young Australians, increase awareness of harms and encourage and support decisions not to use illicit drugs.
- 13.141 A 2016 evaluation of the campaign found:²²²
- It increased awareness of crystal methamphetamine-related harms and negative attitudes towards the drug among young people.
 - Ninety-one per cent of young people reported positive actions and intentions as a result of the campaign.
 - Sixty-seven per cent of parents talked to their children about drugs in the previous two months, which was directly attributable to having seen the campaign even though this was not a campaign aim.
 - Young people and their parents found the campaign messages believable and effective.
 - Young people considered at risk of using drugs were more likely than those not at risk to say they *'will avoid using ice'*.
 - The most common impact of the campaign among parents was to reinforce existing knowledge about crystal methamphetamine (51%), while 45% felt better informed about the drug as a result of the campaign.
- 13.142 However, another evaluation of the campaign looked at differences in the perceptions of people who had used and people who had not used crystal methamphetamine.²²³ This evaluation highlighted a campaign video depicting a male character stealing from and physically assaulting his mother in the presence of a young child, and concluded that the campaign contributed to negative stereotypes and stigma and was unlikely to increase help seeking for people who used the drug.²²⁴ It found that:²²⁵
- Participants who had previously used crystal methamphetamine were significantly less likely to believe that the campaign was accurate, helpful or effective. Adults with a history of injecting drug use who were interviewed did not identify with the behaviour portrayed.
 - Participants who had never used crystal methamphetamine were more likely to agree that the campaign made them think people who use it are dangerous.

Case study: Crystalline Methamphetamine Community Education Program

The NSW Government's Crystalline Methamphetamine Community Education Program was delivered between September 2015 and February 2017 as part of an election commitment to educate the community about the dangers of crystal methamphetamine.

The three main components of the program, delivered by the Alcohol and Drug Foundation, were:

- community forums to raise awareness of crystal methamphetamine issues and improve knowledge of sources of help, as well as develop local skills
- Aboriginal workforce information sessions
- online support information comprising the *Breaking the Ice* website, resources and e-learning modules.

The major community forums were delivered in 10 metropolitan, regional, rural and remote locations across NSW. The forums attracted more people with a professional interest than families affected by crystal methamphetamine and general community members. An estimated two-thirds of participants in forums had a professional interest in the issue. Six information sessions were held in five regional towns as part of the Aboriginal workforce information sessions. Of the 120 attendees, 95% were local service workers.

Program evaluation

An evaluation of the program found that, overall, the components were successfully delivered and well received, with 71% reporting they had a better understanding of crystal methamphetamine immediately after the forum, though some expressed uncertainties in relation to navigating the service system.²²⁶ Many participants expressed a strong interest in hearing directly from people who had previously used crystal methamphetamine and their families.²²⁷

The evaluation findings identified that the NSW Government should consider promoting events more widely to increase attendance and provide a process for communities to request more education forums.

Overall, participants were very satisfied with the Aboriginal workforce information sessions they attended. They were most interested in information on crystal methamphetamine and other drugs, and information about services and skills to support people using crystal methamphetamine and their families. The evaluation found there was a need to continue building professional capability and coalitions.²²⁸

There is little evidence about satisfaction with the online resources as only a small number of respondents engaged with the evaluation tool. Of those who did, three-quarters found what they were looking for in this resource.²²⁹

Priority populations

- 13.143 Best practice principles recognise that drug education should be tailored to the social and cultural contexts and needs of the intended audience.²³⁰ Universal messages delivered via mass media campaigns may not be relevant or persuasive for priority population groups,²³¹ and drug information is likely to be more effective if it is tailored for particular targeted groups.²³²

- 13.144 Understanding how different populations use ATS, their drivers of use and how ATS use affects them is important to ensuring that education meets their needs. These broader questions are explored in Chapter 8.

General principles for working with priority populations

- 13.145 For programs to be effective, they must address the identified needs of the target population. Different groups are likely to have different education and information needs, communication styles and education channels. There are general principles that can be applied to different priority populations, such as developing education resources in consultation and partnership with them, embedding education in the community²³³ and capitalising on the strengths of different groups. Within these priority populations, information about drugs must be further tailored to accommodate differences in language, culture and age of individuals.²³⁴
- 13.146 Collaboration with the intended audience to develop health education and other initiatives provides the opportunity to understand the needs of the audience and the range of solutions available to effectively address those needs.²³⁵ The development of education for priority populations should take place in close consultation with those groups. The cost of not adequately understanding target audiences was highlighted in a 2014 Australian study with young Australian men who consumed MDMA and other drugs.²³⁶ This study identified that participants were sceptical of the intent behind government messages, and of public health messages that ignored or contradicted their own experiences with illicit drugs. The researchers concluded that drug-related education must understand and work with the cultural contexts that influence how target audiences relate to and take up health education advice.²³⁷
- 13.147 In developing a whole-of-government drug education strategy, the NSW Government should consult with identified populations to understand their needs, and develop AOD messages and education that are targeted, credible and relevant.
- 13.148 The Inquiry heard there is a need to build health literacy among priority populations.²³⁸ Health literacy helps people understand information about health and health care, and how they can apply it to their lives and use it to make decisions.²³⁹ Enhancing public health literacy for individuals and communities goes beyond the provision of information. Interventions that rely primarily on communication and education have not resulted in behaviour change, and have had little impact in terms of closing the gap in health status between different social and economic groups in society.²⁴⁰
- 13.149 An holistic approach to health education recognises that information provision alone is not necessarily sufficient to improve health outcomes. As research noted:

*'Health education has often been considered in a rather limited way as contributing only to improvements in individual knowledge and beliefs about risk factors for disease, and as having only a limited role in promoting behaviour change in relation to those risk factors. This may have had the unintended consequence of underestimating the role of health education, and fails to properly capture the potential of health education as a tool to support a full range of contemporary public health interventions.'*²⁴¹

Targeting education to the spectrum of people who use ATS

- 13.150 People using ATS can benefit from tailored messages and education, reflecting the possible harms associated with their pattern or stage of use and opportunities to intervene. Dr Scott Clark, Clinical Director of Mental Health and Drug and Alcohol Services, Western NSW Local Health District, told the Inquiry that GPs could have a role in delivering education to people who use drugs recreationally.

‘The broader [group] of people are using it recreationally, may not be aware of the health effects, and so simple psychoeducation around those effects can be useful, and a general practitioner is probably best placed to do that during a visit for ... something unrelated.’²⁴²

- 13.151 Education content needs to be tailored to different levels of exposure to, and experience of, drug use. For example, a United States study found that public health messages about marijuana use had very different impacts on college students who used marijuana compared with those who did not. Those who used marijuana tended to think the primary prevention messages lacked credibility and believability.²⁴³ This aligns with the findings of the study, discussed above, involving young Australian men who use MDMA and other party drugs.²⁴⁴ A review of studies of text messaging interventions for people with illicit drug and alcohol dependence found that tailoring text messages to an individual’s circumstances is more likely to achieve a better outcome.²⁴⁵
- 13.152 The spectrum of ATS use is discussed in Chapter 5. Harm reduction is discussed in Chapter 15.

References

- 1 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [47]; School Drug Education and Road Aware, *Teaching drug education in schools* (Fact Sheet, 2016) 1.
- 2 Fiona Lindsay, Richard Midford and Martin Cooper, 'Researching drug information needs in Australia' (2002) 21 *Drug and Alcohol Review* 287, 287-288.
- 3 Richard Midford, 'Is Australia fair dinkum about drug education in schools?' (2007) 26 *Drug and Alcohol Review* 421, 421.
- 4 Matilda Centre for Research in Mental Health & Substance Use, University of Sydney and the Centre for Brain and Mental Health Research, University of Newcastle, Submission No 74 (7 May 2019) 15.
- 5 'Alcohol and other drug education programs', *Better Health Channel, Department of Health & Human Services, Victorian Government* (Web Page, 2018) <<https://www.betterhealth.vic.gov.au/health/ServicesAndSupport/alcohol-and-other-drug-education-programs>>.
- 6 Victorian Government Department of Human Services, *Victorian amphetamine-type stimulant (ATS) and related drugs strategy 2009-2012* (2008) 11.
- 7 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [47].
- 8 'Alcohol and other drug education programs', *Better Health Channel, Department of Health & Human Services, Victorian Government* (Web Page, 2018) <<https://www.betterhealth.vic.gov.au/health/ServicesAndSupport/alcohol-and-other-drug-education-programs>>.
- 9 Penington Institute, Submission No 56 (May 2019) 27.
- 10 Harm Reduction Hearing, Sydney, Exhibit A, Tab 71, Statement of Stephen Bright to Coronial Inquest into Deaths Arising at Music Festivals, 27 May 2019, [6].
- 11 See Amy O'Donnell et al, 'Which individual, social and environmental influences shape key phases in the amphetamine type stimulant use trajectory? A systematic narrative review and thematic synthesis of the qualitative literature' (2018) 114 *Addiction* 24, 25, 44; E Jane Marshall, 'Adolescent Alcohol Use: Risks and Consequences' (2014) 49(2) *Alcohol and Alcoholism* 160, 160.
- 12 Victorian Drug and Alcohol Prevention Council, *2009 Victorian Youth and Alcohol Drug Survey* (Final Report, 2010) 64-6; Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 8.
- 13 Sydney Schools (private session), Sydney, Exhibit A, Tab 2, Statement of Dean White, 21 June 2019, [25].
- 14 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 3.
- 15 Northern Beaches Council, Submission No 53 (undated, received 7 May 2019) 3; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21.
- 16 Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21.
- 17 Literacy for Life, Submission No 96 (7 May 2019) 2; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21.
- 18 Literacy for Life, Submission No 96 (7 May 2019) 2.
- 19 Sydney (General) Hearing, Sydney, 8 May 2019, TS 159.26-33 (Professor Milroy).
- 20 'Alcohol and other drug education programs', *Better Health Channel, Department of Health & Human Services, Victorian Government* (Web Page, 2018) <<https://www.betterhealth.vic.gov.au/health/ServicesAndSupport/alcohol-and-other-drug-education-programs>>.
- 21 'Methamphetamine', *Your Room, NSW Health* (Web Page) <<https://yourroom.health.nsw.gov.au/a-z-of-drugs/Pages/methamphetamine.aspx>>.
- 22 Sydney Schools (private session), Sydney, Exhibit A, Tab 8, Statement of Maree Teesson, 27 August 2019, [26].
- 23 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 174.
- 24 Lois Meyer and Helen Cahill, Australian Government Department of Education, Science and Training, *Principles for school drug education* (Report, 2004) 12-14.
- 25 United Kingdom Advisory Council on the Misuse of Drugs, Recovery Committee, *Prevention of drug and alcohol dependence* (Briefing, February 2015) 11.
- 26 Adrian Farrugia and Suzanne Fraser, 'Science and scepticism: Drug information, young men and counterpublic health' (2017) 21(6) *Health*, 595, 612.
- 27 United Kingdom Advisory Council on the Misuse of Drugs, Recovery Committee, *Prevention of drug and alcohol dependence* (Briefing, February 2015) 6; Law Reform, Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamines, Particularly Ice, in Victoria* (Final Report, September 2014) vol 1, xxv.
- 28 G Turner and J Shepherd, 'A method in search of a theory: peer education and health promotion' (1999) 14(2) *Health Education Research* 235, 236-7.
- 29 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 6.
- 30 Don Nutbeam, 'Health Literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century' (2000) 15(3) *Health Promotion International* 259, 260.
- 31 East Maitland Hearing, East Maitland, 19 June 2019, TS 2056.5-11 (Dr Sadler).
- 32 East Maitland Hearing (Private), East Maitland, 21 June 2019, TS 2229.29-32 (Lived Experience Witness, Name Withheld).
- 33 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 44, 51.
- 34 Steve Parkin and Neil McKeganey, 'The Rise and Rise of Peer Education Approaches' (2000) 7(3) *Drugs: education prevention and policy* 293, 294-5.
- 35 G Turner and J Shepherd, 'A method in search of a theory: peer education and health promotion' (1999) 14(2) *Health Education Research* 235, 236-7.
- 36 Sex Workers Outreach Project, Submission No 83 (7 May 2019) 4.
- 37 Youth Roundtable (Private), Sydney, 1 April 2019, TS 20.36-21.1, 22.16-30, 24.27-25.20 (P4, P7, P1 and P3).
- 38 Harm Reduction Hearing, Sydney, Exhibit A, Tab 81A, Statement of Erica Franklin to Coronial Inquest into Deaths Arising at Music Festivals, 28 June 2019, [9].

- 39 Harm Reduction Hearing, Sydney, Exhibit A, Tab 81A, Statement of Erica Franklin to *Coronial Inquest into Deaths Arising at Music Festivals*, 28 June 2019, [1].
- 40 G Turner and J Shepherd, 'A method in search of a theory: peer education and health promotion' (1999) 14(2) *Health Education Research* 235, 236-7.
- 41 G Turner and J Shepherd, 'A method in search of a theory: peer education and health promotion' (1999) 14(2) *Health Education Research* 235, 236-7.
- 42 For example, peer programs have been used in cancer treatment settings. See Marlyn Allicock et al, 'Implementing a One-on-One Peer Support Program for Cancer Survivors Using a Motivational Interviewing Approach: Results and Lessons Learned' (2014) 29(1) *Journal Cancer Education* 91. See also NSW various peer support programs run by the Cancer Council including Cancer Connect where patients can talk to someone who has experienced cancer.
- 43 'iCanQuit', *NSW Government* (Web Page) <<https://www.icanquit.com.au/>>.
- 44 Jane M Simoni et al, 'Peer Interventions to Promote Health: Conceptual Considerations' (2011) 81(3) *American Journal of Orthopsychiatry* 351, 352.
- 45 Annie Bleeker et al, National Drug and Alcohol Research Centre, University of New South Wales Sydney, *The feasibility of peer-led interventions to deliver health information to ecstasy and related drug (ERDs) users* (Technical Report No 299, 2009) vii-viii.
- 46 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 10; Youth Roundtable (Private), Sydney, 1 April 2019, TS 49.5-13 (P6); Edmund Silins et al, 'Does peer-delivered information at music events reduce ecstasy and methamphetamine use at three month follow-up? Findings from a quasi-experiment across three study sites' (November 2013) 1(3) *Journal of Addiction and Prevention* 1, 2.
- 47 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 177.
- 48 Katrina Champion et al, 'Chapter 7: Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 140.
- 49 Jane M Simoni et al, 'Peer Interventions to Promote Health: Conceptual Considerations' (2011) 81(3) *American Journal of Orthopsychiatry* 351, 352.
- 50 'About Us', *DanceWise NSW* (Web Page) <<https://www.dancewizenw.org.au/about-us>>.
- 51 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 10.
- 52 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 10.
- 53 See, for example, 'Track 2 Health literacy and health behaviour – 7th Global Conference on Health Promotion: track themes', *World Health Organization* (Web Page) <<https://www.who.int/healthpromotion/conferences/7gchp/track2/en>>; Cornelia Geukes Janine Broder and Anne-Dorte Latteck, 'Health Literacy and People with Intellectual Disabilities: What We Know, What We Do Not Know, and What We Need: A Theoretical Discourse' (2019) 16 *International Journal of Environmental Research and Public Health* 463, 470.
- 54 World Health Organization, *Health in All Policies – Framework for Country Action* (2013).
- 55 World Health Organization, *The Helsinki Statement on Health in All Policies* (Statement, 8th Global Conference on Health Promotion, Helsinki, Finland, 10-14 June 2013).
- 56 NSW Nurses and Midwives' Association, Submission No 34 (May 2019) 9; Network of Alcohol and Other Drugs Agencies (NADA), Submission No 79 (May 2019) 18.
- 57 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 13[51], 14[56].
- 58 Sydney Schools (private session), Sydney, 10 September 2019, TS 3765.10-3766.30 (Summerhayes); TS 3766.35-9 (Alonso Love); 12 September 2019, TS 3817.24-3818.44 (McLean and Ridings); 20 September 2019, TS 4107.20-4108.21 (Sortwell and Said).
- 59 Sydney Schools (private session), Sydney, 20 September 2019, TS 4107.20-4108.7 (Sortwell and Said).
- 60 Sydney Schools (private session), Sydney, 12 September 2019, TS 3817.24-3818.1 (McLean and Ridings).
- 61 Sydney Schools (private session), Sydney, 12 September 2019, TS 3817.33-44 (McLean).
- 62 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [47].
- 63 Sydney Schools (private session), Sydney, 10 September 2019, TS 3765.18-25 (Summerhayes).
- 64 'Schools', *Alcohol and Drug Foundation* (Web Page, 2019) <www.adf.org.au/talking-about-drugs/parenting/schools>.
- 65 Sydney Schools (private session), Sydney, 10 September 2019, TS 3765.18-35 (Summerhayes).
- 66 Sydney Schools (private session), Sydney, 12 September 2019, TS 3821.32-40 (McLean).
- 67 Steve Allsop, 'The role of prevention and public health strategies in responding to ATS use' (Opening Plenary, Australian Drugs Conference, 14 and 15 October 2014) Slide 15.
- 68 East Maitland Hearing, East Maitland, 18 June 2019, TS 1860.7-12 (Beckwith).
- 69 See Amy O'Donnell et al, 'Which individual, social and environmental influences shape key phases in the amphetamine type stimulant use trajectory? A systematic narrative review and thematic synthesis of the qualitative literature' (2018) 114 *Addiction* 24, 25, 44; Katrina Champion et al, 'Chapter 7: Primary Prevention for Alcohol and Other Drug Use among Australian Adolescents' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 124, 125.
- 70 School Drug Education and Road Aware, *Teaching drug education in schools* (Fact Sheet, 2016) 1.
- 71 'Education in Schools Overview', *Alcohol and Drug Foundation* (Web Page, 2018) <<https://community.adf.org.au/plan/project-and-activity-toolkits/education-schools/education-schools-overview>>.
- 72 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 6, 12-13; Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [33].
- 73 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [33].
- 74 Sydney Schools (private session), Sydney, Exhibit A, Tab C, Wendy Loxley et al, The National Drug Research Institute and the Centre for Adolescent Health, *The prevention of substance use, risk and harm in Australia: a review of the evidence* (Monograph, January 2004) 118-126; Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 176.
- 75 Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 6.
- 76 Sydney Schools (private session), Sydney, Exhibit A, Tab F, Fabrizio Faggiano et al, 'School based prevention for illicit drugs: A systematic review' (2008) 46 *Preventative Medicine* 385, 394.

- 77 Sydney Schools (private session), Sydney, Exhibit A, Tab 14, Transcript Excerpt, Oral Evidence of Paul Dillon to the *Coronial Inquest into Deaths Arising at Music Festivals*, Lidcombe, 9 July 2019, 2.
- 78 Sydney Schools (private session), Sydney, 10 September 2019, TS 3740.39-43 (Summerhayes).
- 79 Sydney Schools (private session), Sydney, Exhibit A, Tab C, Wendy Loxley et al, The National Drug Research Institute and the Centre for Adolescent Health, *The prevention of substance use, risk and harm in Australia: a review of the evidence* (Monograph, January 2004) 104.
- 80 Sydney Schools (private session), Sydney, Exhibit A, Tab C, Wendy Loxley et al, The National Drug Research Institute and the Centre for Adolescent Health, *The prevention of substance use, risk and harm in Australia: a review of the evidence* (Monograph, January 2004) 105.
- 81 Sydney Schools (private session), Sydney, Exhibit A, Tab 14, Transcript Excerpt, Oral Evidence of Paul Dillon to the *Coronial Inquest into Deaths Arising at Music Festivals*, Lidcombe, 9 July 2019, 2.
- 82 Chudley E Werch and Deborah M Owen, 'Iatrogenic Effects of Alcohol and Drug Prevention Programs' (2002) 63(5) *Journal of Studies on Alcohol* 581, 587; East Maitland Hearing, East Maitland, Exhibit F, Frances Kay-Lambkin et al, Priority Research Centre in Brain and Mental Health, University of Newcastle, *Evidence Check: Media Reporting of Alcohol and Other Drug Use* (Report for Everymind, 20 March 2018) 26.
- 83 Chudley Werch and Deborah Owen, 'Iatrogenic effects of alcohol and drug education programs' (2002) 63(5) *Journal of Studies on Alcohol* 581, 587.
- 84 Lois Meyer and Helen Cahill, Australian Government Department of Education, Science and Training, *Principles for school drug education* (Report, 2004) 9.
- 85 Lois Meyer and Helen Cahill, Australian Government Department of Education, Science and Training, *Principles for school drug education* (Report, 2004) 12-14.
- 86 Adam Fletcher et al, 'How might schools influence young people's drug use? Development of theory from qualitative case-study research' (2009) 45 *Journal of Adolescent Health* 126, 131; Lois Meyer and Helen Cahill, Australian Government Department of Education, Science and Training, *Principles for school drug education* (Report, 2004) 19; Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [48].
- 87 Sydney Schools (private session), Sydney, Exhibit A, Tab C, Wendy Loxley et al, The National Drug Research Institute and the Centre for Adolescent Health, *The prevention of substance use, risk and harm in Australia: a review of the evidence* (Monograph, January 2004) 95.
- 88 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 177.
- 89 Lois Meyer and Helen Cahill, Australian Government Department of Education, Science and Training, *Principles for school drug education* (Report, 2004) 12.
- 90 Sydney Schools (private session), Sydney, 12 September 2019, TS 3819.33-3820.10 (McLean).
- 91 Sydney Schools (private session), Sydney, Exhibit A, Tab 11, Statement of Craig Petersen, 8 September 2019, [8]; Tab 12, Statement of Lynette Davis, 10 September 2019, [7].
- 92 Sydney Schools (private session), Sydney, Exhibit A, Tab 11, Statement of Craig Petersen, 8 September 2019, [8].
- 93 Victorian Government Department of Human Services, *Victorian amphetamine-type stimulant (ATS) and related drugs strategy 2009-2012* (2008) 13.
- 94 'Schools', *Alcohol and Drug Foundation* (Web Page, 2019) <www.adf.org.au/talking-about-drugs/parenting/schools>.
- 95 *Inquest into the deaths of six patrons of NSW music festivals*, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King (Findings of Deputy State Coroner Grahame, 8 November 2019) 137.
- 96 Sydney Schools (private session), Sydney, Exhibit A, Tab 2, Statement of Dean White, 21 June 2019, [36]-[39]; Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [45], [47].
- 97 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [47].
- 98 'National report on schooling in Australia data portal: Student Numbers', *Australian Curriculum, Assessment and Reporting Authority*, (Web Page) <www.acara.edu.au/reporting/national-report-on-schooling-in-australia/national-report-on-schooling-in-australia-data-portal/student-numbers#view1>.
- 99 Sydney Schools (private session), Sydney, Exhibit A, Tab 6, Statement of Karen Ingram, 31 May 2019, [3]; Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [32].
- 100 Sydney Schools (private session), Sydney, Exhibit A, Tab 6, Statement of Karen Ingram, 31 May 2019, [3].
- 101 Sydney Schools (private session), Sydney, Exhibit A, Tab 6, Statement of Karen Ingram, 31 May 2019, [3].
- 102 Sydney Schools (private session), Sydney, Exhibit A, Tab 2, Statement of Dean White, 21 June 2019, [27].
- 103 Sydney Schools (private session), Sydney, Exhibit A, Tab 6, Statement of Karen Ingram, 31 May 2019, [3].
- 104 Sydney Schools (private session) Sydney, 12 September 2019, TS 3817.1-6 (McLean).
- 105 Sydney Schools (private session), Sydney, Exhibit A, Tab 6, Statement of Karen Ingram, 31 May 2019, [3].
- 106 Sydney Schools (private session), Sydney, Exhibit A, Tab 6, Statement of Karen Ingram, 31 May 2019, [3].
- 107 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [59].
- 108 Sydney Schools (private session), Sydney, 10 September 2019, TS 3739.33-44 (Summerhayes).
- 109 *Inquest into the deaths of six patrons of NSW music festivals*, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King (Findings of Deputy State Coroner Grahame, 8 November 2019) 139-140.
- 110 NSW Government, *NSW Government response to the Coroner's Inquest into the deaths of six patrons of NSW music festivals* (Table, received 11 December 2019) 14.
- 111 Closing Submissions on behalf of NSW Department of Education, received 8 November 2019 [35].
- 112 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [39], [41].
- 113 Sydney Schools (private session), Sydney, 10 September 2019, TS 3756.25-6 (Summerhayes).
- 114 Closing Submissions on behalf of NSW Department of Education (received 8 November 2019) [28]-[29].
- 115 Sydney Schools (private session), Sydney, Exhibit A, Tab 10, Statement of Andrew Turvey, 4 September 2019, 2; Tab 11, Statement of Craig Petersen, 8 September 2019, [4].
- 116 Sydney Schools (private session), Sydney, Exhibit A, Tab 10, Statement of Andrew Turvey, 4 September 2019, [2].
- 117 Sydney Schools (private session), Sydney, Exhibit A, Tab 11, Statement of Craig Petersen, 8 September 2019, [4].
- 118 Sydney Schools (private session), Sydney, Exhibit A, Tab 11, Statement of Craig Petersen, 8 September 2019, [4].

- 119 NSW Government, *NSW Government response to the Coroner's Inquest into the deaths of six patrons of NSW music festivals* (Table, received 11 December 2019) 13.
- 120 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 139.
- 121 Sydney Schools (private session), Sydney, 12 September 2019, TS 3805.25-32 (McLean); 20 September 2019, TS 4111.19-27 (Said).
- 122 Sydney Schools (private session), Sydney, 20 September 2019, TS 4111.29-38 (Said).
- 123 Sydney Schools (private session), Sydney, 12 September 2019, TS 3805.27-32 (McLean).
- 124 Sydney Schools (private session), Sydney, Exhibit A, Tab 8, Statement of Maree Teesson, 27 August 2019, [35].
- 125 Sydney Schools (private session), Sydney, Exhibit A, Tab 16, 'Summary of evidence given at Music Festival Deaths inquest re Drug education in schools', 1-2.
- 126 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 129[547].
- 127 Sydney Schools (private session), Sydney, Exhibit A, Tab 16, 'Summary of evidence given at Music Festival Deaths inquest re Drug education in schools', 2.
- 128 Youth Roundtable (Private), Sydney, 1 April 2019, TS 21.8-21 (P3 and P6).
- 129 Sydney Schools (private session), Sydney, 10 September 2019, TS 3754.29-38 (Summerhayes).
- 130 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [51].
- 131 Nicole K Lee et al, 'What works in school-based alcohol education: A systemic review' (2016) 75(7) *Health Education Journal* 780, 789.
- 132 Nicole K Lee et al, 'What works in school-based alcohol education: A systemic review' (2016) 75(7) *Health Education Journal* 780, 789.
- 133 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 129[548].
- 134 Sydney Schools (private session), Sydney, Exhibit A, Tab 2, Statement of Dean White, 21 June 2019, [27].
- 135 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [44].
- 136 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [44].
- 137 Youth Roundtable (Private), Sydney, 1 April 2019, TS 21.5-6 (P4).
- 138 Sydney Schools (private session), Sydney, 20 September 2019, TS 4116.9-15 (Sortwell).
- 139 Youth Roundtable (Private), Sydney, 1 April 2019, TS 68.1-4. (P3).
- 140 Sydney Schools (private session), Sydney, Exhibit A, Tab 6, Statement of Karen Ingram, 31 May 2019, [4].
- 141 Sydney Schools (private session), Sydney, Exhibit A, Tab 4, Statement of Geoff Newcombe, 30 May 2019, [38].
- 142 Sydney Schools (private session), Sydney, 20 September 2019, TS 4097.8-20 (Sortwell).
- 143 Sydney Schools (private session), Sydney, 20 September 2019, TS 4117.31-5 (Said).
- 144 See, for example, Sydney Schools (private session), Sydney, Exhibit A, Tab 4, Statement of Geoff Newcombe, 30 May 2019, [31]; Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [53]; Tab 5A, Supplementary Statement of Stephen Said, 5 September 2019, [25]-[40].
- 145 Sydney Schools (private session), Sydney, Exhibit A, Tab 4, Statement of Geoff Newcombe, 30 May 2019, [31].
- 146 Sydney Schools (private session), Sydney, Exhibit A, Tab 5, Statement of Stephen Said, 27 August 2019, [2].
- 147 Sydney Schools (private session), Sydney, Exhibit A, Tab 5A, Supplementary Statement of Stephen Said, 5 September 2019, [20].
- 148 Sydney Schools (private session), Sydney, Exhibit A, Tab 4, Statement of Geoff Newcombe, 30 May 2019, [25]-[26]; Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [58]-[62]; Tab 2, Statement of Dean White, 21 June 2019, [46]-[48].
- 149 Sydney Schools (private session), Sydney, 20 September 2019, TS 4090.3-16 (Sortwell).
- 150 Sydney Schools (private session), Sydney, Exhibit A, Tab 4, Statement of Geoff Newcombe, 30 May 2019, [39].
- 151 Sydney Schools (private session), Sydney, Exhibit A, Tab 5A, Supplementary Statement of Stephen Said, 5 September 2019, Annexure S, Statement of Andrew Sortwell, 9 May 2019, 3.
- 152 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [62].
- 153 Sydney Schools (private session), Sydney, Exhibit A, Tab 12, Statement of Lynette Davis, 10 September 2019, [5].
- 154 Sydney Schools (private session), Sydney, Exhibit A, Tab 4, Statement of Geoff Newcombe, 30 May 2019, [35]; Tab 10, Statement of Mr Andrew Turvey, 4 September 2019, 3.
- 155 Sydney Schools (private session), Sydney, Exhibit A, Tab 10, Statement of Andrew Turvey, 4 September 2019, 3; Tab 11, Statement of Craig Petersen, 8 September 2019, [6].
- 156 Sydney Schools (private session), Sydney, Exhibit A, Tab 11, Statement of Craig Petersen, 8 September 2019, [6].
- 157 Sydney Schools (private session), Sydney, 12 September 2019, TS 3812.22-3813.6 (McLean).
- 158 Sydney Schools (private session), Sydney, 12 September 2019, TS 3813.11-18 (McLean).
- 159 Sydney Schools (private session), Sydney, 12 September 2019, TS 3813.22-6 (McLean).
- 160 Sydney Schools (private session), Sydney, Exhibit A, Tab 1, Statement of Deborah Summerhayes, 31 May 2019, [58].
- 161 Sydney Schools (private session), Sydney, 20 September 2019, TS 4090.8-21 (Sortwell).
- 162 Sydney Schools (private session), Sydney, 12 September 2019, TS 3813.30-40 (McLean).
- 163 'Telling war stories is not good drug education', *Alcohol and Drug Foundation* (Web Page, 14 September 2017) <www.adf.org.au/insights/drug-education-risks/>.
- 164 Sydney Schools (private session), Sydney, 12 September 2019, TS 3811.42-3812.5 (McLean); Sydney Schools (private session), Sydney, Exhibit A, Tab 11, Statement of Craig Petersen, 8 September 2019, [6].
- 165 Sydney Schools (private session), Sydney, Exhibit A, Tab 11, Statement of Craig Petersen, 8 September 2019, [7].
- 166 Sydney Schools (private session), Sydney, 10 September 2019, TS 3757.31-3758.20 (Summerhayes and Alonso Love).
- 167 Sydney Schools (private session), Sydney, 10 September 2019, TS 3757.36-9 (Love).
- 168 Youth Roundtable (Private), Sydney, 1 April 2019, TS 21.1 (P4).
- 169 Youth Roundtable (Private), Sydney, 1 April 2019, TS 20.36-21.1 (P4).

- 170 The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 13.
- 171 The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 13.
- 172 Youth Roundtable (Private), Sydney, 1 April 2019, TS 73.44-74.4 (P5).
- 173 Youth Roundtable (Private), Sydney, 1 April 2019, TS 47.5-25 (P3).
- 174 Sydney Schools (private session), Sydney, Exhibit A, Tab 16, 'Summary of evidence given at Music Festival Deaths inquest re. Drug education in schools', 2.
- 175 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 175.
- 176 'Talking to young people', *Alcohol and Drug Foundation* (Web Page, 2019) <<https://adf.org.au/talking-about-drugs/parenting/talking-young-people/>>.
- 177 Youth Roundtable (Private), Sydney, 1 April 2019, TS 21.33-5 (P1).
- 178 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 130[556].
- 179 Sydney Schools (private session), Sydney, Exhibit A, Tab 16, 'Summary of evidence given at Music Festival Deaths inquest re. Drug education in schools', 2.
- 180 Sydney Schools (private session), Sydney, Exhibit A, Tab 14, Transcript Excerpt, Oral Evidence of Paul Dillon to the *Coronial Inquest into Deaths Arising at Music Festivals*, 9 July 2019, 5.
- 181 Sydney Schools (private session), Sydney, Exhibit A, Tab 14, Transcript Excerpt, Oral Evidence of Paul Dillon to the *Coronial Inquest into Deaths Arising at Music Festivals*, 9 July 2019, 3.
- 182 Sydney Schools (private session), Sydney, Exhibit A, Tab 14, Transcript Excerpt, Oral Evidence of Paul Dillon to the *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Phan, Callum Brosnan, Joshua Tan and Alexandra Ross-King*, 9 July 2019, 5-6.
- 183 Youth Roundtable (Private), Sydney, 1 April 2019, TS 23.16-23.22 (P1).
- 184 Youth Roundtable (Private), Sydney, 1 April 2019, TS 74.41-6 (P6).
- 185 Youth Roundtable (Private), Sydney, 1 April 2019, TS 75.14-26 (P4).
- 186 Sydney (General) Hearing, Sydney, 8 May 2019, TS 185.3-4 (Dr Harrod).
- 187 Youth Roundtable (Private), Sydney, 1 April 2019), TS 20.42-4 (P4).
- 188 Victorian Government Department of Human Services, *Victorian amphetamine-type stimulant (ATS) and related drugs strategy 2009-2012* (2008) 14.
- 189 Sydney Harm Reduction Hearing, Sydney, Exhibit A, Tab 81A, Statement of Erica Franklin to the Coronial Inquest into Deaths Arising at Music Festivals, 28 June 2019, 3.
- 190 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 176.
- 191 See, for example, Griffith Aboriginal Medical Service, Submission No 16 (undated, received 30 April 2019) 1; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 22; Drug and Alcohol Multicultural Education Centre, Submission No 139 (29 May 2019) 2.
- 192 Custodial Hearing, Sydney, 4 September 2019, TS 3496.14-17 (PG).
- 193 Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2526.21-30, 2530.45-2531.7 (House); Lismore Hearing (Private), 13 May 2019, TS 469.26-27 (Lived Experience Witness, Name Withheld); Nowra Hearing (Private), Nowra, 29 May 2019, TS 1008.19-28 (Name Withheld); Broken Hill Hearing, Broken Hill, 18 July 2019, TS 2851.24-25 (Kemp); see also, Children's Court of NSW, Submission No 63 (7 May 2019) 5.
- 194 Matilda Centre for Research in Mental Health and Substance Use, the University of Sydney and the Priority Research Centre for Brain and Mental Health, the University of Newcastle, Submission No 74 (7 May 2019) 17; Nowra Hearing (Private), Nowra, 29 May 2019, TS 928.25-40 (Preston).
- 195 Lismore Hearing (Private), Lismore, 13 May 2019, TS 482.13-22 (Lived Experience Witness, Name Withheld).
- 196 Roundtable (Private), Dubbo, 3 June 2019, TS 1372.13-16 (Name Withheld).
- 197 Sydney (General) Hearing, Sydney, 8 May 2019, TS 169.42-170.2 (Parkhill).
- 198 Network of Alcohol and Other Drugs Agencies, Submission No 79 (May 2019) 17.
- 199 Richard Midford, 'Does drug education work?' (2000) 19(4) *Drug and Alcohol Review* 441, 442.
- 200 Fiona Lindsay, Richard Midford and Martin Cooper, 'Researching drug information needs in Australia' (2002) 21 *Drug and Alcohol Review* 287, 288.
- 201 Griffith Aboriginal Medical Service, Submission No 16 (undated, received 30 April 2019) 1; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 22; Drug and Alcohol Multicultural Education Centre, Submission No 139 (29 May 2019) 2.
- 202 Melanie A Wakefield, Barbara Loken and Robert C Hornik, 'Use of mass media campaigns to change health behaviour' (2010) 376 *The Lancet* 1261, 1261.
- 203 European Monitoring Centre for Drugs and Drug Addiction, *Perspectives on Drugs: Mass media campaigns for the prevention of drug use in young people* (Report, 28 May 2013) 3.
- 204 Adapted from European Monitoring Centre for Drugs and Drug Addiction, *Perspectives on Drugs: Mass media campaigns for the prevention of drug use in young people* (Report, 28 May 2013).
- 205 Melanie A Wakefield, Barbara Loken and Robert C Hornik, 'Use of mass media campaigns to change health behaviour' (2010) 376 *The Lancet* 1261, 1261.
- 206 Melanie A Wakefield, Barbara Loken and Robert C Hornik, 'Use of mass media campaigns to change health behaviour' (2010) 376 *The Lancet* 1261, 1261.
- 207 Melanie A Wakefield, Barbara Loken and Robert C Hornik, 'Use of mass media campaigns to change health behaviour' (2010) 376 *The Lancet* 1261, 1261.
- 208 'Aboriginal Quit Smoking mini series', *Cancer Institute NSW* (Web Page, 2 July 2018) <www.cancer.nsw.gov.au/how-we-help/cancer-prevention/stopping-smoking/quit-smoking-campaigns/aboriginal-quit-smoking-mini-series>.
- 209 'Engagement Strategy for Arabic and Chinese Communities', *Cancer Institute NSW* (Web Page, 2 July 2018) <<https://www.cancer.nsw.gov.au/how-we-help/screening-and-early-detection/cervical-screening/campaigns-and-projects/priority-populations/engagement-strategy-for-arabic-and-chinese-communi>>.

- 210 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 175.
- 211 Dan I Lubman et al, 'Intervening early to reduce developmentally harmful substance use among youth populations' (2007) 187(7) *Medical Journal of Australia* 22, 23.
- 212 Steve Allsop, National Drug Research Institute, 'Preventing and responding to drug problems: where does the evidence take us?' (Presentation, Alcohol, Tobacco and Other Drugs Council of Tasmania Conference, 18-20 October 2010) slide 14.
- 213 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 175.
- 214 Steve Allsop, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm' in Steve Allsop and Nicole Lee (eds), *Evidence to inform responses to harm, Prevention and Public Health Approaches* (IP Communications, 2012) 173, 175; See also Melanie A Wakefield, Barbara Loken and Robert C Hornik, 'Use of mass media campaigns to change health behaviour' (2010) 376 *The Lancet* 1261, 1268.
- 215 'Methamphetamine', *Your Room, NSW Health* (Web Page) <<https://yourroom.health.nsw.gov.au/a-z-of-drugs/Pages/methamphetamine.aspx>>.
- 216 Penington Institute, 'Ice campaign hits home with those most at risk' (Media Release, 19 November 2014).
- 217 Penington Institute, 'Ice campaign hits home with those most at risk' (Media Release, 19 November 2014).
- 218 Western Australia Government, *Methamphetamine Action Plan Taskforce Final Report* (August 2018) 94.
- 219 'Meth Can Take Control', *Drug Aware* (Web Page) <<https://drugaware.com.au/about-us/current-campaigns/meth-can-take-control/>>.
- 220 Western Australia Government, *Methamphetamine Action Plan Taskforce Final Report* (August 2018) 95.
- 221 'Meth Helpline', *Mental Health Commission, Western Australia Government* (Web Page) <<https://www.mhc.wa.gov.au/methhelpline>>.
- 222 Stancombe Research and Planning Ltd, *National Drugs Campaign 2015 Second Evaluation Research* (Quantitative Research Report 2016) 5-7, 27.
- 223 Caitlin Douglass et al, 'Just not all ice users do that: investigating perceptions and potential harms of Australia's *Ice Destroys Lives* campaign in two studies' (2017) 14 *Harm Reduction Journal* 1.
- 224 Caitlin Douglass et al, 'Just not all ice users do that: investigating perceptions and potential harms of Australia's *Ice Destroys Lives* campaign in two studies' (2017) 14 *Harm Reduction Journal* 1, 2.
- 225 Caitlin Douglass et al, 'Just not all ice users do that: investigating perceptions and potential harms of Australia's *Ice Destroys Lives* campaign in two studies' (2017) 14 *Harm Reduction Journal* 1, 6.
- 226 ARTD Consultants, *Crystalline Methamphetamine Community Education Program Evaluation* (Final Report, 4 May 2017) xiii.
- 227 ARTD Consultants, *Crystalline Methamphetamine Community Education Program Evaluation* (Final Report, 4 May 2017) xi.
- 228 ARTD Consultants, *Crystalline Methamphetamine Community Education Program Evaluation* (Final Report, 4 May 2017) xv.
- 229 ARTD Consultants, *Crystalline Methamphetamine Community Education Program Evaluation* (Final Report, 4 May 2017) xii.
- 230 United Kingdom Advisory Council on the Misuse of Drugs, Recovery Committee, *Prevention of drug and alcohol dependence* (Briefing, February 2015) 11.
- 231 Melanie A Wakefield, Barbara Loken and Robert C Hornik, 'Use of mass media campaigns to change health behaviour' (2010) 376 *The Lancet* 1261, 1261.
- 232 Fiona Lindsay, Richard Midford and Martin Cooper, 'Researching drug information needs in Australia' (2002) 21 *Drug and Alcohol Review* 287, 288.
- 233 ACON, Submission No 77 (May 2019) 24.
- 234 Fiona Lindsay, Richard Midford and Martin Cooper, 'Researching drug information needs in Australia' (2002) 21 *Drug and Alcohol Review* 287, 288.
- 235 Cath Roper, Flick Grey and Emma Cadogan, 'Co-production: Putting principles into practice in mental health contexts' (Report, 2018) 2.
- 236 Adrian Farrugia and Suzanne Fraser, 'Science and scepticism: Drug information, young men and counterpublic health' (2017) 21(6) *Health*, 595.
- 237 Adrian Farrugia and Suzanne Fraser, 'Science and scepticism: Drug information, young men and counterpublic health' (2017) 21(6) *Health*, 595, 608-610, 612.
- 238 ACON, Submission No 77 (May 2019) 3; Drug and Alcohol Multicultural Education Centre, Submission No 139 (29 May 2019) 2.
- 239 'Health Literacy', *Australian Commission on Safety and Quality in Health Care* (Web Page, 2019) <<https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy>>.
- 240 Don Nutbeam, 'Health Literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century' (2000) 15(3) *Health Promotion International* 259, 260.
- 241 Don Nutbeam, 'Health Literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century' (2000) 15(3) *Health Promotion International* 259, 261.
- 242 Dubbo Hearing, Dubbo, 4 June 2019, TS 1500.17-20 (Dr Clark).
- 243 Amy Wotring et al, 'Primary versus secondary prevention messages: College students' perceptions of effectiveness by marijuana user status' (2019) 67(8) *Journal of American College Health* 743, 749.
- 244 Adrian Farrugia and Suzanne Fraser, 'Science and scepticism: Drug information, young men and counterpublic health' (2017) 21(6) *Health* 21 595, 601-612.
- 245 Babak Tofighi et al, 'Text message content preferences to improve buprenorphine maintenance treatment in primary care' (2016) 35(2) *Journal of Addictive Diseases* 92, 92; Di Liang et al, 'A pilot study of a smartphone application supporting recovery from drug addiction' (2018) 88 *Journal of Substance Abuse Treatment* 51, 51.

Chapter 14. Health services

Introduction

- 14.1 This chapter describes the funding, service planning and governance of health services in NSW that play a role in identifying, managing and treating ATS use and harms, as well as the workforce that provides these services. It describes demand and service utilisation, particularly noting that current service capacity is not sufficient to meet demand.
- 14.2 Individuals who use ATS may present to health services for a variety of reasons that relate to their use of drugs. Like the rest of the population, people who use drugs also present to health services for many other health needs, which might not be related to the use of drugs. This engagement with health services can present an opportunity to identify drug use, for early and brief interventions to occur, or for referrals onto AOD treatment if required.
- 14.3 This chapter details the types of treatment options and models of care available, including services provided by the government and non-government sectors in acute and non-acute settings. It identifies significant barriers to treatment and numerous shortcomings in current service provision. A number of recommendations are made to address these and other issues.
- 14.4 Finally, this chapter concludes with consideration of ways to more effectively and efficiently integrate health and social services that will best meet the needs of people who use ATS.

Health governance, planning and funding

- 14.5 The Commonwealth and state and territory governments have shared responsibility for funding and delivering healthcare services.
- 14.6 Australia's health system has been described as '*a multifaceted web of public and private providers, settings, participants and supporting mechanisms.*'¹ Simply by virtue of its size and functions, it is inherently complex.
- 14.7 The main roles of government in Australia's healthcare system are depicted in Figure 14.1.

Figure 14.1: Roles of government in Australia's healthcare system

Commonwealth Government	State and territory governments	Local governments
<ul style="list-style-type: none"> • Sets national policies • Is responsible for Medicare (including subsidising medical services and joint funding, with states and territories, of public hospital services) • Funds pharmaceuticals through the Pharmaceuticals Benefits Scheme • Funds community-controlled Aboriginal and Torres Strait Islander primary health care • Supports access to private health insurance • Regulates private health insurance • Organises health services for veterans • Is a major funder of health and medical research, including through the national Health and Medical Research Council • Regulates medicines, devices and blood 	<ul style="list-style-type: none"> • Manage public hospitals • License private hospitals • Are responsible for public community-based and outpatient health services (including mental health, dental health, alcohol and drug services) • Deliver preventive services such as cancer screening and immunisation programs • Are responsible for ambulance services • Are responsible for handling health complaints 	<ul style="list-style-type: none"> • Provide environmental health-related services (for example, waste disposal, water fluoridation, water supply, food safety monitoring) • Deliver some community- and home-based health and support services • Deliver some public health and health promotion activities
Shared		
<ul style="list-style-type: none"> • Regulation of health workforce • Education and training of health professionals • Regulation of pharmaceuticals and pharmacies • Support improvements in safety and quality of health care • Funding of public health programs and services • Funding of Aboriginal and Torres Strait Islander health services 		

14.8 In 2011, the National Health Reform Agreement introduced significant funding reforms for Australia's public health services. This agreement outlined the separation of responsibilities between governments for healthcare delivery, and required all levels to work together to improve health outcomes and ensure the sustainability of the national health system.² The agreement articulates responsibilities across public hospitals, primary care and general practice, and aged care and disability services, however it does not descend to the level of AOD funding or servicing responsibilities.³

14.9 The ability of NSW to respond to ATS use is affected by the complexity of funding arrangements for public and non-government organisation (NGO) AOD services. Such complexity requires a clear planning framework to ensure that, at a minimum, there are no services missing or duplicated. St Vincent's Health Australia submitted that the availability and quality of AOD treatment is limited by lack of funding, inadequate coordination between the state and Commonwealth, and fragmentation, poor integration and a lack of accountability and transparency.⁴

NSW Health organisational governance and accountability

- 14.10 The NSW Health *Corporate Governance and Accountability Compendium* outlines the governance requirements, roles, relationships and responsibilities of the organisations that form part of NSW Health.⁵ Boards and chief executives are responsible for ensuring arrangements are in place to secure efficient and effective resource use by their organisation.⁶
- 14.11 Some of the key components of this document are outlined below.

NSW Health Performance Framework

- 14.12 The NSW Health Performance Framework sets out how the Ministry of Health monitors and assesses the performance of public sector health services.⁷ Under the framework, there are annual service agreements, monthly performance reports, performance review meetings, performance assessment criteria, performance triggers and indicative guidelines for performance responses.⁸
- 14.13 The Performance Framework is part of a robust suite of oversight mechanisms and processes for NSW Health. Quarterly meetings are held with each local health district (LHD) and specialty network to discuss their performance.⁹

Service agreements

- 14.14 Under the National Health Reform Agreement,¹⁰ service agreements are required to be established between the NSW Government and each LHD.¹¹ Similar arrangements exist in all states and territories.
- 14.15 Service agreements make public the annual operating targets and funding allocations for each LHD.¹² LHDs are accountable for the delivery of health service activity, and for delivering on the strategies and targets set out in the service agreements.¹³ Service agreements were described by Elizabeth Wood, Executive Director of System Purchasing for the NSW Ministry of Health as '*the mechanism for the state to determine and articulate what the strategic priorities are for the [NSW Health] system*'.¹⁴ They are developed over nearly a 12-month period for implementation the following year.¹⁵
- 14.16 Performance of health services is assessed in terms of whether individual LHDs meet the performance target set for each key performance indicator (KPI).¹⁶ The Inquiry further heard that any concerns can be raised with LHDs, regardless of whether or not they form part of the formal service agreement.¹⁷
- 14.17 Service agreements for 2019–20 include new AOD-specific KPIs, such as targets for changes in purchased volumes of AOD-related service activity (admitted and non-admitted), as well as a target to support the timeliness and accessibility of hospital drug and alcohol consultation liaison services. CL services provide specialist care in AOD to people admitted to hospital for other reasons.
- 14.18 To be considered as 'performing' under the drug and alcohol CL KPI, LHDs must either maintain or increase the number of hospital drug and alcohol CL services performed, compared with the previous year. Discussing the inclusion of these AOD-specific KPIs in the 2019–20 service agreements, Dr Jo Mitchell, Executive Director for the Centre for Population Health, NSW Ministry of Health, noted that such targets were included in recognition that AOD treatment activity is an '*important area that we need to grow*'.¹⁸

- 14.19 Choice of KPIs can affect service delivery for people who use or are affected by ATS. As noted by the Drug Policy Modelling Program (DPMP), Social Policy Research Centre, UNSW Sydney, in its submission to the Inquiry, there is a tendency for AOD program evaluations to focus on very basic quantitative indicators, weighted towards reduced AOD consumption and offending, despite it being well established that pathways to reduced harm involve considerably more than just reducing or ceasing substance use. The DPMP observes that more meaningful pictures of treatment success incorporate matters such as quality of life, reconnection with family and community, level of functioning in one's career or job, and level of involvement with the legal system.¹⁹
- 14.20 It is noted that NSW Health is moving toward a value-based healthcare system and, as part of this, is increasingly focused on outcomes as opposed to outputs.²⁰ NSW Health describes this as a move from '*volume to value*'.²¹ The Inquiry considers it is important that KPIs for AOD services are moving in this direction also, and recommends that outcome-based indicators be implemented in the coming years.
- 14.21 The inclusion of new AOD-specific KPIs in service agreements for 2019–20 is a positive development. However, the new KPIs remain based on output rather than outcome, which limits the accountability of the LHDs in providing a quality service to clients. Ms Wood, NSW Ministry of Health, told the Inquiry that with adequate planning and robust consultation within the sector, including with consumers, service agreements could accommodate such outcome-based KPIs relating to alcohol and other drugs.²²

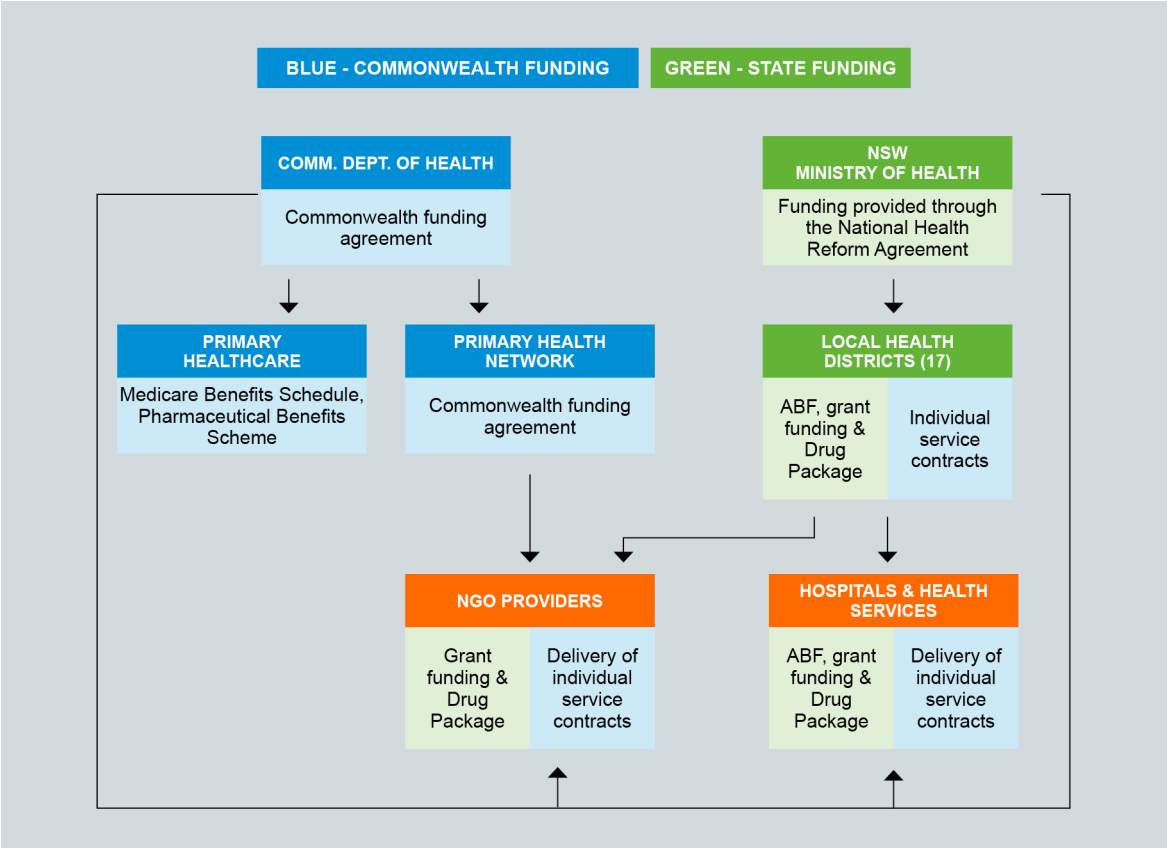
Recommendation 24:

That the NSW Government develop further KPIs related to AOD treatment services that include a mix of output and outcomes for inclusion in all local health district service agreements.

Health AOD funding structure and models

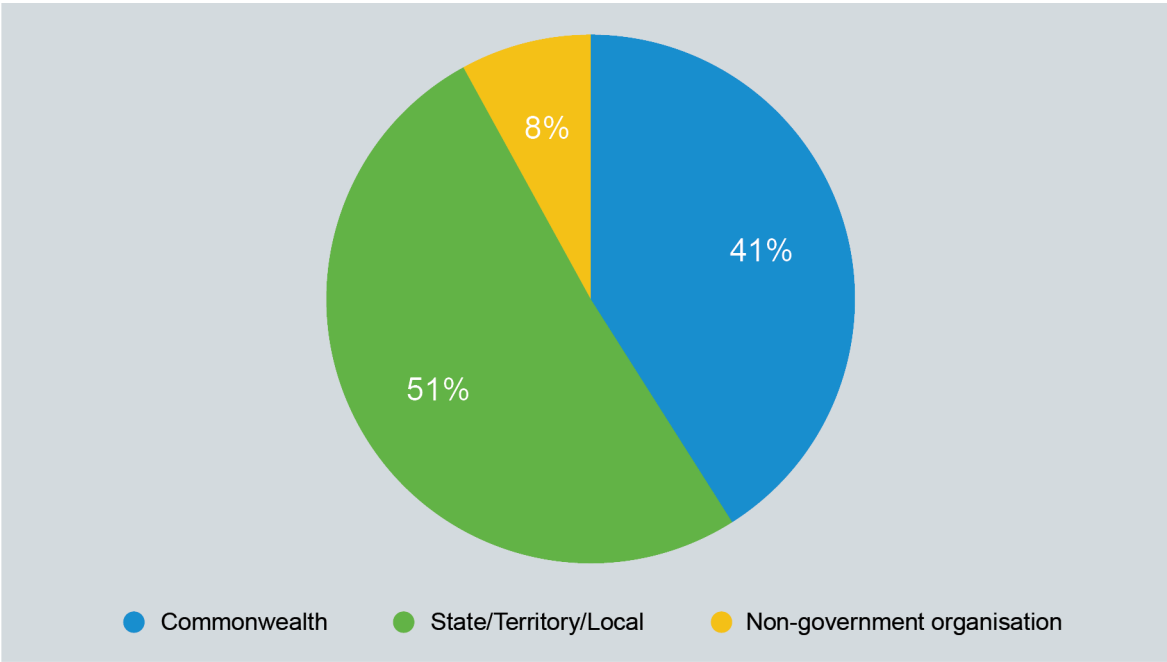
- 14.22 Funding for health services is provided primarily by the Commonwealth and state governments. For the purposes of this Inquiry, private investment and services fees have not been considered.
- 14.23 Figure 14.2 summarises the funding structure for AOD health services.

Figure 14.2: Simplified funding structure for AOD services



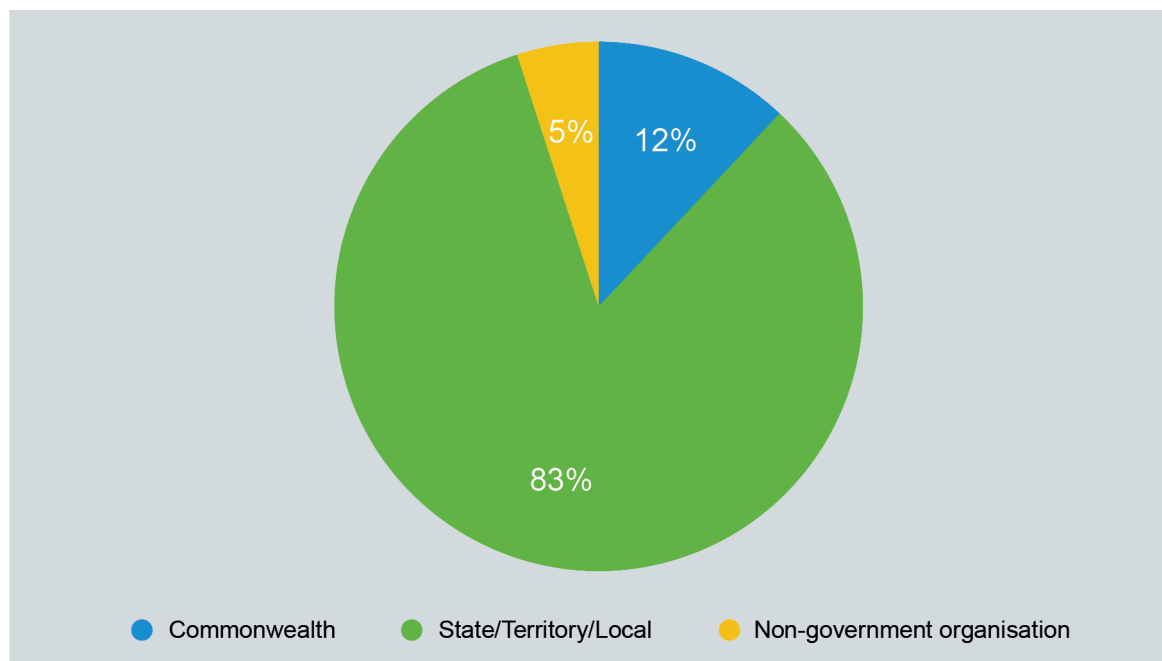
14.24 The funding of public hospital services is shared primarily between the Commonwealth and the states and territories. The split for 2016–17 is demonstrated by Figure 14.3.

Figure 14.3: Share of recurrent health expenditure on public hospital services, by source of funds, 2016–17²³



- 14.25 Community health services, which include many AOD treatment and rehabilitation services, are primarily funded by state/territory governments, as demonstrated by Figure 14.4.

Figure 14.4: Share of total health expenditure, community health, 2016–17²⁴



Activity-based funding and block funding

- 14.26 The budget and expenditure for AOD services is generally allocated through block funding/grants or through activity-based funding (ABF).
- 14.27 Block funding is the term used by government to describe the funding given to organisations to deliver programs through grants. Block funding is generally tied to a range of conditions, including the service to be delivered.
- 14.28 ABF is a way of funding hospitals for the number and mix of patients they treat. It was introduced after the 2011 National Health Reform Agreement, which included the establishment of the Independent Hospital Pricing Authority, a government agency with the primary function to calculate and deliver an annual National Efficient Price (NEP) for public hospital services on which to base payments under ABF.²⁵ The NEP in 2019–20 is \$5,134 per National Weighted Activity Unit (NWAU).²⁶
- 14.29 Before the establishment of service agreements, LHDs funded their AOD activities through block funding only. During this time, it was very difficult for LHDs to clearly measure and articulate their health servicing activities, as outlined by Amanda Larkin, Chief Executive of South Western Sydney LHD, during the Funding Roundtable:

*'Prior to 2011 we were not in an ABF environment. We did not have service level agreements. We really were funded ... pretty much year to year you just got whatever you got last year and you may have got CPI. So understanding what the system was delivering in terms of – let's just talk from an activity point of view – was very hard to articulate.'*²⁷

- 14.30 From 1 July 2012, NSW Health commenced implementing ABF, and AOD services have been funded through a combination of ABF and block funding grants since that time. The Inquiry received evidence that the movement to ABF requires adequate and accurate data capture to enable the funding to be apportioned properly. Over time, more services have been moved into ABF funding streams, however, block funding is still needed in some services.²⁸ ABF is a more transparent funding model and was described in evidence as providing *‘a language in which we can communicate more effectively with each other’*.²⁹
- 14.31 Some AOD services are now funded under the ABF model, but it is unclear to the Inquiry how much has transitioned to ABF and what remains block funded. During the course of the Inquiry, NSW Health provided information relating to the funding of various specific AOD services across the state.³⁰ Ms Wood, NSW Ministry of Health, told the Inquiry that funding for AOD services is spread across many services in the health system, such as cardiology, respiratory and dental services, which makes it difficult to extract data about specific funding amounts across the entire system.³¹ NSW Health subsequently confirmed that a more comprehensive breakdown of AOD spending across the state than had been provided – and which is set out in this part of the report – could not be provided.³²

Budget for NSW Health AOD services

- 14.32 Information provided to the Inquiry by NSW Health indicated a total budget for AOD services in 2018–19 of approximately \$274.8 million, broken down as follows:³³
- \$172.4 million to LHDs to commission AOD services
 - \$11.0 million to Justice Health and Forensic Mental Health
 - \$34.3 million for NSW Health Research Grants and staffing
 - \$57.1 million to NGOs for commissioned work.
- 14.33 However, NSW Health advised these figures do not include generic funding for non-specialist AOD health services, telling the Inquiry that the information provided reflects operational funding, and that *‘[p]eople affected by AOD issues will receive treatment in a range of LHD settings (for example emergency departments, maternal health services and mental health) and so the information provided will be an underestimate of AOD service activity and investment’*.³⁴
- 14.34 The Inquiry did not receive similar information from NSW Health for the 2019–20 AOD budget, however, publicly available information states that it is \$231.6 million.³⁵ A calculation based on the information provided by NSW Health and publicly available information suggests that the 2019–20 AOD budget is \$43.2 million less than the 2018–19 budget.
- 14.35 As described above, NSW Health has introduced a specific line in 2019–20 LHD service agreements measuring activity in AOD service provision under the ABF model. Each LHD has been provided with a target relating to AOD services, with funding tied to this activity. One NWAU attracts a NSW state price of \$4,925 in 2019–20.³⁶

- 14.36 It is unclear to the Inquiry how the shift to ABF will affect LHD AOD budgets. For example, the Western NSW LHD 2019–20 service agreement indicates that the Ministry of Health has purchased 527 NWAUs of activity from Western NSW LHD for admitted AOD services, and 4,317 NWAUs for non-admitted AOD services.³⁷ Multiplying these NWAUs by the state price suggests that the funding allocated for purchased activity in Western NSW LHD AOD services is \$2.6 million for admitted services and \$21.3 million for non-admitted services, a total amount of \$23.9 million. NSW Health advised the Inquiry that in 2018–19 Western NSW LHD received \$10.4 million for AOD services including \$3.2 million for their inpatient involuntary treatment unit.³⁸ The information from the new service agreement suggests that the shift to ABF may represent an increase in AOD funding for Western NSW LHD of approximately \$13.5 million for 2019–20.
- 14.37 Such a simplistic analysis of the effect of the change to ABF is unlikely to take account of the complexities of that funding model in operation. However, it provides a clear example of the challenges faced by the Inquiry in examining the way AOD services are funded in NSW.
- 14.38 It has proved extremely difficult for the Inquiry to obtain an accurate picture of the funding for AOD services in NSW, with different sources of information leading to different conclusions about how that funding operates in practice. This apparent lack of transparency and consistency presents a barrier to effective scrutiny and monitoring of spending on AOD services in NSW.

Coordination and planning of AOD health services

NSW and Commonwealth Governments

- 14.39 Both the Commonwealth³⁹ and NSW⁴⁰ Governments fund and provide AOD counselling, treatment, information and support services.
- 14.40 As described in Chapter 4, the National Drug Strategy is the guiding policy document for AOD in Australia. NSW currently has no policy or strategy that provides direction for or guides AOD service planning or delivery. As such, it has no policy or strategy that guides planning and coordination between governments. Lack of planning and coordination between governments has the potential to lead to duplication and/or service gaps,⁴¹ and funding arrangements are creating (or failing to address) barriers to coordinated, effective and efficient health care.⁴²
- 14.41 The Commonwealth Department of Health was invited to attend the Inquiry's Planning and Funding Roundtable, but declined the Inquiry's invitation.

Local health districts and primary health networks

- 14.42 At a regional level, LHDs and primary health networks (PHNs) each have a responsibility to effectively plan services to enable service delivery that is responsive to the health needs of the people they serve,⁴³ including by working together. For example, the NSW Health Performance Framework states that LHDs should develop cooperative arrangements with their stakeholders, including PHNs, to support achievement of performance requirements and to further the strategic priorities of NSW Health.⁴⁴

- 14.43 The Commonwealth Government has given PHNs a particular role in the planning and commissioning of AOD services, with a focus on methamphetamine use in the community.⁴⁵ Their purchasing/commissioning of AOD services must be evidence-based and responsive to community needs. Each PHN is required to consult with Commonwealth, state and territory health services within its region to avoid service overlap and gaps.⁴⁶
- 14.44 The development of a needs assessment (and an annual work plan) is mandated for PHNs as part of the first phase in the PHN Commissioning Framework.⁴⁷ Through needs assessments, PHNs identify health and service needs within their regions and prioritise activities to address those needs.⁴⁸ Commissioning of services by the PHN is then informed by that needs assessment and set out in the work plan.
- 14.45 NSW Health informed the Inquiry that the primary relationship with PHNs is at the local level. It was noted that LHDs work collaboratively to address local needs through participation in PHN needs assessment and planning processes and sharing of local service data. The Ministry of Health also has state-wide mechanisms to improve care coordination including through a NSW-PHN state-wide committee, and through cross-representation on the NSW Drug and Alcohol Program Council and the NSW/ACT PHN Drug and Alcohol Network.⁴⁹
- 14.46 PHNs are '*expected to develop collaborative working relationships with [LHDs] and public and private hospitals to reduce duplication of effort and resources*' and particularly to '*undertake population health planning in conjunction with [LHDs] and jurisdictional organisations*'.⁵⁰
- 14.47 PHNs can do so in various ways. For example, the Inquiry was advised that Central and Eastern Sydney PHN does so through:⁵¹
- contribution and consultation as part of annual needs assessment
 - LHD membership on the Central and Eastern Sydney PHN AOD advisory committee, which meets quarterly and monitors commissioned programs
 - commissioning LHDs and NGOs through a competitive tender process.
- 14.48 Similarly, the North Coast PHN reported to the Inquiry that it consults and works with local service providers, including LHDs, in service planning to ensure alignment and reduce duplication. Further, senior leadership teams of the PHN and LHD meet regularly.⁵² The Inquiry also heard evidence of the North Coast Collective, a co-commissioning initiative between the North Coast PHN, Mid North Coast LHD and Northern NSW LHD.⁵³ Stewart Dowrick, Chief Executive of the Mid North Coast LHD told the Inquiry that this initiative allows a mapping of services across health, family and community, police and other social services, and that responsibility and accountability are shared across the partnership.⁵⁴
- 14.49 Although these examples show that some LHDs and PHNs undertake a high level of joint planning and coordination, the Inquiry also heard evidence that this may not always be the case due to different local needs, relationships and ways of working.
- 14.50 The coordination between LHDs and PHNs in their development of planning and resourcing is done at a local level, and across varying sections of the workforce. The evidence received by the Inquiry suggests that the unstructured processes of such coordination can result in miscommunication within and between services, and may reduce clarity as to who is involved, and what accountabilities each party has. For example, some evidence indicated that senior executives are at times unaware of how their district is involved in collaborative planning activities between the LHD and PHN.⁵⁵

- 14.51 An evaluation of PHNs commissioned by the Commonwealth Department of Health (the PHN Review) noted that state and territory health departments had become increasingly engaged with PHNs, and that those PHNs with more mature relationships with state and territory health departments were beginning to undertake co-commissioning.⁵⁶ The PHN Review noted that co-commissioning was being undertaken by over half the PHNs at the end of the evaluation process, with 55% of PHNs reporting that they had co-commissioned a new service with another party in the previous six months.⁵⁷ There is no indication of how many, if any, of these co-commissioned services were AOD-related.
- 14.52 The PHN Review also noted that there remained areas where coordination was less advanced or had room for further improvement, including the better sharing of information and intelligence to support integrated services delivery.⁵⁸ Current impediments to progress in this area include conflicting policies, turnover of key staff, resistance to engagement and resistance to sharing data.⁵⁹
- 14.53 The Commonwealth has indicated to the Inquiry that, in addition to the consultation process between PHNs and state and territory governments, the Commonwealth Government is developing a National Treatment Framework (NTF) to coordinate efforts between all levels of government related to the drug and alcohol sector.⁶⁰ The NTF will enable a nationally shared strategic vision for AOD treatment and facilitate better treatment planning, commissioning and monitoring.⁶¹ The University of NSW has been engaged to consult and develop the NTF, and the Commonwealth has indicated that consultation has taken place. The NTF was expected to be finalised by the end of 2019.⁶²

The Drug and Alcohol Service Planning model

- 14.54 In 2010, NSW Health was commissioned to develop the Drug and Alcohol Service Planning model (DASP) by the Ministerial Council on Drug Strategy through the Intergovernmental Committee on Drugs.⁶³ The development was facilitated by a project steering committee, comprised of senior health officials from all jurisdictions. The project steering committee provided final decisions on all matters related to the development of the DASP from 2010 to 2013.⁶⁴
- 14.55 The DASP was designed to provide a standardised national measure for estimating the need for AOD services, across the spectrum from prevention and early intervention to the most intensive treatment. It could also provide a basis for all jurisdictions to consistently estimate the gap between estimated need and current resources.⁶⁵ The DASP model includes five different drug types (alcohol, benzodiazepines, cannabis, amphetamine and illicit opioids),⁶⁶ and estimates the workforce, bed numbers and costs required to meet predicted service delivery needs.⁶⁷
- 14.56 It is noted that recommendations 1 and 2 arising out of the 2017 *NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW* referred to the need for the NSW Government and NSW Health to use the DASP model, or similar, to guide service planning and funding.⁶⁸ The NSW Government supported this recommendation.⁶⁹
- 14.57 The Inquiry was advised that NSW Health currently uses the DASP model as one input to their AOD service planning. This, along with other service utilisation analyses, is informing activity purchasing decisions between the Ministry of Health and LHDs from 2019–20 onward.⁷⁰

- 14.58 According to further information from NSW Health, analyses supported by the DASP were used in 2018 to inform planning and the investment approach at a high level, by identifying the areas with greatest modelled unmet need, such as for non-admitted care and services in regional areas. This was accompanied by targets for an increase in non-admitted AOD service activity for LHDs that were found to have lower AOD service activity than the state average (after adjustment for population and burden).⁷¹ The Inquiry heard that the DASP cannot be relied on alone, as it does not cover all AOD services.⁷² Planning tools need to be supplemented by other data and information to understand outcomes of care and treatment delivery.⁷³
- 14.59 Notwithstanding the above activity planning, the Inquiry heard that the DASP could be improved,⁷⁴ including by making it more suitable to ATS treatment services.⁷⁵ The Inquiry also heard that broadening access to outputs of the DASP tool to service providers would increase transparency around service availability, planning and provision.⁷⁶ In its submission to the Inquiry, St Vincent's Health Australia stated that *'the alcohol and other drugs treatment sector is one of the last sectors not to utilise a national evidence-informed planning framework to guide and plan public investment'*.⁷⁷
- 14.60 The evidence suggests that there are opportunities to improve funding and service planning within the AOD health sector and that the DASP tool has the potential to supply an evidence base for this purpose. It would also be beneficial to make such a resourcing tool available for service providers to improve transparency and help achieve consistency in objectives and planning across the AOD sector.⁷⁸

Recommendation 25:

- A. That NSW Health continue to use the Drug and Alcohol Service Planning Model as one input into service planning processes.
- B. That to ensure that the Drug and Alcohol Service Planning Model is being used in the most effective manner, NSW Health:
 - engage an appropriate expert to periodically review and update the Drug and Alcohol Service Planning Model to reflect current use patterns and associated harms and treatment needs related to amphetamine-type stimulants
 - make the Drug and Alcohol Service Planning tool and its relevant outputs and data available for use as a planning tool by all local health districts, NSW primary health networks and non-government AOD service providers
 - make the Drug and Alcohol Service Planning tool and its relevant outputs and data available to other states and territories, and to the Commonwealth Department of Health.

Health service commissioning

- 14.61 Commissioning is a strategic and evidence-based approach to planning, purchasing and monitoring services focused on outcomes. As well as purchasing or procurement, commissioning involves an assessment of population needs, prioritisation and planning, working with other stakeholders and monitoring and evaluating effectiveness.⁷⁹

- 14.62 The Commonwealth and NSW Governments each commission AOD specialist health services, either directly or through locally-based PHNs or LHDs. Strong coordination between these two systems is needed to ensure the most effective coverage of services within each region.⁸⁰

Commonwealth and PHN commissioning

- 14.63 The Primary Health Network Grant Programme Guidelines include information specific to AOD treatment activity, and refer to the Commonwealth Government's response to the National Ice Taskforce. These guidelines established a role for PHNs in the planning and commissioning of AOD services, with a focus on methamphetamine use in the community.⁸¹ Overarching principles for purchasing and commissioning AOD services are articulated, including the need for coordinated, evidence-based and integrated approaches to care that are responsive to changing needs and provide value for money.⁸²
- 14.64 PHNs are required to report on their commissioning activity. This reporting includes six monthly performance reporting, performance indicators, ongoing data reporting via the Alcohol and Other Drug Treatment Services National Minimum Data Set and annual income and expenditure reports.⁸³

NSW Health and LHD commissioning

- 14.65 In the past 10 years, there have been a number of reviews into the way NSW Health funds service providers, including:
- 2010: NSW Health released a recommendations report from the NSW Health NGO Program Review. This review considered ways to deliver the most efficient, effective and responsive Grants Management Program. The review was focused on reducing red tape, increasing collaboration and strengthening partnerships⁸⁴
 - 2012: Grants Management Improvement Program Taskforce (GMIT). Forty-three recommendations were provided to NSW Health to improve the way NSW Health enters into funding arrangements with NGOs.⁸⁵
- 14.66 Following the GMIT, NSW Health developed Partnerships for Health,⁸⁶ which introduced contestability to NGO funding, with the aim of improving transparency in funding and resource allocation decisions, and streamlining the funding process.⁸⁷
- 14.67 From 1 July 2016, NSW Health has prioritised entering into longer-term funding agreements (two to three years) with AOD providers that have been assessed as suitable, with continuing development and consolidation of KPIs, reporting requirements and service monitoring frameworks.⁸⁸ New AOD funding for priority initiatives were subject to competitive tendering processes.⁸⁹
- 14.68 In 2017, the NSW Health Commissioning and Contestability Working Group was established, with responsibility for a structured and coordinated approach to delivering better value health care and outcomes across NSW Health.⁹⁰ NSW Health also developed a NSW Health Commissioning and Contestability Framework that supports NSW Health to identify appropriate projects.⁹¹ In 2018, NSW Health published an update on NGO reform achievements, and indicated that there was an ongoing focus on performance monitoring, management and feedback in relation to AOD services provided by NGOs and funded by NSW Health.⁹²

Contract lengths, terms and reporting requirements

- 14.69 Notwithstanding the improvements in commissioning that have been made over the past few years, the Inquiry heard evidence from various NGO service providers and peak bodies about the challenges they continue to face with models of commissioning AOD services. These challenges and their implications include the following.
- Service providers can rely on multiple funding sources simultaneously from one or more LHD and/or PHN (and from both Commonwealth and state sources).⁹³
 - Reporting requirements and obligations attached to the different funding sources can differ,⁹⁴ leading to increased reporting and administrative requirements on NGOs, which can redirect valuable time away from service delivery.⁹⁵ Reporting and KPI requirements are often inconsistent across jurisdictions, creating an unnecessary and costly administrative burden, particularly for small NGOs.⁹⁶
 - Funding is often contracted annually which can create significant funding uncertainty as well as impacting on the ability to strategically plan and recruit staff to roles.⁹⁷
- 14.70 The Inquiry heard evidence of these challenges during its regional hearings. In Dubbo, Michele Campbell, Group Manager, Clinical Services of Lives Lived Well, told the Inquiry that short-term contracts and funding resulted in difficulties attracting and retaining staff, as they are only able to offer short-term employment contracts. Often this means staff leave towards the end of funding periods due to uncertainty, resulting in workforce instability and sometimes vacant positions. This has a flow-on effect to service delivery.⁹⁸ Leone Crayden, CEO of The Buttery, a rehabilitation provider in northern NSW, told the Inquiry that her service is losing staff to other services as a result of not being able to offer longer-term employment contracts, circumstances she described as '*less than desirable*'. Along with a lack of job security, staff in these roles also experience difficulties securing car loans or mortgages.⁹⁹
- 14.71 The Inquiry heard that NGOs can receive multiple funding streams from within the same level of government,¹⁰⁰ and that different funding bodies may not always be informed of what is being funded by other sources.¹⁰¹ In his evidence to the Inquiry, Larry Pierce, CEO of the Network of Alcohol and other Drug Agencies (NADA), raised the administrative burden of managing the multiple contractual arrangements accompanying multiple funding sources for a service. Mr Pierce described a patchwork of funding arrangements that have developed over time in response to historical and contemporary state and Commonwealth AOD funding initiatives, describing funding arrangements as a '*house of cards*' where each different funding contract is operationally interdependent. Mr Pierce observed that this leads to a situation where the withdrawal of one or two funding contracts at any point in the life of a contract could result in the whole, or a major part of a service collapsing.¹⁰²
- 14.72 As noted above, multiple funders means multiple sets of reporting requirements:
- '[W]e have a situation where we have this treatment place funded by the Commonwealth and that treatment place funded by the state. We're delivering the same service to both but we have different reporting requirements, and we're reporting on different outcomes ...'*¹⁰³
- 14.73 NADA submitted that the funding system should be enhanced by introducing five-year contract arrangements to build security, sustainability and opportunities for long-term planning,¹⁰⁴ a proposal supported by other witnesses.¹⁰⁵ This is also in line with recommendation 6 arising out of the 2017 *NSW Parliamentary Inquiry into Drug Rehabilitation*.¹⁰⁶

Improving planning, funding and commissioning to deliver better patient outcomes

- 14.74 The Inquiry heard evidence about some effective collaboration between LHDs and PHNs. On the north coast of NSW for example, two LHDs and a PHN are working in a 'collective', to map the array of services they provide and develop joint accountability for the delivery of these. Over time, it is envisaged that new ways of funding can be implemented through the collective, including shared investment and co-commissioning. This approach also involves additional partners outside of the health sector, including education, corrections, police and family and community services.¹⁰⁷
- 14.75 However, the Inquiry also heard that the success of such collaboration is often based on personal relationships and is not consistent across the sector.¹⁰⁸ Geographical boundaries of organisations can also affect how coordinated planning and service delivery take place.¹⁰⁹ For example, LHDs, PHNs and other services such as police and Department of Communities and Justice (DCJ) typically do not share the same geographical boundaries within regions.
- 14.76 The Inquiry heard that there are opportunities for the state and Commonwealth governments to better coordinate funding and planning activities.¹¹⁰ Further to this, one witness suggested requiring local service providers to work together rather than independently, including through co-commissioning arrangements, observing that moving funding out of current silos would be required to do so properly.¹¹¹
- 14.77 The Inquiry also heard that overly prescriptive contracts can stifle innovation,¹¹² as well as reduce PHNs to the role of contract managers.¹¹³ The Inquiry recognises that there is a need for flexibility to suit local contexts, and to allow for new approaches to planning and service delivery.
- 14.78 In the United Kingdom, such collaborative approaches to commissioning health and social services are becoming more prominent, due in part to their ability to deliver more integrated care, achieve economies of scale and increased efficiencies.¹¹⁴
- 14.79 The evidence received by the Inquiry demonstrates that joint funding between the Commonwealth and NSW Governments would ensure coordination between the two jurisdictions and help prevent duplication and funding gaps.¹¹⁵ As described, there are also ways to facilitate collaborative arrangements towards planning and co-commissioning of services that best meet the needs of the local population. The benefits of this would be a more well-coordinated and efficient AOD health service system that provides more integrated care with increased efficiency and less duplication.
- 14.80 The Inquiry heard from health funding and governance experts across the NSW Health system that it is possible to have a consistent agreed contracting model between the Commonwealth and NSW Governments for unit prices, contestability approaches and performance reporting.¹¹⁶ Larry Pierce, NADA, identified such an approach as a way to harmonise contract reporting and improved information sharing between the Commonwealth and state health departments regarding commonly funded NGO services.¹¹⁷ Longer-term contracts would also enable service providers to better strategically plan, reduce administrative burden from tendering, manage their business and fund/retain their staff.

Recommendation 26:

That NSW Health work with the Commonwealth Department of Health to identify opportunities to better support and facilitate enhanced collaboration and joint AOD service planning between primary health networks and local health districts, including a focus on co-commissioning of services.

Recommendation 27:

That the NSW Government:

- increase standard NGO contract lengths to a minimum of five years
- align the terms, performance and data reporting requirement across all AOD contracts (including commissioning terms, procurement criteria and performance reporting).

The health workforce

- 14.81 Being able to attract, recruit and retain an adequately skilled and qualified workforce is essential to creating a sustainable response to ATS in NSW. In its engagement with AOD and other healthcare workers, the Inquiry has been impressed with the variety of skills they provide to people who use ATS, and their level of commitment in the face of often challenging circumstances. However, the health workforce in NSW is currently experiencing multiple challenges that affect its ability to respond to ATS use in NSW.
- 14.82 The sector struggles to recruit and retain appropriately trained staff. There is no dedicated and compulsory AOD training included in core health degrees such as medicine and nursing. Both generalist health workers and specialist AOD workers lack adequate training to respond safely and appropriately to people who use ATS.
- 14.83 AOD specialist positions are not well remunerated, especially in the non-government sector, and there is stigma surrounding jobs in AOD. As a result, the AOD specialist workforce is stretched, particularly in regional and rural areas. There is a concerning lack of trained Aboriginal AOD workers.
- 14.84 Finally, there is no dedicated development strategy for supporting and growing the AOD workforce in NSW. In terms of existing workforce strategies, there is a NSW Health Professionals Workforce Plan running from 2012 to 2022.¹¹⁸ The NSW Health Professionals Workforce Plan does not discuss the workforce development needs of the specialist AOD workforce (except for listing addiction medicine as a moderate priority for workforce planning in NSW).¹¹⁹ It also does not incorporate the NGO AOD sector, since workforce development and training of the NGO sector is a component of the contract between the NSW Ministry of Health and the peak body, the NADA.¹²⁰ A National AOD Workforce Strategy ran from 2015 to 2018, but it has not been extended.¹²¹ Evidence received by the Inquiry supports the need to develop such a strategy to respond to the challenges faced by AOD workers responding to ATS use.

AOD health workforce groups and roles

- 14.85 The AOD specialist workforce comprises people working in AOD-specific services and people delivering AOD-specific programs. A key role of the AOD specialist workforce is to prevent and respond to AOD-related harms.¹²²
- 14.86 The AOD specialist workforce is spread across the government and non-government sectors. It includes AOD workers, nurses, social workers, doctors, peer workers, needle and syringe program workers, prevention workers, addiction medicine specialists and specialist psychiatrists and psychologists.¹²³ They may work either in AOD specialist organisation agencies or in AOD programs within non-AOD specialist organisations.¹²⁴
- 14.87 The other important component of the health workforce that responds to ATS use is made up of workers from mainstream services, such as nurses, ambulance officers and medical practitioners. These are often the first point of contact for people who use ATS and some come into frequent contact with those people.¹²⁵
- 14.88 AOD specialist workers can provide intensive treatment for individuals experiencing harm due to their AOD use, while generalist workers such as GPs are well positioned to screen individuals for AOD problems and provide brief interventions.¹²⁶ Both workforces are employed across a diverse range of organisations that straddle the government, NGOs and, to a lesser extent, the private sector. Moreover, the systems and structures within which the AOD workforces operate vary across sectors, jurisdictions and individual agencies.¹²⁷

Profile of the AOD workforce

Australian and NSW AOD workforce data

- 14.89 There is currently limited information concerning the size and composition of the AOD specialist workforce in Australia and NSW. Some data on the specialist non-government workforce are available through NADA. Data on the specialist government workforce are available through NSW Health. Data on the non-specialist workforces are available through the Public Service Commission.
- 14.90 The Inquiry has been unable to identify a pooled data resource that is able to quantify or categorise the workforce across both sectors.
- 14.91 Uncertainty in this context is not new. The Australian Government's National AOD Workforce Strategy 2015–2018 identified the need to gain a better understanding of the extent and nature of the AOD workforce to improve skills and to prepare the workforce for the future.¹²⁸
- 14.92 The Workforce Strategy suggested a national census of workers employed in specialist AOD prevention and treatment roles, including those working in non-specialist organisations. It recommended that the census utilise nationally agreed-upon data definitions and be supplemented with other sources of data such as those provided by Health Workforce Australia, the Australian Bureau of Statistics and peak bodies. It also suggested that as well as basic demographic/occupational data, the census should collect information on issues such as employment intentions, Indigenous status, ethnicity and language skills.¹²⁹ It is unclear to the Inquiry whether such a census has been conducted; however, the Inquiry would support it being done in order to assist in providing a comprehensive picture of the current workforce.

The government and non-government sectors

- 14.93 There are different approaches to workforce planning and strategy in the government versus non-government context. This is because each sector adopts different service models.
- 14.94 In the government sector, AOD treatment is delivered in a variety of settings across NSW Health. This includes mental health services, emergency departments, Aboriginal health services and community health services.¹³⁰ The government workforce is dominated by people working in clinical and community health settings. In contrast, the non-government AOD workforce is predominantly employed in residential rehabilitation and counselling services.¹³¹
- 14.95 Non-government organisations are more likely to employ non-professional staff as these are more affordable for organisations that face significant budget restraints.¹³²

The government specialist workforce

Demographics

- 14.96 The Inquiry was unable to locate any material identifying the relevant demographics of the government specialist workforce.

Service composition

- 14.97 NSW Health advised the Inquiry that NSW Health clinical staff who work in AOD have a range of backgrounds. There is no central register of clinical types and locations maintained by the Ministry of Health.¹³³
- 14.98 In April 2018, it was estimated there were 1,150 drug and alcohol full-time equivalent (FTE) roles across NSW Health, of which 544 were located in non-metropolitan locations. Sixty-six roles were within the state-wide Justice Health and Forensic Mental Health Network.¹³⁴
- 14.99 NSW Health advised the Inquiry that there are two specialist medical workforces commonly associated with AOD services and support – addiction psychiatry and addiction medicine.¹³⁵
- 14.100 Addiction medicine involves primary, secondary and tertiary prevention of harm related to the non-medical use of drugs, management of acute drug-related problems and rehabilitation of people who have become dependent on drugs.¹³⁶
- 14.101 NSW Health indicated that based on workforce specialty coding data, at June 2019 there were 81.75 FTE addiction medicine specialists across NSW Health (comprising 7% of total AOD full-time equivalent roles). There were no roles coded against addiction psychiatry.¹³⁷

The non-government specialist workforce

Demographics

- 14.102 The demographics of the NSW AOD specialist workforce appear to reflect those found elsewhere in Australia. According to surveys undertaken of the NADA member agency workforce, it is female-dominated and mature, with most workers aged over 40 and more than half aged over 45. There are small percentages of Aboriginal and culturally and linguistically diverse workers.¹³⁸

- 14.103 There are two main sources of recent data characterising the non-government specialist workforce, a 2017 study conducted by the National Centre for Education and Training on Addiction (NCETA), NADA, and Matua Raki (NZ), and a 2013 survey undertaken of the NADA member agency workforce.¹³⁹ The 2017 survey provided more demographics of the non-government AOD specialist workforce in NSW than have been previously available. See Table 14.1
- 14.104 The 2017 online survey of 294 participants found that most respondents were women (66%) and aged 40 or over (60%). Aboriginal people made up 8% of the respondents, and 13% of respondents spoke languages other than English at home.¹⁴⁰
- 14.105 The survey indicated that there was a high turnover of staff: that most (72%) respondents had been in their current role for less than five years and 38% had been in their current role for less than one year. Just under half the respondents (44%) had been in the AOD sector for less than five years.¹⁴¹
- 14.106 About half (53%) of respondents worked in urban locations, with a third (32%) in regional, 14% in rural, and 1% in remote areas.¹⁴²
- 14.107 The majority (68%) were employed full-time, with slightly more than half in permanent positions (58%). However, many participants expressed dissatisfaction with remuneration levels, with most earning \$50,001 to \$70,000.¹⁴³
- 14.108 The data also indicated that many respondents did not hold relevant accredited qualifications and/or training. While 40% had undergraduate or postgraduate qualifications (26% were 'AOD-specific'), almost one in five (18%) did not have an AOD-related qualification.¹⁴⁴

Service composition

- 14.109 Recent surveys also gave an indication about the composition of the workforce by service provided. The 2013 NADA workforce survey, with a sample of 339 participants, found that a large portion of respondents worked in frontline AOD positions, with 40.7% of respondents working as AOD workers, residential support workers or AOD counsellors and a further 17.4% of respondents indicating 'other', which included roles as counsellors, case managers, case workers, teachers, educators, family support workers, program coordinators, program development officers or team leaders.¹⁴⁵
- 14.110 A 2008 NADA survey, with a sample of 698 participants, similarly found that frontline AOD workers formed the bulk of job roles in the sector, with 48% of workers employed as AOD caseworkers, AOD counsellors, support workers, intake officers and welfare workers. Management and administration roles formed the next highest proportion at 23%, with the remainder of the workforce fairly evenly divided between the professional roles of psychologists, doctors and nurses and health promotion, research and community development roles.¹⁴⁶

Table 14.1: Indication of the composition of the workforce by service provided¹⁴⁷

Primary role	No.	%
AOD worker	93	33.9
Case manager / Case worker	65	23.7
Counsellor	51	18.6
Manager / Team leader	36	13.1
Residential support worker	18	6.6
Nurse	16	5.8
Organisation / Service manager	13	4.7
Social worker	12	4.4
Administration officer / Receptionist	11	4.0
Psychologist	11	4.0
Health education officer	8	2.9
Community development worker	7	2.6
Educator / trainer	7	2.6
Peer worker	6	2.2
Project officer	6	2.2
Youth worker	6	2.2
Other	24	8.8

Note: Respondents could select all that applied. Percentages are based on 274 NSW respondents who answered the location question and at least one other question within the survey.

The generalist government health workforce

14.111 As noted above, the generalist health workforce is loosely defined, referring to the many professions that come into contact with people who use ATS, including specialist and generalist health professionals.¹⁴⁸ Table 14.2 lists the size of various NSW Government workforces that may come into contact with people who use AOD on a regular basis, based on 2018 data from the Public Service Commission. It is important to note that these figures relate to *all* members of this workforce, giving no indication of how many are in fact coming into contact with people who use ATS, or other illicit drugs.

Table 14.2: Size of NSW Government health workforce, 2018¹⁴⁹

Workforce	2018 Total
Nurses	47,942
Medical practitioners	11,932
Social and welfare professionals	7,303
Ambulance officers	4,030
TOTAL	71,207

Challenges facing the AOD workforce

14.112 In its submission to the Inquiry, NADA expressed the view that limited government investment into workforce development and/or remuneration in the AOD treatment sector has meant that suitably qualified and skilled staff are not attracted and retained, which affects treatment availability.¹⁵⁰ In NADA's view, *'[a]n immediate doubling of the NSW alcohol and other drugs budget would go a long way to ensuring improved access to all treatment types and could be utilised to attract and retain a suitable workforce.'*¹⁵¹

14.113 The Inquiry also heard evidence that there is currently a lack of addiction medicine specialists in NSW. For example, Dr Bronwyn Hudson, a GP who also works as an advanced trainee in addiction medicine at the Riverlands Drug and Alcohol Service in Lismore, told the Inquiry that:

*'The [inpatient withdrawal] unit itself has run successfully and achieved good outcomes based on the work of a solo addiction specialist who is passionate and dedicated to his field. This is an unsustainable model as it is dependent on one person. If this person was to leave the LHD, then the unit itself would be left without any clinical leadership.'*¹⁵²

14.114 A submission from the Australian Medical Association NSW (AMA NSW) noted that psychiatrists are another profession involved in managing dependence, but that workforce projections indicate a future undersupply of 125 psychiatrists by 2030 in NSW.¹⁵³ In its submission to the Inquiry, the NSW branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) advised that there is an undersupply of addiction medicine specialists in NSW, including psychiatrists, resulting from low investment in training at undergraduate and postgraduate level.¹⁵⁴

14.115 It appears that the lack of AOD trained specialists may be a barrier to the holistic, integrated treatment of people who use ATS. For example, a submission from Drug and Alcohol Nurses of Australasia (DANA) noted that nurses working in emergency departments, drug treatment centres, mental health and community health services and medical clinics typically lack access to specialist AOD trained staff, including AOD nurse practitioners, to support treatment planning at point of first contact. DANA also observed that nurses also have limited or no access to hospital AOD consultation liaison (CL) staff, especially after hours, and in rural and remote areas.¹⁵⁵

Recruitment and retention of AOD specialist workers

14.116 The National AOD Workforce Strategy 2015–2018 highlighted the need to improve recruitment into specialist AOD roles, including through the promotion of the AOD sector as a career choice for qualified applicants.¹⁵⁶ Inquiry evidence also suggested that one of the greatest challenges for the AOD workforce in NSW is the recruitment and retention of sufficient numbers of appropriately skilled, trained and qualified workers. Glen James, Executive Director for Mental Health and AOD of the North Coast PHN, told the Inquiry:

*'We also really want to build the workforce, because we actually recognise that we can roll out programs, but if we don't have a skilled AOD workforce, we're not going to have an AOD sector, and the health burden and the economic burden on the state and the Commonwealth is going to be really, really significant. So we have to – we have a responsibility as funders – to build that workforce and to support it.'*¹⁵⁷

- 14.117 The NGO sector faces particular challenges in recruiting and retaining AOD specialist workers. In addition to difficulties finding staff with appropriate qualifications,¹⁵⁸ challenges include lower salaries than those offered in the government sector, decreased appeal of working in the AOD sector, lack of opportunity for career progression for nonprofessional staff, disincentives for potential staff from the government AOD sector, such as loss of pay benefits and superannuation, and difficulties in moving between NGOs which likewise raises the issue of potential loss of benefits and superannuation.¹⁵⁹
- 14.118 As discussed above, the Inquiry heard consistently that the lack of adequate funding for AOD treatment services makes it difficult to grow the AOD workforce, especially in the non-government sector.¹⁶⁰ The Inquiry heard that NGOs face uncertainty created by short-term contracts, and/or pressure resulting from a lack of funding increases in line with CPI.¹⁶¹ Both of these factors add additional difficulty for NGOs in recruiting and retaining AOD workers, who the Inquiry heard receive higher wages and greater opportunity for career progression in the public sector.¹⁶² David Kelly, Manager of Moree's Maayu Mali Aboriginal Residential Rehabilitation Service, told the Inquiry that the service has seen an increasing workload over the past five years, and stated that with no CPI or any other increase to funding, that the service has '*...really been going backwards*'.¹⁶³

Rural, regional and remote areas

- 14.119 Evidence received by the Inquiry suggests that rural, regional and remote areas present a number of special challenges, with a small number of specialist staff required to service many people spread over a large area.¹⁶⁴
- 14.120 As noted in Chapter 7, the available evidence suggests that the proportion of the population in NSW who use methamphetamine is higher in regional and rural/remote areas.¹⁶⁵ Accordingly, a joint submission to the Inquiry by the Matilda Centre for Research in Mental Health and Substance Use and the Priority Research Centre for Brain and Mental Health indicated that there is a particular need to increase public AOD treatment and rehabilitation services in rural and regional areas of NSW, noting that the rates of methamphetamine use are higher in rural and remote areas compared to regional areas and major cities and that the reported availability of services is lower.¹⁶⁶ This evidence accords with data provided by NADA to the 2017 *NSW Parliamentary inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales* indicating that half of all member service drug treatments in NSW are in regional areas, even though almost 62% of the population live in Greater Sydney.¹⁶⁷ The Legislative Council Inquiry also heard that the number of AOD clients in regional and remote areas seeking treatment for methamphetamine dependence is increasing.¹⁶⁸
- 14.121 This Inquiry heard that ensuring adequate workforce capacity to respond to ATS in regional and remote areas can be difficult. Dr Adrian Dunlop, Director and Addiction Medicine Senior Staff Specialist, Drug and Alcohol Clinical Service, Hunter New England LHD, gave evidence highlighting that services being spread across large geographical regions due to low population density represents a significant challenge for AOD specialist workers in rural, regional and remote areas.¹⁶⁹ For example, Dr Dunlop told the Inquiry that clinicians travel great distances in his LHD to provide outreach, in order to mitigate the lack of AOD specialists available in the regional, rural and remote context.¹⁷⁰

- 14.122 A lack of medical specialists in rural, regional and remote areas is another challenge. The AMA NSW noted that despite an increase in full-time equivalent registered medical practitioners in recent years, there remains significant healthcare workforce shortages in rural and remote NSW. The submission further stated:

*'Factors such as an ageing workforce, difficulties in attracting new graduates and recruitment and retention of midcareer professionals have contributed to the doctor-drought. The shortage of doctors in regional and rural areas forces patients to travel longer distances to access services, particularly specialist services. Travelling long distances for treatment impacts on patients' time and also creates greater financial burden. As a result, regional and rural patients may delay in accessing drug treatment services, resulting in poorer success rates of treatment or relapse.'*¹⁷¹

- 14.123 Broken Hill City Council submitted that there is significant unmet need for drug detoxification, rehabilitation and other support services in far west NSW. The Council's submission suggested that the region needs an holistic, suitably resourced centre for drug detoxification, rehabilitation services and case management with experienced specialists in comorbidity.¹⁷² The Council raised workforce capacity as a particular issue and submitted that insufficient access to service and network provision creates less chance to provide early interventions and supports:

*'[I]f services had been available to provide the support to families at the base point, addictions may have been curbed and there would have been a better outcome. There is a lack of beds and specialised staff in the region to deal with such cases.'*¹⁷³

- 14.124 Dr Dunlop, Hunter New England LHD, gave evidence that his LHD, which covers both regional and rural areas, was using the AOD workforce from the regional hub in Newcastle to support rural areas, with AOD workers and various specialists visiting rural areas to provide services.¹⁷⁴ However, Dr Dunlop stated that it was important to have a local workforce providing withdrawal, ambulatory, outpatient and different levels of inpatient care services.¹⁷⁵ Ensuring that there is such a varied workforce available at the local level would make it easier for people who use ATS to gain initial access to care. Dr Dunlop suggested a lack of specialist support may lead to a reluctance by primary care providers to manage patients with AOD issues:

*'[Since] if somebody doesn't have a clinician, they can see that it's really hard to try to get a GP in a rural town interested in doing anything because they get no support, so it's easier just to say no than to say yes some of the time.'*¹⁷⁶

- 14.125 Professor Alan Rosen, a psychiatrist associated with the Universities of Sydney and Wollongong who has extensive experience working in Broken Hill, observed that it is 'not easy to recruit people to work in remote areas. There are some young professionals seeking to move out here to gain experience. Some stay a long time, but most only stay a few years'.¹⁷⁷ Professor Rosen noted a particular need for senior staff providing oversight for more junior staff:

*'We have some very junior staff in our mental health and drug and alcohol service, but we need very good senior supervision by people with expertise in both areas. The senior clinical psychologist who provided very competent supervision for intern psychologists and other interdisciplinary staff for many years was terminated as a cost saving measure by the LHD. In the past, senior multidisciplinary clinicians have been seconded to the executive office to do policy work – we need these experienced people in the community centre and on the wards as role models and supervisors for our junior staff ... Things have gone astray before, not because of lack of commitment of staff, but because of lack of expert supervision.'*¹⁷⁸

- 14.126 Deidre Robinson, General Manager of Northern NSW LHD Mental Health and Drug and Alcohol Services, also referred to the importance of experienced practitioners being available to act as mentors, telling the Inquiry that a lack of addiction medicine specialists limits her service's ability to attract trainees to the area.¹⁷⁹
- 14.127 The promotion of innovative methods such as online treatment and peer support is another important strategy to support the health workforce and improve access to services in regional areas.¹⁸⁰ Examples of such models of online treatment and support include Cracks in the Ice,¹⁸¹ Crystal Clear¹⁸² and the Family Friends and Support Program.¹⁸³ Jason Crisp, Director of Mental Health and Drug and Alcohol services for Western NSW LHD, told the Inquiry that his LHD had relied heavily on telehealth services, using a network of facilities with teleconferencing and videoconferencing capacity across the LHD.¹⁸⁴ Telehealth is discussed in more detail later in this chapter.

Stigma

- 14.128 The Inquiry heard from a number of witnesses about workforce stigma. For example, Dr Teresa Anderson, the Chief Executive of the Sydney LHD, acknowledged that the AOD workforce faces stigma.¹⁸⁵ The Inquiry also heard that stigma associated with working in AOD can prevent workers entering the profession. Dr David Helliwell, Clinical Lead of Alcohol and Other Drugs at Riverlands Drug and Alcohol Service, stated at the Lismore Hearing that AOD workers are often associated with 'difficult' patients and the stigma patients experience can be transferred to the AOD worker:

*'We'll often get calls from a general ward – and this is a generalisation, not so much a criticism, but we may get a call from a general ward saying, "One of your patients is giving us trouble," and it might be someone who's actually in that general ward for a valid medical reason, and their substance dependency is not being adequately managed. That's the sort of stigma and – that we see, and I think many of us who work in the field often feel quite stigmatised, in terms of, "You work with those sorts of people," and I think that might have an implication in terms of workforce needs in the area.'*¹⁸⁶

- 14.129 A submission from NCETA noted that it is important that organisations be aware of the impact of 'stigma by association' on their workforce and implement measures to address this, for example by highlighting stories of client recovery and achievement and reinforcing the valuable role played by workers.¹⁸⁷
- 14.130 Stigma and how to address it is dealt with in more detail in Chapter 9.

Workplace dissatisfaction and retention rates

14.131 Recent research shows that AOD specialist workers experience dissatisfaction with their workplace, due to issues such as organisational communication, leadership quality, access to supervision, workplace bullying, staffing levels, workload, stress, remuneration and job security. However, this research also suggests that many of these factors have the potential to be improved through targeted initiatives, programs, and policies,¹⁸⁸ including through:

- worker wellbeing policies
- multifaceted health promotion programs
- programs to enhance worker resilience
- effective clinical supervision
- ensuring that organisations are well managed
- encouraging help-seeking behaviours in the workplace
- programs to prevent and reduce stress and burnout
- encouraging individual self-care approaches.¹⁸⁹

Safety and wellbeing

14.132 The Inquiry heard that safety is a particular concern for healthcare workers who come into contact with people who use ATS in a harmful way, particularly if they are violent and aggressive towards staff.¹⁹⁰ DANA, the peak nursing organisation in Australia, submitted that nurses working in a range of health settings have concerns when working with people affected by methamphetamine use, including fears for their personal safety.¹⁹¹ Adam Bryant, Acting Director of Mental Health at Illawarra Shoalhaven LHD, told the Inquiry that the aggression and agitation displayed by those affected by ATS can cause staff to feel intimidated and fearful for their own and others' safety.¹⁹²

14.133 The Inquiry also heard that staff wellbeing is critical to recruiting and retaining staff. Vicarious trauma was discussed by clinicians as something that impacts upon staff who work with people affected by ATS. This may stem from hearing about traumatic life experiences and childhoods, and can be further compounded by the verbal and physical aggression which these patients may display. These were described as emotionally taxing situations that create risk of staff burnout. Dr Bronwyn Hudson, a GP and trainee in addiction medicine in the Northern NSW LHD, and Margaret Terry, Director of Mental Health and Substance Use Service at Hunter New England LHD, both gave evidence that suggests more needs to be done to support staff in such situations.¹⁹³

14.134 As articulated by DANA, the safety of clinicians and other staff in healthcare settings must be a priority for health services.¹⁹⁴

14.135 A further discussion on incidents involving patients affected by ATS in acute care settings is outlined below in this chapter.

Lack of training specific to ATS

- 14.136 NCETA stated in its submission to the Inquiry that *'a key challenge facing AOD workers is that until recently primary health care, specialist and nonspecialist services were usually designed to meet the needs of people with depressant drug problems (such as heroin and alcohol).'*¹⁹⁵ NCETA submitted that it is imperative that workers dealing with clients with complex needs, such as people using crystal methamphetamine and/or other ATS, are properly supported. NCETA submitted that clinical supervision and mentoring by senior staff can be utilised to develop the skills, knowledge and workplace practices of frontline workers in this respect, noting that this may also minimise the potential for stress and burnout.¹⁹⁶
- 14.137 DANA noted that generalist nursing staff suffer from a *'[l]ack of clinical expertise to provide effective intervention and care'*, and that the existing workforce's knowledge of and skill with working effectively with people impacted by methamphetamine use needs to be enhanced.¹⁹⁷
- 14.138 Dr Scott Clark, Clinical Director Mental Health and Drug & Alcohol Services, Western NSW LHD, suggested that education and training, whether directly or indirectly concerning ATS, has assisted staff in managing people who use ATS. He stated *'however, there is always room for more training and education which would require some additional resources'*.¹⁹⁸
- 14.139 St Vincent's Health Australia said the generalist health workforce must be upskilled to achieve and sustain effective responses to ATS use and dependence.¹⁹⁹
- 14.140 The Inquiry notes that there are also various ATS training modules available in NSW, including AOD accredited modules offered locally through PHNs and online national training resources through Cracks in the Ice.²⁰⁰ NADA also provides ongoing development for the AOD workforce.²⁰¹

Development of the health workforce to respond to ATS use and harm

Accreditation and credentialing

- 14.141 Accreditation refers to the certification by an authority that an entity has met specific standards. Accreditation can apply to entities including organisations, educational institutions or individuals.²⁰² Accreditation provides a degree of consistency in training medical, paramedical, nursing and some allied health professionals. Certain classifications of health practitioners are accredited through a National Registration and Accreditation Scheme (National Scheme) for registered health practitioners, which commenced in 2010.²⁰³ The National Scheme is implemented by the Australian Health Practitioner Regulation Agency. This agency supports National Boards to implement the National Scheme. National Boards oversee registration standards, including ongoing professional development and recency of practice.²⁰⁴ Credentialing is where an employer, such as a hospital, confirms a practitioner's registration or other credentials and authorises the specific scope and content of their clinical practice.²⁰⁵

- 14.142 Nursing is overseen by the Nursing and Midwifery Board of Australia, with the Australian Nursing and Midwifery Accreditation Council responsible for accreditation. Medicine is overseen by the Medical Board of Australia, with the Australian Medical Council acting as the accreditation body. The Australian Medical Council is also the body responsible for accreditation of specialist medical colleges such as Australian College of Emergency Medicine (ACEM) for emergency specialists, RANZCP for psychiatrists and the Australian Chapter of Addiction Medicine, Royal Australasian College of Physicians, for addiction medicine specialists.
- 14.143 Some professions in the AOD sector such as psychologists and social workers require registration with a relevant professional body, however only addiction medicine specialists require accreditation as AOD specialists.²⁰⁶ There are approved accreditation standards for organisations, rather than individuals, that are funded by NSW Health to deliver AOD treatment services. These address minimum standards of operation and service delivery.²⁰⁷
- 14.144 The NSW Government submitted that, according to NCETA, a substantial proportion of the AOD workforce nationally does not hold formal AOD-specific qualifications. It said the workforce generally has other clinical, social services or related training. The NSW Government also advised the Inquiry that there is a variety of AOD training options available at both accredited and non-accredited levels, including Statements of Attainment and Certificates III and IV. These are available to the NSW AOD workforce through TAFE and private training institutions.²⁰⁸ NCETA suggested that increasing relevant teaching in undergraduate clinical and public health/policy tertiary courses would assist in enhancing recruitment to the AOD workforce.²⁰⁹

Inclusion of AOD in health degree training

- 14.145 Evidence received by the Inquiry suggests that the capacity of the health workforce could be increased by incorporating increased AOD training into existing curricula at both the undergraduate and postgraduate level.²¹⁰ This may also help attract applicants to work in the specialist AOD workforce.²¹¹ The Inquiry heard that doctors and nurses receive little, if any, AOD-focused training as part of their undergraduate degrees.²¹² This means that a GP or nurse coming into contact with a person using ATS may need to offer referral or treatment in the absence of having any training about the nature of dependence, what causes it and how it can be treated. Further, AOD training is not a mandatory subject for annual professional development for non-specialist medical practitioners.²¹³ This may lead to significant deficits in the skills and/or knowledge of people at the front line of responding to ATS.
- 14.146 The RANZCP noted there is little investment at undergraduate and postgraduate level to train addiction medicine specialists, including psychiatrists, in NSW. It expressed support for training and the creation of specialist positions in order to decrease this shortfall.²¹⁴ Dr Helliwell, Riverlands Drug and Alcohol Service, suggested that training general practice registrars in the administration of opioid treatment programs may encourage doctors to move into an AOD specialisation: *'I came into the field of addiction medicine via working with needle exchange and then our opioid treatment program, and I think I slowly got hooked on treatment and have been there ever since.'*²¹⁵
- 14.147 DANA recommended ensuring that all nurses and midwives entering the workforce are trained from undergraduate level on how to manage and treat people with harms associated with AOD use.²¹⁶ Mary Wahhab, Clinical Nurse Educator for Drug Health Services in South Western Sydney LHD, also supported this view.²¹⁷

- 14.148 Dr Hester Wilson, Royal Australian College of General Practitioners (RACGP), observed that positive change is possible. Dr Wilson reflected on the changes that have occurred in the way mental health conditions have been managed and treated during her 30 years as a GP. Due in part to '*lots of training*', managing mental health conditions was described as now being a part of what GPs do. Yet while there has been this shift in mental health, the same has not occurred in AOD.²¹⁸ Jolene Mokbel, a psychologist and clinical coordinator for the South-West Sydney AOD and mental health program with the Salvation Army, while discussing the complexities accompanying problematic AOD use such as mental health comorbidity and underlying trauma, also highlighted the importance of professional development in appropriately responding to such complex health conditions.²¹⁹
- 14.149 The evidence before the Inquiry supports the inclusion of AOD-specific training in health workforce training programs to support improved identification and management of AOD use and harm, including ATS.

Recommendation 28:

That NSW Health work with relevant stakeholders, including professional associations and universities, to increase the amount of AOD content in undergraduate and postgraduate accredited training.

Expanding the peer workforce

- 14.150 Peer support involves nonprofessional, nonclinical assistance from people with similar conditions or circumstances to a patient, in order to achieve long-term recovery from psychiatric, alcohol and/or other drug-related problems.²²⁰ Peer support workers often share a common health condition or set of conditions (or cultural history/identity) with patients and use these experiences to promote engagement and facilitate behaviour change.²²¹ Research has suggested that peer support services can result in a range of benefits for the treatment of drug dependence, including higher rates of abstinence, higher rates of treatment satisfaction, significant reductions in relapse rates, and reductions in returns to homelessness.²²² Research also suggests that information about drug use that comes from peers can be more influential than official sources of information. As such, harm reduction messages that are delivered by peers may be perceived as more credible and so be more effective than when delivered by other sources.²²³
- 14.151 A significant amount of evidence to the Inquiry supported the value of a dedicated AOD peer workforce.²²⁴ For example, a joint submission from the Centre for Brain and Mental Health Research and the Matilda Centre for Research in Mental Health and Substance Use stated that the involvement of people with lived experiences as peer workers and general consultants in the development of policies is critical to ensure that they are relevant and effective for the target audiences.²²⁵ The involvement of the peer workforce is not only beneficial for the purposes of developing policies that are relevant and effective, but also for influencing uptake of resources which are developed.

- 14.152 The Inquiry also heard that while peer workers cannot replace hospital CL staff and clinicians, they can support clients in a clinical setting.²²⁶ Dr Dunlop, Hunter New England LHD, stated that '*peer workers can provide a great support, that nobody else can provide*'.²²⁷ Veronica Ganora, a peer worker and consumer representative, told the Inquiry that she had seen the effective and positive work that peer workers provide in health services. They are able to alleviate pressures on clinicians, as well as provide support and referrals for people who access the service. One of the key benefits of peer workers is that they can reach people who may not otherwise access mainstream services.²²⁸
- 14.153 The Inquiry also heard that peer workers can facilitate the transition from the hospital system to reintegrating with community services that are available, using knowledge of available services to provide a '*warm supported journey*' out of the hospital and back into the community.²²⁹
- 14.154 A report by the DPMP from 2018 indicates that peer workers can help to reduce stigma faced by people who use AOD seeking treatment in the healthcare system.²³⁰ The report also argues in favour of formalised arrangements so that peer workers or liaison officers can be employed in all welfare and support networks involved in treating people who use AOD.²³¹ Formal employment of peer workers in health care settings for people who use AOD may help to mitigate the challenges faced in recruiting appropriately trained staff to the field.

Recommendation 29:

That NSW Health grow and better utilise a peer workforce in the delivery of AOD services, including by investing in the development of an AOD peer workforce with formalised employment arrangements and structured clinical supervision where appropriate.

A workforce strategy for NSW

Existing workforce strategies

- 14.155 The Intergovernmental Committee on Drugs commissioned NCETA to develop a National AOD Workforce Strategy that ran from 2015–2018.²³² Although this strategy expired in 2018, it remains current until a further iteration is developed.²³³
- 14.156 There is a current NSW Health Professionals Workforce Plan 2012–2022, which was released in 2012 and refreshed in 2015. The plan outlines strategies to ensure NSW trains, recruits and retains doctors, nurses and midwives, oral health and allied health professionals, as well as non-clinical professions, in order to meet existing and future community needs.²³⁴
- 14.157 The NSW Ministry of Health advised the Inquiry that, in an effort to build the state-wide capacity of the NSW child and adolescent substance use workforce, it has established a Youth Addiction Fellowship using funding from the NSW Drug Package. The Ministry indicated that, in time, the sector will be able to employ those completing the Fellowship to create a sustainable workforce that responds to the needs of young people in NSW, and develop clinical leaders in this area of significant need.²³⁵

- 14.158 The Ministry has provided funding for three Fellowship positions in each of the 2018, 2019 and 2020 academic years.²³⁶ The Sydney Children's Hospital Network was funded for two Fellowship positions for each of these years, with one position based at the Children's Hospital at Westmead, and the other at the Sydney Children's Hospital, Randwick. Hunter New England LHD was funded for one Fellowship position to be based at the John Hunter Children's Hospital for each of these years. Since inception, the Fellowship has already facilitated the transition of some Fellows to staff specialist positions in all three Children's Hospitals in NSW.²³⁷
- 14.159 In addition, the Ministry of Health has provided funding over two years for seven AOD medical specialist training positions in 2019, and nine training positions in 2020. This includes funding for three training positions in regional areas in 2019 and five training positions in regional areas in 2020.²³⁸

The need for an AOD-focused NSW workforce strategy

- 14.160 Despite the NSW Health Professionals Workforce Plan 2012–2022, there is no NSW AOD-specific workforce strategy.²³⁹ The Inquiry heard that the establishment of such a plan is necessary in order increase and retain the number of qualified AOD workers who will be required to support the increase in withdrawal and rehabilitation beds needed to meet demand in NSW.²⁴⁰
- 14.161 In its submission, the RANZCP suggested that such a strategy be established and resourced to support ongoing education, training and capacity building in the sector, with a specific focus on recruiting and retaining suitably qualified staff in rural and remote areas. The RANZCP submitted that combining a state-level strategy with any new national workforce plan would provide supported training, specialist positions, and the allocation of Medicare items to allow for medical remuneration and sufficient time to deliver complex high-quality care.²⁴¹
- 14.162 The AMA NSW noted that in addition to NSW planning for immediate treatment needs, it should also strategically plan for downstream effects of long-term methamphetamine usage, particularly for people with high levels of cognitive dysfunction preventing independent living and who have difficulty finding placement in assisted-living facilities.²⁴² The AMA NSW noted that any strategy would also need to consider local workforce and training needs for the AOD workforce, especially in light of any anticipated undersupply in particular professions, such as a projected undersupply of psychiatrists in the coming years.²⁴³
- 14.163 A dedicated state-wide workforce development strategy would assist in mitigating the challenges faced by the AOD workforce described above. The strategy would help to ensure that the government and non-government AOD workforce is well positioned to meet the needs of people who use drugs, especially the increasing number of people presenting to AOD treatment services with amphetamine as their principal drug of concern.²⁴⁴ The workforce strategy should include a number of elements, each of which would assist in meeting this aim.
- 14.164 First, the strategy would include a detailed workforce profile, including size and key demographics, along with a forecast of future workforce needs based on projected AOD treatment needs. Comparing forecasted needs against the available profile of workers would enable the development of strategies to ensure that the workforce required to meet AOD demand can be adequately resourced.

- 14.165 Second, the strategy would address the difficulties recruiting and retaining staff, particularly in the NGO sector. One strategy relevant to the regional context would be developing methods to move health professionals into AOD specialist positions to support career pathways to AOD, medical, nursing and allied health specialities, including scholarships for people living in regional areas to defray the cost of AOD-specific training and accreditation. Supporting AOD workforce development in the regional context could also occur through the development of strategies to build capacity of the regional AOD medical and allied health workforce including by, for example, offering financial and workplace incentives to encourage people to move into regional areas. Further, given the nature of general practice, specific strategies to support GPs to undertake extended skills training would allow GP registrars to gain a deeper knowledge of AOD, leading to a more skilled general practice workforce and encourage more GPs to train as addiction medicine specialists.
- 14.166 Third, there is a need for strategies to strengthen the peer workforce, in recognition that they are well placed to engage people who are otherwise hard to reach and help them navigate treatment services.
- 14.167 Fourth, there is a need to focus on supporting the unique needs of the Aboriginal AOD workforce (these needs are discussed in Chapter 16).
- 14.168 Finally, there is a need to develop strategies to upskill the AOD workforce so it is responsive to the needs of people who use ATS. Given evidence of comorbidity of people using drugs (including ATS) who also have mental health needs, strategies should be developed to ensure the AOD workforce has appropriate training in mental health. Further, strategies to strengthen continuing professional development for AOD workers and the generalist workforce are needed, such as through online interactive training modules. Ongoing professional development is likely to increase the capacity of generalist workers to engage in screening, referral and intervention when dealing with people who use AOD, while ongoing professional development for specialist workers will increase the proportion of specialist workers with AOD-specific training. ATS-specific training will enable both specialist and generalist health workers to respond better to people who use ATS.

Recommendation 30:

That NSW Health, in collaboration with the NGO sector, develop an AOD workforce strategy to ensure that the government and non-government AOD workforce is well positioned to meet the needs of people who use drugs. This workforce strategy should include the following elements:

- a detailed workforce profile, including size and key demographics
- a forecast of future workforce needs based on projected AOD treatment needs, and strategies to ensure that the required workforce is available
- strategies to address the difficulties faced by the NGO sector in recruiting and retaining staff
- strategies to move health professionals into AOD specialist positions and to support career pathways to AOD medical and allied health specialties, including scholarships for people living in regional areas to defray the cost of AOD-specific training and accreditation, mentoring by senior clinicians and strategies to support GPs to undertake extended skills training in AOD
- a focus on strengthening the peer workforce, in recognition that peer workers are well placed to engage hard-to-reach people and help them navigate treatment services
- a focus on supporting the unique needs of the Aboriginal AOD workforce
- strategies to ensure the AOD workforce has the necessary skills to meet the specific needs of priority populations identified in the National Drug Strategy and in this report
- strategies to build capacity of regional AOD medical and allied health workforce including by, for example, offering financial and workplace incentives to encourage people to move into regional areas
- strategies to strengthen continuing professional development for AOD workers, such as through interactive online training modules
- strategies to ensure the AOD workforce has appropriate amphetamine-type stimulant specific training and training in mental health.

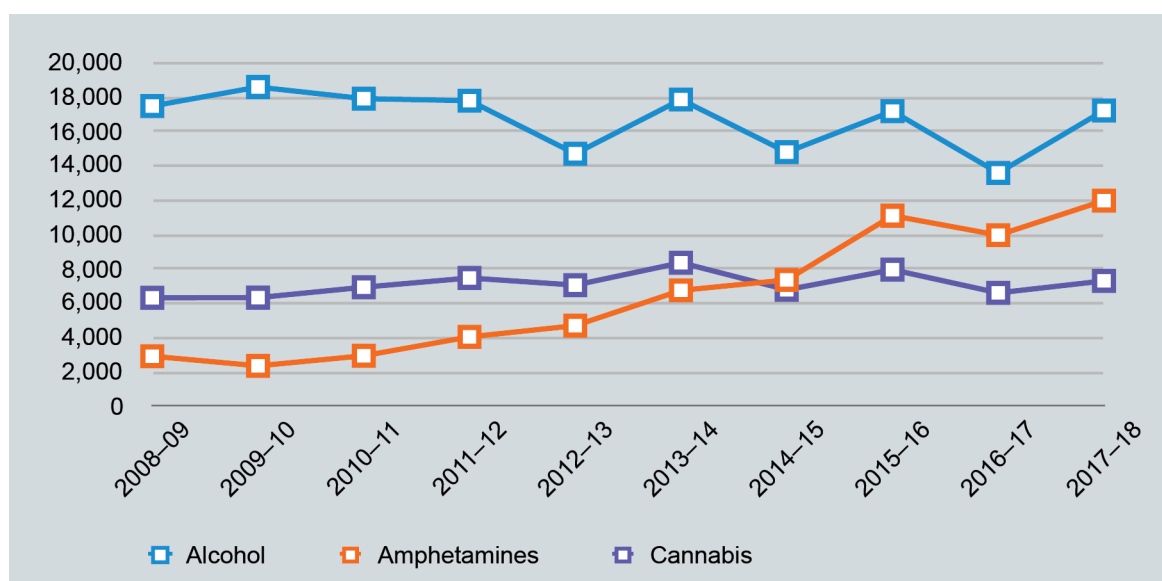
Demand and service utilisation

- 14.169 In Australia, AOD treatment services provide a broad range of services and support to people who use drugs, as well as to families or friends who may seek support for another person's drug use.²⁴⁵ As well as accessing AOD treatment services, people who use drugs also access other types of health care, including GPs, hospital emergency departments and community mental health services.
- 14.170 A recent report released by the Australian Institute of Health and Welfare stated that people who access AOD treatment services commonly experience multiple episodes of treatment spanning several years.²⁴⁶ For closed treatment episodes where amphetamines were the principal drug of concern, the majority (58%) were provided to people who accessed treatment on more than one occasion over multiple years.²⁴⁷ People who had accessed treatment for amphetamines were also more likely to access treatment at least once per year (17%) compared to the rate for all drug types (3%).²⁴⁸
- 14.171 In this context, the phrase 'treatment episode' refers to a period of contact between a client and a treatment provider, or team of providers. The treatment episode is considered 'closed' when treatment is completed, and there has been no further contact between the client and the treatment provider for three months, or when treatment has stopped.²⁴⁹

14.172 Accurate estimates of the impact of methamphetamine use on health services is dependent upon having reliable prevalence estimates.²⁵⁰ As described in Chapter 7, the prevalence of drug use is difficult to assess for a number of reasons, and available figures are generally underestimates. However, in 2013 and 2014 a review by the DPMP of AOD treatment data found that approximately 200,000 people receive AOD treatment across Australia in any one year.²⁵¹

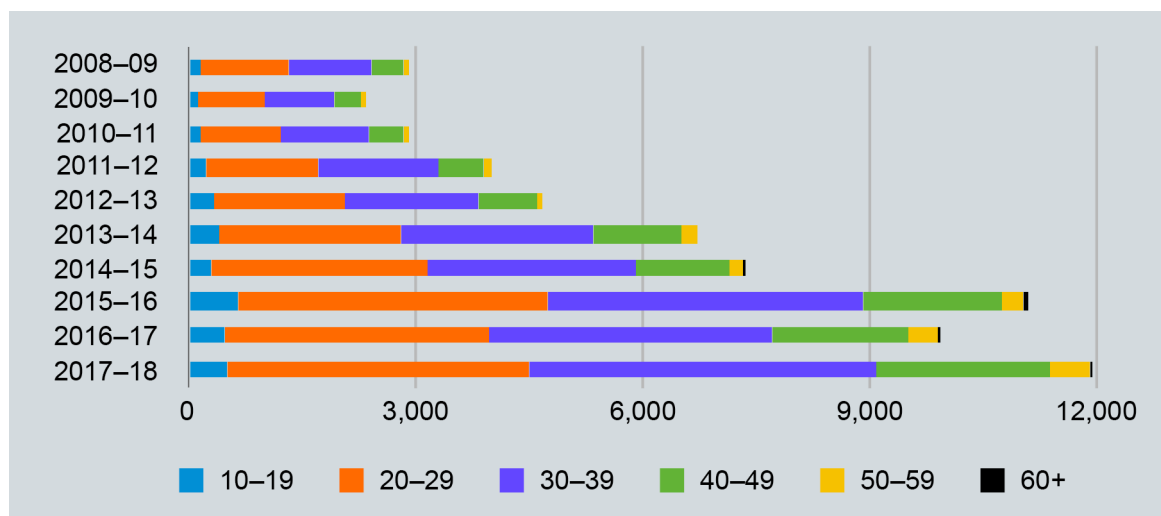
14.173 The available data suggests that amphetamines (not including MDMA) replaced cannabis in 2014–15 as the second most common principal drug of concern in NSW (alcohol was the most common).²⁵² See Figure 14.5 and Figure 14.6

Figure 14.5: Closed episodes provided for own drug use, by principal drug of concern, NSW, 2008–09 to 2017–18²⁵³



14.174 Across Australia, all age groups have seen increases in amphetamine treatment between 2008–09 and 2017–18. The 20–29 and 30–39 year age groups access the most treatment; however, the highest increases over time are in the 50–59 year age group (up 884%) and the 60+ age group (up 1,343%), although it should be noted that these age groups had a much lower base.²⁵⁴

Figure 14.6: Closed episodes provided for own drug use, by principal drug of concern (amphetamines) and age group, Australia, 2008–09 to 2017–18²⁵⁵



14.175 Evidence to the Inquiry confirmed an increase in treatment demand for methamphetamine use. Ms Crayden, The Buttery, told the Inquiry that 24% of people accessing The Buttery's services in 2018 reported methamphetamine as their principal drug of concern – a doubling of such reports received in 2014.²⁵⁶ Similar trends were reported during hearings in Sydney and regional areas, with some services indicating that upwards of 50% of their clients reported ATS as their primary drug of concern.²⁵⁷ Gerard Byrne, State Manager Alcohol & Other Drug Services (NSW, ACT, QLD), Salvation Army, told the Inquiry that:

*'... eight to 10 years ago, 55% of all of our treatments were for alcohol. These days, that's down around 38%. And, you know, we're now up into the ... whether it's primary or secondary drugs ... we're well up over the 50-odd per cent now for methamphetamine users.'*²⁵⁸

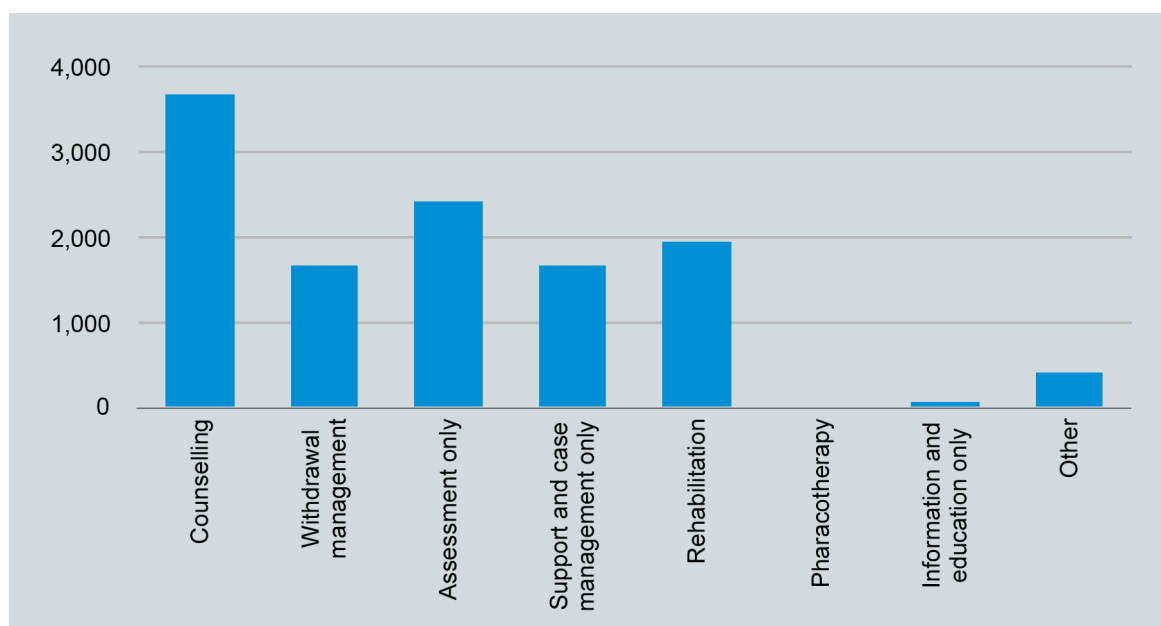
14.176 Norm Henderson, Weigelli Aboriginal Corporation, told the Inquiry that he would *'estimate we would have approximately 70 to 80 people come through our service per year, depending on the length of time people stay, and of that, approximately 75% have a problem with ice'*.²⁵⁹ Alan Bennett, CEO of Orana Haven Aboriginal Corporation Drug and Alcohol Residential Rehabilitation Centre, told the Inquiry that he has *'seen an increase in the number of people affected by ice and amphetamines use, particularly in the local area'*.²⁶⁰

14.177 As detailed above, the rate of people presenting to AOD treatment services with amphetamine as their principal drug of concern has increased in recent years, placing demand on an AOD treatment system that is already stretched. Clearly, this acts as a barrier for individuals trying to access services. However, it is also putting strain on service providers, with one witness telling the Inquiry that it can make even simple operational tasks, such as answering the phone, more difficult to attend to.²⁶¹

Type of treatment

14.178 The most common type of treatment delivered for amphetamine use in 2017–18 in NSW was counselling, followed by assessment only without further treatment²⁶² (see Figure 14.7). The prominence of ‘assessment only’ may indicate missed opportunities for individuals who may have benefited from some form of treatment.

Figure 14.7: Closed episodes provided for own drug use, by main treatment type and principal drug of concern (amphetamines), NSW, 2017–18²⁶³



Referral source

14.179 For all treatment types provided for amphetamine, almost half (45%) of people self-refer. The next most common referral source is through court diversion (15%), followed by correctional services (10%) and other AOD treatment services (10%). Just 4% are referred by a family member or friend, and only 2% are referred from either a medical practitioner, hospital or mental health service.²⁶⁴

14.180 Evidence given to the Inquiry noted that there was generally a ‘push’ for people to seek treatment for themselves:

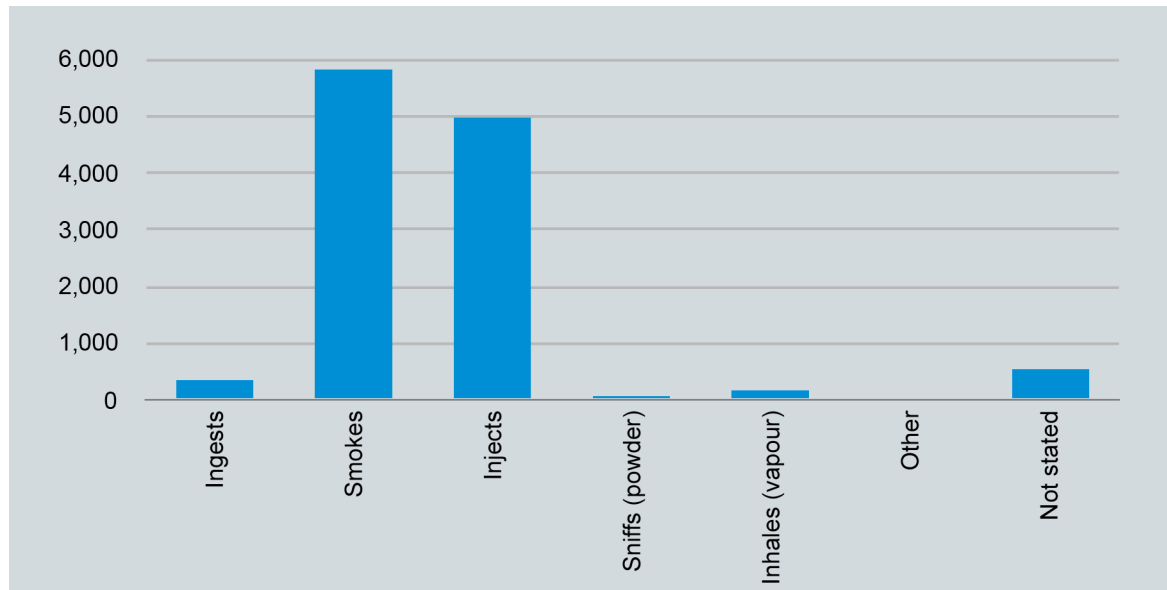
‘[N]ot too many people wake up in the morning and just decide to pop into rehab; there’s usually something pushing them. There’s usually a problem. Whether it be legal, whether it be their partner, whether it be family, there’s generally something pushing them.’²⁶⁵

14.181 The high level of self-referral may also be an indicator that the treatment system is not well coordinated.²⁶⁶

Type of drug use

14.182 Of those who are accessing treatment services in NSW for amphetamine, 49% report that they smoke the drug, and 42% report that they inject²⁶⁷ (see Figure 14.8). Across Australia, of closed episodes of treatment where amphetamine was the principal drug of concern, those accessing treatment who identified as Indigenous were more likely to inject compared to non-Indigenous (52% compared to 36% respectively).²⁶⁸

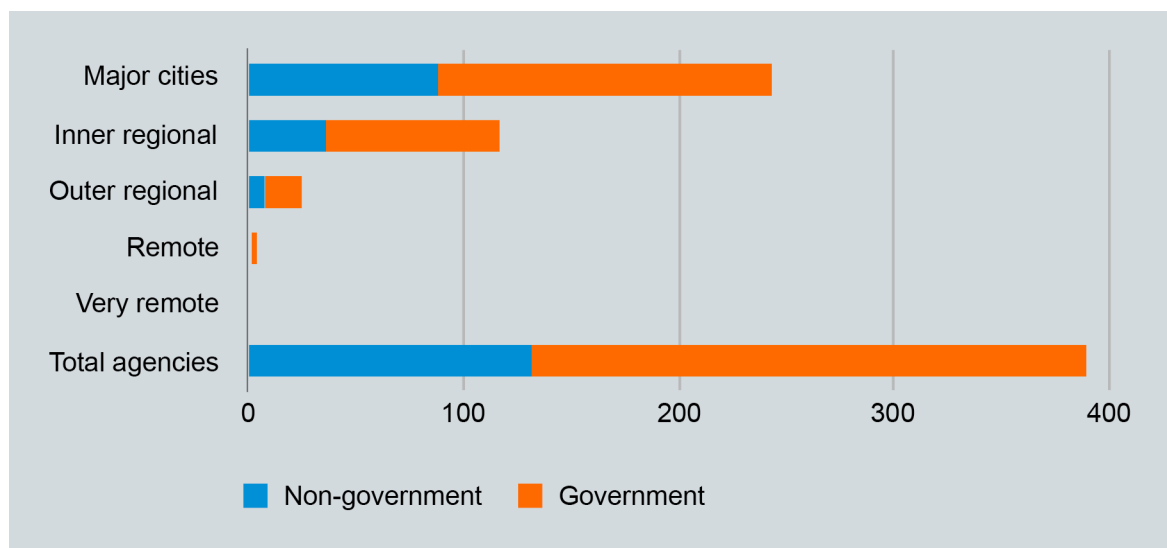
Figure 14.8: Closed episodes provided for own drug use, by principal drug of concern (amphetamine) and method of use, NSW, 2017–18²⁶⁹



Type of service

14.183 In 2017–18, there were 390 publicly funded AOD treatment agencies in NSW, with 63% of these located in major cities.²⁷⁰ Of all publicly funded AOD treatment agencies 66% were government agencies.²⁷¹ See Figure 14.9

Figure 14.9: Publicly funded treatment agencies, NSW, 2017–18, by remoteness area²⁷²



Focus of treatment programs

14.184 Associate Professor Yvonne Bonomo, addiction medicine specialist, noted that, like addiction treatment more broadly, treatment for ATS use needs to be tailored to the individual and should take into account the level of severity of their ATS use. A range of different treatments or foci can assist people in reducing their use of ATS, or in managing comorbid mental health conditions such as anxiety.²⁷³ This was echoed in a submission from St Vincent's Health Australia.²⁷⁴

- 14.185 The Inquiry heard evidence that the focus of treatment or therapeutic programs concerned with amphetamines is different to other drug types, due to the different effects of the drug. Shirley Diskon, Manager of Hope House in Bateman's Bay told the Inquiry:

*'We've also had to change some of the programs that we've done to actually focus on a lot of the domestic violence and a lot of the anger – the trauma that they've gone through – and we need to concentrate a lot on their self-esteem – their self-worth – because they're so down and out, which is a lot more than alcohol or any other drug that people present with.'*²⁷⁵

- 14.186 The Inquiry heard that the use of crystal methamphetamine has resulted in increased issues related to mental health, requiring a change in the way services are provided. Depression, anxiety and schizophrenia are relatively common, and the individual's mental health must first be stabilised before drug education and treatment can commence.²⁷⁶ Gabriella Holmes, Program Manager of Triple Care Farm, told the Inquiry that Triple Care Farm's new specialist withdrawal unit, opened in 2017, was designed to allow for the significantly longer withdrawal periods associated with methamphetamine and to provide close monitoring and support to address the increasing instances of young people using the service who were experiencing suicidal thoughts. This increase was said to coincide with a growth in the number of young people entering the program due to methamphetamine use.²⁷⁷
- 14.187 Turning Point, a national addiction treatment centre dedicated to providing high-quality, evidence-based treatment to people adversely affected by alcohol, drugs and gambling, recommends that stepped care approaches be used in the treatment of people who use methamphetamine, as this allows treatment to respond to client needs and risks. A stepped care approach begins with implementing the least intrusive treatment option, then increasing the intensity and adding treatments if the former approach is ineffective.²⁷⁸ Once an intervention is implemented, its effectiveness will be monitored for a period, along with other aspects associated with drug use and health, such as cravings or physical or mental health concerns. The intensity of interventions or treatments can then either be 'stepped up' or 'stepped down' depending on the needs of the client. The 'step up' or 'step down' of interventions can occur in a number of ways, for example, altering the frequency of treatment sessions, introducing new strategies or altering the delivery of an intervention.²⁷⁹ Research indicates that stepped care approaches have the potential to address challenges faced by both clinicians and clients in treating methamphetamine use problems.²⁸⁰ The Stimulant Treatment Program, described later in this chapter, involves a stepped care approach.²⁸¹

Impact on other health services

- 14.188 Research has found that people with dependent methamphetamine use have high rates of contact with health services in both acute and non-acute settings, and frequent use is associated with significantly more presentations to emergency departments and psychiatric hospitals.²⁸² Methamphetamine use has been estimated to have resulted in 28,400 to 80,900 additional psychiatric admissions to hospitals, and 29,700 to 151,800 additional emergency department admissions nationally in 2013.²⁸³
- 14.189 Further, one study found that people who use methamphetamine are approximately four times more likely than other people to be readmitted to hospital within 28 days of their last admission.²⁸⁴ This is significant, as unplanned hospital readmissions within 28 days are a KPI for LHDs.²⁸⁵

- 14.190 The Inquiry also heard about instances of people who use methamphetamine presenting to emergency departments on a recurring basis. One emergency clinician suggested that limited engagement with drug and alcohol services can lead to such recurring presentations:

*'[W]e see some patients recurrently ... for many months ... we do see a lot of repeat patients, especially those that have been difficult to engage with drug and alcohol [services] ... we do see frequent flyers, as we call them.'*²⁸⁶

- 14.191 Dr Andrew Olesnicky, director of the Emergency Department at Broken Hill Hospital, told the Inquiry that there is an identifiable group of approximately 20 people who recurrently present generally in relation to ATS use, some up to several times a week.²⁸⁷ He told the Inquiry that these *'habitual presenters tend to be aggressive/violent and recover poorly'*.²⁸⁸

Unmet need for treatment services

- 14.192 The DPMP estimated 200,000 to 500,000 people each year across Australia need and seek AOD treatment but do not receive it. Based on DPMP data, unmet demand is higher than met demand.²⁸⁹ The National Ice Taskforce recognised in their 2015 final report that *'unmet demand is a longstanding issue'*.²⁹⁰ In a submission to the Inquiry, St Vincent's Health Australia noted that for individuals and families experiencing harmful AOD use, *'life gets much harder when treatment services are not available'*.²⁹¹
- 14.193 The 2017 *NSW Parliamentary inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales* reported similar evidence and findings, with available spaces in withdrawal and residential rehabilitation facilities not meeting demand. The inquiry noted a *'severe shortage of beds'* and recommended that the NSW Government significantly increase funding to AOD health services.²⁹² The NSW Government has expressed in principle support for this recommendation.²⁹³
- 14.194 Evidence received by this Inquiry demonstrates that this issue remains unaddressed. A clinical nurse consultant from the Central Coast LHD put it simply, stating *'... we want to do more, because the need is there; the demand is there, but we can only do what [we can] – with what we've got'*.²⁹⁴ In its submission, the DPMP noted that *'[s]ervice delivery models of care are not matched to population need and current NSW Government investment is inadequate with substantial unmet demand for treatment'*.²⁹⁵ NADA highlighted resourcing issues and unmet demand as key challenges for the sector, and for individuals who are wanting to access treatment.²⁹⁶
- 14.195 The joint submission from the Matilda Centre and the Centre for Brain and Mental Health Research described a survey of people who have used crystal methamphetamine in which around one-third of NSW respondents reported that the availability of health services that provide support to people who use crystal methamphetamine was poor or extremely poor.²⁹⁷ The AMA NSW noted in its submission that demand for treatment often outstrips availability.²⁹⁸

- 14.196 The Inquiry heard about high levels of unmet demand for AOD services, indicating a lack of investment in specialist AOD health services.²⁹⁹ Unsurprisingly, the Inquiry received numerous submissions calling for an increase in funding for treatment services.³⁰⁰ The RANZCP submitted that there is a significant gap between clinical need and AOD service provision, particularly in rural and remote communities of NSW.³⁰¹ Garth Popple, We Help Ourselves, told the Inquiry that, in his view *‘the state government has not kept pace with the demand’*.³⁰² Larry Pierce, NADA, observed that:

*‘[S]ervices are now becoming so stretched and so unable to cope with the demand, and because the rising costs of service delivery have not been met by any significant increase in government funding ... we’re actually reducing bed numbers as we speak.’*³⁰³

- 14.197 Consistent with these observations, needs assessment reports from PHNs in areas visited during the Inquiry’s regional hearings recorded challenges associated with trying to access AOD treatment services. For example, according to the 2018 North Coast PHN Community Survey, about one-third of respondents with a stated AOD health challenge reported difficulties in accessing AOD services, GPs and other specialists.³⁰⁴
- 14.198 Triple Care Farm, which offers withdrawal, residential rehabilitation and community aftercare services for people aged 16 to 24, reported that inquiries for its services increased more than 50% between 2012 and 2018. It had an average of 231 calls per month in 2018, however, availability is limited to 10 places in withdrawal and 18 in residential rehabilitation.³⁰⁵
- 14.199 Kamira, a service specifically for women, pregnant women and women with children, reported that requests for access to its services increased 500% over the past two years. However, the service has been unable to meet demand for some time, only admitting 48 women from 605 requests for treatment in 2017.³⁰⁶
- 14.200 The lack of available treatment places can result in individuals not being able to get the help they need. One witness described the extreme effects this can have: *‘Sometimes it gets to a point where custody is their only option to be able to detox to then transition into those rehab facilities, which is less than ideal.’*³⁰⁷
- 14.201 The AOD challenges facing people in custody are discussed further in Chapter 20.

Recommendation 31:

That the NSW Government urgently increase its investment in specialist AOD health services to meet the significant unmet demand for services across the state.

Barriers to accessing AOD treatment

- 14.202 The Inquiry heard that individuals face a range of barriers in accessing treatment or support for ATS use. The literature notes that barriers can be systemic, practical and psychosocial. These barriers may relate to stigma, cost, concerns about confidentiality, perceptions that health care is not needed, a lack of appropriate or accessible services, or limited family or other support networks.³⁰⁸

Stigma

- 14.203 As detailed in Chapter 9, people who use ATS commonly face stigma and discrimination. This has a range of negative impacts, such as being a barrier to accessing treatment. The Inquiry heard that *'stigma is one of the most difficult things that our patients encounter in engaging with treatment'*.³⁰⁹ Such stigma can mean individuals feel they cannot access services, including emergency departments,³¹⁰ with one clinician saying:

*'[W]hen my patients suggest to me that they won't go to an emergency department in an emergency for fear of stigma and discrimination, that concerns me because there's nowhere else for them to go, and the perceived stigma for them is a real barrier to attending emergency departments.'*³¹¹

Wait lists and entry criteria

- 14.204 Wait lists for entry into residential rehabilitation were consistently raised as a significant barrier to treatment.³¹² NADA submitted that *'[a]s a result of a demonstrably underfunded sector, waiting lists are common and prioritising clients in need is a challenge'*.³¹³
- 14.205 A range of criteria also excludes many from entry into residential programs, often leaving people few options to address their use of ATS. This is discussed in detail below.

Cost

- 14.206 Accessing AOD treatment can cost money. The Inquiry heard in Nowra that along the south coast of NSW, people have trouble finding a GP who will bulk bill, which is a significant barrier to access.³¹⁴ The Inquiry heard that private residential rehabilitation facilities can have prohibitive costs of up to tens of thousands of dollars.³¹⁵

Geography

- 14.207 The Inquiry heard a significant amount of evidence about the challenge of accessing and providing AOD services in NSW, due in part to the size of the state and distribution of the population. This is particularly the case in regional, rural and remote areas. Norm Henderson from the Weigelli Aboriginal Corporation based in Darbys Falls, just east of Cowra, referred to the practical difficulties this can create:

*'A person needs to detox before they come to rehab, but there is a big bottleneck with detox. There is one in Orange run by Lives Lived Well, but it only takes seven people, and it is 4.5 hours away by car. There is another one in Armidale which is 8–9 hours away. Other than that, we have to send people to the Nepean Inpatient Withdrawal Unit in Sydney for detox.'*³¹⁶

- 14.208 In her report to the Inquiry, Associate Professor Bonomo, addiction medicine specialist, noted that one of the greatest challenges for treating ATS use disorder (see 5.28 for a definition of substance use disorder) is geographical isolation, noting that availability of services is significantly reduced in rural areas, particularly access to withdrawal and rehabilitation services.³¹⁷ Associate Professor Bonomo also indicated that resourcing issues, and bandwidth issues in some areas, can present a barrier to the implementation of telehealth options.³¹⁸

- 14.209 In Lismore, the Inquiry heard that specialised rehabilitation services are limited in the region, meaning that often patients are required to travel to Queensland to access affordable rehabilitation.³¹⁹ Similarly, the Inquiry heard that people requiring treatment for drug use in Broken Hill looked to South Australia to access such services.³²⁰ In Dubbo, Jason Crisp noted that transportation of patients to regional hospitals for mental health and AOD can leave small communities without access to an ambulance for significant periods due to the long distance travel required for transport.³²¹
- 14.210 As stated by St Vincent's Health Australia in its submission, evidence-based and patient-centred treatment and responses are urgently needed in rural and regional Australia.³²²

Models of care and treatment options

- 14.211 A variety of treatment options is available for people who use ATS, such as psychosocial therapies, withdrawal support and counselling.
- 14.212 Such services are provided by both government and non-government services in a range of settings such as primary care, residential rehabilitation, specialist clinics and hospitals.
- 14.213 In 2017–18, NSW had 390 services providing specialist AOD services, 258 of which were government and 132 non-government.³²³ The most common principal drug of concern reported by users of these services was alcohol (38.3% of closed episodes) followed by amphetamines (26.6% of closed episodes).³²⁴
- 14.214 People with health issues related to ATS use, including physical and mental health issues, present to generalist or mainstream health services such as GPs and emergency departments, as well as to specialist AOD services. For example, people who experience mental health issues related to methamphetamine use often present to mainstream health services.³²⁵
- 14.215 As described in Chapters 1 and 5, patterns of drug use vary considerably across individuals, as do the harms that a person may experience in relation to their use of drugs. This variation in both use and associated harms requires a service system that can provide treatment and support that is individualised. Tailoring service delivery to the needs of individuals is important and engaging with individuals during treatment can be an opportunity for education and harm reduction messaging. In a submission to the Inquiry, the AMA NSW noted the requirement for tailored treatment responses due to the addictive nature of ATS. The AMA NSW further noted that current treatment facilities such as emergency departments, acute care hospitals and general practice are not well suited to treatment of methamphetamine dependence.³²⁶

Acute care

- 14.216 Acute care is defined as the provision of medical or surgical care, generally for conditions or events that are immediate or short-term in nature.³²⁷ In NSW, acute care encompasses most care that is provided within public hospitals, including emergency departments.

- 14.217 People who use ATS may present to acute healthcare services for a variety of reasons, ranging from a condition which directly relates to the use of drugs (for example, intoxication) through to something that may be indirectly or not at all associated with the use of drugs, such as an injury. In evidence given to the Inquiry, Dr Robert Davies, Emergency Director, Tweed Hospital, said:

*'[P]atients may have injured themselves, hurt themselves, cut themselves, you know, so we will have people ... put fists through glass windows, punch walls, break knuckles, so there's – there's that first line sort of trauma stuff ... there is those sorts of injuries that need immediate care. Then there's the ... secondary agitation ... and the psychosis, mental illness, and then there's the more longer-term issues, in terms of if they're chronic IVD – injecting IV ... so bacterial infections, local infections, you know, of skin, cellulitis injecting areas, bacterial infections that affect heart, lungs, brain with bacterial endocarditis ... disruption of the heart valves, heart failure ... so there's a ... fairly wide spectrum ...'*³²⁸

- 14.218 Acute episodes of care, such as those provided in emergency departments, are often complex and require management of comorbidities and behavioural disturbances.
- 14.219 As detailed in Chapter 7, NSW Health has seen dramatic increases in ATS-related presentations to emergency departments and admissions to hospital over the past five years. This demonstrates increasing harms and increasing demand on acute health services.

Transfer of ATS-affected patients by ambulance

- 14.220 The Inquiry received evidence from paramedics from across the state.³²⁹ They told the Inquiry that mental health concerns are the most common presentation of patients using crystal methamphetamine, including agitation, aggression and violence.³³⁰ The Inquiry heard that the complexities of the clinical presentations of such patients, and the associated risk to themselves and the community, often lead to transport to hospital.³³¹ Such transport may be involuntary and may involve the use of sedation and restraint.³³² The Inquiry also heard that NSW Police Force officers are often asked to attend and assist paramedics in transporting patients to hospital due to unpredictable behaviour and noncompliance by those patients.³³³
- 14.221 The relationship between the NSW Police Force and NSW Ambulance in such circumstances is governed by the NSW Health – NSW Police Force Memorandum of Understanding 2018 Incorporating provisions of the *Mental Health Act 2007* (NSW) No 8 and the *Mental Health (Forensic Provisions) Act 1990* (NSW). The Inquiry heard that this memorandum of understanding is working well.³³⁴
- 14.222 The Inquiry heard that NSW Ambulance uses a system of caution notes that can be attached to an address within the Computer Aided Dispatch system and may be relied upon by paramedics where previous dangerous interactions have occurred with a patient affected by amphetamines at a known address.³³⁵ The note enables the paramedic to inform themselves of potential situations of risk, however, such notes do not specifically relate to crystal methamphetamine use, instead they alert attending paramedics to previous violent behaviour at the relevant address.

- 14.223 There was not sufficient evidence received by the Inquiry to justify any recommendations directed to NSW Ambulance. However, it is noted that the Inquiry heard that the process for paramedics to make appropriate referrals to AOD services could be improved, as there are presently no formalised referral pathways within NSW Ambulance protocols for paramedics to make such referrals.³³⁶ There was also some support for further training for paramedics directed specifically at dealing with ATS-affected patients,³³⁷ including from the Health Services Union.³³⁸

Emergency departments

- 14.224 Emergency departments have been described as the public face of a hospital, and are often what most people think of when they think of hospital.³³⁹ They are also often the first point of contact a person has with a hospital.³⁴⁰ Hospital emergency departments are defined by the ACEM as:

*'[A] dedicated hospital-based facility specifically designed and staffed to provide 24-hour emergency care. An emergency department cannot operate in isolation and must be part of an integrated health delivery system within a hospital both operationally and structurally.'*³⁴¹

- 14.225 In 2018–19, there were 2.98 million presentations to emergency departments in NSW.³⁴² This accounted for more than a third of the national total.³⁴³ Hospital emergency departments are increasingly seen as a point of access to health care for people with mental health, drug health and acute behavioural problems.³⁴⁴ This may be the case where other services are not easily accessible, such as after hours³⁴⁵ or in geographically isolated places,³⁴⁶ or for people who have English as a second language.³⁴⁷ For example, people in remote and very remote areas access emergency departments at a higher rate than those in metropolitan or regional areas.³⁴⁸
- 14.226 In its submission to the Inquiry, ACEM noted that methamphetamine-related presentations represented 2.3% of emergency department presentations in NSW.³⁴⁹ This proportion is higher than shown by data provided to the Inquiry by NSW Health on a select number of hospitals, although NSW Health indicated that the figures they provided are likely to represent a substantial underestimate. NSW Health indicated that the reason for this underestimate was that data collection for methamphetamine-related emergency department presentations relies on identification and recording of such information in triage text, presenting problem or diagnosis fields, which then proves difficult to comprehensively search while trying to minimise false detections associated with the term 'ice'.³⁵⁰
- 14.227 ACEM described methamphetamine presentations in emergency departments as being of high acuity and typically very resource intensive, as presenting patients have complex needs and require active care, greater clinical resources and longer emergency department lengths of stay for stabilisation.

Impacts on emergency departments

- 14.228 ATS-related presentations to emergency departments do not cluster on a particular day of the week or time of day,³⁵¹ and are generally triaged as being of high acuity. They also often lead to the presenting patient being sedated and/or restrained.³⁵² Given that methamphetamine has the capacity to increase an individual's risk of acute psychosis and agitation, emergency departments and ambulance services can be heavily impacted by patients presenting with methamphetamine-related health issues.³⁵³ ACEM submitted that:

*'AOD harm is one of the largest, preventable public health issues facing [emergency departments]. Due to the volume and nature of presentations, AOD harm can have detrimental effects on [emergency department] staff, other patients and accompanying persons, adversely affecting the way the [emergency departments] function.'*³⁵⁴

- 14.229 One lived experience witness explained being taken to a metropolitan emergency department after using crystal methamphetamine:

*'I was quite high and I couldn't be treated. I was given some Valium, but couldn't stay in emergency because I was screaming and disturbing other patients. My body was starting to close down and wanted to sleep, but the ice kept waking me up.'*³⁵⁵

- 14.230 The Inquiry was told that there are cases of very long delays in emergency departments for methamphetamine-related presentations, with patients waiting in emergency for up to 100 hours for a bed to become available in a mental health or drug and alcohol unit.³⁵⁶ Long delays in resuscitation bays, where many ATS-related presentations are taken, can negatively affect the flow of patients through emergency departments, which has a direct impact on other patient groups that also require resuscitation beds.³⁵⁷

- 14.231 A report from WA noted the results of a study which found that the average time in the Royal Perth Hospital emergency department for methamphetamine-related presentations was 11.4 hours.³⁵⁸ St Vincent's Hospital Sydney reported to the Inquiry that on average, ATS-related presentations spend longer in emergency than the average of all other presentations. For ATS-related presentations during 2018, those who were subsequently admitted to hospital spent an average of 9.7 hours in emergency, and those who were not admitted spent an average of 5.1 hours in emergency. In comparison, all emergency department presentations had an average stay in emergency of 8.5 hours for those subsequently admitted, and 3.8 hours for those not admitted.³⁵⁹ Data provided also showed that there were some instances of individual patients staying in emergency at St Vincent's Hospital for between 30 and 50 hours.³⁶⁰ Notably, the data provided by St Vincent's Hospital included all patient presentations to the emergency department, not just those who were admitted to hospital. NSW Health did not provide equivalent data.³⁶¹

- 14.232 NSW Health advised the Inquiry that it was unable to provide data on the length of stay of ATS-related emergency department presentations who were not subsequently admitted to hospital.³⁶² Of those who were admitted, NSW Health reported that there was '*no meaningful difference*' in the median length of stay in the emergency department for the ATS-related admissions (4 hours 6 minutes) when compared to all other unplanned emergency presentations that were admitted to hospital across the state (3 hours 59 minutes).³⁶³

14.233 It is important to note that the urgency and complexity of emergency department presentations varies considerably, ranging from those requiring resuscitation through to less urgent conditions, such as a skin rash.

14.234 In Dubbo, the Inquiry was told that patients who are affected by crystal methamphetamine impact greatly on the four-hour KPI target for emergency departments. Highly agitated or disordered patients may be sedated for up to eight or 12 hours, and the length of time they stay in emergency is dependent upon how long they sleep or how long they are affected by the drug.³⁶⁴

14.235 Clinicians who gave evidence to the Inquiry also reflected on the impacts of ATS on emergency departments and staff. When in an acute phase of their intoxication, patients were described as ‘*very violent and very dangerous*’, with ‘*unbelievable strength*’, creating a ‘*very volatile, dangerous*’ situation for staff.³⁶⁵ Others echoed this, noting that the use of ATS, specifically crystal methamphetamine, makes some people incredibly aggressive. One emergency clinician told the Inquiry that ‘*some of these patients want to do harm and they tell you so in no uncertain terms*’.³⁶⁶ These scenarios are distressing for staff, and there are concerns from senior clinicians that they will lose their workforce because of this.³⁶⁷ Dr Davies, Tweed Hospital, described the effects on staff during the Inquiry’s hearing in Lismore in the following way:

*‘For healthcare workers, you know, we go into the profession to help people and to have a subset of patients ... that want to do you harm in the course of you trying to care for them is very confronting. And so some staff get very distressed and dismayed and very much want not to be part of the care of those patients.’*³⁶⁸

14.236 While these challenges were noted, the resilience and understanding of health service staff was also clear in the evidence.

*‘[T]he aggressive, violent, dangerous behaviour, it’s a symptom of the disease. And I guess rather than just, as a staff member, looking at the patient and saying: “This patient is acting in a very nasty way” ... if they were looking at it saying: “This patient has signs and symptoms of a disease,” and you treat it as a disease.’*³⁶⁹

Inpatient wards

14.237 Inpatient wards care for people who are admitted to hospital directly or via the emergency department. Inpatient wards can provide care for:

- people with specific groups of conditions, such as mental health, cardiac or respiratory
- people receiving a particular type of care, such as post-surgical
- particular groups of people, such as children, adolescents or pregnant women
- a particular severity of illness, such as intensive care units.

Impact on inpatient wards

14.238 NSW Health provided data to the Inquiry on ATS-related emergency department presentations for hospitals across the state and what ward type the patient was admitted to from the emergency department. The data showed that people admitted to hospital with an ATS diagnosis are more than twice as likely than a control group to need intensive or critical care (9.2% vs 3.8% respectively) and around 22 times more likely to need psychiatric care (50.9% vs 2.3% respectively).³⁷⁰

- 14.239 Dr Marcia Fogarty, Executive Director of Mental Health for Hunter New England LHD, estimated that 10 to 15% of adult admissions to mental health units from the emergency department within her district are related to ATS. Dr Fogarty was of the view that patient care is complicated by the fact that there are no consistent models of care in place for managing ATS-affected individuals who are also agitated and displaying symptoms of psychotic behaviour. One of the major problems is that there are no medications to reverse intoxication.³⁷¹
- 14.240 Like emergency departments, inpatient wards in hospitals manage behaviourally disturbed patients. This can constrain resources due to the high level of care needed. One clinician observed that ATS-affected patients who are very resource intensive can be admitted two to three times per week to a single mental health ward.³⁷² Like emergency departments, patients with acute severe behavioural disturbance inpatient wards require high levels of intervention, constant supervision and constant support. This can take staff away from doing other forms of therapeutic work with other patients.³⁷³
- 14.241 Individuals who are affected by methamphetamine have been found to be twice as likely as other patients to be placed in a seclusion room during an acute mental health admission.³⁷⁴ Such seclusion episodes can increase patient agitation, and can also be *'very distressing and traumatising for the patient'*.³⁷⁵ The Inquiry also heard evidence of the need for sedation and restraint of patients, and the risks to staff in these situations, including the risk of assault and injury.³⁷⁶
- 14.242 However, it was also noted that staff in mental health wards are skilled in the management of people admitted in these circumstances:

*'[T]he emergency department is often not the best place ... to look after these individuals. And in mental health we have the skills – our nursing staff are – are highly skilled in – in managing behavioural disturbance. The psychiatrists are very familiar with the pharmacotherapy of managing behavioural disturbance. So often our – our intervention is necessary, and sometimes admission to our unit is the – the best course of action.'*³⁷⁷

The relationship between emergency departments and mental health wards

- 14.243 People who are affected by ATS and who attend an emergency department might receive treatment there or in an inpatient ward or both. Alternatively, they can be transferred to another facility or discharged. Decisions about the most appropriate form and place of treatment are usually made by an emergency clinician, often in consultation with other specialists within the hospital, such as those from mental health or drug health.³⁷⁸ The ultimate decision is based on both clinical need and available services and resources. NSW Health has 'Admission Policy'³⁷⁹ and 'Emergency Department – Direct Admission to Inpatient Wards'³⁸⁰ policy directives that guide decision-making about admissions to hospital.

- 14.244 However, the decision-making process can be complicated by many factors, such as intoxication. Severe intoxication can raise the question of whether any behavioural issues or psychotic symptoms are related to intoxication, and thus transient, or whether there may be an underlying mental health condition, with a more uncertain timeframe:

*'[U]sually [the emergency department and mental health unit] will collaborate. But, to be honest, often by the time we get to having that discussion the emergency department have had to intervene very quickly to contain and manage this person's behaviour, and often this requires very large doses of sedative medication. And then, therein comes the other dilemma, that the mental health unit is not the best place to manage people who are extremely heavily sedated, where their airway might be compromised. And I have been in the situation in the emergency department where we've had to give somebody a lot of tranquilisation, then it's difficult to do – and it's impossible to do an assessment because the patient is asleep. And then we are trying to get to this fine point about where they are sedated enough to give us a story, but they don't then become so aroused that they become a risk again, and we end up having to go back and having to tranquilise them all over again. So it's a real – I suppose a combination of art and science and collaboration and communication with the emergency department and the mental health physicians to try to find a way of how do we look after this person as best possible?'*³⁸¹

- 14.245 The Inquiry heard that there can be differences in clinical opinion between emergency departments and mental health wards regarding the admission of ATS-affected patients, which can lead to relationships becoming '*fraught*'. However, professional relationships and collaboration were noted as ways in which differences in clinical opinion are overcome.³⁸² In a report to the Inquiry, Dr Shalini Arunogiri, chair of the Binational Faculty of Addiction Psychiatry at the RANZCP, was of the view that severe intoxication presentations, particularly those coupled with ASBD, are best managed in emergency medical settings where appropriate monitoring and resuscitation support is available.³⁸³
- 14.246 The Inquiry also heard of situations where clinicians could see no appropriate place in which to manage people affected by ATS, with intensive care units having limited resources³⁸⁴ and mental health units considered inappropriate where behavioural issues are caused by intoxication rather than mental illness.

*'On some occasions I have seen patients where admission to the mental health unit has not been appropriate because the patient was suffering from amphetamine intoxication, which tends to be self-limiting, as the intoxication tends to run its course and once the patient is no longer intoxicated, admission to the mental health unit is not appropriate.'*³⁸⁵

Incidents involving patients affected by ATS

- 14.247 In 2008, safety and security issues relating to increasing crystal methamphetamine presentations were highlighted by the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals*.³⁸⁶

- 14.248 In 2017, the NSW Legislative Assembly Committee on Law and Safety found that there was significant violence against emergency service staff, most notably, police and ambulance officers. Drug and alcohol use was a contributing factor to this violence.³⁸⁷
- 14.249 In 2018, the NSW Ministry of Health commissioned a review into hospital security to improve the safety of staff, patients and visitors. The interim report released in February 2019 noted that individuals who are affected by alcohol or drugs, particularly crystal methamphetamine, pose significant challenges for emergency departments and hospital wards. Those with behavioural disturbances can increase security risks while waiting in emergency departments.³⁸⁸
- 14.250 Data from the NSW Bureau of Crime Statistics and Research shows that the number of police-recorded assaults occurring on hospital premises increased over a five-year period between October 2010 and September 2015.³⁸⁹
- 14.251 Throughout this Inquiry, evidence was received about the significant risks that hospital staff face when managing people affected by ATS. Aggression can turn to physical violence, often in circumstances where the individual is suffering from disturbed thought processes.³⁹⁰ The Inquiry heard of assaults on hospital staff that resulted in physical injuries and mental health trauma.³⁹¹

*'There are significant risks to staff in [emergency departments] of physical violence and a small but potential risk for transmission of infectious disease, including hep[atitis] C, where ATS-affected patients' behaviour escalates.'*³⁹²

- 14.252 NSW Health provided information on ATS and other drug-related incidents that had occurred at various hospitals across the state. Incidents ranged from verbal abuse through to physical assault of staff. Of the data provided to the Inquiry, there were only a relatively small number of incidents associated with AOD over a four-year period.³⁹³ However, it appears that NSW Health incident data may underreport incidents relating to violence and aggression, particularly those occurring in emergency departments.³⁹⁴ This was also noted by the AMA NSW in its submission to the Inquiry:

*'NSW doctors report several barriers to reporting these incidents. Not only is it time consuming, but staff are reluctant to become involved in the criminal justice process as a witness, particularly when no actions are taken against offenders by the courts.'*³⁹⁵

- 14.253 NSW Health advised that they are working to address this culture of underreporting across the system.³⁹⁶
- 14.254 It has been reported that more than 50% of people admitted to hospital with methamphetamine-related issues are aggressive towards staff.³⁹⁷ In emergency departments, around two-thirds of such people are aggressive towards staff and half are aggressive towards other patients.³⁹⁸ In one WA study, approximately 31% of people affected by methamphetamine attending an emergency department required the attendance of security staff on arrival, with a further 32% requiring subsequent attendance of security for staff safety.³⁹⁹

- 14.255 Clearly, the incidents described above can affect the physical, emotional and mental wellbeing of staff. An emergency department physician from the Royal Prince Alfred Hospital in Sydney noted that nursing staff turnover was high within the emergency department, and that a contributing factor for this was the need to deal with the increasing prevalence of ATS-affected patients.⁴⁰⁰ Others also noted the distress and anxiety that staff can experience:

*'The anxiety that having a severely behaviourally disturbed ATS-affected person coming into an emergency department, in particular, causes is phenomenal... We have been designed or created through our professional training to be compassionate and caring. So to then have to restrain and forcibly medicate somebody – and sometimes have to physically restrain somebody for a prolonged period of time while sedation works, is extremely traumatising. That's from a psychological point of view and a mental health point of view. There's also the perceived threat that I'm going to get assaulted ... I've had nurses, you know, in tears ... telling me about explaining to their child why mummy had a bruise on their face.'*⁴⁰¹

- 14.256 Concern was also expressed for the trauma experienced by people affected by ATS as a result of incidents that led them to be sedated:

*'I've had one client who required large doses of a particular anaesthetic that caused her to dissociate, which is where people lose contact with reality. Now, we weren't aware that that's what her experience was; we just thought that she was continuing to kick out and lash out, so she ended up getting more sedative medication. But she was extremely traumatised by that experience and, you know, it caused a lot of distrust. So this whole cycle is traumatising [for] everybody, and it's a dilemma about how to do it better.'*⁴⁰²

- 14.257 In a report provided to the Inquiry, Professor Daniel Fatovich, a senior emergency physician at the Royal Perth Hospital, highlighted that Australian research on patient experience of sedation for acute severe behavioural disturbance (ASBD) found that a trusting relationship is crucial to minimise the negative impact of coercive measures used while managing patients with ASBD.⁴⁰³ Those patients involved in the study generally agreed that restraint and sedation were the only options given the circumstances of their intoxication and disruptive behaviour. The study emphasised the importance of compassionate care and communication, as well as providing adequate information and follow-up.⁴⁰⁴

Acute severe behavioural disturbance (ASBD)

- 14.258 NSW Health defines ASBD as *'behaviour that puts the patient or others at immediate risk of serious harm and may include threatening or aggressive behaviour, extreme distress and serious self-harm which could cause major injury or death.'*⁴⁰⁵ These disturbances can include verbal abuse, threats, physical assaults, assaults with bodily fluid and aggressive behaviour. Individuals in this state do not generally respond to normal verbal interventions.⁴⁰⁶

- 14.259 The powerful psychostimulant effects of ATS can lead to aggressive and violent behaviour, which can present a challenge for staff in acute care settings. These challenges include managing patient care along with the personal safety of staff and other patients.⁴⁰⁷ This Inquiry heard extensive evidence on the existence and impacts of ASBD on emergency department care. Patients who present with behavioural disturbance may fall along a spectrum, with those at the top end being ‘*resource hungry*’ and ‘*problematic*’.⁴⁰⁸ These patients may be disordered, violent and aggressive, and ‘*are a significant risk to themselves and others*’.⁴⁰⁹
- 14.260 This kind of agitation and aggression is described in the literature. In a cohort of methamphetamine-related emergency department presentations in WA, more than three-quarters (77%) were agitated and almost two-thirds (64%) had at least one psychotic symptom. The majority (87%) required sedation on arrival.⁴¹⁰ Other studies have reported that methamphetamine-related presentations to emergency departments are significantly more agitated, violent and aggressive compared to other presentations, including other toxicology-related presentations.⁴¹¹
- 14.261 Patients with methamphetamine-related presentations are also more likely to display dangerous or homicidal behaviour, arrive with police, be significantly less alert, communicative and cooperative and more frequently require scheduling under the *Mental Health Act 2007* (NSW).⁴¹² These presentations can consume considerable resources and result in prolonged lengths of stay in the emergency department,⁴¹³ which can negatively impact outcomes for other patients.⁴¹⁴
- 14.262 During its hearing in Dubbo, the Inquiry heard that Dubbo Base Hospital would see approximately six presentations a week at the most severe end of the ASBD spectrum – those requiring sedation. Often, these patients would be brought into the emergency department by police.⁴¹⁵ Data provided by NSW Health showed that 10% of methamphetamine-related presentations to Dubbo Base Hospital arrived with police or corrections staff.⁴¹⁶ Responding to these patients requires significant resources, including multiple members of staff.⁴¹⁷ In rare cases, up to 15 staff might be involved.⁴¹⁸ Security staff were also reported as necessary in many cases.⁴¹⁹
- ‘Last Thursday, seven police were required to hold down a gentleman, probably 80 kilograms and that would take myself, three or four nursing staff, away from the positions they’ve been allocated during the day, and they would have to come and assist – plus mental health clinician as well.’*⁴²⁰
- 14.263 The Inquiry also heard of instances where patients are tasered to enable staff to do their job and care for these individuals.⁴²¹
- 14.264 This evidence is supported by the literature. One of the main tertiary hospitals in Sydney conducted a review of ASBD patients that presented to the emergency department. Over three-quarters were intoxicated, frequently from alcohol (47%), methamphetamine (31%) or a combination of alcohol and other drugs (15%). The median number of staff involved during the initial moments of sedation was 10, including medical, nursing and security staff and police. While sedating patients, 12% of staff members received an injury.⁴²²
- 14.265 The requirement for such high levels of staffing to attend to an individual patient has significant implications for resourcing in the state’s emergency departments. With increasing numbers of ATS-related presentations to emergency departments (as detailed in Chapter 7), these challenges are likely to increase.

NSW Health ASBD management guideline

- 14.266 NSW Health has an ASBD guideline, published in 2015, that provides direction for assessing patients, de-escalating situations, sedation, physical restraint and admission or discharge of the patient.⁴²³ There is also a policy which outlines the principles for the safe management of disturbed and/or aggressive behaviour.⁴²⁴ Evidence received by the Inquiry indicated that staff were aware of and used this guideline.⁴²⁵ Reports prepared for the Inquiry about the guidelines noted that they are contemporary, comprehensive, evidence-based and patient-centred. The only recommendations for improvements were to stipulate that female patients have a female staff member as part of the team managing them, and to review pharmacological sedation protocols.⁴²⁶
- 14.267 However, despite the apparent appropriateness of the ASBD guideline, the Inquiry heard a significant amount of evidence about the challenges ASBD patients present to emergency departments, and what might be done to address those challenges.

There is a need for short-stay behavioural units in NSW public hospitals

- 14.268 The management of ASBD in emergency departments creates difficulties for clinicians as the environment is very stimulating with '*lots of noise, lots of lights, lots of stimulation ...*'⁴²⁷ Patients who present under the influence of drugs may be in a heightened state, which can be exacerbated by such a stimulating environment.⁴²⁸ Accordingly, the NSW Health guidelines for managing ASBD recommends that assessments be conducted in a space where distractions are minimised.⁴²⁹
- 14.269 The lack of appropriately designed and designated spaces for the management of ASBD patients was highlighted repeatedly as an issue throughout the Inquiry's regional hearings. The Inquiry heard evidence of patients verbally and physically assaulting staff, as well as indirectly impacting on other patients due to the high level of staff needed to manage patients who are affected by ATS.⁴³⁰ The literature also describes these difficulties, with sedation of ASBD patients occurring in resuscitation bays alongside other patients.⁴³¹ The behaviours exhibited by patients who present with ASBD '*can cause considerable distress to other patients, relatives, staff and members of the public.*'⁴³²
- 14.270 One emergency department clinician told the Inquiry that there is often nowhere to put some ATS-affected patients, such as those who do not require mental health treatment or admission to a mental health ward.⁴³³ Current practice is to make use of available spaces, which can include leaving these patients in the emergency department for the duration of their recovery, or while awaiting mental health assessment. This assessment can be delayed if the patient is under the influence of drugs.⁴³⁴ Clinicians may need to wait until the patient is no longer intoxicated to assess them fully, particularly if it is unclear if violent or aggressive behaviour is due to the intoxication, or if there is an underlying mental health condition.
- 14.271 Without appropriate spaces and adequate resourcing within hospitals and across LHDs, risks can arise, such as patients discharging themselves.

*'[T]he agitated, aggressive, violent patient gets sedated and then it would be a matter of trying to get them to go through to Dubbo. Our hospital [Wellington Hospital] is very reluctant because of staff and when you ring Dubbo they are also reluctant to accept such a – a difficult patient, because of their own resources, and so the system just falls down, and usually the moment the patient sees an opportunity to discharge themselves, that's what happens.'*⁴³⁵

14.272 Time is also an important and complicating factor in the management of these patients. As noted above, patients experiencing behavioural disturbance due to ATS use can require more time in emergency than is contemplated by the four-hour KPI. While emergency departments are aiming to achieve KPIs, it is clear that this is not always possible.⁴³⁶ This was reiterated in a statement from Dr Paul Preisz, Medical Director, St Vincent's Hospital Sydney Emergency Department, who said patients who present with ASBD or complex comorbid medical, AOD and psychiatric needs rarely meet the four-hour target.⁴³⁷ Dr Scott Clark, Clinical Director of Mental Health and Drug and Alcohol Services in Western NSW LHD, told the Inquiry that it can be clinically appropriate to keep patients in emergency for longer than four hours, such as in cases of intoxication and delirium when they may require longer periods of higher-level or intensive medical care.⁴³⁸

14.273 The Inquiry heard that time-based KPIs in emergency departments can create tensions for clinicians who are managing ATS-affected patients: *'There is tension there sometimes, yes. And I might add that there is a lot of disagreement in the literature about the wisdom of the four-hour rule in the first place.'*⁴³⁹ This was further highlighted in evidence from Professor Fatovich, Royal Perth Hospital, who was of the view that the four-hour emergency department KPI was not suitable for highly complex and acute patients who present with ASBD. The safety of the patient, other patients and staff must remain paramount.⁴⁴⁰

14.274 The interim report of the review into security in NSW public hospitals recommended that safe spaces in emergency departments be supported.⁴⁴¹ A similar recommendation was also made by the NSW Legislative Assembly Committee on Law and Safety's *Inquiry into violence against emergency services personnel* in their report released in 2017. It recommended:

*'That NSW Health consider the use of purpose-built rooms or areas within emergency departments to assess aggressive and behaviourally disturbed persons, particularly patients affected by mental health issues, drugs and/or alcohol.'*⁴⁴²

14.275 The NSW Government supported this recommendation; however, its response to that inquiry describes safe assessment rooms.⁴⁴³ Safe assessment rooms were a recommendation from the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals*, primarily directed to smaller hospitals, whereas larger hospitals were recommended to have a psychiatric emergency care centre (PECC). The PECC recommendation arose from an identified need for a safe area to assess and treat mental health patients, with Commissioner Peter Garling SC noting in his report that the safe assessment rooms that were in place at the time were often not available for mental health patients as they were *'occupied with people presenting with the effects of drug and alcohol abuse...'*⁴⁴⁴

14.276 Based on the evidence heard throughout this Inquiry, safe assessment rooms appear to be an inadequate response to managing ASBD in emergency departments, and more specifically, for those that are ATS-related. Safe assessment rooms should not be considered a substitute for an appropriate space to manage ASBD, particularly when exacerbated by drugs and alcohol. In her report to the Inquiry, Dr Arunogiri, RANZCP, said that PECCs and other short-stay models are:

*'... designed to manage high-acuity mental health presentations but not behavioural disturbance. Such units have explicit exclusion criteria relating to aggression, agitation or violence. As such, these units are not the best fit to manage ASBD, which is a frequent feature of the ATS toxidrome.'*⁴⁴⁵

- 14.277 Models of care with designated spaces have been introduced in Australia specifically to manage the complexities associated with patients who present with ASBD, including by taking them out of the emergency department and thereby avoiding the application of the four-hour KPI. These models are discussed below.

Behavioural Assessment Unit at the Royal Melbourne Hospital

- 14.278 At the Royal Melbourne Hospital, a behavioural assessment unit (BAU) is co-located with the emergency department to fast-track the admission of patients affected by acute intoxication, mental illness or psychosocial crisis. The six-bed unit has been specifically designed to be safe and secure, allowing close observation, and providing timely access to specialist expertise and facilities for the appropriate use of sedation and restraint as required. It increases privacy and decreases stimulation. The open unit consists of four cubicles and two unlocked single rooms, an interview room and a medication preparation area. Fixed and personal duress systems are installed and the area is monitored by security staff via closed-circuit television. The unit is staffed by two to three nurses at all times and by a psychiatrist or psychiatric registrar every morning. The unit is co-located with emergency mental health and AOD clinicians to improve access to early intervention.⁴⁴⁶
- 14.279 The Inquiry visited the BAU and was informed of the following. The BAU model of care is short stay (under 24 hours) and for patients with behavioural disturbance, regardless of aetiology.⁴⁴⁷ If patients present with significant mental or physical health comorbidities, they are not considered an appropriate admission for the BAU. The average length of stay in the BAU is approximately 21 hours. Demand for the BAU has been increasing, with around 800 patients admitted quarterly (up from around 300 per quarter in 2016). Prior to the BAU being in place, all BAU type patients were breaching the four-hour emergency department target.
- 14.280 The BAU has strong governance structures in place, with emergency staff specialists determining admissions to beds in the unit, and a memorandum of understanding with the mental health unit supporting decision-making around which patients are admitted to the BAU or to psychiatric wards. A very low proportion of patients are subsequently referred through to a hospital ward following their admission to the BAU, indicating that these decision-making processes work well. The BAU has a minimum 3:1 staff to patient ratio with 24-hour nursing staff.⁴⁴⁸
- 14.281 The results of an evaluation of the BAU showed a substantial reduction in emergency department length of stay, a reduction in the median waiting time to be seen, a reduction in the median time to see an emergency mental health clinician, a reduction in security alerts for an unarmed threat, and a small reduction in patients having mechanical restraint or therapeutic sedation.⁴⁴⁹ The Victorian Department of Health and Human Services released a guideline for BAUs in 2017 which outlines recommended parameters of use, staffing, room design and equipment.⁴⁵⁰

PANDA at St Vincent's Hospital, Sydney

- 14.282 Construction of a specialised unit to be co-located with the emergency department is currently under way at St Vincent's Hospital. The PANDA (Psychiatry, Alcohol, and Non-prescription Drug Assessment) unit has been designed to meet the needs of patients who present with complex comorbidities. It was described to the Inquiry that the cohort of patients that will meet the criteria for admission to the PANDA are a group who otherwise have no appropriate admitting consultant and no appropriate physical ward for admission, due to them being too mentally unwell for a medical ward and too medically unwell for a psychiatric unit. Up to 15% of patients that present to St Vincent's Hospital emergency department require the type of specialist care that PANDA has been designed to provide.

- 14.283 Without a designated space for these patients, St Vincent's Hospital advised that patients have been managed in beds in corridors or unstaffed areas within the emergency department.⁴⁵¹
- 14.284 The PANDA unit has been designed as a six-bed short-stay (48 hour) unit. It is a medical unit in its own right, rather than a subspace of the emergency department. The unit is within a secured 'safe zone', with entry and exit via secure swipe or proximity card. A mental health assessment area will also be located in the zone, with assessment rooms, meeting rooms, chairs and other options to facilitate assessment of patients. It will involve acute medicine, clinical pharmacology, AOD and psychiatry services.

Similar models proposed at other hospitals in NSW

- 14.285 The Inquiry heard that Nepean Hospital, Sydney, is commissioning a new emergency department in 2022. As part of that development, there is a proposal to establish a four-bed BAU which will be classified as an inpatient emergency short-stay unit. The unit will provide a low stimulus environment for patients presenting with behavioural disturbance. A model of care for the unit is still being determined, however, the anticipated patient inclusion criteria includes those with acute and chronic AOD use, patients in psychosocial crisis, patients who present with behavioural disturbance, and patients who are recovering from acute toxidromes secondary to a drug overdose who are unlikely to require a multiday stay. Staffing for the unit is proposed to include emergency, toxicology, AOD and mental health physicians and nurses, as well as social work and other teams as required.⁴⁵²
- 14.286 Another major tertiary hospital, the Royal Prince Alfred in Sydney, has identified the need for different spaces to safely manage ASBD patients. In a prospective observational study of patient presentations requiring sedation for ASBD in the emergency department, it was reported that an increase in aggression and violence is in part due to increasing presentations of patients who are intoxicated. The study demonstrated that managing these patients within the emergency department can be dangerous and resource intensive. Alternate dedicated spaces would separate ASBD patients from others with urgent health problems.⁴⁵³ Dr James Edwards, Acting Director of the emergency department at Royal Prince Alfred Hospital, provided a statement to the Inquiry which noted the impacts of ATS presentations on resourcing and on other patients requiring urgent care.⁴⁵⁴

Design and staffing requirements for a specialist unit to manage ASBD

- 14.287 Based on the material before the Inquiry, essential elements of the design requirements for a specialised space or unit to manage ASBD include:⁴⁵⁵
- high visibility of the space and patients
 - low stimulus environment, including limiting lights, noise and windows or doors looking out to busy environments
 - access to tea or coffee for patients to feel comfortable
 - entry and exit points to be secure where possible, although patients should not feel 'trapped' and staff should be able to move freely in and out of the area
 - availability of medical equipment (including, but not limited to, resuscitation, cardiac and other vital sign monitoring, and sedation)
 - availability of physical restraints
 - as few potential risks as possible, such as ligature risks and equipment that could be picked up and thrown
 - appropriate and readily available security
 - established links to other services
 - consideration of the personal safety of staff

- ability to move patients to a step-down area once settled and medically cleared
 - input from patients into the design of the unit.
- 14.288 Professor Fatovich, Royal Perth Hospital, described why these designated physical spaces are needed:
- 'A dedicated physical space is an essential requirement for contemporary practice in this field. A place that is physically separate from the main [emergency department] clinical area but has the necessary facilities (e.g. resuscitation equipment). It needs to be a low stimulus environment (e.g. quiet), and enable the provision of respectful care that preserves privacy. These features allow the patient to feel safe, while internally they may be in a raging torrent of agitation, paranoid fear and psychosis (out of touch with reality). ASBD should be managed in ways that show decency, humanity and respect for individual rights, while effectively and efficiently managing the risks. These risks are harm to the patient with ASBD, the risks to other patients, and the risks to staff.'*⁴⁵⁶
- 14.289 It is clear from the evidence before the Inquiry that the staffing model for such a unit needs to be multidisciplinary and led by senior medical staff. Common staffing requirements should include:⁴⁵⁷
- emergency physicians/staff specialists (ideally with toxicology experience or expertise, or with this available on-call)
 - co-located emergency mental health and AOD clinicians (including addiction medicine and or addiction psychiatry)
 - specialist emergency and mental health nursing staff
 - a high nurse to patient ratio (such as 2:1)
 - presence of specialist psychiatry staff
 - social worker(s)
 - security staff, located within or very near to the unit and with monitored surveillance
 - provision of in-reach from community support services.
- 14.290 Governance of the unit needs to be well articulated, with clear lines of authority and admitting rights. The training of junior staff should be undertaken to ensure the future workforce is skilled in this model. The development of models should also consider how referrals and access to beds and outpatient services can be streamlined and/or prioritised, as presentation to a unit of the kind described above may be a critical opportunity to engage people in further care, support and treatment.
- 14.291 The above requirements are highly specialised and resource intensive. This level of skill and resource may be difficult to achieve in some settings, such as in rural or remote emergency departments. Design and staffing should therefore be considerate of local needs and capacity when planning the model of care to meet the needs of these patients.
- 14.292 Short-stay behavioural models, like the BAU and PANDA, were identified by three independent expert witnesses to the Inquiry as appropriate settings to manage ASBD and substantial improvements on mainstream emergency department settings. PANDA was described as an excellent model and a credit to those involved in its development.⁴⁵⁸ The Inquiry suggests that PANDA be evaluated in the short-to medium term to ensure it is achieving its intended outcomes, and to benefit future models by understanding what works and what may require improvement.

- 14.293 In response to the evidence of Professor Fatovich, Associate Professor Bonomo and Dr Arunogiri, NSW Health noted its support for service arrangements similar to the BAU or PANDA models, but also indicated that due to the resource intensive nature of these models that they would not be appropriate for all emergency departments in the state. NSW Health further considered that there was risk in diverting too many resources to BAU or PANDA models as *'there is no evidence to support these arrangements as a "best-buy" for reducing methamphetamine-related harms or outcomes'*.⁴⁵⁹
- 14.294 Based on the evidence heard by the Inquiry, short-stay behavioural units akin to the BAU and PANDA can improve outcomes for both patients and staff in acute and inpatient contexts. Accordingly, there would be significant benefit in NSW Health developing a model of care for such a unit and ensuring adequate funding to support the implementation of any such model.

Recommendation 32:

That as a matter of priority, NSW Health investigate the development of behavioural short-stay units within or co-located with emergency departments for the management of patients with acute severe behavioural disturbance, including by:

- developing a model of care, including guidance on design requirements, staffing and arrangements for telehealth input between metropolitan and regional, rural and remote locations
- prioritising funding for required capital works to support local health districts in implementing this model of care
- monitoring and evaluating the implementation and outcomes of the PANDA unit at St Vincent's Hospital.

Other ways to improve acute care provided to people who use ATS

- 14.295 There is a high prevalence of AOD morbidity among people who present to emergency departments, and this is often unidentified at the time of presentation or admission. This may be due to a range of factors, such as the presentation not being AOD-related, routine AOD screening of all patients not being undertaken, or non-disclosure by patients.
- 14.296 Identifying these people and appropriately treating and referring them can improve their outcomes as well as reduce the impact of AOD presentations on hospitals.⁴⁶⁰

Screening patients for AOD use in emergency departments

- 14.297 An accurate understanding of drug use and harm in NSW is affected by the identification of the use of drugs when a patient presents to a health service, often for what may be an unrelated matter. A lack of screening for problematic AOD drug use may contribute to missed opportunities for early intervention and referral into appropriate treatment or support.
- 14.298 The Inquiry received evidence that emergency departments may not be the most appropriate place to conduct such universal screening, however, they are also often the first point of contact for those whose use of ATS has or will become problematic. This creates a tension between the desire for a more accurate picture of drug use and harm, and types of screening that are reasonable or achievable in an emergency department setting.

- 14.299 The ability to screen every patient that presents to an emergency department, for various conditions was described to the Inquiry as '*unattainable*' and '*counterproductive*'.⁴⁶¹ Emergency department staff are already '*overburdened with their core business*'.⁴⁶² The ability to screen every patient for AOD issues is hampered by resourcing and time constraints.⁴⁶³ Further, screening everyone for AOD use may create barriers to people accessing emergency departments if they feel AOD issues are always raised, regardless of whether AOD use was a contributing factor to their presentation. The Inquiry heard that screening is more appropriately done on a case-by-case basis, to ensure it is appropriate.⁴⁶⁴ When AOD screening is deemed appropriate, clinicians should have tools available to support this.
- 14.300 The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) by international researchers and clinicians as a tool to support early identification of substance use in healthcare settings. WHO and the University of Adelaide have resources and guides available for the use of ASSIST.⁴⁶⁵ The screening questionnaire includes questions on ATS and takes 5 to 10 minutes, and generates a risk score that recommends a level of intervention.⁴⁶⁶ An instructional video for administering ASSIST with people who use methamphetamines is available via the Cracks in the Ice website.⁴⁶⁷ The Inquiry heard evidence that ASSIST-Lite, an ultra-rapid screening tool based on the ASSIST tool, could support emergency department staff to better assess patients and initiate clinical pathways.⁴⁶⁸ ASSIST-Lite takes approximately 3–5 minutes to complete and aims to identify the risks associated with substance use and provide personalised feedback to explore options for intervention.⁴⁶⁹
- 14.301 More research is needed to determine the usefulness of AOD screening and brief interventions to better understand outcomes. Dr Arunogiri, RANZCP, suggested that a pilot could be run in a subset of LHDs to test the feasibility and effectiveness of ASSIST in the NSW context. A further option suggested by Dr Arunogiri is trialling a one-question pop-up option in the electronic medical record that specifically asks the clinician if they thought the presentations was related to ATS. This has been successfully piloted in WA.⁴⁷⁰ If screening is broadly taken up by emergency departments, it is likely that dedicated staffing would be required.⁴⁷¹
- 14.302 In response to the evidence of Professor Fatovich, Associate Professor Bonomo and Dr Arunogiri, NSW Health reiterated that there is a need to not overburden clinical staff with the collection of data.⁴⁷² NSW Health suggested that in the emergency context, implementation of screening is complex and uptake is usually low. This was attributed to the multiple competing demands and considerations of timing and appropriateness in the emergency setting and also in the context of intoxication, psychological distress and acute behavioural disturbance.⁴⁷³
- 14.303 The response argued that before implementing a routine screening approach to better identify and manage AOD use, the likely benefit that would derive from such screening should be considered against key measures. Such measures include: the ability to '*distinguish intoxication from non-dependent recreational use, intermittent or continuous heavy use and dependence*'; the availability of a suitable screening tool or test; an agreed policy on whom to treat; the availability and accessibility of treatment services, and the cost of screening.⁴⁷⁴
- 14.304 The Inquiry has considered the evidence and the submissions of NSW Health on this matter. The Inquiry considers that introduction of AOD screening in emergency departments is desirable. To avoid the potential overburdening of practitioners with a process of universal screening, the Inquiry recommends that screening be undertaken when clinically indicated.

Recommendation 33:

That NSW Health train staff to conduct AOD screening when clinically indicated, and refer for treatment as appropriate.

Hospital-based consultation liaison

- 14.305 The CL model of care operates across NSW Health and plays a key role in the assessment and management of AOD-related conditions during hospital presentations and/or admissions. The central aims of the model are to enhance the safety, clinical outcomes, quality and efficiency of services for patients with substance use disorders in hospital settings.⁴⁷⁵ Importantly, these roles can facilitate better linkages with local AOD treatment services,⁴⁷⁶ which can improve patient care pathways. NSW Health has published guidelines on the model of care as a framework for health services to implement these roles.⁴⁷⁷
- 14.306 These roles work between emergency departments and other hospital services including mental health, women's, children's and substance use in pregnancy services.⁴⁷⁸ Through facilitating better linkages with local AOD services, the roles can support the matching of patients to a treatment that meets their needs in a timely way.⁴⁷⁹
- 14.307 The Inquiry consistently heard evidence of the benefits of the CL model, and the important role it plays in engaging and managing people who use drugs who have accessed acute hospital services.
- 14.308 Dr Wilson, RACGP, told the Inquiry that CL services with a specific focus on comorbidities can improve links and referral pathways between different services types.⁴⁸⁰ The Inquiry also heard support for the utility of CL workers with stimulant-specific training,⁴⁸¹ with Dr Robert Davies, Tweed Hospital, suggesting that patient interaction with a stimulant program CL nurse in the Tweed Hospital Emergency Department has led to better patient outcomes.⁴⁸²

*'You certainly get the feeling that they get to engage them ... while they're actually in the emergency department, and they actually get contact and make that connection with those patients. There's a lot higher uptake of those patients actually following up with the drug and alcohol service.'*⁴⁸³

- 14.309 The Inquiry heard that there are not enough staff undertaking this role, despite there being high demand for the services they can provide. The Inquiry heard from a number of witnesses that more CL staff would be welcomed.⁴⁸⁴ This would increase coverage and make the services they provide more effective, and would help engage patients and reduce re-presentations to hospital.⁴⁸⁵ Staff working in CL roles were described as '*amazing*', '*worth their weight in gold*', and able to provide a service that nobody else can provide.⁴⁸⁶ They were also said to bring together different teams in often challenging environments, working not only in emergency departments, but across the whole hospital or even multiple hospitals.⁴⁸⁷

- 14.310 A key area for improvement indicated by evidence to the Inquiry was that CL staff are generally not available outside standard business hours, which can mean that patients presenting after hours and on weekends miss the opportunity for this engagement, with negative consequences.⁴⁸⁸ As one clinician noted, *'if you're not there at the time to offer that service, then, unfortunately ... they can be back out into the community and re-using within days'*.⁴⁸⁹ Further challenges are faced in regional and rural areas, with fewer staff and less access to specialist AOD services.⁴⁹⁰
- 14.311 An evaluation of the CL model in NSW reported that, from a survey of patients who presented to eight selected emergency departments in NSW, more than one-third had an AOD problem. However, only 10% of these patients received AOD CL services in hospital. Of greater concern was that only 25% of those patients who required intensive AOD treatment or referral to specialist assessment received AOD CL services.⁴⁹¹ The evaluation demonstrated that CL services were related to improvements in emergency admission performance, improvements over time in the cost of emergency department presentations, and increased uptake of appropriate pharmaceuticals. The net benefit of the AOD CL services was a saving of at least \$100,000 per hospital per year.⁴⁹²
- 14.312 The evidence set out above demonstrates the enormous benefit of hospital AOD CL roles in the public health system. The ability of these roles to reduce readmissions to hospital⁴⁹³ and reduce re-presentations to emergency departments⁴⁹⁴ is beneficial to both patients and the system, and supports NSW State Health Plan goals.⁴⁹⁵ As noted earlier, CL consultations have been included as a KPI in LHD service agreements, commencing from 2019–20.⁴⁹⁶ This means that LHDs have targets in place for CL services that will be monitored and reported at a state level. Each LHD must either maintain or increase the number of CL consultations during the financial year to be considered *'performing'* against this KPI. This demonstrates that NSW Health recognises that CL services warrant further investment.
- 14.313 However, despite the clear benefits of CL roles, including the financial benefits as indicated by the evaluation referred to above, funding appears to remain a barrier to their wider implementation across NSW Health.⁴⁹⁷ In its submission, St Vincent's Health Australia supports that CL services be adequately funded and available for extended hours.⁴⁹⁸ The lost opportunity from the lack of availability of CL staff outside of ordinary business hours is of particular concern and should be addressed.

Recommendation 34:

- A. That NSW Health increase investment in hospital drug and alcohol consultation liaison services through targeted funding for positions that expands state-wide coverage, including for availability outside of business hours.
- B. That NSW Health engage with local health districts and clinicians to develop appropriate amphetamine-type stimulant specific training resources for consultation liaison staff.

Specialist alcohol and other drug services

- 14.314 Specialist AOD services tend to deal with either the short-term management of withdrawal (also known as detoxification), or with the longer-term management of maintaining rehabilitation. There are some services that provide both withdrawal and residential rehabilitation, along with other services, such as Odyssey House in Sydney.⁴⁹⁹ The Inquiry heard evidence that people will often need to go through withdrawal before they can access residential rehabilitation.⁵⁰⁰ In other evidence it was described that these treatments are not a step-wise process, and not everyone needs residential rehabilitation following withdrawal.⁵⁰¹
- 14.315 This section of the chapter refers to the 'Pathways to Residential Rehabilitation Project' undertaken by NSW Health in 2018. Following consultation with service providers and service users, the project delivered 16 Improvement Directions to guide current and new policy, activities and projects to support better access to AOD treatment. The final report of the project was provided to this Inquiry.⁵⁰²

Withdrawal management

- 14.316 The experience of withdrawal from drugs differs from individual to individual, and between different drug types. The impacts of withdrawal on individuals are described in Chapter 1.
- 14.317 Withdrawal from ATS can be severe, and can be a factor that impacts on relapse.⁵⁰³ Withdrawal symptoms are largely resolved within two weeks of abstinence; however, extended withdrawal periods can be a significant barrier to recovery.⁵⁰⁴ Research suggests that cravings may persist for up to three months or longer following cessation of methamphetamine use.⁵⁰⁵ However, the Inquiry heard that when people are supported through withdrawal and after not using a drug for a few weeks, significant cognitive remediation may be seen, allowing patients to then engage positively with other services.⁵⁰⁶
- 14.318 The NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines state that withdrawal from stimulant drugs, such as amphetamines, is not medically dangerous.⁵⁰⁷ This is consistent with evidence heard by the Inquiry, with Dr Helliwell, Riverlands Drug and Alcohol Service, saying that:

*'It's one of the messages that I think we'd both like to get across is that amphetamine withdrawal is not severe. It's not life-threatening, but in terms of aftercare, it is crucial that people have good evidence-based aftercare for a significant period of time.'*⁵⁰⁸

- 14.319 Withdrawal management, previously known as detoxification, can support people to stop their use of drugs while minimising the experience of unpleasant symptoms and risks of harm. Once withdrawal is complete, individuals can work with healthcare providers to determine their ongoing treatment or management strategies.⁵⁰⁹

Types of care and support provided

- 14.320 The Alcohol and Other Drug Withdrawal Guidelines from Turning Point, a national addiction treatment centre, note that while withdrawal from stimulants is not life-threatening, a thorough clinical assessment and managed withdrawal may be warranted. People who are withdrawing from ATS should be regularly monitored, including for psychiatric disturbances.⁵¹⁰ The primary aim of the withdrawal is to attend to complications and engage the patient in relapse prevention. Symptomatic medications may be used to help alleviate some of the symptoms experienced during withdrawal.⁵¹¹

14.321 A NSW Health fact sheet on treatment for crystal methamphetamine describes that withdrawal services usually provide support for three to 14 days.⁵¹²

14.322 The National Centre for Clinical Research on Emerging Drugs (NCCRED) noted that withdrawal is not a standalone treatment option, and that it should be a first step on a treatment journey.⁵¹³ Other evidence supported this, such as Mary Wahhab, Clinical Nurse Educator, South Western Sydney LHD, who told the Inquiry's Health Responses Roundtable:

*'I think it is really important to make sure that there's an adjunct treatment. So they also need, in addition to pharmacological ... they also require ... psychological treatments as well ... CBT motivation type treatments that would actually support their recovery.'*⁵¹⁴

14.323 Withdrawal was described as '*a prelude to treatment*', as engagement with aftercare is extremely important.⁵¹⁵ Jennifer Frendin, Program Manager Community Services, Odyssey House, told the Inquiry:

*'[I]f they go into a withdrawal unit, they need support post-withdrawal; they can't just go back out into the street or into home. They actually need that ongoing support.'*⁵¹⁶

Settings in which withdrawal management can be provided

14.324 Withdrawal management can occur in different settings.⁵¹⁷

- At home – undertaking withdrawal at home is often a preferred option, and may be particularly appealing for people who use psychostimulants. During home-based withdrawal, a person is supervised in their home by a carer and receives daily visits from a registered nurse or GP.
- Ambulatory (or outpatient) – a person attends a local drug treatment service or hospital daily, or sees their GP daily or every second day, while living at home.
- Community residential settings – these are used when a home environment is not supportive of withdrawal, or ambulatory options are not possible or have not been successful in the past.
- Hospital or other specialist setting – this may be appropriate in instances of severe dependence or an expected complicated withdrawal, or if the person has significant psychiatric complications.

14.325 Most people who are withdrawing can be safely managed in the community with regular monitoring by a GP or other health professional. If there is evidence of significant polydrug use, psychotic symptoms, severe depression or medical complications, an inpatient setting may be more appropriate.⁵¹⁸ This comes down to clinical decision-making based on individual needs and the supports available. Evidence to the Inquiry noted that even those who have been using crystal methamphetamine for many years may not require a bed in an acute care facility.⁵¹⁹

14.326 NSW Health's Drug and Alcohol Withdrawal Clinical Practice Guidelines note that ambulatory withdrawal should always be considered as the first option.⁵²⁰ The appropriateness of this option is dependent on the circumstances of the individual.⁵²¹ In some cases, they may not have a safe space for this to occur, such as if a young person does not have a safe home environment.⁵²² Similarly, an environment where an individual has easy access to people who deal drugs, or where there is ongoing drug use, will not be conducive to ambulatory withdrawal.⁵²³ In addition to a safe environment, the Inquiry heard that culturally appropriate models and support from GPs was required for successful ambulatory withdrawal.⁵²⁴

- 14.327 The Inquiry undertook a survey of withdrawal providers in NSW, and of those who responded (n = 26), only seven indicated that they offered ambulatory or at-home withdrawal services.⁵²⁵
- 14.328 In summary, the Inquiry heard that ambulatory withdrawal should be more readily available.⁵²⁶ Intensive residential or inpatient withdrawal is needed only by a minority of people with ATS use disorder.⁵²⁷ Accordingly, as articulated by Dr Adrian Dunlop, Hunter New England LHD, all models of withdrawal should be available on a case-by-case basis to best meet patient needs. The Inquiry heard that ambulatory withdrawal could be easily provided with appropriate resourcing and could be a more efficient model of care, as hospital-based withdrawal is the most expensive model and not all patients need to come to hospital to withdraw.⁵²⁸ Similar findings were reported in the Pathways to Residential Rehabilitation Project undertaken by NSW Health in 2018. The project found that access to withdrawal, and subsequently residential rehabilitation, could be improved through expanding withdrawal services into more settings, such as outpatient or GP-managed settings, and made an improvement direction to *'[e]xpand availability and access to withdrawal management services, including ambulatory and short-stay stabilisation'*.⁵²⁹

Recommendation 35:

That, in alignment with Improvement Direction 13 of the Pathways to Residential Rehabilitation final report, NSW Health promote and facilitate increased access to ambulatory withdrawal for amphetamine-type stimulants in clinically appropriate circumstances. This should include appropriate support for the workforce, including GPs, to deliver care in non-acute settings.

NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines

- 14.329 The NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines⁵³⁰ were published in 2008 and are currently under review.⁵³¹
- 14.330 The guidelines are comprehensive and provide general principles of withdrawal management, as well as guidance for clinicians to safely manage withdrawal for a range of substances, including psychostimulants (amphetamine, ecstasy and cocaine). The key objectives for managing withdrawal from psychostimulants are to support the patient to interrupt a period or pattern of compulsive use, identify and manage comorbid conditions, and initiate relapse prevention treatment.⁵³² Ongoing assessment and regular monitoring is required, particularly as signs and symptoms of mental health conditions can fluctuate over time. Managing the high prevalence of comorbid physical and mental health conditions requires that withdrawal services have adequate resourcing and coordination with medical and psychiatric services. Continuing care, such as through post-withdrawal services, is required, as is harm reduction messaging for those who plan to continue the use of stimulants or other drugs.⁵³³
- 14.331 Expert evidence to the Inquiry noted these guidelines are aligned to best practice, however, the ATS section could be strengthened by providing information on:⁵³⁴
- ATS withdrawal during pregnancy and in young people
 - domestic and family violence
 - assessment of suicide risk.

- 14.332 Other evidence from Dr Dunlop, Hunter New England LHD, suggested that while there have not been major evolutions in amphetamine withdrawal management, updated guidelines are important and these should reflect the more up-to-date health service system in which they are operating.⁵³⁵
- 14.333 NCCRED advised that it is contributing to the update of NSW Health's guidelines, but noted that the current lack of evidence underpinning clinical guidance is of concern. More efforts should be made to increase the evidence base.⁵³⁶
- 14.334 The Turning Point withdrawal guidelines are a current and useful source of information and guidance, including for specific population groups.⁵³⁷

Recommendation 36:

That NSW Health, as part of the current review and update of the NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines, ensure the Guidelines:

- address the needs of priority populations who use amphetamine-type stimulants, such as pregnant women and young people
- guide the delivery of culturally appropriate and trauma-informed care during withdrawal from amphetamine-type stimulants
- include guidance and information on domestic and family violence, mental health conditions and suicide risk, given their association with amphetamine-type stimulant use.

Residential rehabilitation

- 14.335 Residential rehabilitation involves psychological care for people in an alcohol and drug-free residential community setting. These services are usually indicated for people who have used drugs for a long period of time, who have dysfunction in their lives, who suffer significant harms from their use of drugs, and whose social networks are supportive of continued drug use. While this is the case, this cohort should not be considered the sole treatment population.⁵³⁸
- 14.336 There is considerable variety across residential treatment services. Types of programs include:
- short-term residential treatment, often provided in conjunction with a medically supervised withdrawal program
 - longer-term residential treatment over three to 12 months
 - low intensity residential treatment and extended care, in which clients live semi-independently with support
 - opioid substitution treatment tapering to abstinence.
- 14.337 Some residential rehabilitation services provide programs for populations with specific needs, such as young people or women with children.⁵³⁹ For example, Phoebe House in Sydney offers maintenance on the opioid treatment program in a residential environment for women with children.⁵⁴⁰
- 14.338 Some residential rehabilitation programs describe themselves as '*therapeutic communities*', which emphasise an holistic approach to treatment and address the psychosocial and other issues behind substance use. The '*community*' is thought of as both the context and method of the treatment model, where both staff and other residents assist the resident to deal with their drug dependence.⁵⁴¹

- 14.339 Other residential programs deliver regular treatment to residents, such as counselling, skills training and relapse prevention, to address the psychosocial causes of drug dependence.

Lack of withdrawal facilities

- 14.340 The Inquiry heard a significant amount of evidence about the difficulties people face gaining access to residential rehabilitation. Entering residential rehabilitation often requires that an individual has first completed withdrawal. There can be difficulties if the services are not delivered by a single provider or are not well linked. Further, a lack of withdrawal management services can create a bottleneck for those seeking placement into rehabilitation.⁵⁴² The Inquiry heard that the transition from withdrawal to rehabilitation is 'bumpy',⁵⁴³ despite providers working hard to support the process.⁵⁴⁴ One medical witness said they have never seen a rehabilitation admission organised immediately after withdrawal.⁵⁴⁵ Clearly, there can be negative impacts for individuals if they cannot access services when required. Ms Crayden, The Buttery, said: '*What happens is people detox, they go out, they don't get into rehab, they relapse again. So that's a constant battle.*'⁵⁴⁶ Dr Edward Wims, Clinical Director and psychiatrist in the Northern NSW LHD, also said that delay in accessing residential rehabilitation following withdrawal is a '*missed opportunity*' for patients when they are '*in a state of readiness to change*'.⁵⁴⁷
- 14.341 This disconnect between withdrawal and rehabilitation may be due to resourcing constraints, as residential rehabilitation facilities often do not have the appropriate staff, capacity or capability to manage withdrawal. This may be particularly the case if someone has attributes that complicate withdrawal, such as a physical or mental health condition.⁵⁴⁸
- 14.342 Even in those circumstances where withdrawal has taken place, formal arrangements between withdrawal facilities and residential rehabilitation facilities may not be in place to transfer patients in a timely way. This can mean patients are required to do the groundwork to find themselves a place,⁵⁴⁹ where there are a number of barriers to doing so.
- 14.343 The NSW Young Lawyers Criminal Law Committee submitted that where evidence such as written approval for admission to a rehabilitation facility is provided, lengthy adjournments, bail and deferrals of sentencing pursuant to section 11 of the *Crimes (Sentencing Procedure) Act 1999* (NSW) are reportedly '*granted with relative ease*' when deemed appropriate to allow access to residential rehabilitation. However, the submission indicated that many Young Lawyers members reported facing lengthy wait times and difficulties communicating with service providers when seeking access for clients with ATS dependence to rehabilitation.⁵⁵⁰

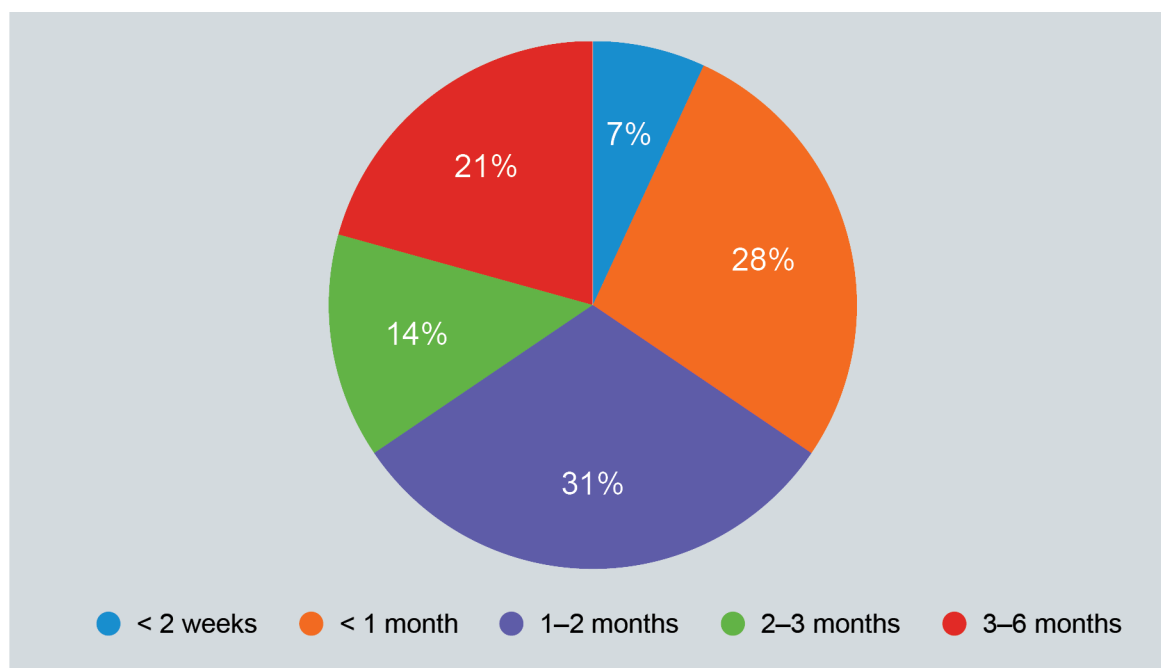
Wait lists

- 14.344 Long waiting lists were identified to the Inquiry as a major barrier to entry into rehabilitation. The Inquiry undertook a survey of 34 residential rehabilitation facilities across the state, including the 25 NSW Health-funded residential rehabilitation services listed on the NSW Health website.⁵⁵¹ Of the services contacted, 29 responded and two-thirds of these facilities had typical wait lists of two months or less. Approximately 14% had waits between two and three months, and the remaining 21% had waits between three and six months. See Figure 14.10

- 14.345 Ms Crayden, The Buttery, gave evidence that the wait list for entry into The Buttery's therapeutic community *'is increasing, but it's fairly steady. We're usually around about 50 or 60 people waiting on our waiting list at any one time.'*⁵⁵² Rhiannon McMillan, a clinical nurse consultant for the Western NSW LHD told the Inquiry that:

*'[t]here's a waiting list everywhere for drug and alcohol treatment, for residential programs. It's – I've rang certain places, and they've said, "Yes. We can do a detox. Haven't got a rehab bed for at least another eight weeks." It's a state-wide issue. It's been a state-wide issue for a long, long time...'*⁵⁵³

Figure 14.10: Typical wait times for entry to a residential rehabilitation place in NSW, 2019 (n=29)



Note: Percentages have been rounded to the nearest integer.

- 14.346 The Inquiry heard from numerous witnesses who have experienced substantial waiting times to secure places in residential rehabilitation services.⁵⁵⁴ One witness told the Inquiry: *'To be waiting six months to get into The Buttery is ridiculous. In six months I could have been dead. I have seen plenty of people my age get to that point and not make it.'*⁵⁵⁵ More than half of residential rehabilitation facilities surveyed identified non-contact as a reason why someone would be removed from wait lists – with the onus for this contact generally being on the individual who is attempting to access treatment. This is despite evidence that individuals who use crystal methamphetamine can be leading chaotic lives, and often have less motivation and commitment to maintaining this contact.⁵⁵⁶
- 14.347 Submissions to the Inquiry noted that the lengthy wait times in being able to access residential rehabilitation are problematic.⁵⁵⁷

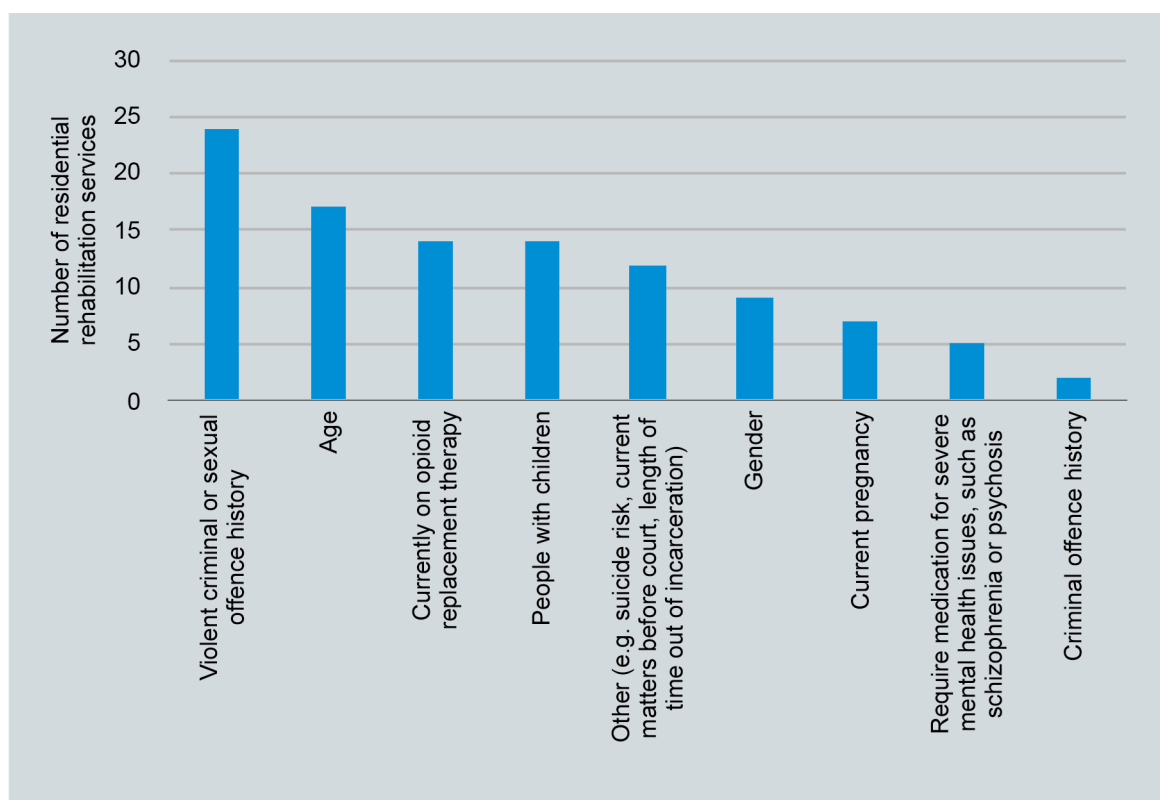
14.348 People who are aggressive or abusive on their call may also be removed from a wait list.⁵⁵⁸ It is not clear how this subjective assessment is made, or what other assistance is provided to people in such cases. Some services noted that their intake, assessment or referral teams aim to maintain engagement with people to keep them on wait lists. Others said they were not funded to undertake this type of outreach.⁵⁵⁹ As noted in this chapter and elsewhere in the report, aggressive behaviour is not an uncommon manifestation of methamphetamine use. The removal of people from wait lists for displaying this kind of behaviour may be a major barrier to access to treatment for those who may need it.

Exclusion

14.349 All residential facilities have the option of excluding people from care, as shown by the Inquiry's survey of residential rehabilitation facilities. See Figure 14.11

14.350 Most (83%) exclude those with a violent criminal or sexual offence history, almost half (48%) exclude those on opioid substitution therapy, and about one-quarter exclude women who are currently pregnant. A number of facilities exclude individuals who require medication for severe mental health conditions, such as schizophrenia or psychosis, and some do not accept people at high risk of suicide. For example, The Buttery does not accept people with '*severe mental illness [who] are on psychotropic medications such as people with schizophrenia that are on any of the antipsychotics.*'⁵⁶⁰ It was noted that this was due to not being funded to have medical staff on site who can dispense medications.⁵⁶¹

Figure 14.11: Residential rehabilitation services, exclusion criteria, 2019 (n=29)



- 14.351 Such exclusions were also highlighted in oral evidence before the Inquiry, namely for those people with intersecting kinds of marginalisation.

*'[A] lot of rehab services in NSW exclude you if you're homeless. A lot of them exclude you if you're mentally ill. A lot of services will exclude you if you have multiple – so if you're on treatment for opioid dependence or anxiety, you will be excluded for a service, and we have quite specific examples of that, and stigma excludes people from services.'*⁵⁶²

- 14.352 Some service providers do have flexibility in applying their exclusion criteria, with many stating they undertake risk assessments on a case-by-case basis.⁵⁶³
- 14.353 Many respondents to the Inquiry's survey were not able to provide information on how many people had been excluded from their facilities over the past two years. Those who did have this data available reported a very broad range of numbers of people excluded, ranging from only a few up to around 200 to 300 people.⁵⁶⁴
- 14.354 Submissions to the Inquiry noted the existence and impacts of exclusion criteria in residential rehabilitation facilities.⁵⁶⁵

Approach to and effectiveness of treatment

- 14.355 An Australian longitudinal study demonstrated that, compared to those in a control group (not in treatment), individuals in residential rehabilitation for methamphetamine dependence were significantly more likely to have reduced their methamphetamine use. However, these positive effects were time-limited, with longer-term follow-ups at one and three years showing that use levels had risen again to what would have been expected if they had not received treatment or had received detoxification alone.⁵⁶⁶ The finding of this study highlights the nature of methamphetamine dependence, and that it is chronic and relapsing in nature. It is consistent with anecdotal evidence heard by the Inquiry. For example, Andrew House told the Inquiry in Broken Hill that he dropped out of rehabilitation seven times before ceasing amphetamine use.⁵⁶⁷
- 14.356 There are also questions over whether or not residential rehabilitation is suitable for people seeking to reduce amphetamine use.⁵⁶⁸ Further research is needed to better understand barriers to compliance and how retention could be improved in these settings, as well as how individual improvements can be sustained over time. However, it is noted that when asked if he considered the first seven attempts as failures, Mr House told the Inquiry:

*'No, no, they were – every one was a significant intervention. Like, every time I went back – and the reason I kept going back, because I knew there was something there that would work for me, and I had hope for the first time in my life. I knew there was a way out. I saw people that were like me that were living drug-free. I saw the way they were. I saw how alive they were. I saw how they were actually embracing and supporting each other. I saw how they were actually being able to meet responsibilities. You know, I was pretty sort of impressed, you know, by the people that had sort of gone before me. So, yes, I was – it gave me a lot of [hope], you know.'*⁵⁶⁹

- 14.357 NSW Health's 'Drug and alcohol treatment guidelines for residential settings'⁵⁷⁰ provide principles for effective treatment, taken from the United States National Institute on Drug Abuse.⁵⁷¹ They are that:

- no single treatment is appropriate for all individuals
 - treatment needs to be readily available
 - effective treatment attends to multiple needs of the individual, not just his or her drug use
 - an individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs
 - remaining in treatment for an adequate period of time is critical for treatment effectiveness
 - counselling (individual and/or group) and other behavioural therapies are critical components of effective treatment for people with drug dependence
 - medications are an important element of treatment for many people in treatment, especially when combined with counselling and other behavioural therapies
 - dependent or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way
 - medical detoxification is only one stage of treatment and by itself does little to change long-term drug use
 - treatment does not need to be voluntary to be effective
 - possible drug use during treatment must be monitored continuously
 - treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counselling to help modify or change behaviours that place those being treated or others at risk of infection
 - recovery from drug dependence can be a long-term process and frequently requires multiple episodes of treatment.
- 14.358 The Inquiry notes that NSW Health's AOD treatment guidelines for residential settings are more than a decade old, and that best practice approaches may have evolved since their publication.
- 14.359 Notably, the integration of treatment of comorbid drug and mental health conditions does not seem to be occurring as a general rule. As described above, individuals may be excluded from treatment if they require medication for severe mental health conditions. A submission from the NSW Young Lawyers Criminal Law Committee also noted the lack of rehabilitation services that can effectively treat people with AOD and mental health comorbidity.⁵⁷²
- 14.360 Dr Arunogiri, RANZCP, noted that, given the high prevalence of comorbid AOD issues and mental health conditions, *'the existence of mental health conditions should not be accepted to serve as a barrier to treatment'*. Dr Arunogiri suggested that existing barriers could be overcome by:⁵⁷³
- bolstering AOD workforce capacity in residential rehabilitation settings
 - enhancing (and mandating) access to specialist mental health input
 - setting up a quality and safety framework that enables near misses, critical incidents and complaints relating to mental health comorbidity to be escalated appropriately.
- 14.361 Further, Dr Arunogiri was of the opinion that the absence of specialist psychiatric input into residential rehabilitation models of care is concerning, as the period of abstinence within these settings:
- '[O]ffers individuals a rare opportunity to reflect on the interaction between substance use and mental health symptoms, and specialists (e.g. addiction psychiatrists) a unique opportunity to provide diagnostic clarification and conclusive mental health diagnoses.'*⁵⁷⁴

Recommendation 37:

- A. That, to best manage and treat comorbid patients, NSW Health ensure that access to specialist mental health input is available in all alcohol and other drug services, including those provided by non-government organisations.
- B. That further to Improvement Direction 15 of the Scoping Project, NSW Health work with service providers to:
 - improve equity of access to people negatively affected by current entry requirements to residential rehabilitation
 - ensure the capacity of residential rehabilitation services to dispense medication, including antipsychotic medication.

NSW Health Pathways to Residential Rehabilitation Project

- 14.362 As described above, NSW Health undertook the Pathways to Residential Rehabilitation Scoping Project in 2018 to better understand current access to AOD residential rehabilitation in NSW.
- 14.363 A number of findings from the project were notable, and of relevance to this Inquiry:⁵⁷⁵
- publicly available information about AOD treatment options and how to access them are currently inadequate
 - service users continue to experience stigma and discrimination from treatment services
 - entry and/or exclusion criteria are not made clear and can prevent access altogether
 - service users reported a better experience and better outcomes with services who provided a range of support or coordination, such as wait-list supports and pre-treatment care coordination.
- 14.364 The 16 Improvement Directions for the sector to better address the needs of service users are as follows:
1. Expand content and public availability of AOD treatment information, options, pathways and service provider contacts on NSW Ministry of Health, LHD/specialist health network and funded NGO websites and social media.
 2. Provide clearer and additional information about the process and requirements for accessing residential rehabilitation services through the NSW Ministry of Health and funded NGO websites and social media.
 3. Expand AOD treatment information targeted to families and friends and their options for supporting treatment seekers.
 4. Further promote NSW Health AOD websites to health and other service providers and service users through a range of sustained social media, network and communication strategies.
 5. Further promote the role and availability of AOD telephone and online information services to support people seeking treatment, particularly the Alcohol and Drug Information Service (ADIS) and LHD Central Intake.

6. Extend the role of NSW Health-funded AOD telephone and online information services to provide active treatment referrals and service connections.
 7. Increase the standardisation of intake and assessment processes and standards of care across all NSW Health-funded AOD treatment providers.
 8. Implement standardised data collection and monitoring of intake, assessment and wait-list support activity across all NSW Health-funded AOD treatment providers.
 9. Expand intake, assessment and pre-treatment care coordination and support services across all NSW Health-funded AOD treatment providers.
 10. Implement standard protocols and processes of care coordination for clients requiring both withdrawal management and residential rehabilitation.
 11. Refocus processes for client engagement to a trauma-informed approach where responsibility for maintaining contact and communication is more balanced between clients and service providers, particularly while clients are waiting for intake and assessment, and while on wait lists for admission to withdrawal management and residential rehabilitation.
 12. Expand the use of technology in providing AOD treatment information, intake and assessment, wait-list management and pre-treatment support services.
 13. Expand availability and access to withdrawal management services, including ambulatory and short-stay stabilisation.
 14. Expand the role of paid peer workers in AOD treatment services to support better client engagement.
 15. Increase availability and capacity of providers to deliver residential rehabilitation services to respond to a broader range of clients with different needs and situations, including those on the NSW Health Opioid Treatment Program and on other prescribed medications.
 16. Implement strategies in NSW Health-funded AOD treatment services to address stigma and discrimination, particularly where it impacts on treatment access and engagement.
- 14.365 NSW Health has recently developed a website with contact details of withdrawal and rehabilitation providers.⁵⁷⁶ However, that website does not include any details about the entry requirements for each service, nor about community-based withdrawal. NSW Health has advised the Inquiry that additional work is under way to expand publicly available information about AOD treatment options on the NSW Health AOD web pages.⁵⁷⁷ In a submission to the Inquiry, Barnardos Australia commented that *'criteria can be tricky to navigate'*,⁵⁷⁸ so improvements made by NSW Health would be of benefit.

Recommendation 38:

- A. That NSW Health implement, as a matter of priority, the 16 Improvement Directions identified in the final report of the Pathways to Residential Rehabilitation Scoping Project.
- B. That further to Improvement Direction 2 of the Scoping Project, NSW Health update its existing withdrawal management and residential rehabilitation services contact page to include information about community-based and day programs, as well as the entry requirements of each service listed.

Primary and community-based care

- 14.366 Primary and community-based care provide options for treatment, support and management in settings outside of acute healthcare services. GPs are the main primary care workforce. Community-based services may include AOD counselling services and therapeutic day programs. Specialist AOD treatment providers, such as residential rehabilitation facilities, often also offer community-based programs as an adjunct to their services. Online technologies also now allow treatments to be provided via web-based platforms, enabling broader access across geographical areas and reducing some of the barriers individuals may experience with face-to-face services.
- 14.367 As discussed throughout this chapter, PHNs have responsibilities encompassing the planning and commissioning of health services. The objectives of PHNs are to improve efficiency, effectiveness and coordinated care, particularly for those at risk of poor health outcomes. PHNs work closely with GPs and other health professionals to build the health workforce capacity to deliver high-quality care. One of seven key priority areas that the Commonwealth Government has identified for PHNs is alcohol and other drugs.⁵⁷⁹ The Inquiry heard about programs such as the GP Liaison in Alcohol and Other Drugs (GLAD),⁵⁸⁰ a collaboration between the Central Sydney and Eastern Sydney Primary Health Network and three LHDs that provides advice, support, referral and education.⁵⁸¹
- 14.368 Research demonstrates that when people use methamphetamine more frequently, they are less likely to access non-acute health services such as GPs, psychologists and counsellors.⁵⁸² This may be an indication that the system is not equipped to respond to people with more frequent and dependent use in outpatient settings, putting more pressure on acute services.⁵⁸³ The Inquiry heard evidence that people who use drugs more regularly are less engaged in preventive health care, which may be due to fears of stigma and discrimination, or because of their lifestyle.⁵⁸⁴ However, NCCRED submitted that primary and generalist care is an opportunity for early intervention, which can reduce the health harms associated with ATS use, including comorbidities.⁵⁸⁵
- 14.369 The Inquiry also heard about the challenges stemming from the overall lack of available services. If a person has made a commitment to seek help and treatment is not available when they need it, this is a lost opportunity.⁵⁸⁶
- 14.370 It is vital that acute and non-acute, as well as mainstream and specialist services, are all equipped to meet the treatment needs of people who use ATS.

General practitioners

- 14.371 GPs are often the first port of call when an individual has a health issue. A GP takes a whole-of-person approach to care and can coordinate the care of patients by referring to other specialists or services.⁵⁸⁷
- 14.372 GPs are well placed to treat substance use and dependence with a focus on long-term management and support, as with other chronic diseases. GPs and other professionals within multidisciplinary primary care teams can play a key role in prevention, early detection and management of substance use.⁵⁸⁸ The Inquiry heard from Dr Bronwyn Hudson in Lismore, that, in her experience, people who use ATS and present to her as a GP are at the lower or more moderate end of the spectrum of use, and that she takes a harm reduction approach to care in this setting.⁵⁸⁹
- 14.373 According to an Australian study of patient pathways for AOD treatment, GPs play a pivotal role in reducing use of acute services, matching client need to service type and providing ongoing care that enables access to more intensive services as needed.⁵⁹⁰
- 14.374 People who use drugs may be more inclined to see a GP than specialist drug services,⁵⁹¹ and primary care may be the only point of contact for people with AOD use problems.⁵⁹² An Australian study of people dependent on methamphetamine found that most had at least one GP visit within the past year, and the average within the cohort was nine visits per year.⁵⁹³
- 14.375 The Inquiry heard that often GPs will be approached by a family member or partner seeking guidance on how they can assist someone close to them.⁵⁹⁴ GPs are often a first and only point of contact for people with alcohol and/or mental health issues and they provide services including prevention of illness, treatment and rehabilitation, making them uniquely placed to assist with AOD-related health issues. Patients often seek lifestyle advice from GPs, who are able to link illness prevention and brief interventions with ongoing holistic care.⁵⁹⁵ General practice is also an ideal setting in which to treat people with substance use issues as the majority of such patients do not require specialist services.⁵⁹⁶ The Inquiry heard that screening within general practice settings can support harm reduction interventions to be initiated with patients:
- 'So they're at their GPs having their health checks, or they're getting their blood pressure checked, and if there's more screening for substance use, then some more harm reduction could take place, or those patients that are at risk of developing a more moderate or severe substance use disorder can be screened just as we would for any other disorder, and interventions put in place to prevent that from happening, and GPs develop lifelong relationships with their patients. So they know them well. There's trust.'*⁵⁹⁷
- 14.376 While the benefits of GPs providing AOD health services are clear, there remain many barriers that prevent them from becoming more involved in addiction medicine or treating substance use, including:⁵⁹⁸
- perceptions that GPs should not enquire about a patient's AOD use, or are uncomfortable about discussing substance use with patients
 - lack of appropriate training as undergraduates or postgraduates
 - lack of confidence and skill in managing people with AOD issues
 - scepticism
 - lack of effective treatment options
 - time constraints

- perceptions of people who use drugs as chaotic or non-compliant, or other negative attitudes towards these patients.
- 14.377 It is also recognised that while GPs may be ideally placed to manage AOD use in some circumstances, this is not always the case. For example, people who present with very acute care needs may require acute health services. However, those presenting with mild or uncomplicated symptoms could be well supported in general practice settings, and can be referred onto other services as required. The Inquiry heard that Health Pathways is an initiative that is improving these connections between services.⁵⁹⁹
- 14.378 On the other hand, people who use drugs may also have reservations about visiting a GP or other primary care service due to fears of stigma and discrimination, or because health care is not prioritised within their current lifestyle. Dr Hudson observed that *‘if someone’s in active addiction ... going and having their blood pressure checked is not high on their list of priorities’*.⁶⁰⁰ The Inquiry heard that patients may not openly disclose ATS use, putting the onus on the GP to enquire:
- ‘[I]t’s a brave GP that goes: “I think there’s something else going on here, I’ve got a waiting room full of screaming babies out there, I’m going to take a deep breath and dive in.” And so quite often we don’t do that. And there are good reasons why.’*⁶⁰¹
- 14.379 There is also a sense of reluctance which may also be obstructive in general practice settings.
- ‘There’s a really strong theme that comes through the literature of GPs thinking: “I can’t raise this, because my patients are going to think that I’m giving them a hard time.” And: “And if I do, what do I do with this Pandora’s box when I open it?” Because there’s no treatment, there’s nowhere to refer them. There’s a therapeutic nihilism that exists.’*⁶⁰²
- 14.380 The literature suggests that a doctors’ preparedness to work with people who use alcohol or other drugs can be influenced by addressing their beliefs around:⁶⁰³
- role legitimacy (the belief that substance use is a legitimate area of examination)
 - role adequacy (the belief that knowledge, skills and training are sufficient to meet the needs of these patients)
 - role support (the belief that appropriate advice and assistance is available when needed).
- 14.381 The Commonwealth Government released guidelines in 2007 for managing psychostimulant use in general practice. The guidelines are intended to support GPs in identifying and engaging patients who use psychostimulants, and supporting their management of the adverse consequences of use. The guidelines provide management strategies for differing patterns of use, and recommend the development of treatment plans.⁶⁰⁴

- 14.382 Ensuring that GPs have good knowledge of local health services and procedures encourages effective and coordinated treatment, including through timely access to other appropriate services.⁶⁰⁵ One way to achieve this is through nurse in-reach services into general practices. For example, the Inquiry heard that in South Eastern Sydney LHD, AOD nurses provide in-reach support to general practice. In Nowra, the Inquiry heard that a partnership between the LHD and local general practice facilitates links between both services. A clinical nurse consultant works with a GP to create a '*portal*' for patients, meaning GPs are less likely to avoid seeing AOD patients. This model was described as '*fantastic*'.⁶⁰⁶ However, these models appear to be local examples that are not available in all areas of need.⁶⁰⁷
- 14.383 Nurse in-reach models, coordinated between LHDs and PHNs, can help to facilitate strong links between primary and acute care services that can improve pathways for patients by having identified referral routes and mechanisms for urgent escalation when necessary.⁶⁰⁸ Nurse practitioners could be especially appropriate for such models, particularly if they can access Medicare Benefits Schedule (MBS) item numbers under the direction of a GP.⁶⁰⁹ The Inquiry also heard that social workers and those who can provide case management supports would also be extremely helpful to facilitate links between primary care settings and specialist services to address the complex needs of people with substance use disorder.⁶¹⁰ However, as with any health response, local needs and contexts need to be considered in the development of these models, with a nurse in every general practice considered '*impractical*'.⁶¹¹

Recommendation 39:

- A. That NSW Health, in areas of need, build upon and enhance models of AOD nurse in-reach services to GP clinics, co-commissioned through a local health district and primary health network partnership.
- B. That primary health networks in NSW continue to enhance and fund the development of training for GPs to support them to effectively screen for amphetamine-type stimulant use and refer into treatment as required.

Funding models in general practice

- 14.384 The Commonwealth Government funds and oversees the MBS, which is a key component of Australia's Medicare scheme. The MBS lists the services that are entitled to a subsidy or rebate. The MBS also describes the 'schedule fee' for that service and the rate at which the rebate is to be calculated.⁶¹² However, these are a guide only, and many GPs charge fees other than the schedule fee.
- 14.385 The Inquiry heard that small changes in MBS item numbers could increase the financial viability of GPs caring for people who use substances,⁶¹³ and also that the structure of these fees-for-service can be a barrier in general practice.

*'The problem with caring for people who use substances in general practice is that the current MBS model ... doesn't value long consultations which is often required for people who use substances ... a GP who sees a lot of mental health patients and sees a lot of people who use drugs ... their salary ... is much less than somebody who sees six-minute people with coughs and colds and flus ... The lack of support around that is an issue for GPs.'*⁶¹⁴

- 14.386 Aside from time spent face-to-face with patients, the Inquiry heard that GPs also incur other expenses when caring for people who use substances. Urine drug screens, for example, are expensive to purchase yet do not have an item number, unlike pregnancy tests.⁶¹⁵ Other work, like spending time on the phone to coordinate multidisciplinary care with other clinicians, is not remunerated.⁶¹⁶

*'[I]t gets said a lot ... that GPs are ideally placed to do everything, and we are, but we are actually working within constraints, constraints through funding, constraints through the fact that we are in our offices; when you are not seeing patients, you don't get paid ...'*⁶¹⁷

- 14.387 Hospital clinicians also commented on these barriers. Dr Marcia Fogarty, Hunter New England LHD, said that GPs would '*struggle*' with seeing more ATS presentations due to short consultation times and a lack of appropriate training.⁶¹⁸

- 14.388 MBS item numbers are available for mental health conditions; however, the Inquiry heard evidence that they are not often used for AOD issues.⁶¹⁹ Having item numbers available specifically for AOD would legitimise these issues as medical conditions.⁶²⁰ While this is important in supporting GPs to manage patients with AOD use, there is also recognition that patients may be concerned about such diagnosis or treatment being recorded through Medicare:

*'We do need to flag that some people may not want to have a drug and alcohol issue flagged ... on their system as a Medicare item because of the stigma attached to it ... but to have that as an option, and it is part of breaking down that stigma that this is a real – this is like asthma.'*⁶²¹

- 14.389 The MBS covers care plan models for certain disease states, including chronic diseases and mental health. The use of care plan models is an option for AOD use. The Inquiry heard that ATS use disorder could be considered a complex disease and be appropriately managed using a complex care plan.⁶²²

- 14.390 The Inquiry received advice from the Commonwealth Department of Health that since late 2016, there have been 16 MBS items available that are specific to services related to AOD treatment. These items enable patients to receive a Medicare rebate for services with an addiction medicine specialist either as a consultation, as a case conference or as part of group therapy. The Department notes that other services are available for patients to receive support to see their GP or specialist. The Department also advised that a person who is diagnosed with a mental or behavioural disorder due to psychoactive substance use can access up to 10 allied health services annually, under the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative.⁶²³

- 14.391 Further, the Department advised that the MBS Review Taskforce is considering ways to better align services with contemporary clinical evidence and practice. Part of this work is reviewing current addiction medicine and allied mental health services items.⁶²⁴

- 14.392 However, documentation from the MBS Review Taskforce website does not seem to consider AOD use as a chronic medical condition in itself, and instead states it may be more accurately regarded as relating to personal choice and behavioural issues.⁶²⁵ In the Inquiry's view, this view is a profound misconception and is contrary to the clear expert evidence received by the Inquiry recognising the dependent use of drugs as a chronic and relapsing condition,⁶²⁶ consistent with the position of the WHO.⁶²⁷

- 14.393 PHNs have a role in providing support and education to GPs and other primary care providers,⁶²⁸ including in encouraging and supporting the development of care plans.⁶²⁹

- 14.394 From the evidence received, there is capacity to further engage the GP workforce to deliver care and support to individuals with substance use problems. One of the ways to achieve this is through adequate financial incentives.

Recommendation 40:

- A. That primary health networks in NSW continue to enhance, fund and deliver capability building programs for GPs to support them in utilising mental health and chronic disease care plans for AOD use.
- B. That NSW Health engage with the Commonwealth and advocate for the inclusion of additional AOD-specific items in the MBS to better enable responses to AOD misuse in primary care settings.

Online treatment and new technologies

- 14.395 Online treatment options provide opportunities to engage with people who may otherwise not attend or engage with face-to-face treatment. A relatively small proportion of people who use methamphetamines access treatment, indicative of the many barriers they face in engaging in current treatment options.⁶³⁰
- 14.396 NCCRED submitted that new technologies and social media could be explored more systematically to increase engagement, particularly to improve reach and uptake in rural and regional areas.⁶³¹ As well as providing greater reach, online treatment options are also cost-effective⁶³² and present '*unprecedented opportunities*'.⁶³³
- 14.397 Cracks in the Ice is one initiative that aims to increase access to trusted, evidence-based information and resources about methamphetamine via online channels. It provides resources and information for individuals, families, friends, schools, health professionals, the media and broader communities.⁶³⁴ Breaking the Ice is a web-based early intervention for psychostimulant use, including methamphetamines. An evaluation of Breaking the Ice showed while participant use of ATS was not reduced relative to a control group, participants showed more help-seeking behaviour.⁶³⁵
- 14.398 Online approaches have been successful in delivering treatment to people with anxiety and depression.⁶³⁶ Online mental health services such as Mind Spot and Beyond Blue have been shown to be effective in improving access to services, providing effective online treatments and increasing public awareness and mental health literacy. Further, these initiatives have been shown to reduce stigma and social barriers.⁶³⁷ Psychosocial therapies such as motivational interviewing, contingency management and cognitive behavioural therapy are all options that could be adapted for delivery via alternatives to face-to-face therapy.⁶³⁸

Telehealth

- 14.399 Telehealth is a method of delivering health care remotely using information communications technology (ICT), whereby clinicians, patients and/or carers connect to each other from separate locations.⁶³⁹ It can be used between a clinician and a patient/carer, or between clinicians, to assist with assessment, intervention, consultation, education and/or supervision.

14.400 Telehealth benefits patients by providing access to a greater range of services, and benefits clinicians by facilitating the sharing of knowledge more broadly across the system. Telehealth can be billed through Medicare when it meets specific requirements. The NSW Agency for Clinical Innovation (ACI) has published guidelines for telehealth in NSW.⁶⁴⁰ Associate Professor Bonomo, addiction medicine specialist, was of the opinion that the ACI's guidelines are aligned with best practice.⁶⁴¹ More recently, the ACI has published a guide to the use of telehealth in practice.⁶⁴² In that guide, the ACI encouraged all services and models of care to consider the use of telehealth as a part of normal practice and noted that all levels of the NSW Health system are responsible for supporting the appropriate use, growth and development of evidence of telehealth applications.⁶⁴³

14.401 The Inquiry heard a significant amount of evidence about the strengths and weaknesses of telehealth services and how their effectiveness is further enhanced if used in a complementary way with face-to-face engagement with a clinician.⁶⁴⁴ Associate Professor Bonomo expressed the view that telehealth provided in accordance with the ACI's guidelines would provide an appropriate management option for many people with ATS-related problems.⁶⁴⁵ In a response to Associate Professor Bonomo's report (and two other expert reports received by the Inquiry relating to health services), Dr Kerry Chant, Chief Health Officer & Deputy Secretary Population and Public Health, NSW Ministry of Health, stated that:

*'Given the methamphetamine treatments that are evidence-based are psychosocial, NSW Health supports examining the provision of evidence-informed psychosocial interventions via specialist outreach services delivered using a mix of telehealth and face-to-face service delivery. Telehealth logically lends itself to psychosocial treatments, and a range of assessments and other interventions.'*⁶⁴⁶

14.402 However, Associate Professor Bonomo also noted key challenges in implementing telehealth including:⁶⁴⁷

- technical issues such as bandwidth limitations
- resourcing of treatment service staff, including for training on appropriate behaviours and etiquette
- the need for incentives to facilitate cultural change to accept telehealth as routine and standard practice in drug treatment
- the engagement of rural and regional service providers including GPs and other health professionals as partners in the process.

14.403 The challenges described by Associate Professor Bonomo align broadly with those articulated in the ACI's guide to the use of telehealth in practice. That guide describes critical success factors for effective telehealth-enabled models of care to include workplace culture and capacity, and a sustainable funding model.⁶⁴⁸ Dr Chant, NSW Ministry of Health, also noted that:

*'... the feasibility, acceptability and cost-benefit analyses in relation to the provision of specialist outreach services via telehealth for methamphetamine-related problems are yet to be conducted. One such study has recently commenced in NSW, funded by the NSW Translational Grants Scheme in 2019, "The Hub Project".'*⁶⁴⁹

- 14.404 Professor Nadine Ezard, Clinical Director, Alcohol and Drug Service, St Vincent's Hospital, provided the Inquiry with information about the Hub Project and another telehealth project, the Alcohol and Drug Telehealth Project, both aimed at addressing issues associated with limitations in access to specialist substance use disorder treatment in rural and remote areas.⁶⁵⁰ A submission from St Vincent's Health Australia also recommended that new technologies be expanded to increase access to treatment.⁶⁵¹
- 14.405 The Inquiry understands that there are other practices that can improve healthcare delivery through ICT, such as telementoring, which is a transfer of specialist knowledge and experience to other providers.⁶⁵² The Inquiry received evidence about Project ECHO, which was said to have promise in supporting rural, regional and remote clinicians.⁶⁵³ Research has demonstrated this form of telementoring to be an effective model in different clinical areas, including addiction medicine.⁶⁵⁴

The Alcohol & Drug Telehealth Service

- 14.406 The Alcohol & Drug Telehealth (ADT) Service is a pilot initiative that involves the provision of addiction medicine specialist telehealth clinics by St Vincent's Hospital to clients referred from the Murrumbidgee LHD Drug & Alcohol Service.⁶⁵⁵
- 14.407 According to information provided by Professor Ezard, the ADT Service commenced in August 2019 and will run until May 2020. During that period, St Vincent's Hospital will provide two half-day addiction medicine specialist telehealth clinics a week. GPs have been invited by St Vincent's Hospital to refer and support clients to access the ADT Service. With client consent, GPs with videoconferencing capability can also participate in case conferencing appointments with the client and the ADT Service practitioners. GPs will be able to bill Medicare for their time.⁶⁵⁶
- 14.408 The ADT Service also provides for St Vincent's Hospital addiction medicine specialists to support clinical skills training, capacity building and support for health professionals in the Murrumbidgee LHD region, including upskilling and clinical support to GPs through the Opioid Treatment Accreditation Course.⁶⁵⁷
- 14.409 The decision on whether to continue the ADT Service beyond the pilot period will be influenced by the reported effectiveness of the telehealth model of care, satisfaction of clients, carers and providers within the ADT Service, and whether operating costs of the ADT Service can be sustained.⁶⁵⁸

The Hub Project

- 14.410 The Hub Project seeks to address the lack of access to rural specialist AOD treatment services by formally evaluating the telehealth model of care that has been developed as part of the ADT Service. The Hub Project has been partially funded through the NSW Health Translational Research Grant program.⁶⁵⁹
- 14.411 According to the information provided by Professor Ezard, the Hub Project will trial, monitor and evaluate the delivery of addiction medicine specialist services from the metropolitan area to community AOD services located at regional hubs. These services will be provided to clients and clinicians using an integrated, coordinated mixed-methods approach, including telehealth and face-to-face services by fly-in/fly-out health professionals. The research will measure the effectiveness of the model in expanding access to specialist care in two regional hubs when compared to a control regional hub.⁶⁶⁰

- 14.412 The Hub Project is due to be implemented in July 2020, with data analysis and reporting continuing to June 2022.⁶⁶¹
- 14.413 As the ACI notes, *'telehealth models of care can be initiated or implemented across any system settings (first response, emergency, admitted, non-admitted and the wider community) – with our imagination the only limitation.'*⁶⁶² In light of the evidence outlined above about the challenges of providing adequate care to people affected by ATS in rural, regional and remote areas, creative solutions are required to address these issues. As indicated by the projects outlined by Professor Ezard, telehealth presents an opportunity to fill at least some of those treatment gaps and warrants adequate resourcing by NSW Health to ensure that opportunity is used to its full advantage.

Phone-based services

- 14.414 A number of 24-hour telephone lines providing ATS-related information and support are available within NSW including:
- ADIS
 - the Drug and Alcohol Specialist Advisory Service
 - the Stimulant Treatment Line.
- 14.415 These lines are all run by the Contact Centre at St Vincent's Hospital's Alcohol and Drug Service.⁶⁶³ The total number of calls to all lines operated by the Contact Centre in 2017–18 (including some not listed above) was 30,020, 60% of which were to ADIS.⁶⁶⁴
- 14.416 St Vincent's Health Australia submitted that although demographic information was withheld in many instances, callers to the contact centre are predominantly male (60%) and that very few callers are under 19 (2%) or over 60 (5%). One-third of the professional callers were GPs, followed by hospital doctors/medical officers (22%) and hospital nurses (16%). Approximately 80% of non-professional callers in the same period were calling in relation to themselves. Of those calling for others, 40% identified as parents, 17% as partners, 14% as friends and 11% as siblings.⁶⁶⁵

Drug and Alcohol Specialist Advisory Service (DASAS)

- 14.417 DASAS is a support service designed for health professionals, particularly regional and rural health professionals.⁶⁶⁶ It is available throughout NSW on a 24-hour basis and is hosted by St Vincent's Hospital on behalf of NSW Health.⁶⁶⁷ DASAS is staffed by St Vincent's Hospital staff who are able to provide general advice and can connect callers to a rotating roster of approximately 20 addiction medicine consultants⁶⁶⁸ for specialist advice to assist clinicians with clinical diagnoses, treatment and client management.⁶⁶⁹ In 2017–18, DASAS received 1,280 calls.⁶⁷⁰
- 14.418 Dr Wilson, RACGP, described DASAS as *'a great secret'* about which many GPs were not aware.⁶⁷¹ Debbie Kaplan, Manager, Drug and Alcohol Clinical Policy, Ministry of Health, agreed that DASAS had been a *'relatively hidden'* resource.⁶⁷² Ms Kaplan told the Inquiry that the service received additional resources for the 2019–20 financial year to include the services of a clinical nurse consultant to alter the model to a nurse-led one.⁶⁷³ Ms Kaplan told the Inquiry that:

*'the increase in resourcing this financial year was as a result of probably not having adequate capacity and, you know, it wasn't utilised as widely as, you know, the intention now is. So I think now – I mean, it's early days to say whether or not it's adequate capacity and I think there has been a relative reluctance to promote it given the resource that was available, but, you know, it's much more structured now, so I think there will be a – ... but there should be access when it's needed.'*⁶⁷⁴

Recommendation 41:

That NSW Health:

- take immediate steps to promote the Drug and Alcohol Specialist Advisory Service to clinicians through local health districts, primary health networks, professional colleges and associations and other networks
- support the establishment of formal networks of addiction medicine and addiction psychiatry clinical support between metropolitan and regional/rural locations, ensuring:
 - capacity of telehealth services for these specialties, including specific funding to support service delivery
 - funding structures which are adequate to support clinicians in the delivery of these services
 - necessary technical support is provided to deliver these services.

Alcohol and Drug Information Service

- 14.419 ADIS is sponsored by NSW Health to provide telephone (and, soon, web-based) education, information, referral support and crisis counselling to the general public.⁶⁷⁵ Callers receive confidential and non-judgmental support on any issues related to substance use and treatment options. The call service can also be accessed by family members, friends or other professionals.⁶⁷⁶ A mandatory education session provided by ADIS was introduced for offenders who receive a second cannabis caution as part of the Cannabis Cautioning Scheme, which is discussed in more detail in Chapter 11.
- 14.420 In the last three years, ADIS answered 67,087 calls: 24,638 in 2016; 22,207 in 2017; and 20,242 in 2018. Over that three-year period 17,637 (26%) of the calls related to ATS.⁶⁷⁷ Forty-one per cent of calls in 2017 were from people seeking information for themselves, 20% were from 'concerned others' and 18% from professionals.⁶⁷⁸ The Inquiry notes that some calls are classified as 'uncategorised' as callers do not wish to identify themselves.
- 14.421 St Vincent's Health Australia's submission indicated that between September 2017 and August 2018, alcohol was most frequently reported as the substance of concern during ADIS calls (32.1%), followed by 'methamphetamine/crystal/ice' (23.1%), cannabis (12.0%), and cocaine (4.6%). The submission also noted that over time, the proportion of alcohol-related calls has remained relatively constant, calls related to 'crystal/ice' and cocaine have increased, and calls relating to cannabis, heroin and opioid/opiates have slightly decreased. The proportion of methamphetamine-related calls was said to have remained relatively constant.⁶⁷⁹
- 14.422 It is noted that figures provided to the Inquiry from NSW Health and St Vincent's Health Australia regarding overall call numbers received by ADIS varied slightly.⁶⁸⁰

- 14.423 A submission from NCCRED noted that technologies such as ADIS could be explored more systematically, and that the introduction and expansion of webchat functions and online counselling approaches could improve uptake and reach, specifically in rural and regional areas.⁶⁸¹
- 14.424 In terms of accessibility of information, the Pathways to Residential Rehabilitation project report noted that ADIS does not currently provide active referrals or facilitate coordinated care into AOD treatment services, and that residential rehabilitation services cannot refer clients to ADIS for pre-admission support under current arrangements. Consultation undertaken as part of the project suggested that the role of ADIS could be expanded to actively link or refer people to treatment providers. Such pre-admission supports were described as critical in engaging people who are seeking treatment.⁶⁸² The Inquiry further heard from service providers and those with lived experience about the importance of assertive outreach and follow-up as part of AOD treatment.⁶⁸³
- 14.425 As previously detailed in this chapter, the Inquiry recommends that all 16 Improvement Directions from the NSW Health Pathways to Residential Rehabilitation project be implemented. Improvement Directions 5 and 6 relate specifically to ADIS. However, the evidence received by the Inquiry suggests that outreach, follow-up and guidance for families and carers warrant specific attention as part of any improvements to ADIS.

Recommendation 42:

That, in alignment with Improvement Directions 5 and 6 of the Pathways to Residential Rehabilitation Report, NSW Health expand the Alcohol and Drug Information Service to provide outreach and follow up of calls made to the service, as well as guidance for families and carers who are seeking support and take immediate steps to more widely and effectively promote, and appropriately resource, this service.

Stimulant Treatment Line

- 14.426 The Stimulant Treatment Line is a free, 24-hour, confidential service providing education, information, referral, crisis counselling and support for stimulant use, including ATS.⁶⁸⁴ Calls to the Stimulant Treatment Line increased significantly between 2013 and 2017 from 558 to 1297.⁶⁸⁵ In 2017–18, the Stimulant Treatment Line received 1678 calls.⁶⁸⁶

Psychosocial interventions

- 14.427 Psychosocial interventions are currently regarded as the most effective treatment for people who use methamphetamine. Studies have demonstrated these interventions have moderate effectiveness in reducing or ceasing methamphetamine use, and improving psychosocial functioning.⁶⁸⁷ Psychosocial interventions are often used in combination with other treatment options, which can reduce drop-out rates and increase periods of abstinence.⁶⁸⁸ The aims of psychosocial interventions are to:⁶⁸⁹
- engage individuals in treatment
 - retain individuals in treatment
 - encourage compliance with treatment
 - provide relapse prevention support.

- 14.428 There are a range of psychosocial interventions available, some of the key ones being:
- 14.429 **Brief interventions:** Brief interventions are ones that take very little time, and are generally undertaken in an opportunistic manner with individuals who are identified through other routine screening. The general principles of brief interventions are making the most of opportunities to raise awareness about risky AOD use, and motivating individuals to address this.⁶⁹⁰ This model of screening and assessment is more effective for individuals who are at risk of developing dependence, rather than those who are already dependent or experiencing significant drug-related harm.⁶⁹¹ Brief interventions have typically focused on primary care settings, as this workforce is in a unique position to identify and intervene with patients whose substance use is harmful to their health and wellbeing.⁶⁹² These may be conducted by GPs or practice nurses⁶⁹³ who can develop positive rapport with patients through ongoing relationships.⁶⁹⁴ Repeating these interventions, rather than focusing on a single session, can prove effective. There are many frameworks in place to guide clinicians; however, some are developed specifically for alcohol.⁶⁹⁵ As a very rapid screening tool, ASSIST-Lite (described earlier) has been recommended as particularly useful for drugs such as amphetamines.⁶⁹⁶
- 14.430 **Cognitive behavioural therapy (CBT):** CBT is a psychological therapy that aims to modify distorted thoughts, beliefs and maladaptive behaviours and subsequently decrease drug use and prevent relapse. The CBT approach has been applied to people with ATS-use disorder following its well documented effectiveness for other substance use disorders (e.g. alcohol, opioids and cocaine). CBT generally employs a set of structured techniques such as motivational enhancement, relapse prevention, skills training, cognitive restructuring, stress management, emotional control and contingency management. When used as a therapy for a substance use disorder, CBT is based on the assumption that drug use is a learned behaviour and so emphasises an individual's commitment to recovery in order to learn new adaptive behaviours and ways of thinking.⁶⁹⁷ Several studies have been published on CBT for methamphetamine use/dependence, and these have indicated that CBT can be effective in reducing use and increasing abstinence rates while in treatment.⁶⁹⁸
- 14.431 **Counselling:** One of the main psychosocial treatment approaches to AOD issues is counselling. The literature describes the benefits of counselling approaches for people who use ATS.⁶⁹⁹ Counselling was described in evidence to the Inquiry as both a standalone treatment and an adjunct to other therapeutic and management approaches.⁷⁰⁰
- 14.432 **Motivational interviewing:** Motivational interviewing can be integrated into other models of care, such as during intake procedures for community drug treatment programs, and this has been shown to improve retention rates.⁷⁰¹ Motivational interviewing can be a form of brief intervention, which is a directive and client-centred interaction aimed at helping people to explore and resolve their ambivalence about their substance use.⁷⁰²
- 14.433 The Inquiry heard that psychosocial interventions are commonly used for drug use or substance use disorders, particularly in lieu of effective pharmacotherapy options. These types of interventions were described by Dr Jonathan Brett, a specialist in clinical pharmacology, toxicology and addiction medicine at St Vincent's Hospital, as '*somewhat effective*', but need to be tailored to individual needs and levels of cognition.⁷⁰³ Associate Professor Bonomo, addiction medicine specialist, noted that there is no specific psychosocial or behavioural approach that is better than another.⁷⁰⁴

- 14.434 The Inquiry heard from ACON Northern Rivers that its therapeutic counselling incorporates a range of cognitive behavioural approaches, including motivational interviewing and acceptance and commitment therapy.⁷⁰⁵ In Dubbo the Inquiry heard that the way in which programs or interventions are delivered is important, and that the greatest impact comes from the *'quality of the conversation'*.⁷⁰⁶
- 14.435 The Inquiry heard from Dr Mindy Sotiri, Program Director, Advocacy, Policy and Research, Community Restorative Centre, that psychosocial approaches are often not focused on trauma, which is a common factor associated with the use of drugs.⁷⁰⁷ This reiterates the need for a whole-of-person approach to drug treatment which can address both individual and external factors.

The S-Check Clinic, St Vincent's Hospital

- 14.436 The S-Check Clinic was designed to engage in brief psychosocial interventions with people who use stimulants. The model comprises four sessions, including a psychosocial assessment, medical assessment, medical feedback and a psychosocial feedback session. Information about stimulant use, counselling and referral services are also provided. An evaluation of the service found it was valuable and beneficial as an accessible and low-threshold model. The stimulant-specific nature of the service was valued by clients, and its harm reduction and non-judgmental focus was welcomed.⁷⁰⁸

Pharmacotherapy

- 14.437 At present, no medication is approved for use in methamphetamine dependence. A number of systematic reviews have concluded that the available evidence on current pharmacological treatments has not demonstrated consistent evidence of benefit.⁷⁰⁹
- 14.438 The need for a suitable, safe and effective pharmacotherapy option for methamphetamine dependence was highlighted during the Inquiry's hearings, with Dr Dunlop, Hunter New England LHD, noting that *'we don't have a medication that's safe and effective, that's easy to prescribe'*.⁷¹⁰ The Inquiry heard that opportunities can be missed where treatment options are not available when a person has come to a point where they are willing to engage in addressing their ATS use. The Inquiry also heard that existing treatment options, including counselling and rehabilitation are limited, especially in regional areas.⁷¹¹ Evidence indicated that a lack of treatment and referral options can impact on the confidence of GPs to treat patients for substance use disorders.⁷¹² Each of these issues would benefit from a pharmacotherapy treatment option to engage with people who use methamphetamine,⁷¹³ with the addition of a pharmacological option in treatment serving as a helpful adjunct to current treatment options.⁷¹⁴
- 14.439 A number of medications continue to be trialled, including those that try to reduce methamphetamine use, those that try to reduce cravings, and those that try to be a substitute.
- 14.440 Psychostimulants have been trialled in the treatment of methamphetamine dependence as a safer alternative to the illicit substance, similar to the use of agonist therapies such as methadone or buprenorphine for the treatment of heroin dependence. Such drugs increase dopamine and mimic the effects of amphetamine. Drugs with lower abuse liability are preferable as treatment options.⁷¹⁵ An example of this type of therapy is currently being trialled in NSW. The lisdexamfetamine for the treatment of methamphetamine dependence (LiMA) trial is a double-blind placebo-controlled randomised controlled trial which is being run at one site in Melbourne, one site in Adelaide and four in NSW:

- St Vincent's Hospital
 - Drug and Alcohol Clinical Services, Hunter New England LHD
 - Drug Health, Western Sydney LHD
 - Royal Prince Alfred Hospital.
- 14.441 With funding from the National Health and Medical Research Council, the study aimed to enrol 180 individuals by 2020. The objectives are to test the efficacy of lisdexamfetamine for reducing methamphetamine use among people who have not previously responded to psychosocial treatments. Other objectives to be measured include wellbeing, physical and mental health, cognitive and psychosocial functioning, craving and withdrawal symptoms, severity of dependence and retention rates.⁷¹⁶
- 14.442 Also being trialled are antagonist or non-agonist approaches – these medications do not mimic the drug, but block or minimise activation of brain cell receptors, which is important in developing dependence.⁷¹⁷ Clinical services in Wollongong, Melbourne and Geelong are investigating the safety and efficacy of *N*-acetylcysteine in the 'N-ICE Trial'. Funded by the National Health and Medical Research Council, the double-blind placebo-controlled randomised controlled trial aims to enrol 180 individuals, and success will be measured on reduced methamphetamine use. The study will also consider effects on cravings, dependence, withdrawal symptoms, symptoms of psychosis, hostility, depression, suicidality, the use of other major drug classes, and adverse events. This study will run for three years.⁷¹⁸ *N*-acetylcysteine has a well-established safety profile and previous clinical trials of the drug have demonstrated reductions in drug craving, as well as reductions in psychiatric symptoms.⁷¹⁹
- 14.443 Dr Brett, St Vincent's Hospital, noted that while there are these promising treatments in the pipeline, there are long lead times for research and approvals.⁷²⁰ Submissions to the Inquiry highlighted that there is a need for more research into pharmacotherapies for methamphetamine use and dependence.⁷²¹

Recommendation 43:

That the NSW Government continue to invest in research on treatment interventions for people who use amphetamine-type stimulants, including pharmacotherapy options.

The NSW Health Stimulant Treatment Program

- 14.444 In 2006, the NSW Government committed funds to establish the Stimulant Treatment Program (STP) in response to an increase in the use of stimulants, including methamphetamine, across Australia and NSW in the early 2000s.⁷²² There had previously been no specialised treatment service for stimulants, with people using stimulants managed by AOD services, mental health services and the criminal justice and social welfare systems.⁷²³
- 14.445 The NSW Government advised the Inquiry that STP services are located at St Vincent's Hospital, and in the Hunter New England, Illawarra Shoalhaven, Mid North Coast, Northern NSW and Western Sydney LHDs.⁷²⁴ The Inquiry heard that the funding provided for the STP has been used in various ways by LHDs. In Northern NSW LHD, for example, the funding was used to establish CL positions across a number of hospitals.⁷²⁵

- 14.446 As a program, the STP provides clinical support to improve the health and social outcomes of people who use stimulants, such as methamphetamine, cocaine and ecstasy, through psychosocial support services such as counselling and relapse prevention.⁷²⁶ Pharmacotherapy is an aspect of the STP, with oral dexamphetamine being prescribed '*off-label*' for a small cohort of individuals who meet stringent eligibility criteria. Given the potential for misuse, daily dosing is supervised.⁷²⁷
- 14.447 Evaluations have shown some promising outcomes of the STP such as reduced stimulant use, and significant reductions in psychotic symptoms, hostility and disability associated with poor mental health.⁷²⁸ Despite this, the Inquiry has also heard evidence that STP effectiveness has its limitations, especially in light of the lack of pharmacological treatment options. Dr Brett, St Vincent's Hospital, told the Inquiry that although the STP is somewhat effective, at best only one out of every three to five people treated by the program successfully transition to not having a substance use disorder.⁷²⁹

Involuntary treatment

- 14.448 Involuntary (or compulsory) drug treatment is the mandatory enrolment of individuals into a drug treatment program, most often consisting of forced supervised inpatient treatment. Compulsory treatment can also be designed as outpatient treatment, consisting of individualised treatment or group-based programs. This type of treatment is often abstinence-based and located within a broader criminal justice response to drug use and harm.⁷³⁰

The NSW Involuntary Drug and Alcohol Treatment program

- 14.449 The NSW Involuntary Drug and Alcohol Treatment (IDAT) program provides short-term care to protect the health and safety of people with severe substance dependence who have experienced, or are at risk of, serious harm and whose decision-making capacity is considered to be compromised due to their substance use. The program includes an involuntary supervised withdrawal component.⁷³¹
- 14.450 The IDAT program is a state-wide service delivered through two sites – one in the Northern Sydney LHD at the Royal North Shore Hospital campus, and the other in the Western NSW LHD at Bloomfield Hospital in Orange. There are 12 beds available – eight in Orange and four in Sydney.
- 14.451 The legislative basis for the IDAT Program is the *Drug and Alcohol Treatment Act 2007* (NSW).⁷³² The objects of that Act are:
- to provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety
 - to facilitate a comprehensive assessment of those persons in relation to their dependence
 - to facilitate the stabilisation of those persons through medical treatment, including, for example, medically assisted withdrawal
 - to give those persons the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and personal welfare.⁷³³

14.452 The Act must be interpreted, and every function conferred or imposed by this Act must be performed or exercised, so that, as far as practicable:

- involuntary detention and treatment of those persons is a consideration of last resort
- the interests of those persons is paramount in decisions made under the Act
- those persons will receive the best possible treatment in the least restrictive environment that will enable treatment to be effectively given
- any interference with the rights, dignity and self-respect of those persons will be kept to the minimum necessary.⁷³⁴

14.453 Referral and screening is undertaken by an involuntary treatment liaison officer or another medical practitioner to identify if an individual is suitable for referral. An accredited medical practitioner, usually based at the treatment site, is then required to assess if the individual meets the admission criteria.⁷³⁵

14.454 NSW Health provided information to the Inquiry about the IDAT and data on the number of people treated through the program since January 2014. This is shown in Table 14.3.

Table 14.3: Number of people treated or provided services by the IDAT Program annually since January 2014, disaggregated by primary drug of concern⁷³⁶

Admitted patient primary drug of concern	2014	2015	2016	2017	2018	2019	TOTAL
Alcohol	85	76	73	68	68	26	396
Amphetamine-type substances	8	8	13	6	4	3	42
Benzodiazepines	1	0	1	0	0	1	3
Cannabinoids	4	0	1	1	0	0	6
Opioids	1	0	6	4	4	1	16
Miscellaneous	0	1	0	1	0	0	2
TOTAL	99	85	94	80	76	31	465

14.455 The majority (85%) of patients who have been through the program had alcohol as their primary drug of concern. Only 9% had ATS as a primary drug of concern, and the number of ATS-related patients in the program has declined since reaching a peak of 13 patients during 2016. A number of clinicians commented that they had never had a case of ATS use that warranted referral to IDAT.⁷³⁷ At times a decision to refer can be driven by family, who see no other option available to support their family member:

*'Often, in my experience around IDAT, the decision to refer is often driven by family, very concerned family who have that: "We have to do something. We have to do something" ... that's a hard place for them to be.'*⁷³⁸

- 14.456 In cases where IDAT is deemed an appropriate treatment option, the Inquiry heard that access to the program is limited. This is due to both the limited bed numbers across the state and transport issues given the sites of the two facilities, and can lead to extended wait periods for access.⁷³⁹ Dr Mark Montebello, Clinical Director, Northern Sydney LHD Drug and Alcohol Services, told the Inquiry that at any one time there are 15 to 30 people on the waiting list for treatment.⁷⁴⁰ A proposal has been made for a new unit that would increase the capacity in Sydney from four to eight beds, which would assist with the wait list.⁷⁴¹ Dr Montebello also advised that one of the big problems faced by the service is geography and access into the units, noting that there are still many patients in Sydney who have to travel to Orange because there are insufficient facilities to treat them in Sydney.⁷⁴² He also noted that there are a number of inappropriate referrals to the service, and steps are being taken to try and address that through better education about the service.⁷⁴³
- 14.457 Data received from NSW Health showed that the host LHD (either Northern Sydney or Western NSW) had the highest proportion of patients referred and admitted into the program. This was particularly apparent for Northern Sydney LHD, which accounted for 40% of admissions to the program within the LHD between 1 January 2014 and 30 June 2019. In this period, there was greater parity of access to the facility at Bloomfield Hospital in Orange.⁷⁴⁴ These data are shown in Table 14.4.

Table 14.4: Referred and admitted clients to IDAT, by referral LHD, 1 January 2014 to 30 June 2019⁷⁴⁵

Royal North Shore Hospital, Sydney			Bloomfield Hospital, Orange		
Referral LHD	No	Proportion of total	Referral LHD	No	Proportion of total
Central Coast	5	3%	Central Coast	11	3%
Far West	0	0%	Far West	1	0%
Hunter New England	4	3%	Hunter New England	43	12%
Illawarra Shoalhaven	17	11%	Illawarra Shoalhaven	5	1%
Mid North Coast	2	1%	Mid North Coast	12	3%
Murrumbidgee	2	1%	Murrumbidgee	15	4%
Nepean Blue Mountains	1	1%	Nepean Blue Mountains	10	3%
Northern NSW	2	1%	Northern NSW	33	9%
Northern Sydney	61	40%	Northern Sydney	16	4%
Southern NSW	2	1%	Southern NSW	30	8%
South Eastern Sydney	24	16%	South Eastern Sydney	8	2%
South Western Sydney	7	5%	South Western Sydney	16	4%
St Vincent's	11	7%	St Vincent's	6	2%
Sydney	11	7%	Sydney	40	11%
Western NSW	2	1%	Western NSW	86	23%
Western Sydney	0	0%	Western Sydney	25	7%
Not recorded	2	1%	Not recorded	10	3%
	153	100%		367	100%

- 14.458 Dr Montebello was aware that Royal North Shore Hospital and Bloomfield Hospital each received most referrals from within its LHD. He attributed the differences in referral numbers based on geography at least partially to a lack of understanding about the program within those LHDs that do not make referrals.⁷⁴⁶ Work is occurring to increase referrals from other LHDs.⁷⁴⁷

- 14.459 The evidence about the IDAT program and its appropriateness for people who use crystal methamphetamine was mixed. In highly selective cases, such as when there is severe morbidity or risk of mortality, the program may be effective.⁷⁴⁸ However, the duration of effectiveness or success may be limited to the length of time the individual is in the program.⁷⁴⁹ By nature of the program itself, an unwillingness or lack of motivation to engage in treatment can further hinder effectiveness.⁷⁵⁰ Dr Montebello advised on the outcomes of IDAT, noting that at six months post-treatment, approximately 30% were abstinent, 30% were 'better', 30% had relapsed and 10% had died.⁷⁵¹ Dr Montebello also singled out the importance of brokerage funds available to assist patients exiting the program and returning to the community.⁷⁵²
- 14.460 Associate Professor Bonomo, addiction medicine specialist, noted that IDAT is '*highly controversial within the alcohol and drug sector*' with there being '*many who believe that it is an infringement of human rights and therefore it should never be implemented*'.⁷⁵³ Associate Professor Bonomo advised the Inquiry that there is little evidence for best practice in involuntary treatment for ATS-related substance use disorder. She noted that the United Nations Office on Drugs and Crime (UNODC) has reported that mandatory treatment settings do not represent an effective environment for the treatment of drug dependence and should be replaced by '*voluntary, evidence-informed and rights-based health and social services in the community*'.⁷⁵⁴ However, Associate Professor Bonomo acknowledged that, notwithstanding this, involuntary treatment does occur in Australia and that '*research and evaluation are needed to determine whether there are specific benefits that have not yet been examined in the literature such as preventing imminent death, interrupting the cycle of addiction temporarily, or other potential benefit*'.⁷⁵⁵
- 14.461 Dr Arunogiri, RANZCP, was of a similar opinion.
- 'There are a number of features of ATS use disorder that limit the utility of involuntary treatment programs like IDAT ... Involuntary treatment is indicated where the individual is likely to benefit from the treatment. There is insufficient evidence to clearly demonstrate that the IDAT program would be of benefit for individuals with ATS-related use disorder.'*⁷⁵⁶
- 14.462 Dr Arunogiri also described practical and logistical barriers of the NSW IDAT, including capacity constraints, the need for transport to a facility, and the inappropriateness of sedating individuals for transport. Legislative and administrative processes can also take weeks or months of planning.⁷⁵⁷
- 14.463 A 2016 systematic review of compulsory drug treatment reported that the limited evidence available does not overall suggest improved outcomes, and further to this, some studies suggest potential harms. This review suggested that those who advocate such treatment should be contributing to the evidence base on its effectiveness, safety and ethical nature.⁷⁵⁸ In its submission to the Inquiry, St Vincent's Health Australia referred to this systematic review and noted that available evidence on compulsory treatment does not overall suggest improved outcomes for patients. Further, it suggested this form of treatment '*further stigmatises*' people who use alcohol and drugs.⁷⁵⁹
- 14.464 There have been significant violations of human rights in compulsory treatment in overseas locations, such as forced labour, physical and sexual abuse, and being held without clinical determination of drug dependence.⁷⁶⁰ However, the strong clinical oversight and shortened periods of involuntary treatment have been described as positive within the NSW model, improving protection of human rights and better reflecting international best practice.⁷⁶¹

Assessments and evaluations of the IDAT Program in NSW

14.465 In February 2016, the NSW Ministry of Health engaged the DPMP to conduct an evaluation of the IDAT program, comprised of four components: a process evaluation, an outcome evaluation, a cost assessment and a data linkage study.⁷⁶² The process evaluation was completed in April 2017, the costs assessment completed in March 2018 and the outcome evaluation completed in July 2019. The Inquiry received the final report of each. The Inquiry did not receive the report of the data linkage study.

Process evaluation

14.466 The aim of the process evaluation was to provide descriptive information about the IDAT program's operations, reach, strengths and weaknesses, patient progression through the model of care, and the feasibility and appropriateness of the model of care. It also aimed to evaluate whether the *Drug and Alcohol Treatment Act 2007* (NSW) was being implemented in a manner consistent with its intended use and the extent to which the implementation of the IDAT program was consistent with the model of care.⁷⁶³

14.467 A complete copy of the IDAT program database was made available to the evaluators, covering the period from program commencement (31 May 2012) to 24 June 2016.⁷⁶⁴ The evaluators conducted 12 in-depth interviews with patients, interviewed 37 stakeholders and received written submissions from two stakeholders. Four weekly staff meetings were observed across the two treatment units. The evaluators also reviewed the *Drug and Alcohol Treatment Act 2007* (NSW), the model of care, the official visitors' books and five complete patient files.⁷⁶⁵

14.468 The key issue identified by the process evaluation was the extent to which the IDAT program should focus on the provision of comprehensive AOD treatment as opposed to providing immediate medical care (including detoxification) when people are at acute risk of harm to themselves.⁷⁶⁶ The provision of comprehensive AOD treatment was associated with a program capacity problem, represented by waiting times and reflecting a low acceptance rate (approximately 50% of referrals were admitted over the evaluation period).⁷⁶⁷ The evaluators associated this problem with disincentives to refer, alongside resource intensive pre-program assessment and referral procedures. It was also noted that the community aftercare component of the program appeared not to have been implemented as originally envisaged in the model of care. However, the evaluators concluded that if the focus of the program was acute resolution of immediate health issues, then the uneven aftercare implementation identified was less of a concern.⁷⁶⁸

Cost assessment

14.469 The overall objective of the cost assessment was to report on the estimates of the costs of delivering the IDAT program from the commencement in July 2012 to June 2016.⁷⁶⁹ The assessment focused on the clinical costs associated with delivery of IDAT, excluding infrastructure costs. Wherever possible the study used cost estimates of actual program delivery rather than the funding allocated to the program, which was considered important for understanding the real costs of service provision, planning for future budget allocations, and providing the basis for potential future comparative analyses.⁷⁷⁰

- 14.470 The cost of the IDAT program over the first four years of its operation was estimated to have been \$32,474,955 (assuming only 26% of IDAT patients received aftercare) or \$33,009,593 (if it was assumed that 100% of IDAT patients received aftercare).⁷⁷¹ On average, each IDAT referral was estimated to have cost \$929, each inpatient treatment episode \$83,678 and the unit cost of six-month aftercare coordination was \$2,196.⁷⁷²
- 14.471 The four-year total costs for transporting patients to the IDAT treatment units was estimated to have been \$1,337,529 and the four-year total costs for the brokerage fund was estimated to have been \$2,824,650.⁷⁷³ When all components were combined (assessment and referral cost, cost of transportation, inpatient treatment cost, cost of aftercare coordination, and expenditure of the Brokerage Fund), the estimated average cost for one IDAT treatment episode was \$99,454.⁷⁷⁴ The report authors noted that this indicated that IDAT was an expensive program, especially when compared to voluntary residential rehabilitation, with average inpatient treatment cost per day being 10 times higher in IDAT than residential rehabilitation.⁷⁷⁵ It was acknowledged that the complexity of the patients admitted to the IDAT program meant that this was not surprising, but that the extent to which the difference was '*reasonable*' was not able to be made from the cost assessment alone. Instead, a cost-effectiveness study, taking into account patient characteristics and underlying health status, would be required to answer that question.⁷⁷⁶

Outcome evaluation

- 14.472 The primary objective of the outcome evaluation was to determine the effectiveness of the IDAT program in reducing AOD use and improving health and social outcomes.⁷⁷⁷ Participants in the outcome evaluation were interviewed at entry to the program, at point of discharge from the program and six months after leaving the program.⁷⁷⁸ Alcohol was the principal drug of concern for the majority of IDAT patients (85.7%), followed by methamphetamine (9.3%).⁷⁷⁹ In summary, the outcome evaluation found positive results for the reduction of alcohol consumption and improvements in physical and psychological health of patients, as well as improvements in quality of life.⁷⁸⁰ There were also significant reductions in unplanned hospital admissions and emergency department visits.⁷⁸¹
- 14.473 However, there was no significant change in quantity of drug used per day for the people who participated in the evaluation for whom '*meth/amphetamine*' was the principal drug of concern,⁷⁸² notwithstanding a decrease in the number of days used.⁷⁸³
- 14.474 Overall, the evaluators concluded that it was not possible to ascertain the change in '*meth/amphetamine*' use attributable to the program due to small subsamples.⁷⁸⁴

Other involuntary treatment programs

- 14.475 Other involuntary AOD treatment programs have been or continue to run elsewhere in Australia. In the Northern Territory, involuntary treatment for alcohol is no longer provided for. In Victoria, like NSW, the majority of admissions to their involuntary treatment program have been related to alcohol. In comparison to NSW, the number of admissions in Victoria is much lower.

The Alcohol Mandatory Treatment Act 2013 (repealed) in the Northern Territory

- 14.476 The *Alcohol Mandatory Treatment Act 2013* (NT) permitted the involuntary commitment of a non-offender into residential alcohol rehabilitation for up to three months.⁷⁸⁵ PwC and the Menzies School of Health Research evaluated the program and reported various issues with processes and questioned whether the Act was a health intervention or punishment.⁷⁸⁶ The Act was also criticised in the literature for its discriminatory application to Aboriginal and Torres Strait Islander peoples, the use of a medical intervention to target a social problem, and lack of transparency around proceedings.⁷⁸⁷
- 14.477 The Act was repealed in 2017 and replaced by the *Alcohol Harm Reduction Act 2017* (NT). This Act has provisions to enforce Banned Drinker Orders and people can be referred to a clinician for assessment or treatment, however, there are no provisions for involuntary treatment.⁷⁸⁸

The Severe Substance Dependence Treatment Act 2010 in Victoria

- 14.478 The *Severe Substance Dependence Treatment Act 2010* (Vic) allows for up to 14 days of detention and treatment of people with severe substance dependence in a treatment centre, where this is necessary as a matter of urgency to save the person's life or prevent serious damage to their health. The person must be incapable of making decisions about their substance use and their personal health, welfare and safety due primarily to their substance dependence.⁷⁸⁹
- 14.479 The Act was independently reviewed in 2014. There was a total of 28 admissions (23 separate clients) for detention and treatment between 1 March 2011 and 2 February 2015, with an average of six clients per year. For 16 clients, alcohol dependence led to the admission and the other seven reported polydrug use, all including alcohol. Other substances used by the polydrug group were solvents, cannabis, opioids, benzodiazepines and amphetamines.⁷⁹⁰ The review team reported that it was encouraging that almost 30% of clients had either reduced their use or abstained from use at six-month follow-up. Stakeholders supported that the detention and treatment period should be increased to 28 days.⁷⁹¹
- 14.480 The Victorian Government's response to the evaluation included that:

'The Government acknowledges that the review's finding that the Act is effective insofar as improvement has been reported for around one-third of clients, six months after discharge. Given the nature of the client group and their complexity, such improvements are encouraging.'

and

*'The Government notes the review's findings that the vast majority of stakeholders, while recognising the infringement on human rights associated with involuntary detention and treatment, believe that the Act remains appropriate as a last resort for a small group of people.'*⁷⁹²

- 14.481 In 2014, Victorian Magistrate Jennifer Bowles was granted a Churchill Fellowship to research residential therapeutic treatment options for young people using drugs and with mental illness. Magistrate Bowles subsequently published a report of her research. A steering committee was then formed to progress the recommendation made. The What Can Be Done steering committee comprised 25 people who worked in senior positions in Victoria across the fields of AOD and mental health support services, including psychiatrists, addiction specialists, the CEOs of residential AOD treatment services and key advocacy organisations. The Inquiry received a submission from the steering committee, attaching a copy of Magistrate Bowles' Churchill Fellowship report. The steering committee advised the Inquiry that it was:⁷⁹³

'... unanimously of the view that there is a critical need to support young people who are not effectively engaging with or accessing drug and alcohol therapeutic treatment services at present. Many of the young people appearing before the Criminal and Family (child protection) Divisions of the Children's Court of Victoria have been subject to trauma, abuse or neglect. The Court does not have the power to make orders to ensure effective secure therapeutic treatment opportunities are provided for them. Many of these young people lead extremely chaotic and vulnerable lives and are unwilling or unable to make rational decisions about accessing voluntary detoxification or rehabilitation services.'

- 14.482 Magistrate Bowles' research led her to conclude that *'mandated secure residential services can be of benefit, provided the young people receive high-quality, professional therapeutic support in a non-punitive environment'*.⁷⁹⁴ Magistrate Bowles proposed legislative changes to permit the Children's Court in Victoria to make a Youth Therapeutic Order for young people suffering from serious substance use/mental health issues that are impacting adversely on their health, which would allow for mandatory treatment of the young person.⁷⁹⁵ Recommendation 19 of the Final Report of the *Victorian Inquiry into Youth Justice Centres* recommended that the Victorian Government *'establish a trial program of Youth Therapeutic Orders based on the What Can Be Done model'*.⁷⁹⁶
- 14.483 Based upon evidence received by the Inquiry, there is little to no evidence on the effectiveness of involuntary treatment for ATS. It is noted that in some instances, clinicians may determine involuntary treatment to be appropriate as a 'last resort' option.
- 14.484 Based on data provided by NSW Health, there seem to be inequities in access to the IDAT program in NSW. This may warrant further consideration.

Recommendation 44:

That in any further review or decision to expand the Involuntary Drug and Alcohol Treatment Program, NSW Health consider how the current geographic inequity of access to the program can be overcome.

The need for an integrated health and social service system to manage and treat ATS use and harm

- 14.485 Homelessness, social disadvantage, temporary or unstable housing, involvement with the justice system, unemployment, and trauma are all factors that lead to an increased need for support services both within and outside of the health sector.⁷⁹⁷ These should be delivered in an holistic and person-centred way that meets the unique needs of the individual. Service delivery should not be focused on one aspect of a person's health, or one aspect of their life. As one service provider noted:

*'Mental health and addictions, criminal behaviour, homelessness, I believe – and what I've seen – go hand in hand and you need to focus on the whole person, not just the addiction or not just the mental health. They all go together.'*⁷⁹⁸

- 14.486 There is a clear need for the health and community services sector to work closely together to support people in addressing their use of drugs and any harms that are associated with this. However, the health and other social support service systems are siloed, making it difficult for people to identify and access the services that are critical to their care.⁷⁹⁹ Submissions to the Inquiry from the NGO sector called for better coordination and integration of care across the AOD sector.⁸⁰⁰ Such an approach is supported by the NSW Health State Health Plan,⁸⁰¹ the National Drug Strategy⁸⁰² and literature on best practice.⁸⁰³

- 14.487 Various levels of government and NGOs fund, plan, manage and deliver AOD and mental health services. With AOD and mental health services generally funded and administered separately, as well as being geographically separated,⁸⁰⁴ there is a lack of a clear policy framework for well-defined comorbidity treatment models.⁸⁰⁵ This fragmentation of the system creates difficulty for both service providers and patients.

- 14.488 The Inquiry heard evidence about the gaps between services that can impact on coordination and continuity of care, often resulting in negative consequences for the patient. One lived experience witness said:

*'When I asked for help, my GP referred me to [Narcotics Anonymous] or other groups. These groups didn't work for me. I also called Lifeline a number of times. I would reach out for help when I was desperate and at the end of my road. I just wanted someone to help me. I didn't have any family and didn't want to bother my straight, non-using drug friends – non-drug using friends. Lifeline referred me to the Mental Health Access Line, which I think is run by NSW Health. I would wait days or sometimes weeks for someone to call me back to do an assessment over the phone. They would put me in touch with a psychologist in my area or a support group, some sort of therapy or drug counselling, but the whole process would take weeks or months. This was hard, because sometimes, by the time they got back in touch, I might be using again and not interested in getting help, or I might be feeling okay about myself and just say, "I'm fine." The only time that services would act immediately was if I said I would kill myself. Then the police or emergency services would come.'*⁸⁰⁶

- 14.489 Another witness, sharing their experience of supporting a relative addressing ATS use, told the Inquiry:

*'Some time when he was still out of home, [name withheld] started the MERIT program and stimulant treatment programs ... Whilst I wouldn't say the programs don't work, but there seem to be barriers for addicts to engage, and there doesn't seem to be a bridge to ongoing rehabilitation. [Name withheld] went once or twice without success in stopping his ice use. He struggled to keep track of the time, attendance, appointments. He didn't complete the program, and they did not result in him staying off ice.'*⁸⁰⁷

- 14.490 Fragmentation of care pathways occurs within the AOD service system itself, as well as with other parts of the healthcare system. Notably, the Inquiry heard that despite the well-established co-occurrence of AOD issues with mental health conditions, individuals face significant difficulty in accessing services that meet these comorbid care needs.
- 14.491 Currently, models of care governing responses to ATS-related health needs, the implementation of those models and their availability vary widely across regions and settings. This may be partly due to the lack of an AOD treatment services plan for NSW Health that articulates the role of each type of service, how people move between them, where they should be distributed, and who should use them. As outlined in Chapters 4 and 10, the lack of a state-wide AOD strategy is a further barrier to more coordinated approaches to health and social care.

Disconnect between the AOD and mental health systems

- 14.492 As described in Chapter 1, many people experience both mental health conditions and substance use. Service providers report that this comorbidity is the expectation, rather than the exception.⁸⁰⁸ People who use methamphetamine and have psychotic symptoms are often reluctant to seek treatment and have been described as *'difficult-to-access individuals with complex needs.'*⁸⁰⁹
- 14.493 The failure of services to meet the needs of comorbid, or dual diagnosis, patients has been recognised in the literature for some decades. The siloed structure of the healthcare system has historically managed and treated patients in a sequential way, with treatment of the primary disorder completed before other health concerns are addressed. This single treatment disorder model remains dominant.⁸¹⁰ This is despite this approach having been recognised by NSW Health as one which leads to patients *'being "lost" to treatment due to the restrictions or criteria that a client was required to meet prior to service acceptance. This has been referred to as "ping-pong therapy", ultimately resulting in no treatment.'*⁸¹¹
- 14.494 The barriers to overcoming such fragmented approaches have been articulated as lack of planning and resources, fragmented services, inadequate clinical skills, lack of assertive follow-up and attitudes of staff.⁸¹² This is a significant challenge for the health service system.
- 14.495 ACEM submitted that NSW treatment pathways do not meet the needs of dual diagnosis patients despite there being a relationship between drug dependence and mental illness. ACEM also noted missed opportunities for early intervention, treatment and recovery due to a lack of integration with community services.⁸¹³

- 14.496 Divisions between AOD and mental health services were also clear in oral evidence before the Inquiry, which noted the concept of needing to treat AOD prior to mental health conditions.

*'[I]f they're not at that immediate risk of suicide, but they need more complex case support, they will simply say: "Okay. They need to address your AOD issue first", but there's not much acknowledgment that there's something beneath – or there's something on the side that needs to be addressed. So that's when, a lot of the times, they are falling between the cracks.'*⁸¹⁴

- 14.497 A submission from Barnardos Australia reflected on people being precluded from AOD services due to mental health conditions, and also conversely being excluded from mental health services until AOD concerns have been addressed.⁸¹⁵

- 14.498 Similarly, the Inquiry heard that there can be a lack of clarity in relation to what part of the health system is responsible for treating comorbid drug and mental health patients. Professor Helen Milroy, Professor of Child Psychiatry, University of Western Australia, Commissioner with the National Mental Health Commission, expressed the view that all clinicians, regardless of whether they work in AOD, mental health, or trauma, *'should be able to deal with all of the problems that their clients or that their consumers are facing.'*⁸¹⁶ She observed that:

*'[I]t seems kind of strange for me, having worked in this mental health system for a long, long time and across a number of different areas, that you would send – you would treat someone for depression, but you wouldn't treat the trauma or the drug use. You would send them to two other services for that. That seems to me to be a waste of the person's time that's coming to see you when, as a clinician trained in mental health or in psychiatry, you should be across all of those things. Or your system should have the capacity to do all of those things. Now, it may be that if it's a pure drug addiction problem, yes, the alcohol – or the Drug and Alcohol Rehabilitation Services is the right pathway for you. But most of them are not that simple. Most of them are complex. And it shouldn't be a problem where your entry point is. You should be able to get the ... comprehensive service wherever you are.'*⁸¹⁷

- 14.499 The notion of a great divide was articulated by a number of witnesses.⁸¹⁸

- 14.500 The literature cites instances where AOD use is missed by mental health staff, and where comorbid patients are excluded from programs that could have helped them.⁸¹⁹ Treatment services across the AOD and mental health sectors may also have fundamental differences in their approach. Negotiating the two has been described as *'an overwhelming, disorganising and demoralising experience'* for people with a dual diagnosis.⁸²⁰

- 14.501 People with comorbid mental and drug health conditions can have poorer treatment outcomes and compliance rates, as well as having higher treatment costs for the treatment system.⁸²¹ As noted by ACEM, a lack of appropriate pathways can increase pressures on the acute care system:

*'A driving force behind the increased number of ATS/methamphetamine [emergency department] presentations, is the limited pathways into expert care and support. Service fragmentation and system gaps contribute to people to seek help from [emergency departments] when they are in crisis – they have nowhere else to go.'*⁸²²

- 14.502 SMART Recovery Australia submitted that there needs to be further planning and investment for treating comorbid AOD and mental health concerns.⁸²³

Division of AOD and mental health services within NSW Health

- 14.503 The Ministry of Health is the ‘*system manager*’ of the NSW public health system, and guides the development of services and investments in the NSW public health system to ensure NSW Government priorities are achieved for the community.⁸²⁴ The Ministry is also responsible for providing regulatory functions, public health policy and monitoring the performance of hospitals and health services.⁸²⁵ The NSW public health system has a decentralised system of management and governance, with LHDs delegated responsibility for how they each deliver healthcare services to meet the needs of local populations, within the framework of service agreements and strategic plans. The relationship between the Ministry and LHDs is that of a purchaser-provider relationship.⁸²⁶
- 14.504 In the Ministry of Health, AOD and mental health are separate functional areas. The Mental Health Branch currently sits within the Health System Strategy and Planning division and the AOD Branch sits within the Population and Public Health division. Each undertakes its own planning and priority setting processes.
- 14.505 There are varying models of mental health and AOD service delivery across LHDs, with some combined and others separate. The Inquiry heard there are benefits to both approaches. As described in oral evidence:

‘[I]t’s interesting that some of the LHDs are integrated with mental health and drug and alcohol ... and others aren’t ... And, you know – intuitively, it kind of makes sense for them to – to work together, but certainly our experience, in South East Sydney [LHD] ... we had a time when we were under the auspices of mental health – it was disastrous for drug and alcohol ... it didn’t actually increase the collaboration; it just felt like drug and alcohol was crushed, and defunded and not supported, you know.’⁸²⁷

- 14.506 An alternative view was that it was important to have AOD and mental health services run collectively:

‘It certainly makes it easier when the senior leadership team sitting around the table is from both services. So as we start to discuss some of the challenges in the services, some of the issues around pathways – you know, access to service, workforce, is that both teams are sitting together, often saying the same thing. So, you know, part of my role is to bring that together and say – we say how do we do this? ... how do we do this better, that we’re working in a more integrated way, recognising that they’re both specialty fields in their own right, but at the same time ... the client doesn’t ... walk up to your service in half. They’re a whole. So we need to be able to have both services being able to provide at least the first component of assessment, done by any staff member.’⁸²⁸

14.507 Such reflections on the implications of a separated AOD and mental health service system in NSW have been recently highlighted by the NSW Auditor-General in a report on mental health service planning for Aboriginal people in NSW. Specifically, the report noted that the separation of oversight between mental health and AOD within the Ministry and a number of LHDs prevents joint service planning and resource sharing. Further to this, the administrative separation of mental health and AOD has created barriers to integrated treatment for patients with a dual diagnosis.⁸²⁹

14.508 In its submission to the Inquiry, the NSW Government stated that decisions about integrating service delivery are best made at a LHD level, due to the differences in how and why patients present to local health services.⁸³⁰ Notwithstanding this, the NSW Government also asserted that:

‘NSW Health delivers an integrated care system to ensure that individuals in need of drug and alcohol treatment have access to a full spectrum of services from acute care and general health services through to specialist public services and the non-government sector.’⁸³¹

14.509 The Ministry of Health, at the time when mental health and AOD were a combined function, commissioned multiple reviews on comorbid mental health and AOD conditions, including best practice integrated models of care.⁸³² The extent to which these reviews were used to inform clinical practice across NSW, or how widely any recommendations for improvement have been adopted, is unclear.

Division between different service types

14.510 As described earlier in this chapter, people seeking treatment or support for their AOD use face barriers to accessing services. There are often inadequate links between primary, acute and specialist services, with each type of service operating in a siloed way.

14.511 NCCRED submitted that it is recognised locally and internationally that treatment responses need to be integrated into mainstream health care,⁸³³ quoting the UNODC:

‘With the growing understanding of psychostimulant use disorder as a chronic health disorder, and the increasing availability of medical treatments, it is acceptable to provide treatment in the public health system, in parallel to the treatment of other chronic psychiatric and medical disorders.’

14.512 The UNODC also note that mainstream services can support early identification and treatment and can refer to specialised programs as required.⁸³⁴

14.513 Evidence to the Inquiry suggested that links between services could be improved.

14.514 Dr Craig Sadler, Director of the Alcohol and Drug Unit of the Calvary Mater Newcastle Hospital, stated that following presentation to the emergency department, there are gaps in existing referral pathways into mental health services. Dr Sadler noted that inpatient and community mental health teams often only assess and treat those with serious and acute mental health concerns.⁸³⁵

- 14.515 Similarly, the Inquiry heard from Dr Helliwell, Riverlands Drug and Alcohol Service, that more could be done to link different parts of the health service system and thereby deliver better patient outcomes:

*'[T]here is, I think, a disconnect a lot of the time between general practice and the public drug and alcohol services, that if we could break down and resource each other more effectively, I think we could produce much better outcomes for our patients.'*⁸³⁶

- 14.516 St Vincent's Health Australia submitted that there is poor integration between AOD treatment services and other clinical and social services.⁸³⁷

Managing comorbidity in health services

- 14.517 As described in this chapter and throughout this report, the Inquiry heard evidence that harmful ATS use is often associated with comorbid mental health conditions. The current disconnect within the service system, outlined above, creates challenges for meeting the needs of people who present to services with comorbid conditions.

Guidelines available to support best practice care of dual diagnosis patients

- 14.518 Comprehensive guidelines for the management of comorbid AOD and mental health conditions have been developed by researchers at the Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney, with funding from the Commonwealth Government Department of Health. These guidelines, as well as training and resources, are available online. The Matilda Centre described these resources as a '*huge success*', with potential for upscaling at a national level to enhance workforce capability to identify and manage AOD and mental health comorbidity.⁸³⁸
- 14.519 NSW Health published clinical guidelines in 2009 for the care of AOD and mental health comorbidity in acute care settings. This document included guidance on the delineation between AOD and mental health services, as well as the expectations of clinicians in each of these clinical fields.⁸³⁹
- 14.520 Other jurisdictions are successfully addressing system fragmentation, and increasingly recognising the importance of the co-delivery of these services. In Victoria, areas for reform in the mental health care system include improving the effectiveness of responding to clients with comorbid AOD and mental health conditions, including enhancing dual diagnosis services.⁸⁴⁰ An Inquiry into mental health and addiction has recently concluded in New Zealand, which recommended the establishment of an independent commission to lead and oversee mental health and addiction in New Zealand.⁸⁴¹ The New Zealand Government has accepted that recommendation and a range of others.⁸⁴²

Supporting the workforce to meet the needs of comorbid patients

- 14.521 People who are experiencing harms from their drug use, as well as co-occurring mental health conditions, can present to a range of different health services depending on their needs and what services are available to them. There is a need for clinicians and other health service workers to be aware of, understand and be able to respond to these presentations.

- 14.522 The Inquiry received evidence that suggested there are opportunities to upskill health professionals so they are confident and able to respond to people with comorbid AOD and mental health conditions.⁸⁴³ To achieve a greater integration of care and to address professional siloing, it would be beneficial for clinicians working with patients with comorbidities to be able to manage both the AOD and mental health conditions that their clients are experiencing.⁸⁴⁴
- 14.523 Through submissions and evidence, the Inquiry received a number of suggestions about how to strengthen the response of health workers to comorbidity. The RANZCP recommended resourcing the AOD workforce to increase capacity to address mental health issues, including early identification and appropriate interventions.⁸⁴⁵ Professor Milroy, University of Western Australia, stated that training in dual diagnosis approaches to care could be beneficial.⁸⁴⁶
- 14.524 Ms Robinson, Northern NSW LHD, acknowledged that there are challenges faced by clinicians in responding to comorbid patients, but told the Inquiry that her LHD was developing the capability and skills of staff so they are better able to care for patients in an holistic way.⁸⁴⁷
- 14.525 The evidence suggests that the first step towards increasing the capacity of NSW Health to respond to comorbid AOD and mental health conditions is ensuring that staff who are likely to engage with patients with these comorbidities have the skills and understanding to *'care for the ... person completely'*.⁸⁴⁸

Recommendation 45:

That to support dual diagnosis approaches to care, NSW Health introduce mandatory training in mental health for all AOD client-facing roles and mandatory training in AOD for all mental health consumer-facing roles.

Driving improvement in AOD support and treatment

- 14.526 Gaps between AOD and mental health continue to create challenges in NSW. The Inquiry heard that LHDs attempt to manage such gaps in relation to their local context and need. In Lismore, the Inquiry heard that facilitating and supporting a crossover of skills between clinical areas can support better approaches to collaborative and coordinated patient care.⁸⁴⁹ It also heard that resource allocation needs to be supportive of collaborative service delivery, so mental health and AOD services can work better together in meeting the needs of vulnerable patients.⁸⁵⁰
- 14.527 To the extent that the Inquiry has heard about effective linkages between health services, they have largely been ad hoc and reliant on the goodwill and determination of people who work in the relevant services. For example, the Inquiry heard in Sydney from Gerard Byrne, Salvation Army, that:
- '[W]e have, you know, good relationships with the hospital-based detoxes for our residential services. We do have good relationships, but the grease that keeps the wheels turning is the individual relationships between our staff and their staff.'*⁸⁵¹
- 14.528 Locally led initiatives are needed and stem from a devolved health system. However, formalising approaches at a state level would support more equitable and accountable systems of case management.

- 14.529 There is a clear need to manage AOD clients and people with comorbidities in a coordinated way, which benefits the individual and the system. As has been described, evidence received by the Inquiry does not reflect that this has been achieved in the AOD space. More needs to be done to address the barriers that people face in accessing and navigating the system, particularly when they are vulnerable and in most need of care and support.
- 14.530 Despite some evidence that services are developing better coordinated services, there is still a long way to go.⁸⁵² The models of care governing responses to ATS-related health needs, the implementation of those models and their availability, vary widely across regions and settings in NSW. The lack of an AOD treatment services plan for NSW Health that articulates the role of each type of service, how people move between them, where they should be distributed, and who should use them, is likely to be contributing to this lack of consistency.

Models of integrated, coordinated and collaborative care

- 14.531 Integrated care connects physical, mental and social care so services are coordinated around the needs of patients.⁸⁵³ Integrated care can come in many different forms, for example, real integration, which involves organisations merging their services, and virtual integration, where providers work together via networks and alliances.⁸⁵⁴
- 14.532 Delivering integrated care is one of three strategic directions in the NSW State Health Plan. Such integration is said to enable patients and their carers to ‘*easily navigate the health system*’.⁸⁵⁵ NSW Health’s Strategic Framework for Integrating Care notes an ongoing commitment for the health system to prioritise the integration of health and social care services, which ‘*is vital to improving outcomes for vulnerable and at-risk populations and people with complex health and social needs*’.⁸⁵⁶ The Framework does not refer expressly to AOD. The framework also acknowledges that information sharing is critical in integrating care.⁸⁵⁷ However, the Inquiry has heard evidence that such sharing of information is not currently done well in the specialist AOD sector.⁸⁵⁸
- 14.533 Integrated models of care and service delivery should typically be well supported for treating comorbid mental health and substance use concerns.⁸⁵⁹ Improved integration is a way to overcome the barriers of siloed treatment services, improve access to and individualisation of care, and provide benefits for patients, their carers and the health system more broadly.⁸⁶⁰ Many previous inquiries have recommended, as a matter of priority, that the AOD service system in Australia receive a significant overhaul to provide more coordinated, comprehensive and person-centred care.
- The 2017 Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice) recommended that ‘*Commonwealth, state and territory health departments ensure adequate pre- and post-care services are provided in partnership with residential treatment programs*’.⁸⁶¹
 - The 2015 National Ice Taskforce recommended that ‘*... the Commonwealth, state and territory governments should work together to improve coordination between community-based alcohol and other drug services, and support referral pathways between local health, support, employment and other programmes*’ and ‘*The Commonwealth, state and territory governments should work in partnership to develop a national approach to strengthening the collaboration and intersection between the mental health and alcohol and other drug treatment sectors*’.⁸⁶²

- Western Australia's Methamphetamine Action Plan Taskforce recommended that *'The Mental Health Commission works with the Department of Health and other key stakeholders to ensure a "no wrong door" approach by making sure that service providers are applying the nationally development and validated tools to assess and evaluate service capability to deliver integrated services'*.⁸⁶³
- 14.534 Research suggests that integration between AOD and mental health services could be improved by, for example, sharing patient information, having joint case conferences, developing shared treatment plans and providing consultation or supervision between services and clinicians.⁸⁶⁴
- 14.535 Ensuring people with lived experience have a voice in the design of services and pathways can also support better delivery and outcomes. Ms Robinson, Northern NSW LHD, described the importance of that voice in the following way:
- 'I think with good clinical leadership and – and actually bring the voice of the – the patient themselves into the discussion around pathways actually starts to change how we develop pathways, and drug and alcohol services are, I would say, a little bit behind mental health services in the sense of the voice of the consumer in the – the co-design of services, and I think that's one of the – the ways that we need to bring that into the sphere of service development because the clients themselves know what they need, and they don't want to have to tell their story three and four times to three and four different clinicians...'*⁸⁶⁵
- 14.536 St Vincent's Health Australia suggested that multidisciplinary services/hubs in rural and regional areas could greatly improve access to evidence-based and patient-centred treatment approaches. Such hubs would incorporate building on current infrastructure, services and programs of work; utilising a mix of new technology and face-to-face service delivery; building local knowledge and capacity; and upskilling local workforces. Importantly, these services would actively engage and work with local services, including Aboriginal health services, youth services and social services.⁸⁶⁶
- 14.537 The NSW Government noted three examples of integrated and holistic models of care for AOD in NSW Health, including the CL model (described earlier in this chapter), the Continuing Coordinated Care (CCC) Program and the Assertive Community Management Program.⁸⁶⁷

Continuing Coordinated Care Program

- 14.538 As part of the 2016 Drug Package, NSW Health funded the state-wide CCC Program, provided by three NGOs – The Buttery, St Vincent de Paul and Mission Australia.⁸⁶⁸
- 14.539 The service operates at 17 sites across the regions of South-East, Northern and Western NSW and in Hunter New England, Murrumbidgee, Nepean Blue Mountains and Sydney LHDs. NADA also employs a clinical consultant under the CCC Program who provides support and training to the CCC Program teams.⁸⁶⁹
- 14.540 The CCC Program provides wraparound support services for people who are currently in or recently exited from AOD treatment. The CCC Program assists with or provides care coordination, intensive outreach support, connections with AOD and other health services, living skills, housing tenancy, vocational and educational support and assistance to maintain or renew family and community connections.⁸⁷⁰

- 14.541 The model of care was developed to address the high needs of clients with substance dependence.⁸⁷¹ As with the ACM Program, the CCC Program involves active case management in order to facilitate linkages between different supports.⁸⁷²
- 14.542 Jenna Bottrell, a program manager for Mission Australia who oversees the CCC Program in west and far west NSW, stated that the most common reasons for referral to the program are financial distress, lack of family and/or positive social connections, lack of stable or affordable accommodation, and legal issues. Ms Bottrell indicated that while the CCC Program has only been operational for just over a year, in her opinion it has had positive outcomes in providing support to individuals with complex needs.⁸⁷³

Assertive Community Management (ACM) program

- 14.543 The ACM aims to provide an holistic approach to treatment and ongoing support for people with severe substance dependence and highly complex needs, including chronic physical health issues and significant social issues, who otherwise have difficulty engaging in AOD treatment.⁸⁷⁴
- 14.544 ACM involves the provision of outreach support such as care coordination, including assisting patients with access to referrals, transport arrangements for appointments and assisting patients in engaging with local community support services. ACM staff can meet patients at their home or other venue depending on patient preference and suitability.⁸⁷⁵
- 14.545 ACM has received funding from the NSW Government over four years, as part of the 2016 Drug Package, across seven local health districts and one speciality health network.⁸⁷⁶

The 'no wrong door' approach

- 14.546 The 'no wrong door' approach is guided by the principle that all people who present to a health service for support should be provided with appropriate treatment, or should be referred to another service. This should happen regardless of where they enter the treatment system. This approach has been adopted, at least in principle, across many government agencies within Australia and elsewhere in the world.⁸⁷⁷
- 14.547 In 2000, the Commonwealth Government launched the National Comorbidity Project, bringing together the National Drug Strategy and the National Mental Health Strategy to identify areas for greater collaboration, interaction and capacity for services to meet the needs of people with coexisting drug and mental health conditions.⁸⁷⁸ In the 2003–04 Federal Budget, the Commonwealth Government allocated \$9.7 million for the development of the National Comorbidity Initiative to improve service coordination and treatment outcomes.⁸⁷⁹ An evaluation project recommended that a 'no wrong door' approach be promoted and supported in the treatment of comorbid mental health and AOD conditions.⁸⁸⁰ It is not clear if this initiative is still running, or if any funding is allocated under it.
- 14.548 The principle of a '*flexible fit*' is another relevant concept that acknowledges that treatment models and pathways are not pre-determined or the same for all individuals. Treatment plans and options should meet the needs of individual patients.⁸⁸¹ The Inquiry heard evidence that services need to meet people wherever they are on their journey:⁸⁸² '*[I]t shouldn't be a problem where your entry point is. You should be able to get the complexity or the comprehensive service wherever you are.*'⁸⁸³

- 14.549 Specifically in NSW, the *NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings* articulates a ‘no wrong door’ principle to inform service delivery, recognising that people should receive care that addresses the full spectrum of their illness(es), regardless of where they present.⁸⁸⁴ The goal is to remove the onus of negotiating different services and providers from the client and thereby reduce the incidence of clients ‘falling through the cracks’ of a complex service delivery system.
- 14.550 The ‘no wrong door’ approach is well-established in mental health services, an example being the no wrong door mental health service collaboration delivered by the South Western Sydney PHN, originally developed in partnership with Partners in Recovery. The initiative aims to bring together government, non-government and community managed organisations to reduce barriers and enhance support for individuals, their carers and families who are facing severe and persistent mental illness with complex need. Training is provided to participating organisations and a web portal exists to collaborate, share and streamline referral pathways.⁸⁸⁵
- 14.551 However, as articulated by one witness to the Inquiry, in the absence of better integration and coordination between services, it is difficult to establish an effective ‘no wrong door’ approach to service delivery.

‘[O]rganisations say no wrong door, some define it as “Okay. We gave them the number for this service. Let’s put it in their hands to contact...”. Realistically speaking, AOD users are not going to do that, that’s one thing. Secondly, they’re already sick of people getting on their backs and making them. There’s also, I think, a lack of communication between organisations and the consumers.’⁸⁸⁶

Assertive care, follow-up and wraparound services

- 14.552 The Inquiry heard evidence about the importance of assertive care, follow-up and wraparound services in the AOD sector. Such comprehensive approaches to care support more positive connections to services, and improved outcomes for individuals.
- 14.553 Wraparound approaches to care, treatment and support are seen in many settings and programs, such as mental health, homelessness, justice and diversion.⁸⁸⁷ The Inquiry heard that these holistic approaches, delivered by multidisciplinary teams, are occurring in various services and can greatly benefit individuals by supporting the individual as a whole, rather than simply treating one condition.⁸⁸⁸ Research suggests that case management and wraparound support are examples of best practice in managing those with substance use disorders.⁸⁸⁹
- 14.554 The Inquiry heard evidence about the importance of wraparound support:

‘We know that aftercare doesn’t just consist of psychological services. Recovery is really a process of what we call psychosocial, possibly cultural, reintegration of the patient. So that includes things like housing. That includes things like developing healthy peer groups. This includes things like assisting with employment. I think the challenge in recovery, for someone who’s had a severe substance use disorder, is – like all the rest of us, it’s getting up each day and making meaning...’⁸⁹⁰

- 14.555 One witness told the Inquiry that when there is a lack of wraparound services, there is a sense that services do not understand what support the individual needs.⁸⁹¹

- 14.556 Assertive models of care, like the ACM Program, are a way to more actively engage individuals in their care and support them in accessing and maintaining contact with the services they need. The Inquiry heard that these approaches mean services are not giving up on people, they are advocating for their clients and supporting them by assertive engagement and follow-up.⁸⁹² Anita McRae from the Murrumbidgee PHN described how pre- and post-support can be beneficial in supporting individuals who have made contact with services but are not able to get immediate access to those services. This might include phone calls or linking people in with GPs and other care coordination.⁸⁹³
- 14.557 As already outlined, the health and social care systems are incredibly complex, recently described as *'too complex to navigate'*.⁸⁹⁴ Assertive care recognises this complexity and better outreach and follow-up can guide people through their care journey. A clinician on the north coast of NSW said *'if a patient drops out of – of follow-up, we actually chase them down'*.⁸⁹⁵ Aftercare programs, at times run by public and NGO services, can provide this assertive outreach as well as programs to maintain contact and engagement with people when they may be vulnerable.⁸⁹⁶
- 14.558 Assertive models can improve outcomes for people, with Dr Grant Sara, a psychiatrist and researcher, as well as a Director at the NSW Ministry of Health, observing that *'offering people an opportunity to be engaged in good care, being really assertive with that...can make a big difference.'*⁸⁹⁷

Recommendation 46:

That NSW Health adopt, implement and resource a *'no wrong door'* approach in AOD policy and practice so that all people who access a service are appropriately treated, managed or referred, including by way of assertive follow-up.

Models of co-located or combined health and social services

- 14.559 As described throughout this report, the Inquiry received extensive evidence highlighting that the harmful use of drugs is often coupled with aspects of social disadvantage such as histories of trauma, homelessness or insecure housing and unemployment.⁸⁹⁸ The need for better coordination of health and social services has been a consistent theme in the evidence received by the Inquiry. For example, in its submission, NADA noted:
- 'Improved client health and wellbeing outcomes could be achieved with a commitment to mechanisms that facilitate cross-sector partnerships with housing, employment, education and other services essential for building strong community resilience, in addition to genuine and appropriate engagement with carer and consumer support networks.'*⁸⁹⁹
- 14.560 Co-location models can provide single points of access to care, coordinate pathways and support holistic assessment and support.

14.561 In its submission to the 2015 Legislative Council *Inquiry into service coordination in communities with high social needs*, the NSW Government defined differing types and levels of intensity of service coordination to meet the needs of people with high social needs. The levels of coordination were:⁹⁰⁰

- consultation, such as sharing information about service activities
- coordinated activity across agencies, including strategic plans with different agencies leading different elements, and referrals and case coordination across agencies
- joint service delivery at the client level, including integrated service delivery in response to particular issues and the co-location of service delivery
- joint service design and planning, such as collaboration at a systems level towards joint outcomes, pooled funding and co-commissioning of services
- structural reform, which may include the amalgamation of service providers.

HealthOne

14.562 As an example in NSW, the HealthOne model operates a range of service models including co-location, hub-and-spoke models and/or virtual integration of community health and GPs. Other health and social care providers can also be involved in these models, including other government, NGO and private providers.⁹⁰¹ A number of HealthOne services also provide or coordinate access to other government and non-government health and human services. This can include coordination with the Department of Communities and Justice, Youth Justice, Aboriginal Health Services, Transcultural Mental Health Services, interpreter services and others.⁹⁰²

14.563 The goal of the program is to deliver integrated, client-focused, multidisciplinary care across a spectrum of needs.⁹⁰³ The NSW Health web site indicates that in the development of HealthOne services, community and consumer representatives should be consulted as part of both the service planning processes and in the delivery of services to clients.⁹⁰⁴

14.564 In 2006, HealthOne was established in Mount Druitt, an area in Sydney's west which has high levels of socioeconomic disadvantage and associated health needs. The model enabled better integration and coordination between health and social care, and a review found that communication and information exchange between clients and service providers was improved, and individuals felt more supported through their care journeys.⁹⁰⁵ The Inquiry heard that the Mount Druitt model required a lot of groundwork with GPs and primary and community health, but once under way, it was considered extremely successful.⁹⁰⁶

14.565 The Inquiry heard that HealthOne models are often GP-led, with other services and organisations providing in-reach services.⁹⁰⁷ A model in Sutherland, in Sydney's south, was described as having an allied health focus, which provides integrated health care as well as programs specific for Aboriginal communities.⁹⁰⁸

14.566 Since 2006–07, the NSW Government committed almost \$46 million to the capital development of integrated HealthOne services across the state, and in 2015 committed an additional \$100 million to develop new HealthOne facilities, enhance existing facilities or develop information and communications technology.⁹⁰⁹

- 14.567 The NSW Health web site indicates that there are 27 operational HealthOne service locations across the state and also indicates that a number of new sites are being developed in addition to upgrades of existing facilities. The operational services include five in each of Hunter New England LHD and Western NSW LHD, three in the Murrumbidgee LHD, two in each of Northern NSW LHD and Northern Sydney LHD, and one in each of Far West LHD, Mid North Coast LHD, Nepean Blue Mountains LHD, South Eastern Sydney LHD, Southern NSW LHD and Western Sydney LHD.⁹¹⁰

Consortium models

- 14.568 It is recognised that any integrated or co-located model of health and social services delivery require significant investment, as well as a strong commitment from services to make the model 'work'.
- 14.569 The Inquiry heard there are options to better integrate and coordinate using the resourcing and infrastructure that already exists.⁹¹¹ Consortium arrangements were noted as models that work, with multiple providers working collaboratively to provide a full suite of services. These partnerships can cross government and non-government boundaries, with common elements for success being multidisciplinary teams and supports, active case management and structured communication processes.⁹¹² At a foundational level, this is a 'collective' of organisations that have shared objectives of improving the health and social outcomes of their clients. Such models can be developed based on local context and need, with agreements as to the roles and responsibilities clearly articulated for those involved.
- 14.570 There are clear benefits to having better linkages between a variety of health and social services that would facilitate more integrated approaches to whole-of-person care and provide the wraparound supports that vulnerable individuals often need. The Inquiry heard that *'ideally, you always have an integrated service rather than a standalone service.'*⁹¹³ There are a range of factors which may constrain the models available to implement, but evidence to the Inquiry indicates that the concept of a 'one-stop-shop' would deliver better outcomes for people as they are more likely to make use of the services available to them when they can be found within the one location.⁹¹⁴
- 14.571 The NSW Government should work to deliver integrated and holistic support services to improve the health and social outcomes of people seeking health and social treatment and support for ATS. This may require consideration of funding mechanisms or incentives that can drive collaborative and integrated approaches, as well as how planning and commissioning processes can support more efficient and effective models.

Recommendation 47:

- A. That, to foster coordinated and collaborative approaches to health and psychosocial wellbeing of people seeking health and social treatment and support for amphetamine-type stimulants, the NSW Government trial a consortium model of care between various agencies and services, including community, primary and acute care, employment, housing and family support and court advocacy services. The location of this trial should be based on area of need.
- B. That, to improve care pathways for AOD clients with chronic and complex care needs, NSW Health should:
 - expand the current Strategic Framework for Integrating Care to expressly refer to AOD
 - develop formalised AOD care coordination protocols in consultation with NSW primary health networks, the Network of Alcohol and Other Drug Agencies, and the NSW Users and AIDS Association.
- C. That, to improve care pathways and accountability, NSW Health facilitate the sharing of client information across sectors, subject to clients' informed consent.

References

- 1 Australian Institute of Health and Welfare, Commonwealth, *Australia's Health 2016* (Report, 2016) 23.
- 2 Council on Federal Financial Relations, *National Health Reform Agreement* (Report, August 2011) 1, 4-10.
- 3 See, Council on Federal Financial Relations, *National Health Reform Agreement* (Report, August 2011).
- 4 St Vincent's Health Australia, Submission No 127 (14 May 2019) 22.
- 5 NSW Ministry of Health, *Corporate Governance & Accountability Compendium for NSW Health* (Report, May 2019) i.
- 6 NSW Ministry of Health, *Corporate Governance & Accountability Compendium for NSW Health* (Report, May 2019) 2.04.
- 7 NSW Ministry of Health, *NSW Health Performance Framework – NSW Health Services and Support Organisations* (June 2017) 3.
- 8 NSW Ministry of Health, *NSW Health Performance Framework* (Fact Sheet, 1 July 2012) 1
<<https://www.health.nsw.gov.au/healthreform/2012/Documents/performance.pdf>>.
- 9 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3906.15 (Wood).
- 10 Council on Federal Financial Relations, *National Health Reform Agreement* (Report, August 2011).
- 11 NSW Ministry of Health, *NSW Health Performance Framework – NSW Health Services and Support Organisations* (June 2017) 3.
- 12 NSW Ministry of Health, *Corporate Governance & Accountability Compendium for NSW Health* (Report, May 2019) 2.07; NSW Ministry of Health, *Submission No 13: Inquiry into the Management of Health Care Delivery in NSW* (Submission, 11 May 2017) 16.
- 13 NSW Ministry of Health, *Submission No 13: Inquiry into the Management of Health Care Delivery in NSW* (Submission, 11 May 2017) 16.
- 14 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3889.43 (Wood).
- 15 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3889.41-3 (Wood).
- 16 NSW Ministry of Health, *Submission No 13: Inquiry into the Management of Health Care Delivery in NSW* (Submission, 11 May 2017) 16.
- 17 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3906.20 (Wood).
- 18 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3907.01 (Dr Mitchell); Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 127, Response of NSW Health dated 6 September 2019, to Request for Information dated 16 August 2019, 9-10. See, for example, NSW Health, *2019-20 Service Agreement: An agreement between Secretary, NSW Health and the Sydney Local Health District for the period 1 July 2019- 30 June 2020* (30 July 2019) 27, 30.
- 19 Drug Policy Modelling Program, Submission No 57 (7 May 2019) 19.
- 20 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 91, Response of NSW Health dated 23 August 2019, to Request for Information dated 8 July 2019, 1. See also, NSW Treasury, 'Outcome Budgeting', *Treasury* (Web Page, 10 July 2018) <<https://www.treasury.nsw.gov.au/budget-financial-management/reform/outcome-budgeting>>.
- 21 Elizabeth Koff, 'From Volume to Value Driven Care' (Presentation, NSW Health, 2016) <<https://www.health.nsw.gov.au/innovation/2016symposium/Documents/presentations/elizabeth-koff.pdf>> 7; NSW Health, *Value based healthcare* (Web Page, 24 January 2019) <<https://www.health.nsw.gov.au/Value/Pages/default.aspx>>.
- 22 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3923.23-40 (Wood).
- 23 Australian Institute of Health and Welfare, Commonwealth, *Health expenditure Australia 2016-17* (Report, 2018) 30, Figure 3.3; Australian Institute of Health and Welfare, Commonwealth, *Health expenditure Australia 2016-17: Supplementary tables and figures* (Data, 2018) Table A10: Recurrent funding of public hospital services, constant prices, by source of funds and annual growth rates, 2007-07 to 2016-17 (%).
- 24 Australian Institute of Health and Welfare, Commonwealth, *Health expenditure Australia 2016-17* (Report, 2018) 52, Table A3; Australian Institute of Health and Welfare, Commonwealth, *Health expenditure Australia 2016-17: Supplementary tables and figures* (Data, 2018) Table A3: Total health expenditure, current prices, by area of expenditure and source of funds, 2016-17 (\$ million).
- 25 NSW Ministry of Health, *Submission No 13: Inquiry into the Management of Health Care Delivery in NSW* (Submission, 11 May 2017) 8.
- 26 Independent Hospital Pricing Authority, *National Efficient Price Determination 2019-20* (Report, March 2019) 7.
- 27 Planning and Funding Roundtable, Sydney, 16 September 2019 TS 3914.12 (Larkin).
- 28 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3922.21 (Wood).
- 29 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3909.9 (Dr Anderson).
- 30 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 92, Response of NSW Health dated 23 August 2019, to Request for Information dated 8 July 2019.
- 31 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3922.21-30 (Wood).
- 32 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 715, Correspondence from Paulina Moncrieff dated 6 November 2019 addressing queries raised in relation to NSW Health during Planning and Funding Roundtable.
- 33 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 715, Correspondence from Paulina Moncrieff dated 6 November 2019 addressing queries raised in relation to NSW Health during Planning and Funding Roundtable, 'Attachment A - AOD Funding.xlsx'.
- 34 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 91, Response of NSW Health dated 23 August 2019, to Request for Information dated 8 July 2019, [1].
- 35 NSW Health, 'About us', *Alcohol and other drugs* (Web Page) <<https://www.health.nsw.gov.au/aod/Pages/about.aspx>>.
- 36 NSW Health, *2019-20 Service Agreement: An agreement between Secretary, NSW Health and the Western NSW Health District for the period 1 July 2019-30 June 2020* (16 August 2019) 17.
- 37 NSW Health, *2019-20 Service Agreement: An agreement between Secretary, NSW Health and the Western NSW Health District for the period 1 July 2019-30 June 2020* (16 August 2019) 23.
- 38 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 715, Correspondence from Paulina Moncrieff dated 6 November 2019 addressing queries raised in relation to NSW Health during Planning and Funding Roundtable.

- 39 Department of Health, Commonwealth, 'What services are there?', *Drug Help* (Web Page, 24 October 2017) <<https://campaigns.health.gov.au/drughelp/what-services-are-there>>.
- 40 NSW Health, 'Drug and alcohol treatment', *Health* (Web Page, September 2017) <<https://www.health.nsw.gov.au/aod/programs/Pages/treatment.aspx>>.
- 41 Alison Ritter et al, Drug Policy Modelling Program, *New Horizons: The review of alcohol and other drug treatment services in Australia* (Final Report, July 2014) 17-18, 312.
- 42 Australian Health Policy Collaboration, Victoria University, *Australian health services: too complex to navigate – A review of the national reviews of Australia's health service arrangements* (Policy Issues Paper No 1, February 2019) 2.
- 43 Department of Health, Commonwealth, *Primary Health Networks, Grant Programme Guidelines* (Guidelines, February 2016) 7-8; NSW Health, Northern Sydney Local Health District, *Clinical Services Plan 2015-2022* (Plan, March 2015) 5.
- 44 NSW Ministry of Health, *NSW Health Performance Framework – NSW Health Services and Support Organisations* (June 2017) 6.
- 45 Department of Health, Commonwealth, *Primary Health Networks, Grant Programme Guidelines* (Guidelines, February 2016) 'Annexure A2 – Drug and Alcohol Treatment Services', 1.
- 46 Department of Health, Commonwealth, *Primary Health Networks, Grant Programme Guidelines* (Guidelines, February 2016) 'Annexure A2 – Drug and Alcohol Treatment Services', 5-6.
- 47 Department of Health, Commonwealth, *Needs Assessment Guide* (Report, December 2015) 2-3.
- 48 Department of Health, Commonwealth, *Needs Assessment Guide* (Report, December 2015) 3.
- 49 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 127, Response from NSW Health dated 6 September 2019, to Request for Information dated 16 August 2019, 11.
- 50 Department of Health, Commonwealth, *Primary Health Networks, Grant Programme Guidelines* (Report, February 2016) 8.
- 51 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 509, Response of Central and Eastern Sydney Primary Health Network dated 3 September 2019, to Request for Information dated 29 August 2019, 3.
- 52 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 511, Response of North Coast Primary Health Network dated 5 September 2019, to Request for Information dated 29 August 2019, 1-2.
- 53 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 511, Response of North Coast Primary Health Network dated 5 September 2019, to Request for Information dated 29 August 2019, 2.
- 54 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3868.8-47 (Dowrick).
- 55 Dubbo Hearing, Dubbo, 5 June 2019, TS 1689.40-1690.30 (Crisp); Broken Hill Hearing, Broken Hill, Exhibit D, Tab 24C, Supplementary Statement of Andrew Harvey, 16 July 2019, [3]; Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2759.28 (Miller).
- 56 UNSW Sydney, Monash University and EY, *Evaluation of the Primary Health Networks Program* (Final Report, July 2018) 40.
- 57 UNSW Sydney, Monash University and EY, *Evaluation of the Primary Health Networks Program* (Final Report, July 2018) 58.
- 58 UNSW Sydney, Monash University and EY, *Evaluation of the Primary Health Networks Program* (Final Report, July 2018) 44.
- 59 UNSW Sydney, Monash University and EY, *Evaluation of the Primary Health Networks Program* (Final Report, July 2018) 41.
- 60 UNSW Sydney, Drug Policy Modelling Program, 'National Treatment Framework', *Social Policy Research Centre* (Web Page) <<https://www.arts.unsw.edu.au/social-policy-research-centre/our-projects/national-treatment-framework>>; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 218, Response of Commonwealth Department of Health dated 4 September 2019 to Request for Information dated 29 August 2019, 2.
- 61 UNSW Sydney, Drug Policy Modelling Program, 'National Treatment Framework', *Social Policy Research Centre* (Web Page) <<https://www.arts.unsw.edu.au/social-policy-research-centre/our-projects/national-treatment-framework>>.
- 62 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 218, Response of Commonwealth Department of Health dated 4 September 2019, to Request for Information dated 29 August 2019, 2.
- 63 NSW Health, *Drug and Alcohol Service Planning Model for Australia: Technical Manual for the Intergovernmental Committee of Drugs (IGCD)* (Technical Manual, 26 August 2013) 10.
- 64 NSW Health, *Drug and Alcohol Service Planning Model for Australia: Technical Manual for the Intergovernmental Committee of Drugs (IGCD)* (Technical Manual, 26 August 2013) 12.
- 65 NSW Health, *Drug and Alcohol Service Planning Model for Australia: Technical Manual for the Intergovernmental Committee of Drugs (IGCD)* (Technical Manual, 26 August 2013) 14.
- 66 NSW Health, *Drug and Alcohol Service Planning Model for Australia: Technical Manual for the Intergovernmental Committee of Drugs (IGCD)* (Technical Manual, 26 August 2013) 16.
- 67 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3886.21-9 (Professor Ritter).
- 68 Portfolio Committee No 2 – Health and Community Services, *Provision of drug rehabilitation services in regional, rural and remote New South Wales* (Legislative Council Report 49, 6 August 2018) ix.
- 69 Brad Hazzard MP, *NSW Government response to the Portfolio Committee No 2 (Health and Community Services) Report 49 into the provision of drug rehabilitation services in regional, rural and remote New South Wales* (Response, 21 January 2019) 4.
- 70 NSW Government, Submission No 143 (12 June 2019) 30-1, [9.13]; see also, Planning and Funding Roundtable, 16 September 2019, TS 3886.13 (Professor Ritter).
- 71 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 127, Response of NSW Health dated 6 September 2019, to Request for Information dated 16 August 2019, 8.
- 72 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3900.44 (Dr Anderson).
- 73 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3901.20 (Dr Mitchell), TS 3901.29 (Cox).
- 74 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3330.39 (Dr Dunlop); Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3892.9 (James); Drug Policy Modelling Program, Submission No 57 (7 May 2019) 19.
- 75 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3887.1, 3902.16 (Professor Ritter).
- 76 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3891.14-3892.2 (Kmet), TS 3893.6-23 (Professor Ritter), TS 3894.10-15 (Hewett), TS 3898.39-3899.2 (James).
- 77 St Vincent's Health Australia, Submission No 127 (14 May 2019) 5.
- 78 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3891.24-47 (Kmet), TS 3892.6 (James), TS 3893.15 (Professor Ritter).

- 79 Australian Government, Department of Health, *PHNs: Commissioning Health Services Frequently Asked Questions* (Fact Sheet) 1 <[https://www1.health.gov.au/internet/main/publishing.nsf/Content/57DA4F780C7944D3CA25829E007C5906/\\$File/PHNs%20and%20Commissioning%20FAQ.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/57DA4F780C7944D3CA25829E007C5906/$File/PHNs%20and%20Commissioning%20FAQ.pdf)>.
- 80 Alison Ritter et al, *New Horizons: The review of alcohol and other drug treatment services in Australia* (Final Report, Drug Policy Modelling Program, July 2014) 19-20, 200-07.
- 81 Department of Health, Commonwealth, *Primary Health Networks, Grant Programme Guidelines* (Guidelines, February 2016) 'Annexure A2 – Drug and Alcohol Treatment Services', 1.
- 82 Department of Health, Commonwealth, *Primary Health Networks, Grant Programme Guidelines* (Guidelines, February 2016) 'Annexure A2 – Drug and Alcohol Treatment Services', 5-6.
- 83 Department of Health, Commonwealth, *Primary Health Networks, Grant Programme Guidelines* (Guidelines, February 2016) 'Annexure A2 – Drug and Alcohol Treatment Services', 6.
- 84 NSW Health, *Partnerships for Health: A response to the Grants Management Improvement Program Taskforce Report* (Report, March 2013) 4.
- 85 NSW Health, *Grants Management Improvement Program Taskforce (GMIT) Report* (Report, November 2012) 5-10.
- 86 NSW Health, 'Working with NGOs and other partners', *NSW Government – Health* (Web Page, 23 May 2017) <<https://web.archive.org/web/20190401071104/https://www0.health.nsw.gov.au/business/partners/Pages/default.aspx>>.
- 87 NSW Health, *Partnerships for Health: A response to the Grants Management Improvement Program Taskforce Report* (Report, March 2013) 4.
- 88 NSW Health, *NGO Reform: Key Program Milestones – Communications Summary* (Summary, 2017) 2; NSW Health, 'Communications - NSW Health grant program in 2018-2019', *NSW Health* (Web Page, 19 September 2019) <<https://www.health.nsw.gov.au/business/partners/Pages/grant-communications.aspx>>.
- 89 NSW Health, *NGO Reform: Key Program Milestones – Communications Summary* (Summary, 2017) 2.
- 90 NSW Health, *Annual Report 2017-18: Performance* (22 November 2018) 47.
- 91 NSW Health, *Annual Report 2017-18: Performance* (22 November 2018) 47.
- 92 NSW Health, *NGO Reform: Key Program Milestones – Communications Summary* (Summary, 2017) 2.
- 93 See, for example, East Maitland Hearing, East Maitland, 20 June 2019, TS 2139.46-2139.4 (Hewett).
- 94 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3934.20-5 (Byrne).
- 95 East Maitland Hearing, East Maitland, 20 June 2019, TS 2140.20-2141.2 (Hewett); Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3877.43-3878.4 (Byrne); Odyssey House, Submission No 71 (7 May 2019) 10.
- 96 Network of Alcohol and Other Drugs Agencies, Submission No 79 (May 2019) 14-15; Alison Ritter et al, Drug Policy Modelling Program, *New Horizons: The review of alcohol and other drug treatment services in Australia* (Final Report, July 2014) 14-15.
- 97 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3258.39-43 (Ganora); Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3863.19-27 (Dr Harrod); Sydney (General) Hearing, Sydney, Exhibit B, Tab 25, Statement of Jennifer Frendin, 1 May 2019, [11]; Lismore Hearing, Lismore, 14 May 2019, TS 624.16-625.23 (Lloyd); 15 May 2019, TS 811.29-47 (Crayden); Nowra Hearing, Nowra, Exhibit A, Tab 33, Statement of Shirley Diskon, 16 May 2019, [45]-[47]; Tab 31, Statement of Gabrielle Holmes, 14 May 2019, [81]; Tab 32, Statement of Mark Buckingham, 24 May 2019, 6; Tab 34, Statement of Will Temple, 27 May 2019, 10; Nowra Hearing, Nowra, 31 May 2019, TS 1233.21-40 (Diskon); East Maitland Hearing, East Maitland, Exhibit A, Tab 27, Statement of Joe Coyte, [50]; Broken Hill Hearing, Broken Hill, Exhibit D, Tab 36A, Statement of Ian Harvey, 12 July 2019, [35]; Moree Hearing, Moree, 16 August 2019, TS 3065.3-7 (Watson); Dubbo Hearing, Dubbo, 6 June 2019, TS 1790.6-39 (Campbell); Dubbo Hearing, Dubbo, 5 June 2019, TS 1689.40-1670.2 (Crisp).
- 98 Dubbo Hearing, Dubbo, Exhibit A, Tab 29, Statement of Michele Campbell, 23 May 2019, [25]; Dubbo Hearing, Dubbo, 6 June 2019, TS 1790.27-39 (Campbell).
- 99 Lismore Hearing, Lismore, 15 May 2019, TS 811.29-812.10 (Crayden).
- 100 See, for example, East Maitland Hearing, East Maitland, 20 June 2019, TS 2139.46-2140.4 (Hewett).
- 101 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3928.28-36 (Hewett).
- 102 Sydney (General) Hearing, Sydney, Exhibit B, Tab 31, Statement of Larry Pierce, April 2019, 7.
- 103 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3934.21-4 (Byrne).
- 104 Network of Alcohol and Other Drugs Agencies, Submission No 79 (May 2019) 7.
- 105 Dubbo Hearing, Dubbo, 6 June 2019, TS 1790.10-15 (Campbell); TS 1791.35-7 (Henderson).
- 106 Portfolio Committee No 2 – Health and Community Services, *Provision of drug rehabilitation services in regional, rural and remote New South Wales* (Report 49, 6 August 2018) ix.
- 107 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3868.8-3869.4 (Dowrick); 3869.17-3870.25 (James).
- 108 UNSW Sydney, Monash University and EY, *Evaluation of the Primary Health Networks Program* (Final Report, July 2018) 3; Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3880.24-32 (Hewett).
- 109 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3881.43-4 (Dr Moore).
- 110 Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services* (Report No 85, 27 October 2017) 2, 7-8; Dubbo Hearing, Dubbo, 5 June 2019, TS 1690.20-30 (Crisp); Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3898.1-16 (Wood); TS 3954.3-20 (Dr Moore); UNSW Sydney, Monash University and EY, *Evaluation of the Primary Health Networks Program* (Final Report, July 2018) 3; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 109, Response of Commonwealth Department of Health, dated 4 September 2019, to Request for Information dated 29 August 2019, 2; Alison Ritter et al, Drug Policy Modelling Program, *New Horizons: The review of alcohol and other drug treatment services in Australia* (Final Report, July 2014) 22; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) [4.2.1].
- 111 Funding Roundtable, Sydney, 16 September 2019, TS 3865.36-3866.9 (Kmet).
- 112 Funding Roundtable, Sydney, 16 September 2019, TS 3882.21-5 (Pierce).
- 113 Funding Roundtable, Sydney, 16 September 2019, TS 3882.29-41 (Kmet).
- 114 See Lillie Wenzel and Ruth Robertson, 'What is commissioning and how is it changing?', *The Kings Fund* (Web Page, 19 September 2019) <<https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing>>.

- 115 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3869.17-39, TS 3942.37-3943.17 (James); TS 3952.26-3953.20 (Professor Ritter); Department of Health, Commonwealth, *Primary Health Network Grant Programme Guidelines: Annexure A2 – Drug and Alcohol Treatment Services* (Summary) 5-6.
- 116 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3943.38-3945.20 (Dr Moore, Pierce, Professor Ritter, Byrne and Kmet).
- 117 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3944.9-12 (Pierce).
- 118 NSW Health, *Health Professionals Workforce Plan 2012-2022 – revised 2015* (Report, September 2015).
- 119 NSW Health, *Health Professionals Workforce Plan 2012-2022 – revised 2015* (Report, September 2015) 24.
- 120 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 17.
- 121 Intergovernmental Committee on Drugs, *National Alcohol and other Drug Workforce Development Strategy 2015-2018* (Strategy, July 2014); It is unknown whether there are plans for replacement of the national strategy past 2018.
- 122 Intergovernmental Committee on Drugs, *National Alcohol and other Drug Workforce Development Strategy 2015-2018* (Strategy, July 2014) 10.
- 123 Intergovernmental Committee on Drugs, *National Alcohol and other Drug Workforce Development Strategy 2015-2018* (Strategy, July 2014) 10.
- 124 Ann Roche and Ken Pidd, National Centre for Education and Training on Addiction (NCETA), *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene* (Report, 2010) 3.
- 125 Ann Roche and Ken Pidd, National Centre for Education and Training on Addiction (NCETA), *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene* (Report, 2010) 3-4.
- 126 Ann Roche and Ken Pidd, National Centre for Education and Training on Addiction (NCETA), *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene* (Report, 2010) 4.
- 127 Ann Roche and Ken Pidd, National Centre for Education and Training on Addiction (NCETA), *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene* (Report, 2010) 4.
- 128 Intergovernmental Committee on Drugs, *National Alcohol and other Drug Workforce Development Strategy 2015-2018* (Strategy, July 2014) 10.
- 129 Intergovernmental Committee on Drugs, *National Alcohol and other Drug Workforce Development Strategy 2015-2018* (Strategy, July 2014) 18.
- 130 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 15.
- 131 Network of Alcohol and Other Drugs Agencies, *NSW Alcohol and Other Drug Non-Government Sector: Workforce Profile and Issues 2008* (Report, 2008) 18; Network of Alcohol and Other Drugs Agencies, *Responding to alcohol and drug related harms in NSW – Mapping the NSW non government alcohol and other drugs sector* (Report, November 2014) 44.
- 132 Network of Alcohol and Other Drugs Agencies, *NSW Alcohol and Other Drug Non-Government Sector: Workforce Profile and Issues 2008* (Report, 2008) 18.
- 133 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 15.
- 134 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 15.
- 135 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 15.
- 136 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 36, Appendix C, 'Addiction Medicine'.
- 137 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 15.
- 138 Network of Alcohol and Other Drugs Agencies, *NSW Alcohol and Other Drug Non-Government Sector: Workforce Profile and Issues 2008* (Report, 2008) 18; Network of Alcohol and Other Drugs Agencies, *Responding to alcohol and drug related harms in NSW – Mapping the NSW non government alcohol and other drugs sector* (Report, November 2014) 42-43.
- 139 Ann Roche et al, National Centre for Education and Training on Addiction (NCETA), *Characteristics & wellbeing of the NSW non-government AOD workforce: A Report to the Network of Alcohol and Other Drugs Agencies (NADA)* (Report, April 2018); Network of Alcohol and Other Drugs Agencies, *Responding to alcohol and drug related harms in NSW – Mapping the NSW non government alcohol and other drugs sector* (Report, November 2014).
- 140 Ann Roche et al, National Centre for Education and Training on Addiction (NCETA), *Characteristics & wellbeing of the NSW non-government AOD workforce: A Report to the Network of Alcohol and Other Drugs Agencies (NADA)* (Report, April 2018) 7, 70.
- 141 Ann Roche et al, National Centre for Education and Training on Addiction (NCETA), *Characteristics & wellbeing of the NSW non-government AOD workforce: A Report to the Network of Alcohol and Other Drugs Agencies (NADA)* (Report, April 2018) 7-8.
- 142 Ann Roche et al, National Centre for Education and Training on Addiction (NCETA), *Characteristics & wellbeing of the NSW non-government AOD workforce: A Report to the Network of Alcohol and Other Drugs Agencies (NADA)* (Report, April 2018) 8.
- 143 Ann Roche et al, National Centre for Education and Training on Addiction (NCETA), *Characteristics & wellbeing of the NSW non-government AOD workforce: A Report to the Network of Alcohol and Other Drugs Agencies (NADA)* (Report, April 2018) 8.
- 144 Ann Roche et al, National Centre for Education and Training on Addiction (NCETA), *Characteristics & wellbeing of the NSW non-government AOD workforce: A Report to the Network of Alcohol and Other Drugs Agencies (NADA)* (Report, April 2018) 8.
- 145 Network of Alcohol and Other Drugs Agencies, *Responding to alcohol and drug related harms in NSW – Mapping the NSW non government alcohol and other drugs sector* (Report, November 2014) 44.
- 146 Network of Alcohol and Other Drugs Agencies, *NSW Alcohol and Other Drug Non-Government Sector: Workforce Profile and Issues 2008* (Report, 2008) 18.
- 147 Ann Roche et al, National Centre for Education and Training on Addiction (NCETA), *Characteristics & wellbeing of the NSW non-government AOD workforce: A Report to the Network of Alcohol and Other Drugs Agencies (NADA)* (Report, April 2018) 22.
- 148 Ann Roche and Ken Pidd, National Centre for Education and Training on Addiction (NCETA), *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene* (Report, 2010) 3.
- 149 Public Service Commission, NSW Government, *Workforce Profile Report 2018* (Report, 2018) 22.
- 150 Network of Alcohol and Other Drugs Agencies, Submission No 79 (May 2019) 16.

- 151 Network of Alcohol and Other Drugs Agencies, Submission No 79 (May 2019) 14.
- 152 Lismore Hearing, Lismore, Exhibit LF, Tab 12, Statement of Dr Bronwyn Hudson, 10 May 2019, [31].
- 153 Australian Medical Association NSW, Submission No 121 (14 May 2019) 3.
- 154 The Royal Australian & New Zealand College of Psychiatrists, New South Wales Branch, Submission No 32 (7 May 2019) 17.
- 155 Drug and Alcohol Nurses Australasia, Submission No 25 (7 May 2019) 3.
- 156 Intergovernmental Committee on Drugs, *National Alcohol and other Drug Workforce Development Strategy 2015-2018* (Strategy, July 2014) 19.
- 157 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3943.11 (James).
- 158 Network of Alcohol and Other Drugs Agencies, *Responding to alcohol and drug related harms in NSW – Mapping the NSW non government alcohol and other drugs sector* (Report, November 2014) 50.
- 159 Network of Alcohol and Other Drugs Agencies, *NSW Alcohol and Other Drug Non-Government Sector: Workforce Profile and Issues 2008* (Report, 2008) 20.
- 160 Network of Alcohol and Other Drugs Agencies, Submission No 79 (May 2019) 16; Sydney (General) Hearing, Sydney, Exhibit B, Tab 25, Statement of Jennifer Frendin, 1 May 2019, [11]-[12]; Tab 30, Statement of Gerard Byrne, 3 May 2019, 9 [11]; Tab 29, Statement of Garth Popple, 3 May 2019, 13-15.
- 161 Moree Hearing, Moree, 15 August 2019, TS 3011.40-3012.20 (Kelly); Dubbo Hearing, Dubbo, 6 June 2019, TS 1790.22-35 (Campbell); TS 1791.1-28 (Henderson); Dubbo Hearing, Dubbo, Exhibit A, Tab 29, Statement of Michele Campbell, 23 May 2019, [26(d)].
- 162 Dubbo Hearing, Dubbo, Exhibit A, Tab 28, Statement of Norm Henderson, 21 May 2019, [25]; Dubbo Hearing, Dubbo, 6 June 2019, TS 1793.14-30 (Campbell); TS 1793.35-46 (Bennett).
- 163 Moree Hearing, Moree, 15 August 2019, TS 3012.11-20 (Kelly).
- 164 Network of Alcohol and Other Drugs Agencies, *Responding to alcohol and drug related harms in NSW – Mapping the NSW non government alcohol and other drugs sector* (Report, November 2014) 50; Ann Roche and Ken Pidd, National Centre for Education and Training on Addiction (NCETA), *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene* (Report, 2010) 20.
- 165 Matilda Centre for Research in Mental Health and Substance Use and the Priority Research Centre for Brain and Mental Health, Submission No 74 (7 May 2019) 5; Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program* (Report No 8, August 2019) 23-4, 26; Australian Institute of Health and Welfare, Commonwealth, *National Drug Household Survey 2016: Detailed findings* (Report, 2017) 101.
- 166 Matilda Centre for Research in Mental Health and Substance Use and the Priority Research Centre for Brain and Mental Health, Submission No 74 (7 May 2019) 5, 7, 24.
- 167 Portfolio Committee No 2 – Health and Community Services, NSW Legislative Council, *Provision of drug rehabilitation services in regional, rural and remote New South Wales* (Report, August 2018) 2-3.
- 168 Portfolio Committee No 2 – Health and Community Services, NSW Legislative Council, *Provision of drug rehabilitation services in regional, rural and remote New South Wales* (Report, August 2018) 3-4.
- 169 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3224.16-3225.40 (Dr Dunlop).
- 170 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3225.17-28 (Dr Dunlop).
- 171 Australian Medical Association NSW, Submission No 121 (14 May 2019) 4.
- 172 Broken Hill City Council, Submission No 20 (1 May 2019) 2.
- 173 Broken Hill City Council, Submission No 20 (1 May 2019) 2.
- 174 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3224.16-3225.22 (Dr Dunlop).
- 175 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3225.9-13 (Dr Dunlop).
- 176 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3225.25-8 (Dr Dunlop).
- 177 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 24D, Statement of Professor Alan Rosen, 17 July 2019, [19].
- 178 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 24D, Statement of Professor Alan Rosen, 17 July 2019, [20].
- 179 Lismore Hearing, Lismore, 15 May 2019, TS 751.21-35 (Robinson).
- 180 Matilda Centre for Research in Mental Health and Substance Use and The Priority Research Centre for Brain and Mental Health, Submission No 74 (7 May 2019) 5.
- 181 Commonwealth Department of Health, 'About Cracks in the Ice', *Cracks in the Ice* (Web Page, 1 August 2019) <<https://cracksintheice.org.au/about-cracks-in-the-ice>>.
- 182 Commonwealth Department of Health, 'Crystal Clear: Understanding and responding to methamphetamine use', *Cracks in the Ice* (Web Page, 7 May 2019) <<https://cracksintheice.org.au/health-professionals/online-resources/crystal-clear-understanding-and-responding-to-methamphetamine-use>>.
- 183 Family and Friends Support Program, 'What is Family and Friend Support Program?', *FFSP* (Web Page, 2019) <<https://ffsp.com.au/>>; Matilda Centre for Research in Mental Health and Substance Use and The Priority Research Centre for Brain and Mental Health, Submission No 74 (7 May 2019) 24.
- 184 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3222.33-9 (Crisp).
- 185 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3950.37 (Dr Anderson).
- 186 Lismore Hearing, Lismore, 15 May 2019, TS 723.38-724.3 (Dr Helliwell).
- 187 The National Centre for Education and Training on Addiction, Submission No 110 (9 May 2019) 7.
- 188 Ann Roche et al, National Centre for Education and Training on Addiction (NCETA), *Characteristics & wellbeing of the NSW non-government AOD workforce: A Report to the Network of Alcohol and Other Drugs Agencies (NADA)* (Report, April 2018) 40-1.
- 189 For more detail on these approaches, see Roger Nicholas et al, National Centre for Education and Training on Addiction (NCETA), *Enhancing alcohol and other drug workers' wellbeing: A literature review* (Report, April 2017).
- 190 Sydney (General) Hearing, Sydney, Exhibit R, Tab 1, Statement of James Edwards, 6 May 2019, [41], [49]; Lismore Hearing, Lismore, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019, [30]; Australian Medical Association NSW, Submission No 121 (14 May 2019) 2-3.
- 191 Drug and Alcohol Nurses of Australasia, Submission No 25 (7 May 2019) 3.
- 192 Nowra Hearing, Nowra, 30 May 2019, TS 1094.25-30 (Bryant).

- 193 Lismore Hearing, Lismore, 15 May 2019, TS 728.45 (Dr Hudson); Lismore Hearing, Lismore, Exhibit LF, Tab 12, Statement of
Dr Bronwyn Hudson, 10 May 2019, [42]; East Maitland Hearing, East Maitland, 19 June 2019, TS 1982.42-1983.3 (Terry).
- 194 Drug and Alcohol Nurses of Australasia, Submission No 25 (7 May 2019) 3-4.
- 195 National Centre for Education and Training on Addiction, Submission No 110 (9 May 2019) 10.
- 196 National Centre for Education and Training on Addiction, Submission No 110 (9 May 2019) 10.
- 197 Drug and Alcohol Nurses Australasia, Submission No 25 (7 May 2019) 3-4.
- 198 Dubbo Hearing, Dubbo, Exhibit A, Tab 15, Statement of Scott Clark, 31 May 2019, [33].
- 199 St Vincent's Health Australia, Submission No 127 (14 May 2019) 19.
- 200 Commonwealth Department of Health, 'Cracks in the Ice', *Cracks in the Ice* (Web Page, 2019) <<https://cracksintheice.org.au/>>.
- 201 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3304.26-34 (Pierce); Network of Alcohol and Other Drugs
Agencies, Submission No 79 (May 2019) 9.
- 202 National Centre for Training on Addiction, 'Accreditation', *NCETA* (Web Page, 2019)
<http://nceta.flinders.edu.au/workforce/what_is_workforce_development/key-workforce-development-issues/accreditation/>.
- 203 Commonwealth Department of Health, 'National Registration and Accreditation Scheme (NRAS)', *The Department of Health* (Web
Page, 17 June 2019) <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-nras>>; Commonwealth Department of
Health, 'AHPRA FAQ', *AHPRA & National Boards* (Web Page, 27 August 2015) <<https://www.ahpra.gov.au/About-AHPRA/What-We-Do/FAQ.aspx>>; *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) s 2.
- 204 Commonwealth Department of Health, Commonwealth, 'Registration Standards', *AHPRA & National Boards* (Web Page,
3 December 2019) <<https://www.ahpra.gov.au/Registration/Registration-Standards.aspx>>.
- 205 Steve Olson and Sarah M Tracey, National Academies of Sciences, Engineering and Medicine, *Training the future child health care
workforce to improve the behavioural health of children, youth and families* (Report, 2017) 46.
- 206 National Centre for Training on Addiction, 'Worker Accreditation', *NCETA* (Web Page, 2019)
<http://nceta.flinders.edu.au/workforce/what_is_workforce_development/key-workforce-development-issues/accreditation/worker-a/>.
- 207 NSW Health, 'Organisation Accreditation for Alcohol and Other Drug Services – Fact Sheet', *NSW Health* (Web Page, 20 June
2018) <<https://www.health.nsw.gov.au/aod/Pages/organisation-accreditation.aspx>>.
- 208 NSW Government, Submission No 143 (12 June 2019) 23.
- 209 National Centre for Education and Training on Addiction, Submission No 110 (9 May 2019) 11-12.
- 210 South Western Sydney Primary Health Network, Submission No 91 (7 May 2019) 2; The Royal Australian and New Zealand
College of Psychiatrists, Submission No 32 (7 May 2019) 17; Health Service Responses Roundtable, Sydney, 20 August 2019,
TS 3213.17-24 (Dr Wilson).
- 211 Lismore Hearing, Lismore, 15 May 2019, TS 743.14-744.7 (Drs Helliwell and Hudson).
- 212 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3213.9-23 (Dr Wilson); 3217.35 (Wahhab).
- 213 Medical Board of Australia, *Registration Standard: Continuing Professional Development* (1 October 2016) 2-3.
- 214 Royal Australian and New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 17.
- 215 Lismore Hearing, Lismore, 15 May 2019, TS 742.7-16 (Dr Helliwell).
- 216 Drug and Alcohol Nurses Australasia, Submission No 25 (7 May 2019) 4.
- 217 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3217.45-3218.9 (Wahhab).
- 218 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3186.10-27 (Dr Wilson).
- 219 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3196.17-22 (Mokbel).
- 220 Kathlene Tracy and Samantha P Wallace, 'Benefits of Peer Support Groups in the Treatment of Addiction' (2016) 7 *Substance
Abuse and Rehabilitation* 143, 143-4.
- 221 Elizabeth Siantz, Benjamin Henwood and Todd Gilmer, 'Implementation of Peer Providers in Integrated Mental Health and Primary
Care Settings' (2016) 7(2) *Journal of the Society for Social Work and Research* 231, 231-2, 240.
- 222 Kathlene Tracy and Samantha P Wallace, 'Benefits of Peer Support Groups in the Treatment of Addiction' (2016) 7 *Substance
Abuse and Rehabilitation* 143, 151.
- 223 Steven Allsop and Nicole Lee, *Perspectives on Amphetamine-Type Stimulants* (IP Communications, 2012) 177-8.
- 224 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3261.38-46 (McRae), 3265.24-35 (Pierce), 3275.46-3276.3
(Ganora), 3278.34-3279.1 (Crisp); Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3957.28-31 (James);
Dubbo Hearing, Dubbo, 5 June 2019, TS 1684.14-30 (Crisp); Dubbo Hearing (Private), Dubbo, 3 June 2019, TS 1312.19-38
(Lived Experience Witness, Name Withheld); St Vincent's Health Australia, Submission No 127 (14 May 2019) 6.
- 225 Matilda Centre for Research in Mental Health and Substance Use and the Priority Research Centre for Brain and Mental Health,
Submission No 74 (7 May 2019) 5.
- 226 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3242.14 (Dr Dunlop).
- 227 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3242.5 (Dr Dunlop).
- 228 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3243.23 (Ganora).
- 229 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3244.20 (McRae).
- 230 Kari Lancaster, Kate Seear and Alison Ritter, *Reducing stigma and discrimination for people experiencing problematic alcohol and
other drug use* (Drug Policy Modelling Program Monograph 26, August 2018) 93-4.
- 231 Kari Lancaster, Kate Seear and Alison Ritter, *Reducing stigma and discrimination for people experiencing problematic alcohol and
other drug use* (Drug Policy Modelling Program Monograph 26, August 2018) 98.
- 232 Intergovernmental Committee on Drugs, *National Alcohol and other Drug Workforce Development Strategy 2015-2018* (Strategy,
July 2014) 41.
- 233 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 166, Response of the Commonwealth Department of Health dated
8 October 2019, to Request for Information dated 2 September 2019, 1-2.
- 234 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for
Information dated 5 July 2019, 16.
- 235 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for
Information dated 5 July 2019, 16.

- 236 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 16.
- 237 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 17.
- 238 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 17.
- 239 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 16-17.
- 240 Sydney (General) Hearing, Sydney, Exhibit B, Tab 31, Statement of Larry Pierce, 2 May 2019, 5; Royal Australian and New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 4, 17.
- 241 Royal Australian and New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 4, 17.
- 242 Australian Medical Association NSW, Submission No 121 (14 May 2019) 3.
- 243 Australian Medical Association NSW, Submission No 121 (14 May 2019) 4.
- 244 Australian Institute of Health and Welfare, Commonwealth, 'Table SE NSW.10 – Closed episodes provided for own drug use, by principal drug of concern, New South Wales, 2008-09 to 2017-18', *Data table: 2017-18 SE.State and territories (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 245 Australian Institute of Health and Welfare, Commonwealth, *Patterns of alcohol and other drug treatment service use in Australia: 1 July 2014 to 30 June 2018* (Report, 6 December 2019) 2.
- 246 Australian Institute of Health and Welfare, Commonwealth, *Patterns of alcohol and other drug treatment service use in Australia: 1 July 2014 to 30 June 2018* (Report, 6 December 2019) iv.
- 247 Australian Institute of Health and Welfare, Commonwealth, *Patterns of alcohol and other drug treatment service use in Australia: 1 July 2014 to 30 June 2018* (Report, 6 December 2019) 7.
- 248 Australian Institute of Health and Welfare, Commonwealth, *Patterns of alcohol and other drug treatment service use in Australia: 1 July 2014 to 30 June 2018* (Report, 6 December 2019) 4, 7.
- 249 Australian Institute of Health and Welfare, Commonwealth, 'Glossary', *Australia's Health* (Web Page, 12 September 2019) <<https://www.aihw.gov.au/reports-data/health-welfare-overview/australias-health/glossary>>.
- 250 Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37(2) *Drug and Alcohol Review* 196, 202.
- 251 Alison Ritter et al, Drug Policy Modelling Program, *New Horizons: The review of alcohol and other drug treatment services in Australia* (Final Report, July 2014) 13.
- 252 Australian Institute of Health and Welfare, Commonwealth, 'Table SE NSW.10 – Closed episodes provided for own drug use, by principal drug of concern, New South Wales, 2008-09 to 2017-18', *Data table: 2017-18 SE.State and territories (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 253 Australian Institute of Health and Welfare, Commonwealth, 'Table SE NSW.10 – Closed episodes provided for own drug use, by principal drug of concern, New South Wales, 2008-09 to 2017-18', *Data table: 2017-18 SE.State and territories (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 254 Australian Institute of Health and Welfare, Commonwealth, 'Table SD.4: Closed episodes provided for own drug use, by principal drug of concern and age group, 2008-09 to 2017-18', *Data table: 2017-18 SD.Drugs (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 255 Australian Institute of Health and Welfare, Commonwealth, 'Table SD.4: Closed episodes provided for own drug use, by principal drug of concern and age group, 2008-09 to 2017-18', *Data table: 2017-18 SD.Drugs (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 256 Lismore Hearing, Lismore, Exhibit LF, Tab 23, Statement of Leone Crayden, 13 May 2019, [4].
- 257 East Maitland Hearing, East Maitland, 20 June 2019, TS 2122.10 (Hewett).
- 258 Sydney (General) Hearing, Sydney, 10 May 2019, TS 366.39 (Byrne).
- 259 Dubbo Hearing, Dubbo, Exhibit A, Tab 28, Statement of Norm Henderson, 23 May 2019, [18].
- 260 Dubbo Hearing, Dubbo, Exhibit A, Tab 31, Statement of Alan Bennett, 27 May 2019, [13].
- 261 East Maitland Hearing, East Maitland, 20 June 2019, TS 2123.15 (Hewett).
- 262 Australian Institute of Health and Welfare, Commonwealth, 'Table SE NSW.25 – Closed episodes provided for own drug use, by main treatment type and principal drug of concern, New South Wales, 2013-14 to 2017-18', *Data table: 2017-18 SE.State and territories (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 263 Australian Institute of Health and Welfare, Commonwealth, 'Table SE NSW.25 – Closed episodes provided for own drug use, by main treatment type and principal drug of concern, New South Wales, 2013-14 to 2017-18', *Data table: 2017-18 SE.State and territories (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 264 Australian Institute of Health and Welfare, Commonwealth, 'Table SE NSW.12 – Closed episodes provided for own drug use, by principal drug of concern and referral source, New South Wales, 2017-18', *Data table: 2017-18 SE.State and territories (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 265 Dubbo Hearing, Dubbo, 6 June 2019, TS 1781.47 (Henderson).
- 266 Julaine Allan et al, 'Increased demand for amphetamine treatment in rural Australia' (2019) 14(13) *Addiction Science and Clinical Practice* 1, 8.
- 267 Australian Institute of Health and Welfare, Commonwealth, 'Table SE NSW.14 – Closed episodes provided for own drug use, by principal drug of concern and method of use for principal drug, New South Wales, 2017-18', *Data table: 2017-18 SE.State and territories (episodes) – AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 268 Australian Institute of Health and Welfare, Commonwealth, 'Table SD.55: Closed episodes provided for own drug use where amphetamines by was a principal drug of concern, by method of use and Indigenous status, 2008-09 to 2017-18', *Data table:*

- 2017-18 SD. *Drugs (episodes)* – AIHW 2019. *Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 269 Australian Institute of Health and Welfare, Commonwealth, 'Table SE NSW.14 – Closed episodes provided for own drug use, by principal drug of concern and method of use for principal drug, New South Wales, 2017-18', *Data table: 2017-18 SE. State and territories (episodes)* – AIHW 2019. *Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 270 Australian Institute of Health and Welfare, 'Table SA.3 - Treatment agencies by remoteness (SA2) and service sector of agency, states and territories, 2017-18', *Data table: 2017-18 SA. Agency (episodes) - AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 271 Australian Institute of Health and Welfare, 'Table SA.1 - Treatment agencies by service sector, states and territories, 2008-09 to 2017-18', *Data table: 2017-18 SA. Agency (episodes) - AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 272 Australian Institute of Health and Welfare, 'Table SA.3 - Treatment agencies by remoteness (SA2) and service sector of agency, states and territories, 2017-18', *Data table: 2017-18 SA. Agency (episodes) - AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 273 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 7.
- 274 St Vincent's Health Australia, Submission No 127 (14 May 2019) 4.
- 275 Nowra Hearing, Nowra, 31 May 2019, TS 1226.15-34 (Diskon).
- 276 Dubbo Hearing, Dubbo Exhibit A, Tab 31, Statement of Alan Bennett, 27 May 2019, [14].
- 277 Nowra Hearing, Nowra, 31 May 2019, TS 1259.37-1260.5 (Holmes).
- 278 Turning Point, *Methamphetamine Treatment Guidelines – Practice Guidelines for Health Professionals* (Guidelines, 2nd Edition, 2018) 22.
- 279 Australian Drug Foundation, *The stepped care model: a useful intervention strategy for people who use methamphetamine* (Fact Sheet, September 2008) 2 <<https://cracksintheice.org.au/doc/stepped-care-model.pdf>>.
- 280 Frances Kay-Lambkin, 'Technology and Innovation in the Psychosocial Treatment of Methamphetamine Use, Risk and Dependence' (2008) 27(3) *Drug and Alcohol Review* 318, 318, 322; Frances Kay-Lambkin et al, 'Stepping Through Treatment: Reflections on an Adaptive Treatment Strategy Among Methamphetamine Users with Depression' (2010) 29(5) *Drug and Alcohol Review* 475, 478-481; Amanda Baker and Sharon Dawe, 'Amphetamine Use and Co-occurring Psychological Problems: Review of the Literature and Implications for Treatment' (2005) 40(2) *Australian Psychologist* 88, 91-3.
- 281 Rebecca McKetin et al, 'Treatment Outcomes for Methamphetamine Users Receiving Outpatient Counselling from the Stimulant Treatment Program in Australia' (2012) 32(1) *Drug and Alcohol Review* 80, 81.
- 282 Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37(2) *Drug and Alcohol Review* 196, 199.
- 283 Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37 *Drug and Alcohol Review* 196, 200.
- 284 Anish Unadkat et al, 'Methamphetamine use in patients presenting to emergency departments and psychiatric inpatient facilities: what are the service implications?' (2018) 27(1) *Australasian Psychiatry* 14, 15.
- 285 NSW Health, *2019-20 KPI and Improvement Measure Data Supplement* (Data Supplement, July 2019) 96.
- 286 Lismore Hearing, Lismore, 14 May 2019, TS 656.28-657.12 (Dr Davies).
- 287 Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2649.15-40 (Dr Olesnick).
- 288 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 13, Statement of Dr Andrew Olesnick, 18 June 2019, [10].
- 289 Alison Ritter et al, Drug Policy Modelling Program, *New Horizons: The review of alcohol and other drug treatment services in Australia* (Final Report, July 2014) 13.
- 290 Commonwealth of Australia, Department of Prime Minister and Cabinet, *Final Report of the National Ice Taskforce* (Report, 2015) 131.
- 291 St Vincent's Health Australia, Submission No 127 (14 May 2019) 4.
- 292 Portfolio Committee No 2 – Health and Community Services, NSW Legislative Council, *Provision of drug rehabilitation services in regional, rural and remote New South Wales* (Report, August 2018) 63-4.
- 293 Brad Hazzard MP, *NSW Government response to the Portfolio Committee No 2 (Health and Community Services) Report 49 into the provision of drug rehabilitation services in regional, rural and remote New South Wales* (Response, 21 January 2019) 4.
- 294 East Maitland Hearing, East Maitland, 20 June 2019, TS 2118.23 (Hartley).
- 295 Drug Policy Modelling Program, University of NSW, Submission No 57 (7 May 2019) 11.
- 296 Network of Alcohol and Other Drug Agencies, Submission No 79 (May 2019) 6.
- 297 Matilda Centre for Research in Mental Health and Substance Use and the Priority Research Centre for Brain and Mental Health, Submission No 74 (7 May 2019) 14.
- 298 Australian Medical Association NSW, Submission No 121 (14 May 2019) 3.
- 299 See, eg, Sydney (General) Hearing, Sydney, Exhibit B, Tab 31, Statement of Larry Pierce, April 2019, 4-6; Alison Ritter et al, Drug Policy Modelling Program, *New Horizons: The review of alcohol and other drug treatment services in Australia* (Final Report, July 2014) 13; Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3899.8-25 (Pierce); TS 3957.28-45 (James); Sydney (General) Hearing, Sydney, Exhibit B, Tab 30, Statement of Gerard Byrne, 3 May 2019, 8; Tab 29, Statement of Garth Popple, 3 May 2019, [13]; Lismore Hearing, Lismore, Exhibit LF, Tab 23, Statement of Leone Crayden, 13 May 2019, [9]-[10]; Dubbo Hearing, Dubbo, Exhibit A, Tab 31, Statement of Alan Bennett, 27 May 2019, [18], [25]; Upper Hunter Mental Health Interagency, Submission 62 (1 May 2019) [3.1.13].
- 300 Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 23; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 6, 9; National Drug Research Institute, Submission No 48 (May 2019) 4; Australasian College for Emergency Medicine, Submission No 52 (May 2019) 3-5; NSW Council of Social Service, Submission No 54 (May 2019) 6-7; St Vincent's Health Australia, No 127 (14 May 2019) 4-5.
- 301 The Royal Australian and New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 4.
- 302 Sydney (General) Hearing, Sydney, 10 May 2019, TS 366.16 (Popple).
- 303 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3334.9 (Pierce).

- 304 North Coast Primary Health Network, *Alcohol and Other Drug Treatment Needs Assessment* (Report, 2018) 10-12.
- 305 Nowra Hearing, Nowra, Exhibit A, Tab 31, Statement of Gabriella Holmes, 24 May 2019, [33]-[37].
- 306 East Maitland Hearing, East Maitland, Exhibit A, Tab 25, Statement of Catherine Hewett, 14 June 2019, [5]; East Maitland Hearing, East Maitland, 20 June 2019, TS 2124.16 (Hewett).
- 307 East Maitland Hearing, East Maitland, 18 June 2019, TS 1932.5 (Lowe).
- 308 Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37(2) *Drug and Alcohol Review* 196, 201; Craig Cumming et al, 'Barriers to accessing methamphetamine treatment: A systematic review and meta-analysis' (2016) 168 *Drug and Alcohol Dependence* 263, 263, 266-271; Amy Pennay and Nicole Lee, 'Barriers to methamphetamine withdrawal treatment in Australia: Findings from a survey of AOD service providers' (2009) 28(6) *Drug and Alcohol Review* 636, 636-640.
- 309 Lismore Hearing, Lismore, 15 May 2019, TS 723.38-43 (Dr Helliwell).
- 310 Dubbo Hearing, Dubbo, 4 June 2019, TS 1463.27-40 (Dr Spencer).
- 311 Lismore Hearing, Lismore, 15 May 2019, TS 723.28-32 (Dr Hudson).
- 312 Dubbo Hearing, Dubbo, 5 June 2019, TS 1641.4-15 (Taylor); East Maitland Hearing, East Maitland, 20 June 2019, TS 2123.38-41, 2134.3-8, 2134.22-31 (Hewett); Sydney (General) Hearing, Sydney, 9 May 2019, TS 309.12-22 (Thomson), 328.11-20 (Green), 358.46-359.12 (Poppo), 402.10-13 (M Bonham); Lismore Hearing, Lismore, 15 May 2019, TS 807.21-34 (Crayden).
- 313 Network of Alcohol and Other Drug Agencies, Submission No 79 (May 2019) 6.
- 314 Nowra Hearing, Nowra, 31 May 2019, TS 1227.46-1228.7 (Diskon).
- 315 Lismore Hearing (Private), Lismore, 13 May 2019, TS 452.42 (Lived Experience Witness, Name Withheld).
- 316 Dubbo Hearing, Dubbo, Exhibit A, Tab 28, Statement of Norm Henderson, 23 May 2019, [14].
- 317 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 11.
- 318 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 13.
- 319 Lismore Hearing, Lismore, 14 May 2019, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019, [20].
- 320 Broken Hill Hearing (Private), Broken Hill, 15 July 2019, TS 2375.20-2 (Lived Experience Witness, Name Withheld); Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2540.13-16, 2542.28-33 (Harvey).
- 321 Dubbo Hearing, Dubbo, 5 June 2019, TS 1663.26-36 (Crisp).
- 322 St Vincent's Health Australia, Submission No 127 (14 May 2019) 15.
- 323 Australian Institute of Health and Welfare, Commonwealth, 'Table SA.1 - Treatment agencies by service sector, states and territories, 2008-09 to 2017-18', *Data table: 2017-18 SA.Agency (episodes) - AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 324 Australian Institute of Health and Welfare, Commonwealth, 'Table SA.8 - Closed treatment episodes by remoteness area (SA2) of agency and principal drug of concern, states and territories, 2017-18', *Data table: 2017-18 SA.Agency (episodes) - AIHW 2019. Alcohol and other drug treatment services in Australia 2017-18* (Online Data, 10 July 2019) <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18/data>>.
- 325 Margaret Hamilton and Adrian Dunlop, 'Ice' (Crystal methamphetamine) concerns and responses' (2016) 204(2) *Medical Journal Australia* 136, 136.
- 326 Australian Medical Association NSW, Submission No 121 (14 May 2019) 3.
- 327 Merriam-Webster, 'Acute care', *Merriam-Webster Medical Dictionary* (Web Page, 2020) <<https://www.merriam-webster.com/medical/acute%20care>>; Australian Institute of Health and Welfare, Commonwealth, 'Glossary', *Hospitals* (Web Page, 28 November 2019) <<https://www.aihw.gov.au/reports-data/myhospitals/content/glossary>>.
- 328 Lismore Hearing, Lismore, 14 May 2019, TS 641.40-642.7 (Dr Davies).
- 329 Sydney (General) Hearing, Sydney, Exhibit R, Tab 4, Statement of Jordan Emery, 6 May 2019; Lismore Hearing, Lismore, Exhibit LF, Tab 11, Statement of Paul Millard, 9 May 2019; Nowra Hearing, Nowra, Exhibit A, Tab 11, Statement of Matthew Sterling, 10 May 2019; Dubbo Hearing, Dubbo, Exhibit A, Tab 17, Statement of Isaac Graham, 15 May 2019; East Maitland Hearing, East Maitland, Exhibit A, Tab 13, Statement of Thomas McPherson, 25 May 2019; Broken Hill Hearing, Broken Hill, Exhibit D, Tab 21, Statement of Jamie Peetz, 20 May 2019.
- 330 Sydney (General) Hearing, Sydney, Exhibit R, Tab 4, Statement of Jordan Emery, 6 May 2019, [7]; Lismore Hearing, Lismore, Exhibit LF, Tab 11, Statement of Paul Millard, 9 May 2019, [10]; Nowra Hearing, Nowra, Exhibit A, Tab 11, Statement of Matthew Sterling, 10 May 2019, [9]; Dubbo Hearing, Dubbo, Exhibit A, Tab 17, Statement of Isaac Graham, 15 May 2019, [11]; East Maitland Hearing, East Maitland, Exhibit A, Tab 13, Statement of Thomas McPherson, 25 May 2019, [4]; Broken Hill Hearing, Broken Hill, Exhibit D, Tab 21, Statement of Jamie Peetz, 20 May 2019, [13], [38]. See also, Health Services Union, Submission No 126 (14 May 2019) 1-2.
- 331 Sydney (General) Hearing, Sydney, Exhibit R, Tab 4, Statement of Jordan Emery, 6 May 2019, [8]; Lismore Hearing, Lismore, Exhibit LF, Tab 11, Statement of Paul Millard, 9 May 2019, [12]; Nowra Hearing, Nowra, Exhibit A, Tab 11, Statement of Matthew Sterling, 10 May 2019, [10]; East Maitland Hearing, East Maitland, Exhibit A, Tab 13, Statement of Thomas McPherson, 25 May 2019, [4], [11].
- 332 Sydney (General) Hearing, Sydney, Exhibit R, Tab 4, Statement of Jordan Emery, 6 May 2019, [8]; Lismore Hearing, Lismore, Exhibit LF, Tab 11, Statement of Paul Millard, 9 May 2019, [18]; Nowra Hearing, Nowra, Exhibit A, Tab 11, Statement of Matthew Sterling, 10 May 2019, [15]; Dubbo Hearing, Dubbo, Exhibit A, Tab 17, Statement of Isaac Graham, 15 May 2019, [19]-[20]; East Maitland Hearing, East Maitland, Exhibit A, Tab 13, Statement of Thomas McPherson, 25 May 2019, [4]; Broken Hill Hearing, Broken Hill, Exhibit D, Tab 21, Statement of Jamie Peetz, 20 May 2019, [23]; Lismore Hearing, Lismore, 15 May 2019, TS 770.19-33 (Millard); Nowra Hearing, Nowra, 30 May 2019, TS 1039.43-1040.23 (Sterling); Dubbo Hearing, Dubbo, 4 June 2019, TS 1429.26-9 (Graham).
- 333 Sydney (General) Hearing, Sydney, Exhibit R, Tab 4, Statement of Jordan Emery, 6 May 2019, [9]; Lismore Hearing, Lismore, Exhibit LF, Tab 11, Statement of Paul Millard, 9 May 2019, [11]; Nowra Hearing, Nowra, Exhibit A, Tab 11, Statement of Matthew Sterling, 10 May 2019, [11]; Dubbo Hearing, Dubbo, Exhibit A, Tab 17, Statement of Isaac Graham, 15 May 2019, [13]; East Maitland Hearing, East Maitland, Exhibit A, Tab 13, Statement of Thomas McPherson, 25 May 2019, [4], [13]; Broken Hill Hearing, Broken Hill, Exhibit D, Tab 21, Statement of Jamie Peetz, 20 May 2019, [18]; Lismore Hearing, Lismore, 15 May 2019, TS 770.19-33 (Millard); Nowra Hearing, Nowra, 30 May 2019, TS 1039.43-1040.23 (Sterling); Dubbo Hearing, Dubbo, 4 June 2019, TS 1430.29-1431.11 (Graham).
- 334 Sydney (General) Hearing, Sydney, 9 May 2019, TS 286.37-43 (Skinner); Lismore Hearing, Lismore, Exhibit LF, Tab 13, Statement of Rob Davies, 8 May 2019, [17]; Dubbo Hearing, Dubbo, 5 June 2019, TS 1665.45-1666.15 (Crisp); Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2654.42-2655.7 (Dr Olesnick).

- 335 Sydney (General) Hearing, Sydney, Exhibit R, Tab 4, Statement of Jordan Emery, 6 May 2019, [12]–[13]; Lismore Hearing, Lismore, Exhibit LF, Tab 11, Statement of Paul Millard, 9 May 2019, [16].
- 336 Dubbo Hearing, Exhibit A, Tab 17, Statement of Isaac Graham, 15 May 2019, [29]; East Maitland Hearing, East Maitland, Exhibit A, Tab 13, Statement of Thomas McPherson, 25 May 2019, [21]; Lismore Hearing, Lismore, 15 May 2019, TS 774.14-24 (Millard); Dubbo Hearing, Dubbo, 4 June 2019, TS 1434.36-1436.4 (Graham).
- 337 Dubbo Hearing, Dubbo, Exhibit A, Tab 17, Statement of Isaac Graham, 15 May 2019, [35]; East Maitland Hearing, East Maitland, Exhibit A, Tab 13, Statement of Thomas McPherson, 25 May 2019, [33]; Broken Hill Hearing, Broken Hill, Exhibit D, Tab 21, Statement of Jamie Peetz, 20 May 2019, [41].
- 338 Health Services Union, Submission No 126 (14 May 2019) 2, 4-5.
- 339 Peter Garling SC, *Final Report of the Special Commission of Inquiry – Acute Care Services in NSW Public Hospitals* (Report, 27 November 2008) Vol 2, 716.
- 340 NSW Health, 'Emergency Department Care', *NSW Health* (Web Page, 4 March 2019) <<https://www.health.nsw.gov.au/Performance/Pages/emergency.aspx>>.
- 341 Australasian College of Emergency Medicine, *Policy on Standard Terminology* (Policy, v5.1, June 2019) 5.
- 342 NSW Health, *Annual Report 2018-19* (Report, October 2019) 269; Australian Institute of Health and Welfare, Commonwealth, 'Table 2.2: Emergency department presentations, by state and territory, 2014-15 to 2018-19', *Emergency department care 2018-19: Australian hospital statistics* (Online Data, 6 December 2019) <<https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>>.
- 343 Australian Institute of Health and Welfare, Commonwealth, 'Table 2.2: Emergency department presentations, by state and territory, 2014-15 to 2018-19', *Emergency department care 2018-19: Australian hospital statistics* (Online Data, 6 December 2019) <<https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>>.
- 344 Matthew Oliver et al, 'Impact of acutely behavioural disturbed patients in the emergency department: A prospective observational study' (2019) 31(3) *Emergency Medicine Australasia* 387, 390.
- 345 Margaret Fry, *Impact of providing after hours care on acute care utilisation: a rapid review* (Review, Sax Institute, November 2008) 2.
- 346 Australian Institute of Health and Welfare, Commonwealth, 'Table 3.3: Emergency department presentations by triage category and remoteness of area of usual residence, 2018-19', *Emergency department care 2018-19: Australian hospital statistics* (Online Data, 6 December 2019) <<https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>>.
- 347 Fiona MacKichan et al, 'Why Do Patients Seek Primary Medical Care in Emergency Departments? An Ethnographic Exploration of Access to General Practice' (2017) 7(4) *BMJ Open* 1, 1.
- 348 Australian Institute of Health and Welfare, Commonwealth, 'Table 3.3: Emergency department presentations by triage category and remoteness of area of usual residence, 2018-19', *Emergency department care 2018-19: Australian hospital statistics* (Online Data, 6 December 2019) <<https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>>.
- 349 Australasian College for Emergency Medicine, Submission No 52 (May 2019) 2.
- 350 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 89, Response of NSW Health dated 23 July 2019, to Request for Information dated 18 June 2019, 1-2.
- 351 Dubbo Hearing, Dubbo, 4 June 2019, TS 1446.24-1447.17 (Waters).
- 352 Dubbo Hearing, Dubbo, 4 June 2019, TS 1452.15-43 (Waters); East Maitland, East Maitland, 19 June 2019, TS 2033.1 (Dr Ryan); Broken Hill, Broken Hill, 17 July 2019, TS 2651.1 (Dr Olesnick); Suzanne Gray et al, 'Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation' (2007) 186(7) *Medical Journal of Australia* 336, 336; Matthew Oliver et al, 'Impact of acutely behavioural disturbed patients in the emergency department: A prospective observational study' (2019) 31(3) *Emergency Medicine Australasia* 387, 387; Anish Unadkat et al, 'Methamphetamine use in patients presenting to emergency departments and psychiatric inpatient facilities: what are the service implications?' (2019) 27(1) *Australasian Psychiatry* 14, 14.
- 353 Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37(2) *Drug and Alcohol Review* 196, 196-7.
- 354 Australasian College of Emergency Medicine, Submission No 52 (May 2019) 2.
- 355 Lismore Hearing (Private), Lismore, 13 May 2019, TS 497.27-30 (Lived Experience Witness, Name Withheld).
- 356 Lismore Hearing, Lismore, 14 May 2019, TS 647.34-5 (Dr Davies); Dubbo Hearing, Dubbo, 4 June 2019, TS 1460.19-32 (Waters).
- 357 Sydney (General) Hearing, Sydney, Exhibit R, Tab 1, Statement of James Edwards, 6 May 2019, [13]–[15].
- 358 Harm Reduction Hearing, Sydney, Exhibit A, Tab 73, Joint Report of David McCutcheon and Jessamine Soderstrom to *Coronial Inquest into deaths at music festivals*, 28 June 2019, 7.
- 359 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 108, Response of St Vincent's Hospital Sydney dated 4 September 2019, to Request for Information dated 13 August 2019.
- 360 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 101, Response of St Vincent's Hospital Sydney dated 30 August 2019, to Request for Information dated 13 August 2019.
- 361 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 89, Response of NSW Health dated 23 July 2019, to Request for Information dated 18 June 2019; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 151, Response of NSW Health dated 20 September 2019, to Request for Information dated 6 September 2019, Attachment A, 1.
- 362 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 151, Response of NSW Health dated 20 September 2019, to Request for Information dated 6 September 2019, Attachment A, 1.
- 363 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 89, Response of NSW Health dated 23 July 2019, to Request for Information dated 18 June 2019, 4.
- 364 Dubbo Hearing, Dubbo, 4 June 2019, TS 1460.42-6 (Waters).
- 365 Dubbo Hearing, Dubbo, 4 June 2019, TS 1468.4 (Dr Spencer); TS 1468.12-19 (Waters).
- 366 Lismore Hearing, Lismore, 14 May 2019, TS 661.28-38 (Dr Davies).
- 367 Lismore Hearing, Lismore, 14 May 2019, TS 661.28-38 (Dr Davies).
- 368 Lismore Hearing, Lismore, 14 May 2019, TS 661.8-12 (Dr Davies).
- 369 Dubbo Hearing, Dubbo, 4 June 2019, TS 1469.19-23 (Dr Spencer).
- 370 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 151, Response of NSW Health dated 20 September 2019, to Request for Information dated 6 September 2019, Attachment A, 2.
- 371 East Maitland Hearing, East Maitland, Exhibit A, Tab 9, Statement of Marcia Fogarty, 29 May 2019, [12], [22].

- 372 Lismore Hearing, Lismore, 14 May 2019, TS 677.43-678.6 (Dr Wims).
- 373 Lismore Hearing, Lismore, 14 May 2019, TS 674.23-36 (Dr Wims).
- 374 Anish Unadkat et al, 'Methamphetamine use in patients presenting to emergency departments and psychiatric inpatient facilities: what are the service implications?' (2019) 27(1) *Australasian Psychiatry* 14, 15.
- 375 Lismore Hearing, Lismore, 14 May 2019, TS 675.35 (Dr Wims).
- 376 Lismore Hearing, Lismore, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019, [30].
- 377 Lismore Hearing, Lismore, 14 May 2019, TS 675.24-31 (Dr Wims).
- 378 Sydney (General) Hearing, Sydney, Exhibit R, Tab 1, Statement of James Edwards, 6 May 2019, [25]-[26].
- 379 NSW Health, *NSW Health Admission Policy* (Policy Directive, 15 June 2017) 3.
- 380 NSW Health, *Emergency Department – Direct Admission to Inpatient Wards* (Policy Directive, 7 September 2009).
- 381 Lismore Hearing, Lismore, 14 May 2019, TS 676.27-42 (Dr Wims).
- 382 East Maitland Hearing, East Maitland, Exhibit A, Tab 9, Statement of Marcia Fogarty, 29 May 2019, [24]; Lismore Hearing, Lismore, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019, [17].
- 383 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 17-18.
- 384 Lismore Hearing, Lismore, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019, [16].
- 385 Lismore Hearing, Lismore, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019, [13].
- 386 Peter Garling SC, *Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Report, 27 November 2008) Vol 2, 811.
- 387 Legislative Assembly of New South Wales Committee on Law and Safety, *Violence Against Emergency Services Personnel* (Report No 1/56, August 2017) 2, 8.
- 388 Peter Anderson, *Improvements to security in hospitals* (Interim Report, February 2019) 5.
- 389 NSW Bureau of Crime Statistics and Research, 'Police-recorded assaults on hospital premises in New South Wales' (Web Page, 26 February 2016) <https://www.bocsar.nsw.gov.au/Pages/bocsar_pages/Assaults-on-hospital-premises.aspx>.
- 390 Sydney (General) Hearing, Sydney, Exhibit R, Tab 1, Statement of James Edwards, 6 May 2019, [40].
- 391 Lismore Hearing, Lismore, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019, [33].
- 392 Sydney (General) Hearing, Sydney, Exhibit R, Tab 1, Statement of James Edwards, 6 May 2019, [41].
- 393 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 89, Response of NSW Health dated 23 July 2019, to Request for Information dated 18 June 2019, 19-56.
- 394 Peter Anderson, *Improvements to security in hospitals* (Interim Report, February 2019) 7-8.
- 395 Australian Medical Association NSW, Submission No 121 (14 May 2019) 3.
- 396 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 89, Response of NSW Health dated 23 July 2019, to Request for Information dated 18 June 2019, 7.
- 397 Anish Unadkat et al, 'Methamphetamine use in patients presenting to emergency departments and psychiatric inpatient facilities: what are the service implications?' (2019) 27(1) *Australasian Psychiatry* 14, 15.
- 398 Anish Unadkat et al, 'Methamphetamine use in patients presenting to emergency departments and psychiatric inpatient facilities: what are the service implications?' (2019) 27(1) *Australasian Psychiatry* 14, 15.
- 399 Harm Reduction Hearing, Sydney, Exhibit A, Tab 73, Joint Report of David McCutcheon and Jessamine Soderstrom to *Coronial Inquest into Deaths at Music Festivals*, 28 June 2019, 7.
- 400 Sydney (General) Hearing, Sydney, Exhibit R, Tab 1, Statement of James Edwards, 6 May 2019, [49].
- 401 Lismore Hearing, Lismore, 14 May 2019, TS 683.24-42 (Dr Wims).
- 402 Lismore Hearing, Lismore, 14 May 2019, TS 684.8-14 (Dr Wims).
- 403 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 684, Report of Daniel Fatovich, 24 September 2019, 6.
- 404 Celene Yap, et al, 'Don't Label Me: A Qualitative Study of Patients' Perceptions and Experiences of Sedation During Behavioural Emergencies in the Emergency Department' (2017) 24(8) *Academic Emergency Medicine* 957, 962, 965-6.
- 405 NSW Health, *Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments* (Guideline GL2015_007, 10 August 2015) 1.
- 406 Tracey Weiland, Sean Ivory and Jennie Hutton, 'Managing Acute Behavioural Disturbances in the Emergency Department Using the Environment, Policies and Practices: A Systematic Review' (2017) 18(4) *Western Journal of Emergency Medicine* 648.
- 407 Dubbo Hearing, Dubbo, 4 June 2019, TS 1454.25-7 (Dr Spencer); Gordian WO Fulde and S Lesley Forster, 'The impact of amphetamine-type stimulants on emergency services' (2015) 28(4) *Current Opinion in Psychiatry* 275, 275.
- 408 Lismore Hearing, Lismore, 14 May 2019, TS 632.18-19 (Dr Davies).
- 409 Lismore Hearing, Lismore, 14 May 2019, TS 632.21-4 (Dr Davies).
- 410 Harm Reduction Hearing, Sydney, Exhibit A, Tab 73, Joint Report of David McCutcheon and Jessamine Soderstrom to *Coronial Inquest into Deaths at Music Festivals*, 28 June 2019, 7.
- 411 Gordian WO Fulde and S Lesley Forster, 'The impact of amphetamine-type stimulants on emergency services' (2015) 28(4) *Current Opinion in Psychiatry* 275, 276; Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37(2) *Drug and Alcohol Review* 196, 197, 201; Philippa Bunting, Gordian Fulde and S Lesley Foster, 'Comparison of crystalline methamphetamine ('ice') users and other patients with toxicology-related problems presenting to a hospital emergency department' (2007) 187(10) *Medical Journal of Australia* 564, 564.
- 412 Philippa Bunting, Gordian Fulde and S Lesley Foster, 'Comparison of crystalline methamphetamine ('ice') users and other patients with toxicology-related problems presenting to a hospital emergency department' (2007) 187(10) *Medical Journal of Australia* 564, 564; Rikki Jones, Cindy Woods and Kim Usher, 'Rates and features of methamphetamine-related presentations to emergency departments: An integrative literature review' (2018) 27(13-14) *Journal of Clinical Nursing* 2569, 2569.
- 413 Suzanne Gray et al, 'Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation' (2007) 186(7) *Medical Journal of Australia* 336, 338.
- 414 Clair Sullivan et al, 'The National Emergency Access Target (NEAT) and the 4-hour rule: time to review the target' (2016) 204(9) *Medical Journal of Australia* 354.e1, 354.e1; Drew Richardson, 'Increase in patient mortality at 10 days associated with emergency department overcrowding' (2006) 184(5) *Medical Journal of Australia* 213, 213.
- 415 Dubbo Hearing, Dubbo, 4 June 2019, TS 1452.15-43 (Waters).

- 416 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 89, Response of NSW Health dated 23 July 2019, to Request for Information dated 18 June 2019, 10.
- 417 Dubbo Hearing, Dubbo, 4 June 2019, TS 1454.9-12 (Waters); East Maitland Hearing, East Maitland, 19 June 2019, TS 2031.37 (Dr Ryan); Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2651.11 (Dr Olesnicky).
- 418 Dubbo Hearing, Dubbo, 4 June 2019, TS 1453.18-26 (Waters).
- 419 Dubbo Hearing, Dubbo, 4 June 2019, TS 1459.21-8 (Waters); East Maitland Hearing, East Maitland, 19 June 2019, TS 2032.4 (Dr Ryan).
- 420 Dubbo Hearing, Dubbo, 4 June 2019, TS 1453.1-4 (Waters).
- 421 Dubbo Hearing, Dubbo, 4 June 2019, TS 1454.25-27 (Dr Spencer); East Maitland Hearing, East Maitland, 19 June 2019, TS 2033.1 (Dr Ryan).
- 422 Matthew Oliver et al, 'Impact of acutely behavioural disturbed patients in the emergency department: A prospective observational study' (2019) 31(3) *Emergency Medicine Australasia* 387, 389.
- 423 NSW Health, *Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments* (Guideline GL2015_007, 10 August 2015).
- 424 NSW Health, *Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint* (Policy Directive PD2015_004, 28 January 2015).
- 425 Lismore Hearing, Lismore, 14 May 2019, TS 632.38-633.20 (Dr Davies); Nowra Hearing, Nowra, 30 May 2019, TS 1052.32-45 (Dr Tucker).
- 426 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 16-17; Tab 684, Report of Daniel Fatovich, 24 September 2019, 9; Tab 682, Report of Yvonne Bonomo, 17 September 2019, 3-4.
- 427 Lismore Hearing, Lismore, 14 May 2019, TS 644.42-5 (Dr Davies).
- 428 Nowra Hearing, Nowra, 30 May 2019, TS 1053.32-5 (Dr Tucker).
- 429 NSW Health, *Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments* (Guideline GL2015_007, 10 August 2015) 3.
- 430 Nowra Hearing, Nowra, Exhibit A, Tab 12, Statement of Simon Tucker, 15 May 2019, [59], [62].
- 431 Matthew Oliver et al, 'Impact of acutely behavioural disturbed patients in the emergency department: A prospective observational study' (2019) 31(3) *Emergency Medicine Australasia* 387, 389.
- 432 Peter Anderson, *Improvements to security in hospitals* (Interim Report, February 2019) 9.
- 433 Dubbo Hearing, Dubbo, 4 June 2019, TS 1458.41-1459.5 (Waters).
- 434 Nowra Hearing, Nowra, Exhibit A, Tab 12, Statement of Simon Tucker, 15 May 2019, [66]-[67].
- 435 Dubbo Hearing, Dubbo, 4 June 2019, TS 1459.44-1460.4 (Dr Spencer).
- 436 Dubbo Hearing, Dubbo, 4 June 2019, TS 1461.13-14 (Waters).
- 437 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 730, Statement of Paul Preisz, 31 August 2019, 2.
- 438 Dubbo Hearing, Dubbo, 4 June 2019, TS 1486.40-3 (Dr Clark).
- 439 Dubbo Hearing, Dubbo, 4 June 2019, TS 1487.22-4 (Dr Clark).
- 440 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 684, Report of Daniel Fatovich, 24 September 2019, 9.
- 441 Peter Anderson, *Improvements to security in hospitals* (Interim Report, February 2019) 18.
- 442 Legislative Assembly of New South Wales Committee on Law and Safety, *Violence Against Emergency Services Personnel* (Report No 1/56, August 2017) 15.
- 443 Brad Hazzard MP, *NSW Government Response to the Recommendations from the Legislative Assembly's Inquiry Into Violence Against Emergency Services Personnel* (Response, tabled 8 February 2018) 2.
- 444 Peter Garling SC, *Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, Volume 2* (Report, 27 November 2008) 806-810.
- 445 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 16.
- 446 Braitberg et al, 'Behavioural assessment unit improves outcomes for patients with complex psychosocial needs' (2018) 30(3) *Emergency Medicine Australasia* 353, 353-354.
- 447 Braitberg et al, 'Behavioural assessment unit improves outcomes for patients with complex psychosocial needs' (2018) 30(3) *Emergency Medicine Australasia* 353, 354.
- 448 Braitberg et al, 'Behavioural assessment unit improves outcomes for patients with complex psychosocial needs' (2018) 30(3) *Emergency Medicine Australasia* 353, 354.
- 449 George Braitberg et al, 'Behavioural assessment unit improved outcomes for patients with complex psychosocial needs' (2018) 30(3) *Emergency Medicine Australia* 353, 355.
- 450 Victorian Government, Department of Health and Human Services, *Guidelines for behavioural assessment rooms in emergency departments* (Publication, May 2017).
- 451 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 679, Statement of Paul Preisz, 31 August 2019, 1.
- 452 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 163, Response of Nepean Blue Mountains Local Health District dated 8 October 2019, to Request for Information dated 6 September 2019, Attachment A, 1-4.
- 453 Matthew Oliver et al, 'Impact of acutely behavioural disturbed patients in the emergency department: A prospective observational study' (2019) 31(3) *Emergency Medicine Australasia* 387.
- 454 Sydney (General) Hearing, Sydney, Exhibit R, Tab 1, Statement of James Edwards, 6 May 2019, [5], [9], [14].
- 455 Nowra Hearing, Nowra, Exhibit A, Tab 12, Statement of Simon Tucker, 15 May 2019, 6, 10-12; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 15; Tab 684, Report of Daniel Fatovich, [10]; Tab 682, Report of Yvonne Bonomo, 17 September 2019, 3-4; Philippa Bunting, Gordian Fulde and S Lesley Foster, 'Comparison of crystalline methamphetamine ('ice') user and other patients with toxicology-related problems presenting to a hospital emergency department' (2007) 187(10) *Medical Journal of Australia* 564, 565-6.
- 456 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 684, Report of Daniel Fatovich, 24 September 2019, [7].
- 457 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 14; Tab 684, Report of Daniel Fatovich, 24 September 2019, [5]; Tab 682, Report of Yvonne Bonomo, 17 September 2019, 4.
- 458 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 15-16; Tab 684, Report of Daniel Fatovich, 24 September 2019, [10]; Tab 682, Report of Yvonne Bonomo, 17 September 2019, 4-5.

- 459 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 712, NSW Health Response to Reports of Yvonne Bonomo, Daniel Fatovich and Shalini Arunogiri dated 7 November 2019, 4.
- 460 Rebecca Reeve et al, 'Evaluating the Impact of Hospital Based Drug and Alcohol Consultation Liaison Services' (2016) 68 *Journal of Substance Abuse Treatment* 36, 36.
- 461 Lismore Hearing, Lismore, 14 May 2019, TS 652.10-11 (Dr Davies); Broken Hill Hearing, Broken Hill, 17 July 2019, T 2645.35-2646.11 (Dr Olesnicky).
- 462 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 684, Report of Daniel Fatovich, 24 September 2019, 4.
- 463 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 13, Statement of Andrew Olesnicky, 18 June 2019, [35].
- 464 Lismore Hearing, Lismore, 14 May 2019, TS 651.18-33 (Dr Davies); Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 684, Report of Daniel Fatovich, 24 September 2019, 2-3.
- 465 'The ASSIST project – Alcohol, Smoking and Substance Involvement Screening Test', *Management of substance abuse* (Web Page, 2020) <https://www.who.int/substance_abuse/activities/assist/en/>; 'ASSIST Screening Tools', *The University of Adelaide, Assist Portal* (Web Page) <<https://assistportal.com.au/>>.
- 466 'ASSIST (Alcohol, Smoking and Substance Involvement Screening Test)', *Drug and alcohol training and development* (Web Page, 9 September 2019) <<https://www.sahealth.sa.gov.au>>.
- 467 'The University of Adelaide' *Assist on Ice Screening Tool*, (Web Page, 11 January 2019) <<https://cracksintheice.org.au/assist-on-ice-screening-tool>>.
- 468 Nowra Hearing, Nowra, 30 May 2019, TS 1114.1-30 (Reid).
- 469 'eASSIST Lite', *The University of Adelaide, Assist Portal*, (Web Page) <<https://eassist.adelaide.edu.au/#/eassist-lite>>.
- 470 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 8.
- 471 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 684, Report of Daniel Fatovich, 24 September 2019, 3-4.
- 472 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 712, NSW Health Response to Reports of Yvonne Bonomo, Daniel Fatovich and Shalini Arunogiri dated 7 November 2019, 2.
- 473 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 712, NSW Health Response to Reports of Yvonne Bonomo, Daniel Fatovich and Shalini Arunogiri dated 7 November 2019, 3.
- 474 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 712, NSW Health Response to Reports of Yvonne Bonomo, Daniel Fatovich and Shalini Arunogiri dated 7 November 2019, 3.
- 475 NSW Health, *The Hospital Drug and Alcohol Consultation Liaison: Model of Care* (Guideline, 3 March 2015) 4.
- 476 NSW Health, *The Hospital Drug and Alcohol Consultation Liaison: Model of Care* (Guideline, 3 March 2015) 12.
- 477 NSW Health, *The Hospital Drug and Alcohol Consultation Liaison Model of Care* (Guideline, 3 March 2015).
- 478 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3289.8-10 (Rao).
- 479 NSW Health, *The Hospital Drug and Alcohol Consultation Liaison: Model of Care* (Guideline, 2015) 12.
- 480 Health Services Responses Roundtable, Sydney, 20 August 2019, TS 3246.1-20 (Dr Wilson).
- 481 Dubbo Hearing, Dubbo, 4 June 2019, TS 1475.6-30 (Waters); TS 1497.3-9 (Dr Clark).
- 482 Lismore Hearing, Lismore, 14 May 2019, TS 656.43-657.8 (Dr Davies).
- 483 Lismore Hearing, Lismore, 14 May 2019, TS 657.1-5 (Dr Davies).
- 484 Dubbo Hearing, Dubbo, 4 June 2019, TS 1496.33-1497.19 (Dr Clark), TS 1562.11-21 (McMillan); Lismore Hearing, Lismore, 14 May 2019, TS 684.26-32 (Dr Wims); East Maitland Hearing, East Maitland, 19 June 2019, TS 2010.42-2011.6 (Dr Fogarty).
- 485 Lismore Hearing, Lismore, 14 May 2019, TS 658.9-22 (Dr Davies); TS 684.36-47 (Dr Wims); East Maitland Hearing, East Maitland, 19 June 2019, TS 2011.1-2 (Dr Fogarty).
- 486 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3223.41-42 (Crisp), TS 3289.8 (Rao), TS 3226.9-23 (Dr Dunlop).
- 487 Health Service Responses, Sydney, 20 August 2019, TS 3223.35-39 (Crisp).
- 488 Lismore Hearing, Lismore, 14 May 2019, TS 659.5-7 (Dr Davies).
- 489 Lismore Hearing, Lismore, 14 May 2019, TS 659.45-660.2 (Dr Davies).
- 490 NSW Health, *The Hospital Drug and Alcohol Consultation Liaison: Model of Care* (Guideline, 2015) 15.
- 491 Rebecca Reeve et al, 'Evaluating the Impact of Hospital Based Drug and Alcohol Consultation Liaison Services' (2016) 68 *Journal of Substance Abuse Treatment* 36, 4-44.
- 492 Rebecca Reeve et al, 'Evaluating the Impact of Hospital Based Drug and Alcohol Consultation Liaison Services' (2016) 68 *Journal of Substance Abuse Treatment* 36, 44.
- 493 Planning and Funding Roundtable, Sydney, 16 September 2019, TS 3907.46-3908.6 (Dr Mitchell).
- 494 Lismore Hearing, Lismore, 14 May 2019, TS 658.9-22 (Dr Davies).
- 495 NSW Health, *NSW State Health Plan – Towards 2021* (Publication, 2014) 18.
- 496 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3229.13-16 (Kaplan).
- 497 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3225.44-3226.7 (Dr Dunlop).
- 498 St Vincent's Health Australia, Submission No 127 (14 May 2019) 7.
- 499 Sydney (General) Hearing, Sydney, Exhibit B, Tab 25, Statement of Jennifer Frendin, 1 May 2019, [4].
- 500 Dubbo Hearing, Dubbo, Exhibit A, Tab 28, Statement of Norm Henderson, 21 May 2019, [14]; Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3266.37-3267.19 (Dr Dunlop); Sydney (General) Hearing, Sydney, 9 May 2019, TS 328.16-20 (Green); Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2540.13-22 (Harvey).
- 501 Lismore Hearing, Lismore, 14 May 2019, TS 703.17-24 (Dr Helliwell).
- 502 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 614, NSW Health – Response to Summons to Produce G05 – Final Report Pathways to Residential Rehabilitation Scoping Project 2019.
- 503 SJ Shoptaw et al, 'Treatment for amphetamine withdrawal (Review) (2009) 15(2) *Cochrane Database of Systematic Reviews*, 2.
- 504 Kelly Courtney and Lara Ray, 'Methamphetamine: An update on epidemiology, pharmacology, clinical phenomenology, and treatment literature' (2014) 143 *Drug and Alcohol Dependence* 11, 14.
- 505 Gulbin Wang et al, 'Effects of Length of Abstinence on Decision-making and Craving in Methamphetamine Abusers' (2013) 8(7) *PLOS ONE*, 1; Turning Point, *Alcohol and Other Drug Withdrawal Guidelines, 3rd Edition* (Guideline, 2018) 155.

- 506 Lismore Hearing, Lismore, 15 May 2019, TS 732.36-41 (Dr Helliwell).
- 507 NSW Health, *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (Guideline, 4 July 2008) 48.
- 508 Lismore Hearing, Lismore, 14 May 2019, TS 701.31-4 (Dr Helliwell).
- 509 NSW Health, *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (Guideline, 4 July 2008) 4.
- 510 Turning Point, *Alcohol and Other Drug Withdrawal Guidelines, 3rd Edition* (Guideline, 2018) 153, 158.
- 511 NSW Health, *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (Guideline, 4 July 2008) 53.
- 512 NSW Health and Australian Drug Foundation, *Treatment for crystalline methamphetamine (ice)* (Fact Sheet, 2016) 2.
- 513 National Centre for Clinical Research on Emerging Drugs, Submission No 123 (14 May 2019) 9.
- 514 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3267.34-42 (Wahhab).
- 515 Lismore Hearing, Lismore, 15 May 2019, TS 745.5-7 (Dr Helliwell).
- 516 Sydney (General) Hearing, Sydney, 10 May 2019, TS 357.41-3 (Freudin).
- 517 Australian Government Department of Health, 'Models of intervention and care for psychostimulant users, 2nd edition – Monograph Series No 51' *Settings for detoxification* (Web Page, April 2004) <<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-modpsy-toc~drugtreat-pubs-modpsy-3~drugtreat-pubs-modpsy-3-7~drugtreat-pubs-modpsy-3-7-set>>.
- 518 Turning Point, *Alcohol and Other Drug Withdrawal Guidelines, 3rd Edition* (Guideline, 2018) 21-3; Commonwealth of Australia, *Management of Patients with Psychostimulant Use Problems: Guidelines for General Practice* (Guideline, 2007) 8.
- 519 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3265.24-9 (Pierce).
- 520 NSW Health, *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (Guideline, 4 July 2008) 15.
- 521 NSW Health, *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (Guideline, 4 July 2008) 15.
- 522 Nowra Hearing, Nowra, 31 May 2019, TS 1261.26-33 (Holmes).
- 523 Dubbo Hearing, Dubbo, Exhibit A, Tab 28, Statement of Norm Henderson, 23 May 2019, [15]; Dubbo Hearing, Dubbo, 6 June 2019, TS 1783.34-40 (Henderson).
- 524 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 6.
- 525 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 731, Withdrawal management survey data (Survey Responses, 2019), 5.
- 526 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 6.
- 527 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 6.
- 528 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3261.2-36 (Dr Dunlop); Lismore Hearing, Lismore, 14 May 2019, TS 700.32-38 (Dr Hudson).
- 529 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 614, Tanya Merinda and Eliza Quinert, Centre for Population Health, NSW Ministry of Health, *Pathways to Residential Rehabilitation Scoping Project* (Final Report, August 2019) 23.
- 530 NSW Health, *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (Guideline, 4 July 2008) 1.
- 531 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3268.3-17 (Kaplan).
- 532 NSW Health, *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (Guideline, 4 July 2008) 1, 4, 48.
- 533 NSW Health, *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (Guideline, 4 July 2008) 50, 53-4.
- 534 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 5.
- 535 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3268.23-3269.13 (Dr Dunlop).
- 536 National Centre for Clinical Research on Emerging Drugs, Submission No 123 (14 May 2019) 8-9.
- 537 Turning Point, *Alcohol and Other Drug Withdrawal Guidelines, 3rd Edition* (Guideline, 2018).
- 538 NSW Health, Drug and alcohol treatment guidelines for residential settings (Guidelines, February 2007) 8.
- 539 NSW Health, 'Alcohol and other drugs', *About alcohol and other drug treatment* (Web Page) <<https://www.health.nsw.gov.au/aod/Pages/about-treatment.aspx>>.
- 540 Phoebe House, *About Us* (Web Page, 2014) <<http://www.phoebehouse.org.au/>>.
- 541 NSW Health, *Drug and alcohol treatment guidelines for residential settings* (Guidelines, February 2007) 5.
- 542 Dubbo Hearing, Dubbo, 6 June 2019, TS 1782.21-1783.17, 1801.32-45 (Henderson).
- 543 Lismore Hearing, Lismore, 15 May 2019, TS 808.45-6 (Crayden).
- 544 Health Service Responses Roundtable, Sydney 20 August 2019, TS 3262.27-33 (Wahhab).
- 545 Dubbo Hearing, Dubbo, 4 June 2019, TS 1466.30-32, TS 1467.27-9 (Dr Spencer).
- 546 Lismore Hearing, Lismore, 15 May 2019, TS 808.22-5 (Crayden).
- 547 Lismore Regional Hearing, Lismore, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019 [20].
- 548 Health Service Responses Roundtable, Sydney 20 August 2019, TS 3266.37-3267.11 (Dr Dunlop).
- 549 Lismore Hearing, Lismore, 14 May 2019, TS 703.7-12 (Dr Helliwell).
- 550 NSW Young Lawyers Criminal Committee, Submission No 124 (12 May 2019) 6.
- 551 NSW Health, 'Withdrawal management and residential rehabilitation services', (Web Page, 12 December 2018) <<https://www.health.nsw.gov.au/aod/Pages/wmrs-contact.aspx>>.
- 552 Lismore Hearing, Lismore, 15 May 2019, TS 805.43-4 (Crayden).
- 553 Dubbo Hearing, Dubbo, 5 June 2019, TS 1559.27-31 (McMillan).
- 554 Sydney (General) Hearing, Sydney, 8 May 2019, TS 218.24-6 (Lived Experience Witness, Name Withheld); Lismore Hearing (Private), Lismore, 13 May 2019, TS 430.38-40 (Lived Experience Witness, Name Withheld), TS 451.17-20 (Lived Experience Witness, Name Withheld), TS 483.27-9 (Lived Experience Witness, Name Withheld); East Maitland Hearing (Private), East Maitland, 21 June 2019, TS 2232.11 (Lived Experience Witness, Name Withheld).
- 555 Lismore Hearing (Private), Lismore, 13 May 2019, TS 469.40-2 (Lived Experience Witness, Name Withheld).
- 556 Lismore Hearing, Lismore, 15 May 2019, TS 807.21-43 (Crayden); Nowra Hearing, Nowra, 31 May 2019, TS 1263.34-8 (Holmes); Dubbo Hearing, Dubbo, 5 June 2019, TS 1640.16-27 (Taylor); Dubbo Hearing, Dubbo, 6 June 2019, TS 1799.36-1800.2 (Campbell).

- 557 Royal Australasian College of Physicians, Submission No 47 (May 2019) 7; Submission No 49 (undated); NSW Young Lawyers Criminal Committee, Submission No 124 (12 May 2019) 6-7; Legal Aid NSW, Submission No 136 (May 2019) 29; Robyn Lewis, Submission No 146 (6 June 2019) 1.
- 558 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 732, Residential rehabilitation survey data summary including free text answers, 13.
- 559 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 732, Residential rehabilitation survey data summary including free text answers, 14-15.
- 560 Lismore Hearing, Lismore, 15 May 2019, TS 806.40-1 (Crayden).
- 561 Lismore Hearing, Lismore, 15 May 2019, TS 807.1-4 (Crayden).
- 562 Sydney (General) Hearing, Sydney, 8 May 2019, TS 179.39 (Dr Harrod).
- 563 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 732, Residential rehabilitation survey data summary including free text answers, 19-20.
- 564 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 732, Residential rehabilitation survey data summary including free text answers, 21-22.
- 565 The Buttery, Submission No 105 (undated) 14; NSW Young Lawyers Criminal Committee, Submission No 124 (12 May 2019) 7-8; Barnardos Australia, Submission No 133 (15 May 2019) 4.
- 566 Rebecca McKetin et al, 'Evaluating the impact of community-based treatment options on methamphetamine use: findings from the Methamphetamine Treatment Evaluation Study (MATES)' (2012) 107(11) *Addiction* 1998, 1998, 2006.
- 567 Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2515.29 (House).
- 568 Rebecca McKetin, Erin Kelly and Devon Indig, 'Characteristics of treatment provided for amphetamine use in New South Wales, Australia' (2003) 24(5) *Drug and Alcohol Review* 433, 433-6.
- 569 Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2517.44-2518.5 (House).
- 570 NSW Health, *Drug and alcohol treatment guidelines for residential settings* (Guidelines, February 2007).
- 571 NSW Health, *Drug and alcohol treatment guidelines for residential settings* (Guidelines, February 2007) 8-10.
- 572 NSW Young Lawyers Criminal Committee, Submission No 124 (12 May 2019) 7.
- 573 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 21.
- 574 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 21.
- 575 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 614, NSW Health – Response to Summons to Produce G05 – Final Report Pathways to Residential Rehabilitation Scoping Project 2019.
- 576 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 83, Response of NSW Health dated 12 March 2019, to Request for Information dated 7 February 2019, 11; NSW Health, 'Withdrawal management and residential rehabilitation services' (Web Page) <<https://www.health.nsw.gov.au/aod/Pages/wmrs-contact.aspx>>.
- 577 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 83, Response of NSW Health dated 12 March 2019, to Request for Information dated 7 February 2019, 11.
- 578 Barnardos Australia, Submission No 133 (15 May 2019) 4.
- 579 Australian Government Department of Health, 'Primary Health Networks', *Fact Sheet: Primary Health Networks* (Web Page, 19 July 2018) <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Networks+>>.
- 580 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3189.24-9 (Faraj); TS 3190.24-9 (Wilson).
- 581 Central and Eastern Sydney PHN, 'Drug and Alcohol Support', *AOD Commissioned Services* (Web Page) <<https://www.cesphn.org.au/community/services-in-your-region/drug-and-alcohol-support/drug-and-alcohol-services-1>>.
- 582 Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37(2) *Drug and Alcohol Review* 196, 201.
- 583 Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37(2) *Drug and Alcohol Review* 196, 201.
- 584 Lismore Hearing, Lismore, 15 May 2019, TS 722.27-40 (Dr Hudson).
- 585 National Centre for Clinical Research on Emerging Drugs, Submission No 123 (14 May 2019) 5.
- 586 Dubbo Hearing, Dubbo, 4 June 2019, TS 1495.4-12 (Dr Clark).
- 587 'What is General Practice?' *Royal Australian College of General Practitioners* (Web Page, 2019) <<https://www.racgp.org.au/education/students/a-career-in-general-practice/what-is-general-practice>>.
- 588 Brian McAvo, 'Addiction and addiction medicine: exploring opportunities for the general practitioner' (2008) 189(2) *Medical Journal of Australia* 115, 115, 116.
- 589 Lismore Hearing, Lismore, 15 May 2019, TS 719.18-19 (Dr Hudson).
- 590 D Lubman et al, *A study of patient pathways in alcohol and other drug treatment* (Final Report, June 2014) 25.
- 591 Brian McAvo, 'Addiction and addiction medicine: exploring opportunities for the general practitioner' (2008) 189(2) *Medical Journal of Australia* 115, 115, 116.
- 592 General Practice NSW, *Australia's National Drug Strategy: Beyond 2009 – General Practice NSW Response* (Statement, 2009) 2.
- 593 Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact' (2018) 37(2) *Drug and Alcohol Review* 196, 199.
- 594 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3185.29-31 (Dr Wilson).
- 595 General Practice NSW, *Australia's National Drug Strategy: Beyond 2009 – General Practice NSW Response* (Statement, 2009) 2.
- 596 Lismore Hearing, Lismore, 15 May 2019, TS 730.5-7 (Dr Hudson).
- 597 Lismore Hearing, Lismore, 15 May 2019, TS 730.7-13 (Dr Hudson).
- 598 Brian McAvo, 'Addiction and addiction medicine: exploring opportunities for the general practitioner' (2008) 189(2) *Medical Journal of Australia* 115, 116; 'AM16 – Addiction medicine contextual unit', *Royal Australian College of General Practitioners* (Web Page) <<https://www.racgp.org.au/education/education-providers/curriculum/contextual-units/presentations/am16-addiction-medicine>>.
- 599 Nowra Hearing, Nowra, 30 May 2019, TS 1121.9-21 (Reid); Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3188.21-31 (Faraj), TS 3202.37-3203.1 (Dr Wilson).

- Lismore Hearing, Lismore, 15 May 2019, TS 723.5-11 (Dr Hudson).
- Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3185.39-42 (Dr Wilson).
- Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3213.36-40 (Dr Wilson).
- Brian McAvoyn, 'Addiction and addiction medicine: exploring opportunities for the general practitioner' (2008) 189(2) *Medical Journal of Australia* 115, 116.
- Commonwealth of Australia, *Management of Patients with Psychostimulant Use Problems: Guidelines for General Practice* (2007) v.
- Commonwealth of Australia, *Management of Patients with Psychostimulant Use Problems: Guidelines for General Practice* (2007) ix.
- Nowra Hearing, Nowra, 30 May 2019, TS 1119.20-32 (Dr Cordaro).
- Lismore Hearing, Lismore, 15 May 2019, TS 730.38-40 (Dr Hudson).
- Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3199.41-5 (Dr Dunlop).
- Lismore Hearing, Lismore, 15 May 2019, TS 741.1-2 (Dr Hudson).
- Lismore Hearing, Lismore, 15 May 2019, TS 740.9-39 (Drs Helliwell and Hudson).
- Nowra Hearing, Nowra, 30 May 2019, TS 1119.42-3 (Reid).
- Commonwealth Department of Health, 'What is the MBS and Medicare?', *Medical Services Advisory Committee* (Web Page, 20 July 2016) <<http://www.msac.gov.au/internet/msac/publishing.nsf/Content/Factsheet-03>>.
- Lismore Hearing, Lismore, 15 May 2019, TS 740.11-18 (Dr Hudson).
- Lismore Hearing, Lismore, 15 May 2019, TS 730.16-23 (Dr Hudson).
- Lismore Hearing, Lismore, 15 May 2019, TS 739.32-42 (Dr Hudson).
- Lismore Hearing, Lismore, 15 May 2019, TS 740.11-25 (Dr Hudson).
- Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3185.10-14 (Dr Wilson).
- East Maitland Hearing, Maitland, 19 June 2019, TS 2015.35-41 (Dr Fogarty).
- Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3214.46-7 (Dr Wilson).
- Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3215.9-16 (Dr Wilson).
- Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3215.20-31 (Dr Wilson).
- Dubbo Hearing, Dubbo, 4 June 2019, TS 1472.24-8 (Dr Spencer).
- Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 162, Response of Commonwealth Department of Health dated 8 October 2019, to Requests for Information dated 20 August 2019, 2 September 2019 and 12 September 2019, 2.
- Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 162, Response of Commonwealth Department of Health dated 8 October 2019, to Requests for Information dated 20 August 2019, 2 September 2019 and 12 September 2019, 2.
- Medicare Benefits Schedule Review Taskforce, *Report from the General Practice and Primary Care Clinical Committee: Phase 2* (August 2018) 38-9.
- Lismore Hearing, Lismore, 15 May 2019, TS 728.33-5; 745.45-6 (Dr Helliwell); East Maitland Hearing, East Maitland, 19 June 2019, TS 1995.7 (Terry); Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3213.44-3214.2 (Wilson); TS 3311.14 (Pierce).
- Custodial Hearing, Sydney, Exhibit A, Tab 67, World Health Organization, *Prisons and Health* (Report, 2014) 115.
- Commonwealth Department of Health, 'Primary Health Networks', *Fact Sheet: Primary Health Networks* (Web Page, 19 July 2018) <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Networks+>>; Central and Eastern Sydney PHN, 'General Practice', *Drug and alcohol support* (Web Page) <<https://www.cesphn.org.au/general-practice/help-my-patients-with-drug-and-alcohol-support>>; Commonwealth Department of Health, 'Primary Health Networks', *Face Sheet: PHN Practice Support* (Web Page, 18 June 2018) <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/3F6455141CE315D3CA25829E007F250C?OpenDocument>>.
- Commonwealth Department of Health, 'PHN Program Guidelines and Policies – Annexure A2: Drug and Alcohol Treatment Services' (Guideline) 5 <[https://www1.health.gov.au/internet/main/publishing.nsf/Content/F4F85B97E22A94CACA257F86007C7D1F/\\$File/Annexure%20A2%20-%20Drug%20and%20Alcohol%20Treatment%20Services%20-%20April%202017.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/F4F85B97E22A94CACA257F86007C7D1F/$File/Annexure%20A2%20-%20Drug%20and%20Alcohol%20Treatment%20Services%20-%20April%202017.pdf)>.
- Eliana Hirakis, Leanne Casey and Bonnie Clough, 'Investigating Website Usability: Enhancing Engagement of Amphetamine Users in Online Treatment' (2018) 16 *International Journal of Mental Health and Addiction* 420, 420-1; Frances Kay-Lambkin, 'Technology and innovation in the psychosocial treatment of methamphetamine use, risk and dependence' (2008) 27 *Drug and Alcohol Review* 318, 320.
- National Centre for Clinical Research on Emerging Drugs, Submission No 123 (14 May 2019) 4.
- Eliana Hirakis, Leanne Casey and Bonnie Clough, 'Investigating Website Usability: Enhancing Engagement of Amphetamine Users in Online Treatment' (2018) 16 *International Journal of Mental Health and Addiction* 420, 432.
- Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 651, Frances Kay-Lambkin, 'Cracks in the Ice – Part 2: Psychosocial and e-health treatment approaches' (Presentation) 8.
- 'Cracks in the Ice', *Commonwealth Department of Health* (Web Page) <<https://cracksintheice.org.au/>>.
- Robert Tait et al, 'Six-Month Outcomes of a Web-Based Intervention for Users of Amphetamine-Type Stimulants: Randomized Controlled Trial' (2017) 17(4) *Journal of Medical Internet Research* 1, 7, 8.
- Judith Proudfoot et al, 'Clinical efficacy of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial' (2004) 185 *British Journal of Psychiatry* 46, 53.
- David Dunt et al, 'beyondblue, Australia's National Depression Initiative: An Evaluation for the Period 2005-2010' (2011) 13(3) *International Journal of Mental Health Promotion* 22, 33; Nickolai Titov et al, 'The First 30 Months of the MindSpot Clinic: Evaluation of a national e-mental health service against project objectives' (2017) 51(12) *Australian and New Zealand Journal of Psychiatry* 1227, 1234-1237; Ian Hickie, 'Can we Reduce the Burden of Depression? The Australian Experience with beyondblue: The National Depression Initiative' (2004) 12(Supplement) *Australasian Psychiatry* S38, S44.
- Frances Kay-Lambkin, 'Technology and innovation in the psychosocial treatment of methamphetamine use, risk and dependence' (2008) 27 *Drug and Alcohol Review* 318, 320.
- Agency for Clinical Innovation, *Telehealth in Practice* (Guide, 2019) 4.
- Agency for Clinical Innovation, *Guidelines for the use of Telehealth for Clinical and Non Clinical Settings in NSW* (2015).

- 641 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 13.
- 642 Agency for Clinical Innovation, *Telehealth in Practice* (Guide, 2019).
- 643 Agency for Clinical Innovation, *Telehealth in Practice* (Guide, 2019) 4.
- 644 Lismore Hearing, Lismore, 15 May 2019, TS 788.37-789.46 (Robinson); Nowra Hearing, Nowra, 30 May 2019, TS 1120.35-1121.43 (Reid, Dr Cordaro and Pepper), TS 1262.36-43 (Holmes); Dubbo Hearing, Dubbo, 4 June 2019, TS 1496.25-31, 1501.40-1592.15 (Dr Clark); 5 June 2019, TS 1671.43-1672.4, 1673.9-21, 1675.9-1677.11, 1678.4-44 (Crisp); 6 June 2019, TS 1805.15-44 (Bennett and Henderson); Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2530.24-41 (House); TS 2555.15-33 (Harvey); 17 July 2019, TS 2682.35-2683.33 (Dr Vaux); Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3226.46-3227.2 (Pierce); TS 3233.7-31 (Dr Wilson), TS 3233.35-3234.18 (Dr Wilson and Crisp); TS 3235.27-36 (Crisp), TS 3236.6-33 (Dr Dunlop); TS 3238.45-3239.28 (Pierce and Dr Dunlop).
- 645 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 13.
- 646 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 712, NSW Health Response to Reports of Yvonne Bonomo, Daniel Fatovich and Shalini Arunogiri dated 7 November 2019, 4.
- 647 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 13.
- 648 Agency for Clinical Innovation, *Telehealth in Practice* (Guide, 2019) 8-10.
- 649 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 712, NSW Health Response to Reports of Yvonne Bonomo, Daniel Fatovich, and Shalini Arunogiri dated 7 November 2019, 4.
- 650 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 172, Response of Nadine Ezard dated 3 October 2019, to Request for Information dated 6 September 2019, 1-9.
- 651 St Vincent's Health Australia, Submission No 127 (14 May 2019) 6.
- 652 Cliona Ni Cheallaigh et al, 'Telementoring with Project ECHO: A pilot study in Europe' (2017) 3(3) *BMJ Innovations* 144, 151.
- 653 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3234.40-3235.10 (Wilson).
- 654 Mallikarjun Rao Sagi, et al, 'Innovative telementoring for addiction management for remote primary care physicians: A feasibility study' (2018) 60(4) *Indian Journal of Psychiatry* 461, 465-6; Ryan Ladd et al, 'Dermatology ECHO: A case presentation demonstrating benefits of specialty telementoring in primary care' (2019) 25(8) *Journal of Telemedicine and Telecare* 506, 509; Lauren Gleason, 'An innovative model using telementoring to provide geriatrics education for nurses and social workers at skilled nursing facilities' (2019) 40 *Geriatric Nursing* 517, 520.
- 655 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 172, Response of Nadine Ezard dated 3 October 2019, to Request for Information dated 6 September 2019, 2.
- 656 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 172, Response of Nadine Ezard dated 3 October 2019, to Request for Information dated 6 September 2019, 2.
- 657 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 172, Response of Nadine Ezard dated 3 October 2019, to Request for Information dated 6 September 2019, 2-3.
- 658 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 172, Response of Nadine Ezard dated 3 October 2019, to Request for Information dated 6 September 2019, 3.
- 659 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 172, Response of Nadine Ezard dated 3 October 2019, to Request for Information dated 6 September 2019, 3.
- 660 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 172, Response of Nadine Ezard dated 3 October 2019, to Request for Information dated 6 September 2019, 4.
- 661 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 172, Response of Nadine Ezard dated 3 October 2019, to Request for Information dated 6 September 2019, 7.
- 662 Agency for Clinical Innovation, *Telehealth in Practice* (Guide, 2019) 5.
- 663 St Vincent's Health Australia, Submission No 127 (14 May 2019) 34.
- 664 St Vincent's Health Australia, Submission No 127 (14 May 2019) 53.
- 665 St Vincent's Health Australia, Submission No 127 (14 May 2019) 54.
- 666 St Vincent's Health Australia, Submission No 127 (14 May 2019) 34; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 282, Response of NSW Health dated 15 October 2019, to Request for Information dated 18 September 2019, 2; see also 'Drug & Alcohol Specialist Advisory Service, *St Vincent's Hospital Sydney* (Web Page) <<https://www.svhs.org.au/our-services/list-of-services/alcohol-drug-service/drug-alcohol-specialist-advisory-service>>.
- 667 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3205.6-8, 3205.31 (Kaplan).
- 668 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 282, Response of NSW Health dated 15 October 2019, to Request for Information dated 18 September 2019, 2; Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3207.16-41 (Dr Dunlop).
- 669 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3205.6-14 (Kaplan).
- 670 St Vincent's Health Australia, Submission No 127 (14 May 2019) 53.
- 671 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3202.37 (Dr Wilson).
- 672 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3205.4-6 (Kaplan).
- 673 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3205.9-12 (Kaplan).
- 674 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3207.5-12 (Kaplan).
- 675 St Vincent's Health Australia, Submission No 127 (14 May 2019) 34; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 191, Response of NSW Health dated 12 March 2019, to Request for Information dated 7 February 2019, 5. See also 'Alcohol Drug Information Service (ADIS) NSW', *Your Room, NSW Health* (Web Page) <<https://yourroom.health.nsw.gov.au/getting-help/Pages/adis.aspx>>.
- 676 St Vincent's Health Australia, Submission No 127 (14 May 2019) 34.
- 677 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 127, Response of NSW Health dated 6 September 2019, to Request for Information dated 16 August 2019, 5.
- 678 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 127, Response of NSW Health dated 6 September 2019, to Request for Information dated 16 August 2019, 5.
- 679 St Vincent's Health Australia, Submission No 127 (14 May 2019) 54.
- 680 St Vincent's Health Australia, Submission No 127 (14 May 2019) 52; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 127, Response of NSW Health dated 6 September 2019, to Request for Information dated 16 August 2019, 5.

- 681 National Centre for Clinical Research on Emerging Drugs, Submission No 123 (14 May 2019) 4.
- 682 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 614, Tanya Merinda and Eliza Quinert, Centre for Population Health, NSW Ministry of Health, *Pathways to Residential Rehabilitation Scoping Project* (Final Report, August 2019) 9, 12, 13, 22.
- 683 Nowra Hearing (Private), Nowra, Exhibit A, Statement of Lived Experience Witness, Name Withheld, 22 May 2019, [15]; East Maitland Hearing, East Maitland, Exhibit A, Statement of Statement of Lived Experience Witness, Name Withheld, 11 June 2019, [30]; Sydney (General) Hearing, Sydney, Exhibit J, Statement of Nicola Tillier, 3 May 2019, [18]; Lismore Hearing, Lismore, 15 May 2019, TS 807.21-43 (Crayden); Sydney (General) Hearing, Sydney, 10 May 2019, TS 358.8-361.31 (Byrne, Popple and Frendin).
- 684 'Stimulant Treatment Line', *St Vincent's Hospital Sydney* (Web Page) <<https://www.svhs.org.au/our-services/list-of-services/alcohol-drug-service/stimulant-treatment-line>>.
- 685 St Vincent's Health Australia, Submission No 127 (14 May 2019) 51.
- 686 St Vincent's Health Australia, Submission No 127 (14 May 2019) 53.
- 687 See Loren Brener et al, 'Providing a model of health care service to stimulant users in Sydney' (2016) 25(2) *Drugs: Education, Prevention and Policy* 130, 131.
- 688 Silvia Minozzi et al, 'Psychosocial Interventions for Psychostimulant Misuse (Review)' (2016) (9) *Cochrane Database of Systematic Reviews* 1, 2.
- 689 Sadmir Ciketic et al, 'A review of psychological and pharmacological treatment options for methamphetamine dependence' (2012) 17(4) *Journal of Substance Use* 363, 377.
- 690 Craig Rodgers, 'Brief interventions for alcohol and other drug use' (2018) 41(4) *Australian Prescriber* 117, 117; Sue Henry-Edwards et al, World Health Organization, *Brief Intervention for Substance Use: A Manual for Use in Primary Care (Draft Version 1.1 for Field Testing)* (Manual, September 2003) 4; Commonwealth Department of Health, *Module 9: working with young people on AOD issues: learner's workbook* (Historical Publication, 2004) 'Topic 6.1: Brief interventions – a definition'.
- 691 Craig Rodgers, 'Brief interventions for alcohol and other drug use' (2018) 41(4) *Australian Prescriber* 117, 117.
- 692 Sue Henry-Edwards et al, World Health Organization, *Brief Intervention for Substance Use: A Manual for Use in Primary Care (Draft Version 1.1 for Field Testing)* (Manual, September 2003) 5.
- 693 Craig Rodgers, 'Brief interventions for alcohol and other drug use' (2018) 41(4) *Australian Prescriber* 117, 118.
- 694 Sue Henry-Edwards et al, World Health Organization, *Brief Intervention for Substance Use: A Manual for Use in Primary Care (Draft Version 1.1 for Field Testing)* (Manual, September 2003) 5.
- 695 Craig Rodgers, 'Brief interventions for alcohol and other drug use' (2018) 41(4) *Australian Prescriber* 117, 118-20.
- 696 Craig Rodgers, 'Brief interventions for alcohol and other drug use' (2018) 41(4) *Australian Prescriber* 117, 120.
- 697 T Harada et al, 'Cognitive-behavioural treatment for amphetamine-type stimulants (ATS)-use disorders (Review)' (2018) (12) *Cochrane Database of Systematic Reviews* 1, 2, 4-5.
- 698 See Sadmir Ciketic et al, 'A review of psychological and pharmacological treatment options for methamphetamine dependence' (2012) 17(4) *Journal of Substance Use* 363, 365.
- 699 Turning Point, *Methamphetamine Treatment Guidelines* (2nd ed, 2018) 26; Silvia Minozzi et al, 'Psychosocial Interventions for Psychostimulant Misuse (Review)' (2016) (9) *Cochrane Database of Systematic Reviews* 1, 2; Sadmir Ciketic et al, 'A review of psychological and pharmacological treatment options for methamphetamine dependence' (2012) 17(4) *Journal of Substance Use* 363, 365, 367.
- 700 Sydney General Hearing, Sydney, 9 May 2019, TS 274.9-13 (Dr Brett); TS 398.15-41 (M Bonham); Lismore Hearing, Lismore, 15 May 2019, TS 752.37-9 (Robinson); TS 779.16-19 (Tys); TS 815.32-3 (Crayden); Nowra Hearing, Nowra, 30 May 2019, TS 1102.11-17 (Pepper); TS 1151.12-18 (Jamieson); Dubbo Hearing, Dubbo, TS 1645.15-23 (Taylor); East Maitland Hearing, East Maitland, 20 June 2019, TS 2111.43-2112.2 (Hartley); Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2550.8-14 (T King); TS 2868.11-13 (Latham); Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3252.14-22 (Dr Dunlop); TS 3301.21-7 (Wahhab).
- 701 Sadmir Ciketic et al, 'A review of psychological and pharmacological treatment options for methamphetamine dependence' (2012) 17(4) *Journal of Substance Use* 363, 374.
- 702 Sue Henry-Edwards et al, World Health Organization, *Brief Intervention for Substance Use: A Manual for Use in Primary Care (Draft Version 1.1 for Field Testing)* (Manual, September 2003) 12.
- 703 Sydney (General) Hearing, Sydney, 9 May 2019, TS 274.9-47 (Dr Brett).
- 704 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 7.
- 705 Lismore Hearing, Lismore, 15 May 2019, TS 779.16-17 (Tys).
- 706 Dubbo Hearing, Dubbo, 5 June 2019, TS 1603.38-41 (Biles).
- 707 Custodial Hearing, Sydney, 9 October 2019, TS 4865.21-40 (Dr Sotiri).
- 708 Loren Brener et al, 'Providing a model of health care service to stimulant users in Sydney' (2016) 25(2) *Drugs: Education, Prevention and Policy* 130, 131, 134-5.
- 709 Roland Härtel-Petri et al, 'Evidence-Based Guidelines for the Pharmacologic Management of Methamphetamine Dependence, Relapse Prevention, Chronic Methamphetamine-Related, and Comorbid Psychiatric Disorders in Post-Acute Settings' (2017) 50(3) *Pharmacopsychiatry* 96, 102; C Pérez-Mañá et al, 'Efficacy of psychostimulant drugs for amphetamine abuse or dependence (Review)' (2013) (9) *Cochrane Database of Systematic Reviews* 1, 19-20.
- 710 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3209.7-8 (Dr Dunlop).
- 711 Dubbo Hearing, Dubbo, 4 June 2019, TS 1494.41-1495.17 (Dr Clark).
- 712 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3213.34-40 (Dr Wilson).
- 713 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4209.46-4210.6 (Professor McKetin).
- 714 East Maitland Hearing, East Maitland, 19 June 2019, TS 2084.3-22 (Robertson).
- 715 C Pérez-Mañá et al, 'Efficacy of psychostimulant drugs for amphetamine abuse or dependence (Review)' (2013) (9) *Cochrane Database of Systematic Reviews* 1, 2, 5-6; Nadine Ezard et al, 'LiMA: a study protocol for a randomised, double-blind, placebo controlled trial for lisdexamfetamine for the treatment of methamphetamine dependence' (2018) *BMJ Open* 1, 2.
- 716 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 698, Statement of Nadine Ezard, 8 August 2019, [15], [19].
- 717 Jennifer Veilleux et al, 'A review of opioid dependence treatment: Pharmacological and psychosocial interventions to treat opioid addiction' (2010) 30 *Clinical Psychology Review* 155, 157; Susanne Rösner et al, 'Opioid Antagonists for Alcohol Dependence' (2010) *Cochrane Database of Systematic Reviews* 1, 3.

- 718 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 657, Statement of Rebecca McKetin, 20 August 2019, 1-3.
- 719 Rebecca McKetin et al, 'A study protocol for the N-ICE trial: A randomised double-blind placebo-controlled study of the safety and efficacy of *N*-acetyl-cysteine (NAC) as a pharmacotherapy for methamphetamine ('ice') dependence' (2019) 20 *Trials* 325, 326.
- 720 Sydney (General) Hearing, Sydney, 9 May 2019, TS 274.17-19 (Dr Brett).
- 721 Australian Medical Association NSW, Submission No 121 (14 May 2019) 4; St Vincent's Health Australia, Submission No 127 (14 May 2019) 7, 19.
- 722 Adrian Dunlop et al, Mental Health and Drug & Alcohol Office, *Preliminary evaluation of the NSW stimulant treatment program* (Report, June 2008) 4.
- 723 Adrian Dunlop et al, Mental Health and Drug & Alcohol Office, *Preliminary evaluation of the NSW stimulant treatment program* (Report, June 2008) 4.
- 724 NSW Government, Submission No 143 (12 June 2019) Attachment A, NSW strategies, services and programs, 6.
- 725 Lismore Hearing, Lismore, 15 May 2019, TS 748.39-749.5 (Robinson); Lismore Hearing, Lismore, Exhibit LF, Tab 15, Statement of Deidre Robinson, 10 May 2019, [7].
- 726 NSW Government, Submission No 143 (12 June 2019) Attachment A, NSW strategies, services and programs, 6; 'Stimulant Treatment Program', *St Vincent's Hospital Sydney* (Web Page) <<https://www.svhs.org.au/our-services/list-of-services/alcohol-drug-service/stimulant-treatment-program>>.
- 727 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 698, Statement of Nadine Ezard, 8 August 2019, [7], [9].
- 728 See, for example, Adrian Dunlop et al, Mental Health and Drug & Alcohol Office, *Preliminary evaluation of the NSW stimulant treatment program* (Report, June 2008) 1-2, 24; Rebecca McKetin et al, 'Treatment outcomes for methamphetamine users receiving outpatient counselling from the Stimulant Treatment Program in Australia' (2012) 32(1) *Drug and Alcohol Review* 80, 84.
- 729 Sydney (General) Hearing, Sydney, 9 May 2019, TS 274.9-17 (Dr Brett).
- 730 Dan Werb et al, 'The effectiveness of compulsory drug treatment: a systematic review' (2016) 28 *International Journal of Drug Policy* 1, 2-3.
- 731 'The Involuntary Drug and Alcohol Treatment Program', *NSW Health* (Web Page) <<https://www.health.nsw.gov.au/aod/programs/Pages/idad-gi.aspx>>.
- 732 *Drug and Alcohol Treatment Act 2007* (NSW) s 3.
- 733 *Drug and Alcohol Treatment Act 2007* (NSW) s 3(1).
- 734 *Drug and Alcohol Treatment Act 2007* (NSW) s 3(2).
- 735 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 207, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 10.
- 736 This information was extracted on 11 July 2019: Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 207, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 11.
- 737 Lismore Regional Hearing, Lismore, 15 May 2019, TS 733.8-10 (Dr Helliwell); TS 733.34-38 (Dr Hudson); Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2962.3-12 (Dr Vaux).
- 738 Lismore Regional Hearing, Lismore, 15 May 2019, TS 734.5-10 (Dr Hudson).
- 739 Lismore Regional Hearing, Lismore, 15 May 2019, TS 732.26-9 (Dr Hudson); Nowra Hearing, Nowra, 30 May 2019, TS 1113.1-7 (Reid); Dubbo, 4 June 2019, TS 1509.18-22 (Dr Clarke).
- 740 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 733, Visit to the Involuntary Drug and Alcohol Treatment Program, St Leonards, 28 August 2019, TS 7.14-15.
- 741 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 733, Visit to the Involuntary Drug and Alcohol Treatment Program, St Leonards, 28 August 2019, TS 15.41-7.
- 742 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 733, Visit to the Involuntary Drug and Alcohol Treatment Program, St Leonards, 28 August 2019, TS 2.35-8.
- 743 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 733, Visit to the Involuntary Drug and Alcohol Treatment Program, St Leonards, 28 August 2019, TS 2.45-3.3.
- 744 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 155, Response of NSW Health dated 30 September 2019, to Request for Information dated 12 September 2019, 2-3.
- 745 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 155, Response of NSW Health dated 30 September 2019, to Request for Information dated 12 September 2019, 2-3.
- 746 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 733, Transcript of visit to the Involuntary Drug and Alcohol Treatment Program, St Leonards, 28 August 2019, TS 3.7-13.
- 747 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 733, Transcript of visit to the Involuntary Drug and Alcohol Treatment Program, St Leonards, 28 August 2019, TS 40.10-30.
- 748 Dubbo Hearing, Dubbo, 4 June 2019, TS 1496.9-17 (Dr Clark).
- 749 Lismore Hearing, Lismore, 14 May 2019, TS 690.28-39 (Dr Wims).
- 750 Lismore Hearing, Lismore, 15 May 2019, TS 732.18-25 (Dr Hudson).
- 751 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 733, Visit to the Involuntary Drug and Alcohol Treatment Program, St Leonards, 28 August 2019, TS 26.43-6.
- 752 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 733, Visit to the Involuntary Drug and Alcohol Treatment Program, St Leonards, 28 August 2019, TS 24.17-25.29.
- 753 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 14.
- 754 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 14.
- 755 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Yvonne Bonomo, 17 September 2019, 15.
- 756 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 29.
- 757 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 681, Report of Shalini Arunogiri, September 2019, 29.
- 758 Dan Werb et al, 'The effectiveness of compulsory drug treatment: a systematic review' (2016) 28 *International Journal of Drug Policy* 1, 10.
- 759 St Vincent's Health Australia, Submission No 127 (14 May 2019) 17.
- 760 Dan Werb et al, 'The effectiveness of compulsory drug treatment: a systematic review' (2016) 28 *International Journal of Drug Policy* 1, 9.

- 761 Fiona Lander, Dennis Gray and Edward Wilkes, 'The Alcohol Mandatory Treatment Act: evidence, ethics and the law' (2015) 203(1) *Medical Journal of Australia* 47, 47.
- 762 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 11.
- 763 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 575, Thu Vuong, Alison Ritter and Marian Shanahan, Drug Policy Modelling Program, *IDAT Process Evaluation Final Report* (April 2017) 6.
- 764 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 575, Thu Vuong, Alison Ritter and Marian Shanahan, Drug Policy Modelling Program, *IDAT Process Evaluation Final Report* (April 2017) 6.
- 765 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 575, Thu Vuong, Alison Ritter and Marian Shanahan, Drug Policy Modelling Program, *IDAT Process Evaluation Final Report* (April 2017) 6, 31.
- 766 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 575, Thu Vuong, Alison Ritter and Marian Shanahan, Drug Policy Modelling Program, *IDAT Process Evaluation Final Report* (April 2017) 13.
- 767 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 575, Thu Vuong, Alison Ritter and Marian Shanahan, Drug Policy Modelling Program, *IDAT Process Evaluation Final Report* (April 2017) 13.
- 768 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 575, Thu Vuong, Alison Ritter and Marian Shanahan, Drug Policy Modelling Program, *IDAT Process Evaluation Final Report* (April 2017) 13.
- 769 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 576, Thu Vuong et al, Drug Policy Modelling Program, *A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, March 2018) 6.
- 770 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 576, Thu Vuong et al, Drug Policy Modelling Program, *A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, March 2018) 6.
- 771 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 576, Thu Vuong et al, Drug Policy Modelling Program, *A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, March 2018) 8.
- 772 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 576, Thu Vuong et al, Drug Policy Modelling Program, *A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, March 2018) 8.
- 773 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 576, Thu Vuong et al, Drug Policy Modelling Program, *A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, March 2018) 9.
- 774 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 576, Thu Vuong et al, Drug Policy Modelling Program, *A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, March 2018) 9.
- 775 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 576, Thu Vuong et al, Drug Policy Modelling Program, *A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, March 2018) 9.
- 776 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 576, Thu Vuong et al, Drug Policy Modelling Program, *A Cost Assessment of the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, March 2018) 9.
- 777 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 11.
- 778 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 3.
- 779 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 3.
- 780 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 56.
- 781 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 56.
- 782 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 3.
- 783 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 3.
- 784 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 577, Thu Vuong et al, Drug Policy Modelling Program, *An evaluation of outcomes in the NSW Involuntary Drug and Alcohol Treatment (IDAT) Program* (Final Report, July 2019) 56.
- 785 *Alcohol Mandatory Treatment Act 2013* (NT) ss 12, 49.
- 786 PricewaterhouseCoopers' Indigenous Consulting and Menzies School of Health Research, *Evaluation of the Alcohol Mandatory Treatment Program* (Report, January 2017) 70.
- 787 Fiona Lander, Dennis Gray and Edward Wilkes, 'The Alcohol Mandatory Treatment Act: evidence, ethics and the law' (2015) 203(1) *Medical Journal of Australia* 47, 47-8.
- 788 See *Alcohol Harm Reduction Act 2017* (NT) ss 7-9, 19.
- 789 'About the Severe Substance Dependence Treatment Act 2010', *Victorian Department of Health and Human Services* (Web Page) <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-policy-research-legislation/aod-legislation/severe-substance-treatment-act-ssdta/about-the-severe-substance-dependence-treatment-act-2010>; *Severe Substance Dependence Act 2010* (Vic) s 20.
- 790 DLA Piper, *Review of the Severe Substance Dependence Treatment Act 2014 (Vic): Report of the Review* (Report, 2014) Volume 1, 1, 10-11.
- 791 DLA Piper, *Review of the Severe Substance Dependence Treatment Act 2014 (Vic): Report of the Review* (Report, 2014) Volume 1, 2-3.
- 792 Victorian Department of Health and Human Services, *Review of the Severe Substance Dependence Treatment Act 2010: Victorian Government Report and Response* (Report, 2015) 8.
- 793 What Can Be Done Steering Committee, Submission No 129 (14 May 2019) 1.
- 794 What Can Be Done Steering Committee, Submission No 129 (14 May 2019) 1-2.
- 795 What Can Be Done Steering Committee, Submission No 129 (14 May 2019) 2.
- 796 What Can Be Done Steering Committee, Submission No 129 (14 May 2019) 2.
- 797 Julaine Allan et al, 'Increased demand for amphetamine treatment in rural Australia' (2019) 14(13) *Addiction Science and Clinical Practice* 1, 8; see also, The Royal Australasian College of Physicians, Submission No 47 (May 2019) 3; NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 17; St Vincent's Health Australia, Submission No 127 (14 May 2019) 37; NSW Government, Submission No 143 (2019) 3.
- 798 Nowra Hearing, Nowra, 31 May 2019, TS 1226.39-42 (Diskon).

- 799 Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Health Conditions* (Final Report, December 2015) 26.
- 800 Network of Alcohol and Other Drugs Agencies, Submission No 79 (May 2019) 7; Waminda South Coast Women's Health & Welfare Aboriginal Corporation, Submission No 51 (7 May 2019) 3-4, 12.
- 801 NSW Ministry of Health, *NSW State Health Plan: Towards 2021* (Report, 2014) 15-18.
- 802 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 9.
- 803 See, for example, Monika Merkes, Virginia Lewis and Rachel Canaway, 'Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models' (2010) 10(325) *BMC Health Services Research* 1, 9; Stacy Sterling, Felicia Chi and Agatha Hinman, 'Integrating Care for People with Co-Occurring Alcohol and Other Drug, Medical, and Mental Health Conditions' (2011) 33(4) *Alcohol Research & Health* 338, 338.
- 804 David J Kavanagh et al, 'Contrasting views and experiences of health professionals on the management of comorbid substance misuse and mental disorders' (2000) 34 *Australian and New Zealand Journal of Psychiatry* 279, 280.
- 805 Monika Merkes, Virginia Lewis and Rachel Canaway, 'Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models' (2010) 10(325) *BMC Health Services Research* 1, 2.
- 806 East Maitland Hearing (Private), East Maitland, 21 June 2019, TS 2244.12-27 (Lewis).
- 807 Sydney (General) Hearing, Sydney, 8 May 2019, TS 214.21-9 (Lived Experience Witness, Name Withheld).
- 808 Monika Merkes, Virginia Lewis and Rachel Canaway, 'Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models' (2010) 10(325) *BMC Health Services Research* 1, 1.
- 809 Julia Lappin, Grant Sara and Michael Farrell, 'Methamphetamine-related psychosis: an opportunity for assertive intervention and prevention' (2016) 112(6) *Addiction* 927, 928.
- 810 Mark Deady et al, Sax Institute, *Comorbid mental illness and illicit substance use* (Evidence Check Review, December 2014) 6.
- 811 NSW Health, *NSW Clinical Guidelines – For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings* (June 2009) 18.
- 812 Michelle Cleary et al, 'Views of Australian mental health stakeholders on clients' problematic drug and alcohol use' (2009) 28 *Drug and Alcohol Review* 122, 123.
- 813 Australasian College for Emergency Medicine, Submission No 52 (May 2019) 4-5.
- 814 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3228.13-18 (Mokbel).
- 815 Barnardos Australia, Submission No 133 (15 May 2019) 4.
- 816 Sydney (General) Hearing, Sydney, 8 May 2019, TS 158.12-14 (Professor Milroy).
- 817 Sydney (General) Hearing, Sydney, 8 May 2019 TS 158.16-27 (Professor Milroy).
- 818 Sydney (General) Hearing, Sydney, 8 May 2019, TS 179.31-45 (Dr Harrod); Nowra Hearing, Nowra, 30 May 2019, TS 1129.12-20 (Power); East Maitland Hearing, East Maitland, 19 June 2019, TS 1989.22-36 (Terry).
- 819 David J Kavanagh et al, 'Contrasting views and experiences of health professionals on the management of comorbid substance misuse and mental disorders' (2000) 34 *Australian and New Zealand Journal of Psychiatry* 279, 280.
- 820 Patricia Hoffman Judd et al, 'A Dual Diagnosis Demonstration Project: Treatment Outcomes and Cost Analysis' (2003) 35(Suppl 1) *Journal of Psychoactive Drugs* 181, 182.
- 821 David J Kavanagh et al, 'Contrasting views and experiences of health professionals on the management of comorbid substance misuse and mental disorders' (2000) 34 *Australian and New Zealand Journal of Psychiatry* 279, 280; Patricia Hoffman Judd et al, 'A Dual Diagnosis Demonstration Project: Treatment Outcomes and Cost Analysis' (2003) 35(Suppl 1) *Journal of Psychoactive Drugs* 181, 182.
- 822 Australasian College for Emergency Medicine, Submission No 52 (May 2019) 4.
- 823 SMART Recovery Australia, Submission No 154 (July 2019) 13.
- 824 'Our structure', *NSW Health* (Web Page, 15 June 2018) <<https://www.health.nsw.gov.au/about/nswhealth/Pages/structure.aspx>>.
- 825 Audit Office of NSW, *Governance of Local Health Districts* (Report, 18 April 2019) 1.
- 826 NSW Health, *Future Arrangements for Governance of NSW Health* (Report) 10-11.
- 827 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3288.27-42 (Dr Wilson).
- 828 Lismore Hearing, Lismore, 15 May 2019, TS 762.1-11 (Robinson).
- 829 Auditor-General NSW, *Mental health service planning for Aboriginal people in New South Wales* (Report, 29 August 2019) 16, 20, 21.
- 830 NSW Government, Submission No 143 (2019) 13.
- 831 NSW Government, Submission No 143 (2019) Attachment A, NSW strategies, services and programs, 5.
- 832 See, for example, Mark Deady et al, Sax Institute, *Comorbid mental illness and illicit substance use* (Evidence Check Review, December 2014); NSW Health, *Effective Models of Care for Comorbid Mental Illness and Illicit Substance Use* (Evidence Check Review, August 2015).
- 833 National Centre for Clinical Research on Emerging Drugs, Submission No 123 (14 May 2019) 4.
- 834 United Nations Office on Drugs and Crime, *Treatment of stimulant use disorders: current practices and promising perspectives* (Discussion Paper, March 2019) 24.
- 835 East Maitland Hearing, East Maitland, Exhibit A, Tab 8, Statement of Craig Sadler, 28 May 2019, [50].
- 836 Lismore Hearing, Lismore, 15 May 2019, TS 731.9-12 (Dr Helliwell).
- 837 St Vincent's Health Australia, Submission No 127 (14 May 2019) 5.
- 838 Matilda Centre for Research in Mental Health and Substance Use, the University of Sydney and the Priority Research Centre for Brain and Mental Health, the University of Newcastle, Submission No 74 (7 May 2019) 22-3.
- 839 NSW Health, *NSW Clinical Guidelines – For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings* (June 2009).
- 840 Victorian Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2017-18* (Report, October 2018) 37.

- 841 New Zealand Government Inquiry into Mental Health and Addiction, *He Ara Oranga* (Report, November 2018) 20.
- 842 New Zealand Ministry of Health, 'Government Inquiry into Mental Health and Addiction', *Mental health and addictions* (Web Page, updated 6 June 2019) <<https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction>>.
- 843 Dubbo Hearing, Dubbo, 5 June 2019, TS 1681.4-20 (Crisp); 6 June 2019, TS 1802.37-45 (Bennett); East Maitland Hearing, East Maitland, Exhibit A, Tab 9, Statement of Marcia Fogarty, 29 May 2019, [41]; Lismore Hearing, Lismore, Exhibit LF, Tab 14, Statement of Edward Wims, 9 May 2019, [30]; Lismore Hearing, Lismore, 14 May 2019, TS 663.33-664.11 (Dr Davies); Nowra Hearing, Nowra, 30 May 2019, TS 1072.23-30 (Dr Tucker); Moree Hearing, Moree, 16 August 2019, TS 3064.19-36 (Watson).
- 844 Sydney (General) Hearing, 7 May 2019, TS 157.44-158.27 (Professor Milroy); Dubbo Hearing, Dubbo, 5 June 2019, TS 1681.4-20 (Crisp); Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3217.13-46 (Wahhab).
- 845 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 2.
- 846 Sydney (General) Hearing, Sydney, 8 May 2019, TS 158.6-14 (Professor Milroy).
- 847 Lismore Hearing, Lismore Hearing, 15 May 2019, TS 754.1-756.29 (Robinson).
- 848 Lismore Hearing, Lismore Hearing, 15 May 2019, TS 754.35 (Robinson).
- 849 Lismore Hearing, Lismore, 15 May 2019, TS 754.22-35 (Robinson).
- 850 Sydney (General) Hearing, Sydney, 9 May 2019, TS 272.25-31 (Dr Brett).
- 851 Sydney (General) Hearing, Sydney, 10 May 2019, TS 359.39-42 (Byrne).
- 852 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3241.9-15 (Dr Sara).
- 853 Sarah E Hetrick et al, 'Integrated (one-stop-shop) youth health care: best available evidence and future directions (2017) 207(10) *Medical Journal of Australia* S5, S5.
- 854 Chris Ham and Natasha Curry, The Kings Fund, *Integrated Care* (Pamphlet, 2011) 2.
- 855 NSW Ministry of Health, *NSW State Health Plan: Towards 2021* (Report, 2014) 5.
- 856 NSW Health, *Strategic Framework for Integrating Care* (2018) 2.
- 857 NSW Health, *Strategic Framework for Integrating Care* (2018) 19.
- 858 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3290.18-3296.02 (Kaplan, Ganora, McRae, Drs Dunlop, Sara and Wilson).
- 859 Monika Merkes, Virginia Lewis and Rachel Canaway, 'Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models' (2010) 10(325) *BMC Health Services Research* 1, 2.
- 860 Maria Donald, Jo Dower and David Kavanagh, 'Integrated versus non-integrated management and care for clients with co-occurring mental health and substance use disorders: a qualitative systematic review of randomised controlled trials' (2005) 60 *Social Science and Medicine* 1371, 1373, 1381; Robert Drake, Erica O'Neal and Michael Wallach, 'A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders' (2008) 34 *Journal of Substance Abuse Treatment* 123, 123.
- 861 Parliamentary Joint Committee on Law Enforcement, Commonwealth, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) 33.
- 862 Department of the Prime Minister and Cabinet, Commonwealth, *Final Report of the National Ice Taskforce* (2015) vi, xi.
- 863 Western Australia Government, *Methamphetamine Action Plan Taskforce Final Report* (August 2018) 21.
- 864 David J Kavanagh et al, 'Contrasting views and experiences of health professionals on the management of comorbid substance misuse and mental disorders' (2000) 34 *Australian and New Zealand Journal of Psychiatry* 279, 279.
- 865 Lismore Hearing, Lismore, 15 May 2019, TS 755.24-31 (Robinson).
- 866 St Vincent's Health Australia, Submission No 127 (14 May 2019) 15.
- 867 NSW Government, Submission No 143 (2019), Attachment A, NSW strategies, services and programs, 6.
- 868 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 4.
- 869 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 4; Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3304.26-30 (Pierce).
- 870 NSW Government, Submission No 143 (2019), Attachment A, NSW strategies, services and programs, 10; Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3304.31-5 (Pierce).
- 871 NSW Government, Submission No 143 (2019), Attachment A, NSW strategies, services and programs, 10.
- 872 Roundtable on Health Responses, Sydney, 20 August 2019, TS 3257.9-17 (Kaplan).
- 873 Broken Hill Hearing, Broken Hill, Exhibit D, Tab 33, Statement of Jenna Bottrell, 3 July 2019, [4].
- 874 NSW Health, 'About Us', *Alcohol and other Drugs* (Web Page) <<https://www.health.nsw.gov.au/aod/Pages/about.aspx>>; NSW Health, 'Assertive Community Management', *Nepean Blue Mountains Local Health District* (Web Page) <<https://www.nbmlhd.health.nsw.gov.au/drug-and-alcohol-service/services/quit-for-new-life>>.
- 875 NSW Health, 'Assertive Community Management', *Nepean Blue Mountains Local Health District* (Web Page) <<https://www.nbmlhd.health.nsw.gov.au/drug-and-alcohol-service/services/quit-for-new-life>>; Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3250.18-27 (Wahhab).
- 876 NSW Health, 'About Us', *Alcohol and other Drugs* (Web Page) <<https://www.health.nsw.gov.au/aod/Pages/about.aspx>>; Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3256.44-3257.4 (Kaplan).
- 877 Australian Institute of Primary Care, La Trobe University, *Comorbidity treatment service model evaluation* (Online Report, August 2009) 'Discussion' <<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/illicit-pubs-cotreat-toc>>.
- 878 Australian Institute of Primary Care, La Trobe University, *Comorbidity treatment service model evaluation* (Online Report, August 2009) 'Background to the project' <<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/illicit-pubs-cotreat-toc>>.
- 879 Australian Institute of Health and Welfare, Commonwealth, *National Comorbidity Initiative: A review of data collections relating to people with coexisting substance use and mental health disorders* (Report, June 2005) xiii, 1.
- 880 Australian Institute of Primary Care, La Trobe University, *Comorbidity treatment service model evaluation* (Online Report, August 2009) 'Discussion' <<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/illicit-pubs-cotreat-toc>>.

- 881 Monika Merkes, Virginia Lewis and Rachel Canaway, 'Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models' (2010) 10(325) *BMC Health Services Research* 1, 2.
- 882 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3309.25-8 (Mokbel).
- 883 Sydney (General) Hearing, Sydney, 8 May 2019, TS 158.25-7 (Professor Milroy).
- 884 NSW Health, NSW Clinical Guidelines – For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings (June 2009) 6.
- 885 South Western Sydney PHN, 'The commitment to mental health service collaboration in South Western Sydney', *No Wrong Door* (Web Page) <<https://nowrongdoor.org.au/>>.
- 886 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3256.1-9 (Mokbel).
- 887 NSW Ministry of Health, *Pathways to Community Living Initiative, Evaluation Report 1, Building the Foundation for Transformational Change* (Report, October 2018) 11; NSW Department of Communities and Justice, *NSW Homelessness Strategy 2018-2023* (Report) 21; NSW Department of Communities and Justice, *Integrated Service Response* (Pamphlet, July 2018) 1; 'Keep Young People Out of Prison and Make Sure it is Safe for Young People', *Youth Action* (Web Page) <http://www.youthaction.org.au/keep_young_people_out_of_prison>.
- 888 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 1; St Vincent's Health Australia, Submission No 127 (14 May 2019) 34-6; Mental Health Review Tribunal, Submission No 10 (29 April 2019) 2; Moree Hearing, Moree, 15 August 2019, TS 3003.2-4 (D Kelly); Health Service Responses Roundtable, Sydney, TS 3313.17-45 (Wahhab and Kaplan); Sydney (General) Hearing, Sydney, 10 May 2019, TS 405.19-31 (M Bonham).
- 889 Diane Logan et al, 'Integrating Addiction Medicine into Rural Primary Care: Strategies and Initial Outcomes' (2019) 87(10) *Journal of Consulting and Clinical Psychology* 952, 954.
- 890 Lismore Hearing, Lismore, 15 May 2019, TS 734.35-41 (Dr Helliwell).
- 891 Nowra Hearing (Private), Nowra, 29 May 2019, TS 905.46-906.1 (Preston).
- 892 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3259.21-7 (McRae); TS 3264.31-47 (Kaplan); Harm Reduction Hearing, Sydney, 23 September 2019, TS 4253.31-7 (Dr Jauncey).
- 893 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3261.38-46 (McRae).
- 894 Rosemary Calder et al, Australian Health Policy Collaboration, *Australian health services: too complex to navigate – A review of the national reviews of Australia's health service arrangements* (Policy Issues Paper No 1-2019, February 2019) 2.
- 895 Lismore Hearing, Lismore, 14 May 2019, TS 701.26-7 (Dr Helliwell).
- 896 Lismore Hearing, Lismore, 14 May 2019, TS 701.25-34 (Dr Helliwell); TS 752.37-42 (Robinson); Dubbo Hearing, Dubbo, 5 June 2019, TS 1543.28-32 (McMillan); Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2727.45-2728.26 (McInnes).
- 897 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3333.10-14 (Dr Sara).
- 898 See, for example, The Royal Australasian College of Physicians, Submission No 47 (May 2019) 3; NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 17; St Vincent's Health Australia, Submission No 127 (14 May 2019) 37; NSW Government, Submission No 143 (2019) 3.
- 899 Network of Alcohol and Other Drug Agencies, Submission No 79 (May 2019) 8.
- 900 NSW Government, Submission No 48 to Legislative Council Standing Committee on Social Issues, *Inquiry into service coordination in communities with high social needs* (August 2015) 5.
- 901 'HealthOne NSW Service Models', *NSW Health* (Web Page, 28 January 2014) <<https://www.health.nsw.gov.au/healthone/Pages/healthone-nsw-service-models.aspx>>.
- 902 'Spectrum of Care', *NSW Health* (Web Page, 28 January 2014) <<https://www.health.nsw.gov.au/healthone/Pages/spectrum-of-care.aspx>>.
- 903 NSW Health, *Guidelines for Developing HealthOne NSW Services* (Version 1.1, March 2012) 20.
- 904 'Client and Community Involvement', *NSW Health* (Web Page, 28 January 2014) <<https://www.health.nsw.gov.au/healthone/Pages/client-and-community-involvement.aspx>>.
- 905 Justin McNab, Kylie-Ann Mallitt and James Gillespie, *Report of the Evaluation of HealthOne Mount Druitt* (February 2013) 82-4; Justin McNab and James A Gillespie, 'Bridging the chronic care gap: HealthOne Mt Druitt, Australia' (2015) 15 *International Journal of Integrated Care* 1, 2.
- 906 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3325.25-3326.15 (Rao).
- 907 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3324.39-3325.2 (Crisp).
- 908 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3326.40-3327.15 (Dr Wilson and Faraj).
- 909 'HealthOne NSW', *NSW Health* (Web Page, 30 April 2018) <<https://www.health.nsw.gov.au/healthone/Pages/default.aspx>>.
- 910 'HealthOne NSW Service Locations', *NSW Health* (Web Page, 30 April 2018) <<https://www.health.nsw.gov.au/healthone/Pages/healthone-nsw-service-locations.aspx>>.
- 911 Health Service Responses Roundtable, Sydney, 20 August 2019, TS 3327.36-3328.6 (Faraj).
- 912 Health Service Responses Roundtable, 20 August 2019, TS 3328.42-3329.13 (Kaplan).
- 913 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4260.3-4 (Dr Jauncey).
- 914 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4260.3-17 (Dr Jauncey); 24 September 2019, TS 4358.28-40 (Dr Read).

Chapter 15. Harm reduction

Introduction

- 15.1 The harms associated with the use of ATS are extensive. They include physical and mental health and social harms, and their impact extends to the families and communities of people who use ATS. The types of harms associated with ATS are detailed in Chapter 1; prevalence of harms is examined in Chapter 7; and the impacts on families and friends are discussed in Chapter 18.
- 15.2 Harm reduction is one of the three pillars of the National Drug Strategy's harm minimisation approach, which recognises that people who use drugs need a range of supports to reduce harms to themselves, their families and the general community. Harm minimisation is a long-established policy approach that does not condone drug use.¹ Harm reduction strategies *'encourage safer behaviours, reduce preventable risk factors and can contribute to a reduction in health and social inequalities among specific population groups'*.² Nationally and internationally, harm reduction is recognised as an effective approach to illicit drug policy.³
- 15.3 In the past, Australia was recognised as a world leader in developing policy responses to illicit drug use. Australia's adoption of the National Drug Strategy followed the special premiers' conference convened by Prime Minister Bob Hawke in 1985. In 1987, the NSW Government endorsed needle and syringe programs following a pilot in 1986 to reduce the prevalence of HIV and other blood-borne viruses. The Medically Supervised Injecting Centre (MSIC) in Kings Cross, the first centre of its kind in the Southern Hemisphere, was established following the 1999 Drug Summit to address the rising harms caused by heroin use. Australia's early harm reduction responses averted a broader public health crisis; Australia has one of the lowest HIV prevalence rates among people who inject drugs internationally.⁴
- 15.4 However, the Inquiry has heard that for the past 20 years policy has not kept pace with changing patterns of drug use and associated harms. As discussed in Chapter 7, ATS-related harms are increasing. The evidence considered in this chapter establishes that current harm reduction measures in NSW do not meet the needs of people who use ATS.
- 15.5 This chapter examines programs and initiatives that have succeeded in reducing drug-related harms overseas and that should be considered for implementation in NSW. They include the provision of safer smoking kits through health services and making drug consumption services accessible to a broader range of people who use ATS, including those who smoke.
- 15.6 Substance testing, also known as pill testing, has been the subject of much public debate. It is a well-established harm reduction measure in international jurisdictions, including in Europe, the United Kingdom and Canada. It helps to monitor the illicit drug market to inform public health and law enforcement responses and enables the provision of education and brief interventions to individuals to reduce drug-related harms. The benefits of substance testing services and concerns about their implementation in NSW are examined in this chapter.
- 15.7 The evidence gathered by the Inquiry, including at the Harm Reduction Hearing and at hearings throughout regional NSW, makes it clear that fresh approaches are needed to reduce the serious harms caused by ATS.

What is harm reduction?

Conceptualising harm reduction

- 15.8 Harm reduction refers to both ‘a *philosophical approach and specific types of programmes or interventions*’⁵ that aim to reduce the harms associated with high-risk behaviours to individuals and/or their communities.⁶ It seeks to understand the behaviour and provide targeted education and support to enable people to make safer choices.⁷ Harm reduction approaches are accepted in many domains including transport safety, sexual health and alcohol and illicit drug use.
- 15.9 People engage in high-risk behaviours, including drug use, for many reasons; there is consensus that high-risk behaviours have always been, and will remain, part of society and the human experience.⁸ Therefore, harm reduction efforts focus on developing tailored interventions to address harms to the individual and society.⁹
- 15.10 Harm reduction focuses on improving quality of life for the individual and society on the assumption that such behaviour will continue, by ‘*letting people come as they are, meet[ing] them where they’re at, and recogni[sing] the power of any positive change*’.¹⁰
- 15.11 Dr Jonathan Brett, Staff Specialist in Clinical Pharmacology, Toxicology and Addiction Medicine at St Vincent’s Hospital, told the Inquiry that:
- ‘[T]he concept of harm reduction is saying, you know, we would encourage people not to use drugs, but we acknowledge that they will anyway. So we know that the war on drugs, zero tolerance is ineffective, because all it does is force people underground. So we know that harm reduction is really important.’*¹¹
- 15.12 Professor Alison Ritter, Director of the Drug Policy Modelling Program at the Social Policy Research Centre, UNSW Sydney, told the Inquiry:
- ‘Harm reduction is about reducing harm without impacting on use. It is only concerned about the harms ... the best way not to be harmed by drugs is not to use drugs; but if you choose to use drugs, harm reduction measures help reduce the risk of harm.’*¹²
- 15.13 This notion is exemplified by the philosophy of Uniting MSIC. Uniting, the service and advocacy arm of the Uniting Church NSW/ACT, has run the MSIC since it opened in Kings Cross in 2001.¹³ Dr Marianne Jauncey, Medical Director of Uniting MSIC, told the Inquiry that Uniting’s harm reduction approach is underpinned by the strong belief that ‘*all life is inherently valuable, that what we need to avoid is harm, and we need to avoid that more strenuously than we need to avoid drug use*’.¹⁴
- 15.14 The Inquiry heard that a prime objective of harm reduction programs is to engage people who use drugs in conversations about drug-related harms.¹⁵ While this engagement may ultimately discourage or stop their drug use, complementing prevention efforts,¹⁶ it is not the main objective.
- 15.15 Harm reduction is a well-established way to improve health and other outcomes for people who use illicit drugs and deliver benefits to society more broadly.

Harm reduction in illicit drug policy

- 15.16 The National Drug Strategy defines harm reduction as '*reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community*'.¹⁷ This is consistent with the International Harm Reduction Association's definition.¹⁸
- 15.17 Harm reduction is recognised as an essential component of a comprehensive strategy, alongside supply reduction and demand reduction, to minimise drug-related harms.¹⁹ As discussed in Chapter 4, the National Drug Strategy promotes a balanced approach to harm reduction, supply reduction and demand reduction, accepting that some members of society will always use drugs.
- 15.18 A broad range of harm reduction initiatives has been implemented internationally and in NSW in response to harms associated with the use of drugs, including ATS. International responses have evolved to reflect changes in drug trends and associated harms, and are described in more detail in this chapter.
- 15.19 Existing harm reduction programs in NSW, such as needle and syringe programs (NSPs) and the MSIC, have a well-established evidence base demonstrating their effectiveness in reducing drug-related harms such as blood-borne virus transmission and overdose.²⁰
- 15.20 Some of the key benefits of harm reduction measures are outlined below.

Harm reduction is best practice

- 15.21 Harm reduction is considered best practice. It is applied worldwide and endorsed by international bodies including the World Health Organization, the United Nations General Assembly and the United Nations Commission on Narcotic Drugs.²¹
- 15.22 The effectiveness of any given harm reduction program is evaluated by reference to whether it reduces drug-related harm, not whether it has reduced or eradicated drug use.²² Programs that aim to reduce drug use fall under the demand reduction pillar, not the harm reduction pillar, of the National Drug Strategy.
- 15.23 Dr Mary Harrod, CEO of the NSW Users and AIDS Association (NUAA), gave evidence that best practice health responses, consistent with human rights and equity approaches, include both harm reduction strategies and treatment for people who want to stop using drugs.²³

Harm reduction facilitates engagement with treatment

- 15.24 Research suggests that harm reduction services have a broad range of benefits, including reductions in mortality and morbidity, increased referrals to treatment, health and social supports and improvements to public amenity.²⁴
- 15.25 The Inquiry received evidence that people who access harm reduction services may have little engagement with mainstream health services²⁵ or may not have previously discussed drug use with a health professional.²⁶ For example, Dr Jauncey told the Inquiry that 70% of people who register to use the MSIC are not linked in with other local health services.²⁷ People who use harm reduction services are much more likely to accept referrals to other health (including treatment) and social welfare services because of the therapeutic relationship and trust that develops between the service and the people who access it.²⁸
- 15.26 It may take years for people to seek treatment²⁹ and relapse is common for people who use ATS.³⁰ Dr Jauncey referred to the role that harm reduction services play in this context by offering people who use drugs something of value in the time before they engage with treatment:

*'[P]roviding a low threshold service makes contact with people and that way, we're able to intervene and start developing a therapeutic ... relationship and a sense of trust and then they're much more likely to listen in terms of our offers of assistance and referral to other health as well as social welfare services.'*³¹

Harm reduction in NSW and internationally

- 15.27 Various initiatives were implemented in NSW in the 1980s to early 2000s with the objective of reducing blood-borne virus transmission and preventing opioid overdoses, including NSPs and the MSIC.
- 15.28 In stark contrast to NSW, there has been ongoing progress and innovation in harm reduction measures in other jurisdictions such as in Europe and Canada. This is demonstrated through widespread application and expansion of programs such as drug consumption and substance testing services and distribution of safer smoking kits. These initiatives are discussed in detail later in this chapter.
- 15.29 Table 15.1 on the next page sets out a timeline of the progression of harm reduction measures in NSW, Australia and internationally.

Table 15.1: Comparison of NSW, Australian and international harm reduction measures³²

Date	Australian Context	International Comparison
1970s		Drug consumption facilities operate unofficially, and briefly, through drug and alcohol and youth services in the Netherlands and England. ^(a)
1985	Australia develops its first coordinated National Drug Strategy, one of the first international drug policies to take an explicit harm minimisation approach, focusing on harm reduction and public health. ^(b)	
1986-1987	The first needle and syringe program (NSP) is established at St Vincent's Hospital, Darlinghurst. NSW adopts the program as policy, amending legislation to permit the possession of injecting equipment and supporting program implementation state-wide. ^(c)	The first official supervised consumption room opens in Berne, Switzerland. These services are expanded in 1988 after the service is determined to be consistent with national legislation. ^(d)
1992	One-year trial of needle and syringe vending machines begins across NSW, with the subsequent evaluation showing it meets its program objectives. ^(e)	The Netherlands establishes the Drugs Information Monitoring System (DIMS) to coordinate national drug checking initiatives and monitoring functions for the illicit drug market. From 2002 the services are provided from fixed-site locations only. ^(f)
1994-1996		From 1994 to 1995, drug consumption rooms become part of service provision in Frankfurt, Germany, and the Netherlands. By 1996 the Netherlands has adopted drug consumption rooms as part of an integrated policy response and develops legal guidelines to support operation. ^(g) By 1996 Spain, France and Belgium have introduced drug checking services onsite at festivals and events, as well as at fixed-site locations. ^(h)
1998		By 1998 Austria, Switzerland and the United States operate onsite drug checking services at events and festivals. ⁽ⁱ⁾
1999	NSW Government commits \$176 million to implementing the recommendations from the NSW Drug Summit, including an 18-month trial of a medically supervised injecting centre. ^(j)	In 1999 Spain, France and Slovenia establish and expand onsite drug checking and fixed-site locations. All fixed-site locations have objectives to improve public health and surveillance functions and develop an early warning system. ^(k)
2001	Sydney's Medically Supervised Injecting Centre (MSIC) opens for an 18-month trial period. ^(l) An independent evaluation of NSPs shows they have succeeded in meeting objectives, including reduced blood-borne virus transmission. ^(m)	Spain opens a 24/7 drug consumption room. ⁽ⁿⁿ⁾
2002-2004		By 2002 fixed-site and onsite drug checking services have been established and extended in Switzerland, Canada, Spain and in the US, where they are approved by the Drug Enforcement Administration. ^(o) In 2003 the first supervised injecting site opens in Vancouver, Canada. By 2004, 62 supervised drug consumption services operate across four countries in Europe, with most facilities accommodating consumption by smoking. ^(p)
2010	An independent evaluation demonstrates the MSIC has met all its stated objectives. Legislation removes the trial status and enables permanent operation. ^(q)	
2013		By 2013 on site drug checking is provided in Portugal and Hungary, with both on site and fixed-site locations established and extended in France and Colombia. ^(r)
2016		There are 92 drug consumption rooms operating across Canada, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Spain and Switzerland, and the MSIC in Australia. ^(s) Onsite drug checking is conducted in the UK, Luxembourg, Poland, Italy, Uruguay, and New Zealand. Both onsite and fixed-site models are provided in Mexico and extended in France, and fixed-site locations are expanded in Switzerland and Austria. ^(t)

Expanding harm reduction services in NSW to address ATS

- 15.30 The Inquiry heard about gaps in services, particularly for people who smoke methamphetamine. A majority of people who use methamphetamine in NSW smoke it (see Chapter 7) but there is a lack of harm reduction services directed to them.³³
- 15.31 Associate Professor Rebecca McKetin, from the National Drug and Alcohol Research Centre (NDARC) at UNSW Sydney, told the Inquiry there is a need to expand harm reduction interventions for people who use methamphetamine, noting a lack of targeted strategies to reduce the risks of sexually transmitted infection and blood-borne viruses for this cohort.³⁴ She also identified a lack of research into strategies to address methamphetamine-related mental health harms, cardiovascular risks and injuries from intoxication.³⁵
- 15.32 In relation to MDMA, the Inquiry received evidence that most young people who use MDMA have never spoken with a health or medical professional about the risks and harms of using the drug.³⁶ Dr David Caldicott, Emergency Consultant at Calvary Hospital in Canberra and the clinical lead for Pill Testing Australia, gave evidence that there is a lack of trust between ‘*this generation or community*’ and the people giving them messages about staying safe.³⁷
- 15.33 One of the key principles underpinning effective drug policy is that it should be evidence based, and the Inquiry acknowledges that there are limited independent or peer-reviewed evaluations of the initiatives proposed in this chapter to address these significant gaps in harm reduction services. However, a lack of evidence should not operate as a barrier to the introduction of harm reduction services novel to NSW. Uniting noted that ‘*good policy is evidence informed but it cannot by definition always be evidence based, because innovation is needed to create new evidence*’.³⁸
- 15.34 Further, research is only one input into policy development. NSPs and the MSIC, both recognised as successful services, were introduced in the expectation that they would reduce harms but without direct evidence of efficacy.³⁹ As Professor Ritter, DPMP, told the Inquiry:

*‘There was good logic and there was medical experience about clean injecting – you know, hygienic injecting equipment, so it had a rational basis to it, but there wasn’t randomised control trials or cost-effectiveness analyses. All of that came many years later...’*⁴⁰

Engaging people who smoke methamphetamine

- 15.35 Data suggest the cohort of people smoking methamphetamine is ‘*definitely a big population*’ but the actual number is not known.⁴¹ NDARC submitted to the Inquiry:

*‘This population represents a growing proportion of people who use methamphetamine in Australia. People who smoke crystal methamphetamine are, on average, a younger group who have limited contact with existing harm reduction services (e.g. NSPs), and have limited knowledge of existing alcohol and other drug services.’*⁴²

- 15.36 The provision of sterile equipment by NSPs engages people who inject drugs and facilitates engagement with harm reduction services, health and social supports, but there are no comparable services for people who smoke methamphetamine.⁴³ The lack of harm reduction services for smokers makes it difficult to engage this cohort to provide education and information, facilitate contact with health and treatment services⁴⁴ and recruit for research purposes.⁴⁵

- 15.37 Dr Phillip Read, Director and Senior Staff Specialist of the Kirketon Road Centre, gave evidence that the fact that NSPs have no contact with non-injecting ATS users is a significant barrier to harm reduction services, such as the provision of messages intended to prevent smokers transitioning to injecting use. *'We're essentially requiring people to start injecting before we offer something valuable to them.'*⁴⁶
- 15.38 Associate Professor McKetin, NDARC, gave evidence that strategies are needed to engage people who smoke.
- 'Smokers, in particular, if they're not injecting, they're not going to the NSP, they're not having any contact with health services where they're going to get that information ... there's a lot of people out here are smoking and we're not engaging with them. We're not getting that harm reduction information to them.'*⁴⁷
- 15.39 NUAA submitted that providing engagement points for people who smoke ATS would facilitate distribution of harm reduction resources, addressing issues including mouth and lung health, sexual health, personal safety, overdose, diet, sleep, treatment access and guidance to assist behaviour change.⁴⁸
- 15.40 Accordingly, measures ought to be taken to find a way to engage with people who smoke methamphetamine to address harms associated with their use as early and effectively as possible.

Recommendation 48:

That NSW Health, in partnership with people who use amphetamine-type stimulants and clinicians involved in providing care for people who develop health-related harms resulting from amphetamine-type stimulants, develop harm reduction and health promotion initiatives directed toward people who smoke amphetamine-type stimulants.

Equipment distribution

- 15.41 Equipment distribution programs reduce the risk of disease transmission associated with the sharing of equipment.⁴⁹ They also provide a contact point for people who use drugs to receive harm reduction messaging⁵⁰ and be referred to other health and social services.⁵¹ In NSW, NSP distribution is limited to the provision of equipment for the purposes of administration by injection. The Inquiry has heard evidence that expanding equipment distribution to smoking equipment may be an effective way to extend harm reduction services to people who smoke methamphetamine.⁵²

Needle and syringe programs

- 15.42 NSPs are a key component in national blood-borne virus prevention strategies,⁵³ aiming to reduce transmission by providing people who inject drugs with sterile injecting equipment and safe means of disposal.⁵⁴ The first Australian NSP was established in 1986 as a pilot program through St Vincent's Hospital in Darlinghurst, Sydney. There was a state-wide increase in service provision after NSPs were adopted as official NSW policy the following year.⁵⁵
- 15.43 There are now 1,092 NSP distribution sites across NSW.⁵⁶ They include primary (or standalone) NSPs, secondary NSPs that are part of broader healthcare services and pharmacy NSPs.⁵⁷

- 15.44 Primary NSPs provide holistic care to meet the needs of people in the local area who inject drugs;⁵⁸ NSW Health considers them ‘*an incredibly important contact point*’ for at-risk marginalised populations.⁵⁹ In addition to providing sterile equipment, primary NSPs aim to facilitate access to social, medical and health services, including treatment, and provide harm reduction and safe injecting education.⁶⁰ Sydney’s Kirketon Road Centre is one of 31 primary NSPs in NSW. Dr Read told the Inquiry that primary sites have ‘*dedicated staff who provide equipment, face-to-face brief interventions, health support and referral pathways to patients*’.⁶¹
- 15.45 NSW also has NSPs delivered through 288 secondary outlets, 540 pharmacies (provided at a small cost) and 233 dispensing machines.⁶² These models do not provide holistic services but enable state-wide needle and syringe distribution, including in rural and regional areas where geographic distances are a barrier to establishing primary services.⁶³

Case study: Kirketon Road Centre⁶⁴

Kirketon Road Centre in Darlinghurst is a primary NSP which offers comprehensive services for people who use drugs.

The centre was established in 1987 as a one-stop shop to address the health needs of disadvantaged and marginalised clients, including young people, sex workers, people who inject drugs, people from LGBTQI+ communities, Aboriginal people and people experiencing homelessness.

The centre recognises that harmful drug use is related to, and often causes, a broad range of medical and social harms. It provides both harm reduction services and a full spectrum of treatment depending on clients’ readiness and desire for change.

In addition to medical services, the centre provides counselling, sexual health, social welfare services and housing assistance projects as part of its holistic model of care.

The Inquiry heard that the centre is unique in NSW in offering an integrated and embedded NSP as part of a targeted, multidisciplinary primary healthcare service. Providing wraparound services to clients when they attend the NSP has been shown to improve overall health outcomes and to increase access to, and engagement with, broader health supports.

- 15.46 A 2009 Commonwealth evaluation found NSPs are cost-effective, providing a \$27 return in healthcare savings for every dollar invested, and that 32,050 new HIV and 96,667 hepatitis C transmissions had been averted over 10 years.⁶⁵ NSPs are internationally recognised as best-practice interventions for blood-borne virus prevention among people who use drugs.⁶⁶
- 15.47 Some concerns have been raised about NSPs, including public amenity, the potential to increase use among people who inject drugs and the potential to initiate people into injecting drug use by reducing the perceived associated risks.⁶⁷ A 2005 review of research into NSPs identified no evidence to support these concerns, instead finding no increases in rates of drug use, decreased initiation to injecting routes of administration and decreased publicly discarded injecting equipment.⁶⁸ A 2010 literature review similarly found sufficient evidence to support the effectiveness of NSPs in reducing self-reported injecting risk behaviour.⁶⁹

Applicability to ATS

15.48 The NSP program has broad state-wide coverage in NSW⁷⁰ and is accessed by people who inject ATS.⁷¹ The Inquiry heard that NSPs are effective public health services and an important component of harm reduction for people who inject drugs.⁷²

15.49 Although NSPs were introduced to address high rates of blood-borne virus transmission among people who inject opioids, particularly heroin, their service objectives are not opioid-specific – they apply to all drugs administered by injection, including ATS. The Inquiry received evidence that people who inject ATS use NSPs.⁷³ However, the Inquiry also heard that there are no clear referral pathways into treatment for people who use ATS. Dr Read, Kirketon Road Centre, gave evidence that:

*‘[W]hen people present to NSPs there is a uniform non-judgmental approach to distribution of equipment regardless of the type of drug used ... There is a clear [referral] pathway for opioid users (whose management often includes doctors) but there are less dedicated and clear pathways for amphetamine-type substance (ATS) users’.*⁷⁴

15.50 The 2018 NSW Needle and Syringe Program Enhanced Data Collection Survey and the 2014–18 Australian Needle and Syringe Program Survey showed an increase in the proportion of people who inject drugs reporting the use of methamphetamine.⁷⁵

15.51 Data show that needle and syringe distribution in NSW has increased each year for the past 10 years.⁷⁶ The Inquiry heard that increased distribution in the Western NSW Local Health District correlates with an increase in the local prevalence of people who inject methamphetamine.⁷⁷

Table 15.2: NSW NSP distribution by public and pharmacy sector 2008 to 2018⁷⁸

NSW	Public	%	Pharmacy	%	Total
2008–09	7,233,830	80%	1,764,267	20%	8,998,097
2009–10	7,514,508	84%	1,454,312	16%	8,968,820
2010–11	8,400,515	84%	1,574,684	16%	9,975,199
2011–12	9,444,001	85%	1,607,376	15%	11,051,377
2012–13	10,230,040	87%	1,572,380	13%	11,802,420
2013–14	10,743,583	87%	1,554,514	13%	12,298,097
2014–15	11,324,378	89%	1,419,126	11%	12,743,504
2015–16	12,114,913	88%	1,705,015	12%	13,819,928
2016–17	12,189,626	87%	1,744,002	13%	13,933,628
2017–18	12,288,628	87%	1,842,141	13%	14,130,769

Distribution of safer smoking kits

15.52 People who smoke methamphetamine are not being engaged by existing harm reduction services. The distribution of smoking equipment represents an opportunity to address this gap, by engaging people who smoke ATS and encouraging them to choose inhalation over injecting to reduce the risk of experiencing the additional harms associated with the latter.

- 15.53 The contents of safer smoking kits can vary.⁷⁹ In addition to a pipe, contents commonly include alcohol swabs to wipe down pipes after use, push sticks (wooden dowels or chopsticks) to avoid blisters from hot glass, and brass screens (to prevent ash falling into the pipe and being inhaled).⁸⁰ The kits may also include additional items such as condoms and harm reduction information.⁸¹

Distribution of safer smoking kits in Canada reduces harm

- 15.54 The Inquiry heard evidence that smoking equipment is distributed in Canada, primarily to address the needs of people who use crack cocaine, and that the contact made through these services can help engage these people in a broader system of care.⁸²

- 15.55 Professor Thomas Kerr, Associate Director and Director of Research at the British Columbia Centre on Substance Use in Vancouver, gave evidence that the provision of safer smoking kits in Canada has the central objectives of reducing health-related harms and facilitating points of contact and engagement with the target audience.

‘The goal of these programs is really to prevent the transmission of infectious diseases and injuries, such as oral sores that can occur from pipe smoking. But also, these programs seek to make contact with people who use drugs and engage them in the broader system of health care.’⁸³

- 15.56 In 2005 the Ottawa NSP began distributing safer smoking kits to reduce drug-related harms caused by smoking crack cocaine. It aimed to reduce blood-borne virus transmission among people who smoked or injected crack cocaine following high rates of reported pipe sharing, high rates of HIV and hepatitis C and evidence indicating a potential for transmission through sharing of smoking equipment.⁸⁴

- 15.57 Safer smoking kits were distributed via the Ottawa NSP both to people who injected drugs and a cohort of younger people who reported smoking only.⁸⁵ The kits contained glass stems, rubber mouthpieces, brass screens, chopsticks, alcohol swabs, condoms, hand wipes, lip balm and chewing gum, and information encouraging people not to share equipment and to dispose of it safely. Complete kits and individual components of the kit were made available.⁸⁶ Other services provided by the NSP through this initiative included education, support, health services and referrals to social services and treatment supports.⁸⁷

- 15.58 A 2006 program evaluation demonstrated a range of positive public health outcomes from the initiative, including an immediate, high and sustained uptake of the service, and evidence of behaviour changes in drug use patterns with transitions to a less harmful mode of administration.⁸⁸ Successful engagement was demonstrated by 4,000 visits from people who smoked crack cocaine who received the additional benefits of harm reduction education, information and support during the 12-month trial.⁸⁹ Harm reduction benefits were extended to people who injected drugs, with 40% of respondents reporting reduced injecting patterns of use due to more accessible safer smoking equipment.⁹⁰ The evaluation noted other health-related benefits such as a reduction in behaviour associated with blood-borne virus transmission, including reduced equipment sharing, and reduced incidence of oral injuries.⁹¹

- 15.59 Professor Kerr told the Inquiry that safer smoking programs have been extended to jurisdictions such as Vancouver, with distribution and engagement through outreach services and community health and hospital settings.⁹² He noted that concerns about program outcomes, including the potential to facilitate, condone and increase levels of crack cocaine use, have not been realised, and that program evaluations show a direct correlation between increased pipe distribution and substantial declines in reported daily use.⁹³

*'[W]e found that in the period where there is a huge increase in the number of crack pipes being distributed, there was actually a substantial decline in the number of people reporting daily crack smoking. Suggesting quite clearly that providing crack pipes was not in any way facilitating crack use or increasing it among people who were already smoking crack.'*⁹⁴

- 15.60 These outcomes demonstrate that facilitating access to smoking equipment is an effective harm reduction measure for people who smoke and for people who inject drugs.

Applicability to NSW

- 15.61 The distribution of safer smoking equipment would provide an opportunity to engage people who smoke ATS. There are opportunities for such an initiative to be facilitated through existing services including primary NSPs and AOD services.
- 15.62 The Inquiry has received substantial evidence that the distribution of safer smoking kits could provide opportunities for engagement and intervention with a broader range of people who use ATS, including a population that is not accessing harm reduction services or being reached with appropriate messaging and education.⁹⁵
- 15.63 NUAA submitted that, in its experience, harms including injection-related injuries associated with methamphetamine have increased; adverse outcomes can extend to hospitalisation, loss of limbs and death.⁹⁶ The 2019 Illicit Drug Reporting System found almost half of all respondents reported the occurrence of an injection-related health issue in the previous month.⁹⁷
- 15.64 The benefits of distributing safer smoking kits could extend to people who inject ATS. Dr Jonathan Brett, St Vincent's Hospital, gave evidence that *'in terms of harm reduction, encouraging people to smoke rather than inject is generally what we try and do clinically'*.⁹⁸ The Inquiry heard that smoking helps to reduce injection-specific harms including blood-borne virus transmission, injection-related injuries and vein damage.⁹⁹ The harms associated with injection are discussed further in Chapter 1.
- 15.65 Associate Professor Charlotte Hespe, Chair of the Royal Australian College of General Practitioners (RACGP) NSW & ACT, supported the distribution of smoking equipment as a way to facilitate engagement, provide information and education, and potentially prevent escalation to injecting drug use, noting: *'Avoiding injecting drug use is a high priority, given the extra risks associated.'*¹⁰⁰
- 15.66 Dr Ingrid van Beek, public health and addiction medicine physician, Conjoint Professor at The Kirby Institute and founding Medical Director of Uniting MSIC, told the Inquiry that there could be merit in providing smoking equipment via NSPs to people who inject ATS to enable their transition to inhalation.¹⁰¹ In support, Dr van Beek referred to research from the United Kingdom indicating that the provision of aluminium foil at NSPs led a number of people to inhale heroin on occasion rather than inject.¹⁰² Dr van Beek also noted that smoking methamphetamine causes a nearly instantaneous, intense and longer-lasting high than when it is injected, such that efforts to encourage transition away from injecting ATS would probably be more successful than targeting heroin, which is more efficient when injected.¹⁰³

- 15.67 Dr Read, Kirketon Road Centre, also gave evidence that methamphetamine has a similar bioavailability whether smoked or injected,¹⁰⁴ and that while *‘the solid science on this is not super strong ... the availability and capacity to inhale or smoke the drug is likely to prevent a certain number of people transitioning to injecting’*.¹⁰⁵ He said the social context of injecting could cause harms that are not shared by people who smoke.

*‘Many of the clients who we’ve seen injecting amphetamines do have a higher – a high issue with dependence and a higher crossover with polydrug use and other drug-related harms. And the sort of social circumstances, sometimes, of some of the individuals who we see who inject can be more tenuous than those people who confine themselves to inhaling it ... I think that those people who end up being most marginalised often end up gravitating towards the injecting end of the spectrum.’*¹⁰⁶

- 15.68 A number of submissions to the Inquiry highlighted the public health benefits of encouraging non-injecting routes of drug administration by distributing safer smoking kits.¹⁰⁷

- 15.69 In Moree, the Inquiry heard from David Kelly, Manager of Community Health Programs, Maayu Mali Residential Rehabilitation Centre, that NSPs would be an ideal place to have smoking equipment and that one of the benefits, besides potentially encouraging people to smoke rather than inject, would be the opportunity for engagement.¹⁰⁸

*‘[Y]ou would be able to engage through a pipe-exchange program ... that’s often the first or only contact, besides contact with police, that the drug user might have and that’s an opportunity to engage with people, provide some very, very early brief interventions and then they know where to come when they want to stop.’*¹⁰⁹

- 15.70 NUAA submitted that the provision of smoking equipment through services such as NSPs would be unlikely to encourage people to start smoking methamphetamine, as they are targeted, specialised services not widely accessed by the general community.¹¹⁰ NUAA’s Dr Harrod gave evidence that distributing equipment via such services is *‘relatively low risk, because they’re accessed by people that are already engaged in drug use’*.¹¹¹ In her experience, the presence of an NSP has never resulted in someone starting to inject. *‘I very much doubt that [providing smoking equipment] would increase the risk of people taking up (a) smoking or (b) transitioning from smoking to injecting.’*¹¹²

- 15.71 Associate Professor McKetin, NDARC, identified *‘modest’* risks of distribution through NSPs, including that people who smoke methamphetamine might be exposed to injecting as a potential new route for administration, and the potential for increased use should people smoke in addition to injecting.¹¹³ The Inquiry notes that any such potential risks could be assessed and addressed through an appropriately-designed trial.

- 15.72 Associate Professor McKetin gave evidence that people who smoke crystal methamphetamine are a high-risk group for the transmission of sexually transmitted infections,¹¹⁴ and that those who smoke and inject methamphetamine are a very high-risk group for the transmission of both blood-borne viruses and sexually transmitted infections.¹¹⁵ In light of these risks, it would be appropriate for condoms and safe sex messaging to accompany the distribution of safer smoking kits in NSW, together with any other harm reduction messaging information to reduce the risks associated with smoking ATS. The Inquiry notes that condoms have been included in safer smoking kits in Canada.¹¹⁶

- 15.73 Detective Acting Superintendent Michael Cook, Acting Commander, Drug and Firearms Squad, NSW Police Force, told the Inquiry that the NSW Police Force supports government-endorsed harm reduction strategies and has a history of collaborating with other agencies such as NSW Health to support implementation. Should safer smoking kits be endorsed, the NSW Police Force would engage with the government, including on the appropriate legislative framework to support the initiative. It is envisaged that a similar approach as that taken towards NSPs would be adopted in such a circumstance.¹¹⁷
- 15.74 There is sufficient evidence to support an evaluated trial distributing safer smoking kits through community health services such as NSPs, to reduce harms to and engage people who smoke ATS, provide them with harm reduction and health messaging, and facilitate access to health services. Implementation should occur in areas of identified need, as assessed in partnership with local communities. An expansion of pilot programs should be subject to an evaluation of clearly determined objectives.

Recommendation 49:

That NSW Health trial the non-commercial distribution of safer smoking kits through community health services, such as needle and syringe programs, in order to engage with people who smoke amphetamine-type stimulants. These points of distribution should facilitate linkages to a broad range of services including primary and mental health, specialist AOD treatment and psychosocial services for the purpose of brief interventions and provision of harm reduction and health promotion advice.

Decriminalisation of ‘ice pipes’

- 15.75 Section 11 of the *Drug Misuse and Trafficking Act 1985* (NSW) (DMT Act) makes it an offence to possess any item of equipment for use in the administration of a prohibited drug. There is an exception for hypodermic needles and syringes, including for the purposes of needle and syringe exchange programs.¹¹⁸ No such exception applies to equipment that may be used for smoking crystal methamphetamine.
- 15.76 The legislation defines ‘ice pipe’ as ‘*a device capable of being used for the administration of a prohibited drug by means of the smoking or inhaling of the smoke or fumes resulting from the heating or burning of the drug in a crystal or powder form*’.¹¹⁹ Amendments to the DMT Act would be necessary to decriminalise the use and possession of such equipment to facilitate the distribution of safer smoking kits as discussed above. They would also be necessary to avoid frustrating the benefits sought to be achieved by the recommendation to decriminalise the offences of use and possession of drugs, as discussed in Chapter 11.
- 15.77 The Inquiry received submissions in support of decriminalising smoking equipment as a possible harm reduction measure,¹²⁰ removing a barrier to providing people with safe equipment¹²¹ and to smoking rather than injecting ATS. The National Centre for Clinical Research on Emerging Drugs (NCCRED) submitted that the criminalisation of smoking equipment constrains the promotion of non-injecting routes of administration and the delivery of health promotion to people who do not inject ATS, noting that the distribution of smoking equipment in Canada has been demonstrated to reduce harm and decrease the frequency of injecting.¹²²

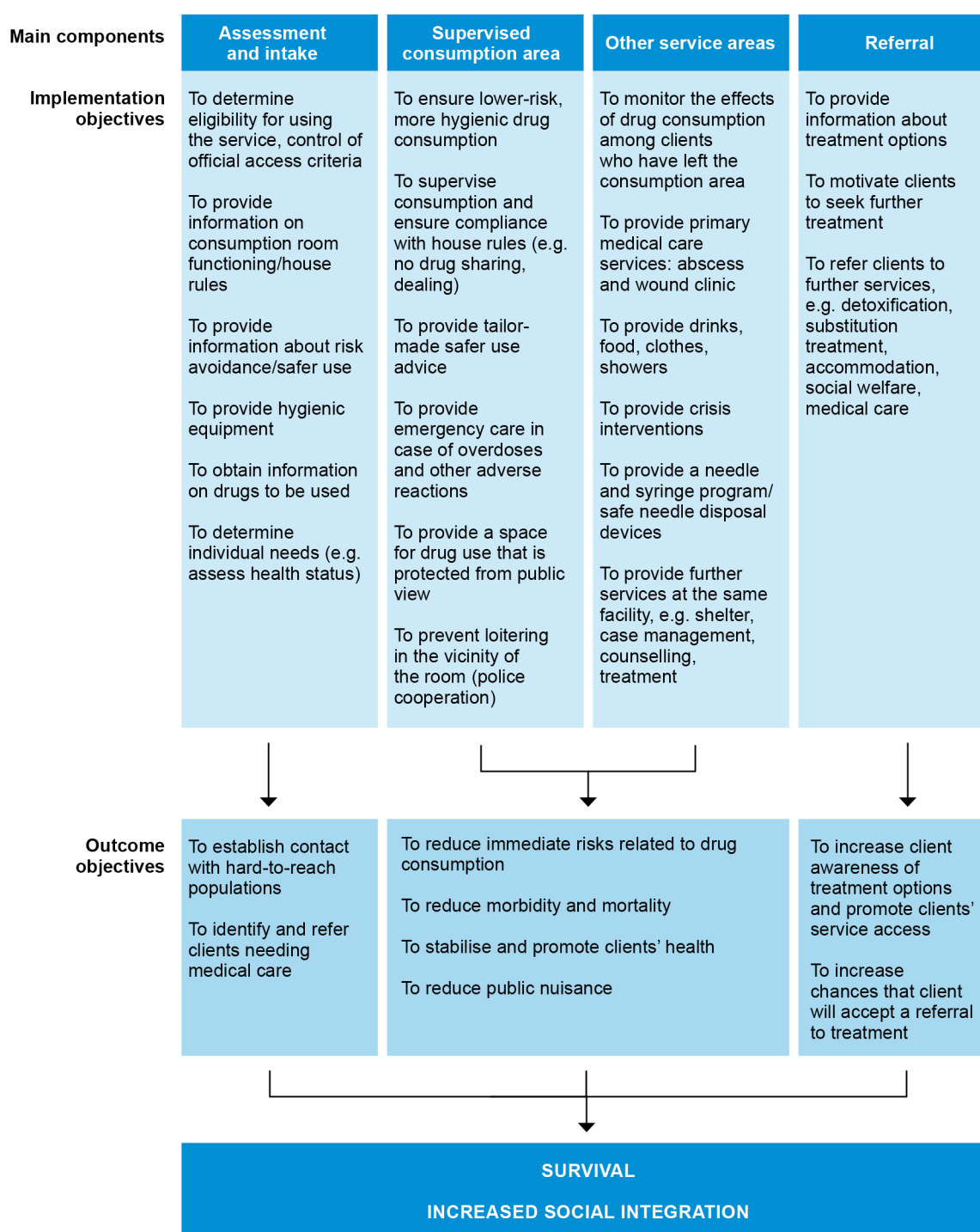
- 15.78 New research from NDARC indicates that if people are unable to access smoking equipment, they are likely to administer crystal methamphetamine by the more harmful methods of injection or homemade pipes.¹²³ Homemade or makeshift pipes have a greater likelihood of exploding or breaking, resulting in oral cuts, burns, blisters and inhalation of other toxic material,¹²⁴ while use of old and damaged pipes is associated with the risk of blood-borne virus transmission.¹²⁵ NDARC interviewed people recruited for the 2019 Illicit Drugs Reporting System and found that of the 19% who had recently smoked methamphetamine and reported challenges in accessing commercial ball pipes, 44% turned to using a homemade pipe and 63% reported injecting instead.¹²⁶ The Inquiry notes that this research involved a cohort of people who regularly inject drugs.
- 15.79 The harms of injection as a route of administering ATS are well known. Uniting MSIC submitted that encouraging non-injecting routes of drug administration is increasingly accepted as being important to public health,¹²⁷ and ACON told the Inquiry that:
- 'For many people who use ATS, avoiding injecting is perceived as a valuable strategy to control or cut back on ATS use ... Decriminalising the possession of inhalant equipment would pose a benefit to those who use ATS but wish to avoid harms associated with injecting.'*¹²⁸
- 15.80 Professor Ritter, DPMP, gave evidence that if carrying a pipe was no longer an offence, people may choose to smoke rather than inject crystal methamphetamine.
- '[The] legal regulation of things like glass pipes actually potentially increases harm and may move people towards an injecting route of administration because glass pipes are illegal and ... there's a risk of prosecution. If methamphetamine were decriminalised in NSW, the carrying of a glass pipe would no longer be an offence, which would mean that people might preferably choose to smoke crystal methamphetamine rather than inject.'*¹²⁹
- 15.81 This was consistent with NUAA's submission, which also highlighted that the risk of arrest for possession of smoking equipment is greater for people who are known to police, for Aboriginal people, and those living in rural and regional communities.¹³⁰
- 15.82 Data supplied by the NSW Bureau of Crime Statistics and Research indicate that between July 2018 and June 2019, there were 148 people detected in possession of smoking equipment by the NSW Police Force and 21 of those were charged. Court outcomes for those found guilty included two non-custodial community-based orders, 10 fines, eight convictions only and one three-month custodial sentence.¹³¹
- 15.83 There is sufficient evidence to support decriminalising the possession of 'ice pipes'. This measure is required to facilitate the distribution of safer smoking kits as a harm reduction measure for the large cohort of people who smoke methamphetamine. Dr Jauncey, Uniting MSIC, told the Inquiry that decriminalising 'ice pipes' is *'a good idea not because we want to see more people using the ice pipes, but we want to make contact with people who are using [them]'*.¹³²
- 15.84 The Inquiry also notes that s 11A of the DMT Act makes it an offence to sell, supply in connection with a commercial transaction, or display in or in connection with a shop, 'ice pipes' and 'water pipes'.¹³³ The evidence to the Inquiry does not suggest any amendment to this section is necessary.

Recommendation 50:

That the NSW Government remove the prohibition in the *Drug Misuse and Trafficking Act 1985* (NSW) on possession of ice pipes.

Supervised drug consumption services

- 15.85 Supervised drug consumption services are places where people may consume prohibited drugs under the supervision of trained staff. The services discussed in this chapter have various designs, relating to different modes of administration permitted on the premises and restrictions on access.
- 15.86 The only supervised drug consumption service that may lawfully operate in NSW is Uniting MSIC.¹³⁴ The Inquiry heard evidence about supervised drug consumption services operating overseas and the benefits of permitting additional supervised drug consumption services to operate in NSW, integrating them with other services in an holistic model of care. The Inquiry also received evidence that supervised consumption services should be expanded to allow smoking, and that restrictions on access by pregnant women and people aged 16 to 18 years should be removed. This evidence is discussed in the following sections of this chapter.
- 15.87 Figure 15.1 on the next page sets out the main components and objectives of supervised drug consumption services.

Figure 15.1: Service model for a supervised drug consumption facility¹³⁵

Overview of drug consumption services

15.88 Supervised drug consumption services aim to reduce drug-related harms to both the individual and the community through the provision of clean, hygienic, medically supervised facilities for the self-administration of pre-obtained drugs.¹³⁶ Such facilities are sometimes referred to as medically supervised centres or facilities. Drug consumption services aim to engage marginalised populations, prevent drug-related overdose deaths, reduce blood-borne virus transmission and injection-related injuries and facilitate access to health and social supports. They also seek to improve public amenity through reducing the visibility of public drug use, public disorder and publicly discarded administration equipment.¹³⁷ The broad aims, outcome objectives and indicators for drug consumption services are detailed in Table 15.3 below.

Table 15.3: Aims and objectives of drug consumption services¹³⁸

Aims	Outcome Objectives	Indicators
Provide an environment for safer drug use	1. Engagement and acceptability by target group	Client profiles, service use patterns, client satisfaction
	2. Service acceptability	Responses of residents, businesses, police and politicians.
	3. Establish conditions for safe and hygienic use	Various process indicators
Improve health status of target group	1. Improve risk-related behaviours	Public drug use, risk awareness, equipment sharing, injection hygiene
	2. Reduce morbidity	Injection injuries, infection, disease transmission
	3. Reduce mortality	Overdose outcomes
	4. Improve access to healthcare and drug treatment	Referrals and treatment uptake
Reduce public disorder	1. Reduce public drug use	Self reported rates of public-injecting, public observations and reports
	2. Improve public perceptions	Perceived nuisance, discarded syringes
	3. No increase in local drug-related crime	Crime statistics

15.89 European countries implemented responses including NSPs, opioid substitution therapy and drug consumption services in response to increasing injection-related harms such as HIV/AIDS transmission in the 1980s.¹³⁹ The model of consumption rooms was initially debated, with questions as to whether they were inconsistent with international drug conventions that limit the use of narcotic drugs to medical and scientific purposes.¹⁴⁰ Despite these concerns, the first official supervised consumption room was established in Berne, Switzerland in 1986. In subsequent years, such services were established in Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece and France.¹⁴¹

15.90 As of 2019, there were 120 drug consumption services operating worldwide¹⁴² including in Switzerland, Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece, France,¹⁴³ Canada, Belgium, Portugal, Mexico and Australia.¹⁴⁴

15.91 The Inquiry heard from Cedric Charvet, Coordinator of De Regenboog Groep drug consumption service in Amsterdam and founding member of the International Network of Drug Consumption Rooms. He said drug consumption services have expanded internationally as a harm reduction response, and that the Network is expected to grow rapidly, adding new members from the US, the UK, Iceland, Finland, Slovenia and Poland.¹⁴⁵ The Inquiry understands there are also plans to establish services in Ireland and Scotland.¹⁴⁶

- 15.92 Evaluations of drug consumption services are limited. While several reports and evaluations have been published on services in Germany, Switzerland and the Netherlands, they are either not publicly available or not available in English. The available service evaluations come from facilities in Australia (the MSIC) and Canada (Insite) rather than European services that have a longer history of operation.¹⁴⁷
- 15.93 Nevertheless, the Inquiry has heard evidence identifying the important benefits these services offer people who use drugs, including ATS.

Services engage the target audience

- 15.94 The international evidence base demonstrates that drug consumption services successfully engage the target audience of high-risk, marginalised people who use drugs.¹⁴⁸ Research from Australia and Canada demonstrates that these services reach and are accepted by their target audience, with no increases observed in initiation or relapse into drug use.¹⁴⁹
- 15.95 Associate Professor Hespe, RACGP, noted that medically supervised drug consumption rooms *'do not induce individuals to consume drugs. They are used by those who already consume drugs, who are seeking safe equipment, supervision etc.'*¹⁵⁰

Services reduce harms associated with drug use

- 15.96 Dagmar Hedrich, Lead Scientist in Harm Reduction at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), told the Inquiry the supervision and education provided by drug consumption services may reduce risks associated with drug use.

*'Often, there are nurses working in the rooms who can teach users how to consume, how to inject properly, hygienically. So what I know in terms of changes in drug use patterns, this has been predominantly in a direction of lower risk.'*¹⁵¹

- 15.97 Professor Kerr, British Columbia Centre on Substance Use, noted that service provision, including safer injecting and harm reduction advice, results in safer practices and a reduced likelihood of injection-related injuries that lead to infections and hospitalisations.¹⁵²
- 15.98 Drug consumption services aim to reduce drug-related morbidity and mortality.¹⁵³ These objectives are supported by a suite of activities including health promotion, education, distribution of sterile equipment, overdose prevention and intervention, and improving access to health services.
- 15.99 Health promotion and education increase service users' awareness of the harms associated with drug use and provide strategies to reduce the risk of those harms, including in relation to blood-borne virus transmission, hygiene and safer administration practices. Such education leads to changes in behaviour that extend beyond the drug consumption service and are associated with reduced drug-related morbidity and mortality.¹⁵⁴
- 15.100 Professor Kerr gave evidence that the establishment of drug consumption services is associated with significant declines in fatal overdoses in the surrounding area.¹⁵⁵ He told the Inquiry that fears about the potential for drug consumption services to send the wrong message, condone drug use or facilitate initiation into injection are unfounded, and no negative impacts on community drug use patterns have been observed.¹⁵⁶ There is no evidence that drug consumption services increase drug use or encourage its initiation.¹⁵⁷

Services facilitate engagement with treatment and support

- 15.101 Research and evidence received by the Inquiry demonstrate that drug consumption services facilitate access to health supports, including addiction treatment services.¹⁵⁸ One of the legislated service objectives of Uniting MSIC is to provide a gateway to health and treatment supports. Since its establishment, the MSIC has made more than 13,500 referrals to a range of health and social welfare services, including treatment supports,¹⁵⁹ with 80% of frequently attending clients ultimately accepting a referral for addiction treatment.¹⁶⁰ As noted by St Vincent's Health Australia, such services cultivate long-term therapeutic relationships with people who inject drugs, facilitating health interventions that would not otherwise have developed.¹⁶¹
- 15.102 Associate Professor Hespe, RACGP, said individuals attending supervised drug consumption services *'are likely to be socially disadvantaged, polydrug users who do not present to their general practitioner with substance abuse issues'* and that, as noted above, evaluation of the MSIC found 70% of people using the service had not accessed local health services before visiting the centre.¹⁶²
- 15.103 Professor Kerr gave evidence that in Canada, frequent use of drug consumption services is associated with more treatment referrals and increased access to detoxification services, including a 30% increase in the number of people entering addiction treatment, many of whom stop injecting drugs.¹⁶³

Services reduce public nuisance and increase public amenity

- 15.104 Various studies across the Netherlands, Germany, Switzerland, Sydney and Vancouver¹⁶⁴ show drug consumption services reduce public nuisance, demonstrated by reductions in public drug use and publicly discarded syringes.¹⁶⁵
- 15.105 One concern raised about drug consumption services is that they will attract people from outside the local area who use drugs.¹⁶⁶ This is known in the literature as a 'honeypot effect'.¹⁶⁷ The EMCDDA's 2004 European report on drug consumption rooms notes that *'consumption rooms are feared to be potential "magnets" for drug users and dealers, resulting in more public nuisance and crime'*.¹⁶⁸ However, services are generally established in local areas of need, which may previously have featured higher levels of drug-related crime.¹⁶⁹
- 15.106 Such an effect has not been observed in Sydney or in Canada. Dr Jauncey said evaluations have shown that about 80% of service visits are from people who have spent the previous 24 hours in the local area.¹⁷⁰ Professor Kerr observed that in Canada, *'many people are unwilling to travel great distances to use these services'*.¹⁷¹
- 15.107 Ms Hedrich, EMCDDA, suggested that any potential 'honeypot effect' may be addressed by establishing drug consumption services in places *'where the people are who want to use them, or additional facilities'*.¹⁷²
- 15.108 The Inquiry heard that where services have sufficient capacity to meet demand there have been reductions in public drug use and associated nuisance, and no increases in drug-related crime.¹⁷³ There is no evidence indicating that the presence of drug consumption services has increased crime in Sydney,¹⁷⁴ Europe¹⁷⁵ or Canada.¹⁷⁶

Models of drug consumption services

15.109 Three models of drug consumption services are employed internationally: integrated, specialised and mobile services. The NSW Government described each as follows in its submission to the Inquiry:¹⁷⁷

- Mobile drug consumption services provide ‘a *geographically flexible deployment of specialised service, and typically cater for a limited number of clients in comparison to fixed premises*’.
- Specialised drug consumption services offer a range of services directly related to supervised consumption, including medical monitoring, intervention and overdose prevention, the distribution of hygienic administration equipment and referrals to health and social services.
- Integrated consumption models provide a range of services in addition to supervised consumption and sterile equipment distribution.

15.110 Mobile drug consumption services appear to have limited application. The Inquiry did not consider these services in any detail.

15.111 Internationally, specialised models are less common than integrated facilities. Australia has two specialised drug consumption services: Uniting MSIC in Sydney and the Medically Supervised Injecting Room in North Richmond, Melbourne. They cater solely to people who inject drugs. Specialised services target marginalised individuals who are usually disengaged from mainstream health and drug services and are located in accessible areas with an established local need.¹⁷⁸ Although the MSIC is a specialised service, Dr Jauncey told the Inquiry it provides access to a range of other health supports, including GP clinics, mental health and dental technicians onsite ‘*because if [it’s] not with us, you know, our clients are probably not going to make it to the other services*’.¹⁷⁹

15.112 The NSW Government noted that the majority of drug consumption services in Europe are integrated into easily accessed facilities.¹⁸⁰ By supporting the basic and social needs of people who use drugs, integrated services aim to improve more than just their health.¹⁸¹ They can also facilitate access to services that clients may not otherwise be engaged with or access. Integrated models, particularly in Europe, offer a range of social and health support services including:

- basic services such as food provision, clothes washing and shower facilities
- practical support, including provision of a postal address and financial and administration support
- medical care, including health education, nurse, mental health and primary care support and referrals to treatment
- social activities, including work reintegration and recreational activities.¹⁸²

15.113 The Inquiry received evidence about two international integrated models: De Regenboog Groep in Amsterdam and ARCHES (AIDS Outreach Community Harm Reduction Education Support Society) in the city of Lethbridge in Alberta, Canada.

Case study: De Regenboog Groep, the Netherlands

De Regenboog Groep (The Rainbow Group) is one of the 24 drug consumption services in the Netherlands.¹⁸³ It uses a low-threshold integrated model, allowing for multiple modes of administration, with the objective of improving the health and social recovery of people who use drugs.¹⁸⁴

Integrated models provide a range of safety net services to improve living conditions, access to health and social services, and community reintegration.¹⁸⁵ These services are embedded within broader public health and drug policy responses.¹⁸⁶ De Regenboog Groep provides supports for people experiencing poverty, homelessness, addiction and mental health concerns,¹⁸⁷ including basic needs such as food, laundry facilities, emergency accommodation, health and treatment referral support, medical care, recreational activities and work reintegration projects.¹⁸⁸ They extend to activities such as an international homelessness football World Cup and bicycle repairs for clients, by clients.¹⁸⁹

In addition to its objectives of reducing public disorder, overdose and blood-borne virus transmission, De Regenboog Groep aims to reduce the loneliness and isolation experienced by people who use drugs, to prevent conditions that may increase the use of drugs.¹⁹⁰

There are no service evaluations available. Care is provided at an individual level, with outcomes relative to personal needs.¹⁹¹ Cedric Charvet, De Regenboog Groep, told the Inquiry:

*'Drug consumption rooms bring only positive to people who use drugs and to its communities. The audacity of hope is my last advice. Go ahead and try. Open drug consumption rooms. And if it doesn't bring the expected outcomes, you can always adapt it, change it or stop the project ... once you will start you may wonder why you didn't start earlier.'*¹⁹²

Uniting MSIC

- 15.114 Uniting MSIC provides a medically supervised environment for people to inject pre-obtained drugs safely and hygienically.¹⁹³ The MSIC caters for people using all substances, including ATS, by injection only. For the past two years it has supervised approximately 1,500 episodes of methamphetamine injection each month.¹⁹⁴

History of the MSIC

- 15.115 The service was established to address problems caused by heroin use in the Kings Cross area. An open drug scene had developed, with a population of homeless people who injected drugs, visible drug use, publicly discarded injecting equipment and the highest rate of drug-related overdose deaths in Australia, accounting for 10% of national fatalities in 1999.¹⁹⁵
- 15.116 There was much political and public debate about the problem, and the Kings Cross community advocated for a supervised injecting facility. Such facilities were well established in Europe, where 60 services were formally recognised by 1999. The *Royal Commission into the NSW Police Force*, reporting in 1997, and the 1999 NSW Parliamentary Drug Summit both recommended that an injection facility be trialled in NSW.¹⁹⁶

- 15.117 The NSW Government accepted the recommendation and established the MSIC on a trial basis in 2001, making it the first supervised injecting facility in the southern hemisphere and the English-speaking world.¹⁹⁷ Its trial status was extended until 2010 when legislation was amended to enable its permanent operation following several successful independent evaluations.¹⁹⁸

Objectives of the MSIC

- 15.118 The licence for the MSIC is issued under Part 2A of the DMT Act.¹⁹⁹ The stipulated service objectives include reducing overdose-related deaths and the transmission of blood-borne viruses, providing a gateway to treatment services, and reducing publicly discarded needles and visible injecting.²⁰⁰
- 15.119 The services provided by the MSIC include overdose management and prevention, drug use education, crisis counselling, mental health support and referrals to social support and health services, including AOD treatment and blood-borne virus checks and treatment.²⁰¹

Evidence of success

- 15.120 When the MSIC was established, the service was innovative, controversial and lacking a substantial evidence base.²⁰² The evidence has built over time, with independent evaluations, government-commissioned analysis, statutory reviews and the academic literature confirming that the MSIC is a very effective harm reduction measure that meets its legislated objectives.²⁰³
- 15.121 Data show that since its establishment, the MSIC has:²⁰⁴
- supervised more than 1.1 million injections
 - successfully managed more than 8,500 overdoses, without a single fatality
 - realised a 80% reduction in ambulance callouts in the Kings Cross and surrounding areas
 - realised a 50% reduction in the number of publicly discarded needles.
- 15.122 A 2016 statutory review found the MSIC's operation was consistent with strategic plans, including the *NSW Hepatitis C and Hepatitis B strategies (2014–2020)*, the *NSW HIV Strategy 2016–2020* and the draft *NSW Health Alcohol and Other Drugs Strategy 2016–2021*.²⁰⁵ No concerns were raised in relation to the effectiveness of the service or its achievement of objectives.²⁰⁶
- 15.123 The NSW Government told the Inquiry that the MSIC successfully engages with its target audience – a highly marginalised population that is disengaged from mainstream services.²⁰⁷ The service facilitates access to social and health services, including treatment supports,²⁰⁸ with more than 13,500 referrals since its inception.²⁰⁹ Improved public amenity outcomes have been confirmed by a decline in local crime rates²¹⁰ and high levels of residential and local business support for the service.²¹¹
- 15.124 The Inquiry received a significant number of submissions supporting the public health and amenity outcomes, described above, that the MSIC has achieved.²¹²

Applicability to people who use ATS

- 15.125 Uniting MSIC submits that its overarching service objectives apply to all injecting drug use, regardless of drug type.²¹³ Dr Jauncey gave evidence that people consume various substances there, including ATS, and that one of the ‘*myths*’ is that the MSIC is only a service for people injecting heroin. She told the Inquiry: ‘*All drug consumption rooms, supervised injecting facilities ... see a variety of people that come in with a variety of substances, and that’s quite deliberate*’.²¹⁴ She also noted that ‘*among the population of people who we see, polysubstance use is actually the norm*’.²¹⁵
- 15.126 Data provided by NSW Health indicate that amphetamines are the second most common drug type injected at the MSIC after opioids, and that the number of visits to inject amphetamines has been increasing each year, up from 5,543 in 2014 to 15,107 in 2018.²¹⁶ ATS overdoses do occur at the MSIC, but the mental health and cardiovascular effects can be managed appropriately through onsite support and health service referrals.²¹⁷
- 15.127 The Inquiry heard there is a need to extend the public health benefits of the MSIC drug consumption services to a broader range of people who use ATS, including to more communities, people aged 16 to 18 and pregnant women.²¹⁸ This is discussed further below.

Expanding drug consumption services in NSW

- 15.128 Uniting MSIC is the only supervised drug consumption service allowed to operate in NSW. The licensing of injecting centres in NSW is governed by Part 2A of the DMT Act. Under s 36A, the Commissioner of Police and Secretary of the Department of Health may only issue one licence to operate an injecting centre in respect of one premises.²¹⁹
- 15.129 The evidence before the Inquiry supports the removal of the restriction on the number of services permitted to operate in NSW. This would enable services to be established in areas of local need, to reduce drug-related harms.

Expanding services to areas of local need

- 15.130 Ms Hedrich, EMCCDA, gave evidence that a primary purpose of drug consumption services is to reduce public drug use and the associated nuisance that can emerge when large groups of people use drugs in public, as well as to prevent an increase in drug-related crime in the relevant area. Accordingly, they are generally established in places where drug use is highly prevalent. They must be placed where people who use drugs can easily find them and set up in such a way as to meet their particular needs.²²⁰
- 15.131 The Inquiry received many submissions recognising the effectiveness of the MSIC²²¹ and supporting the expansion of drug consumption services to areas of identified need.²²² Associate Professor Hespe, RACGP, told the Inquiry it makes sense ‘*that areas with high prevalence of substance use should have an accessible medically supervised drug consumption room. Indeed, it is a shame that there remains only one in the whole of NSW*’.²²³
- 15.132 Dr Jauncey said legislation precluding the operation of supervised drug consumption services other than the MSIC ‘*is less than helpful*’ and that ‘*any health service should be developed and planned and established in relation to need*’.²²⁴

Consideration of local need

15.133 Dr Jauncey expressed the view that planning for any harm reduction or treatment service should include analysis of the relevant data on drug use in the location of the proposed service, which may include ambulance attendance at overdoses, emergency department and hospital data, location and quantities of discarded syringes and the concerns of local residents and police.²²⁵

15.134 Dr Read, Kirketon Road Centre, also referred to the community conditions that informed the establishment of the MSIC in Kings Cross and noted that for any new services it would be necessary to examine:

'... local drug use patterns, whether it was injected or otherwise. You would want to understand what the public impact of that drug use was in the community to make sure there was acceptability. You'd have to, obviously, liaise and work closely with the community and the police force and other local stakeholders to make sure that, you know, there was a sort of cross-party, cross-group agreement around what that would be about ... And you'd need to work with the drug-using community and ask them would they go there; would it be important to them'.²²⁶

15.135 Stacey Bourque, Executive Director of ARCHES, told the Inquiry that the needs of local people who use drugs were particularly important in developing the supervised consumption facility run by ARCHES in Lethbridge, Canada.²²⁷ Ms Bourque gave evidence that she would encourage other communities considering such facilities to collaborate with people who use drugs and take their needs into account. She told the Inquiry that ARCHES allows drugs to be consumed by injection, inhalation, intranasally and oral ingestion,²²⁸ and that it offers these four modes of consumption *'because people who use drugs indicated that it was necessary for a variety reasons. One, it's not the method or the mode that's killing people; it's the drug, regardless of how you're taking it'.²²⁹*

15.136 Dr David Helliwell, Visiting Medical Officer and Clinical Lead, Addiction Medicine at the Riverlands Drug and Alcohol Service, told the Inquiry's Lismore Hearing that in areas where there *'is considerable consumption of methamphetamine, safe consumption rooms would be useful'.²³⁰* In its submission to the Inquiry, the Moree Plains Shire Council stated that the town *'could use a safe injecting room at the new proposed hospital as often truckloads of garbage [are] contaminated from users putting needles in the bins, [it's] a safety issue'.²³¹* The Inquiry received evidence that in 2018, the Moree waste department found 50,000 needles.²³²

15.137 A recent study suggests that there is an unmet need for a supervised injection centre in south-western Sydney.²³³ The authors of the study noted there are just as many or more people who inject drugs in western Sydney as in the inner city, where MSIC is located, and that south-western Sydney is rapidly becoming more densely populated, with transport between western Sydney and the inner city *'awkward and slow'*. Interviews with clients of the MSIC indicated that some chose to *'sleep rough'* to remain closer to the service due to concerns about stigma, surveillance and compromised personal safety from hostile members of the public, security officers and police.²³⁴

Expanding existing services

15.138 The Inquiry heard that supervised drug consumption services could possibly be expanded to areas of need by integrating them with existing services, such as smaller services within existing AOD or primary healthcare services.²³⁵

- 15.139 The Inquiry also received suggestions that NSPs should be expanded as an alternative supervised consumption model.²³⁶ Uniting MSIC submitted that supervised consumption services could be embedded in primary NSPs.

‘Consideration should be given to allowing certain primary needle syringe program sites in NSW some ability to supervise drug use. There are now many international precedents where existing harm reduction sites have been augmented in a relatively modest manner to cater for supervised injection and inhalation ... the creation of such models for safe consumption would mean smaller numbers of individuals are catered for, and the service could be integrated with other onsite service provision.’²³⁷

- 15.140 Dr Jauncey and Dr Read said that smaller drug consumption facility models within existing services, such as AOD or primary healthcare services²³⁸ and NSPs,²³⁹ would be appropriate. Embedding supervised injection services in primary NSPs could provide a cost-effective service solution, including in regional areas where primary NSPs are already established.

The 2016 Statutory Review and recent coronial recommendations

- 15.141 The 2016 Statutory Review of Part 2A of the DMT Act (Statutory Review) considered whether the legislative restriction to one injecting centre remained appropriate. The Statutory Review considered the number of unplanned emergency department admissions for opioids, use/possession data and ambulance callouts related to heroin overdoses, and concluded that there did not appear to be a clear need for another supervised injecting facility elsewhere in NSW.²⁴⁰ However, the Inquiry notes that the review was limited to data relating to opioid-related harms and not those associated with ATS.

- 15.142 The NSW Police Commissioner submitted to the Inquiry that previous reports, including the 2016 Statutory Review and the NSW Government response to the *NSW Coronial Inquest into Opioid-related Deaths*, determined that there was insufficient need for services in other locations. The Commissioner submitted that the MSIC is most relevant to injection of opioids, not ATS, which is mostly smoked and carries a lower risk of overdose.²⁴¹

- 15.143 The Inquiry notes that in the *NSW Coronial Inquest into Opioid-related Deaths*, Deputy State Coroner, Magistrate Harriet Grahame, recommended:

‘12. That consideration be given to additional venues for the medically supervised injection of opiates, including the smaller consumption room model and/or additional medically supervised injection rooms (MSIR), in areas where there are many drug overdoses and where the community supports the establishment of MSIR.’²⁴²

- 15.144 On 17 December 2019, Deputy State Coroner Grahame delivered findings following an inquest into the deaths of Alan Bugden and Amaru Bestrin. Mr Bestrin died from combined drug and alcohol toxicity after injecting drugs and collapsing in a toilet at Liverpool Hospital. The Deputy State Coroner found that Liverpool Hospital, which runs an NSP and dispenses needles from a machine at the entrance to the hospital, is limited to encouraging clients to wait until they get home to inject or to inject in the safest place they can, notwithstanding that some may be homeless or need to inject as soon as they possibly can. This may lead clients to inject in public toilets that are infrequently monitored – as Mr Bestrin did – making it less likely that such clients will get timely access to health care if it is needed.²⁴³

- 15.145 Deputy State Coroner Grahame found there is '*great force and logic*' in characterising the provision of clean syringes as the first part of appropriate harm minimisation services, and that the second – a suitable space to inject, which also facilitates access to counselling or referral to rehabilitation centres – should be provided. Deputy State Coroner Grahame heard that the starting point for planning a medically supervised injecting centre should be identifying a location for the service that is close to people who will use it. Deputy State Coroner Grahame noted there had been a very busy NSP in Richmond, Victoria for many years before the medically supervised injecting room opened in that suburb. In the first 12 months of its operation there was a strong uptake of services, with 172 visits per day, 1,232 overdoses responded to and 1,393 referrals to co-located services and clinics.²⁴⁴
- 15.146 Deputy State Coroner Grahame considered it '*obvious*' that serious contemplation be given to establishing a medically supervised injecting centre in or near Liverpool Hospital, noting the high number of people who inject drugs in the local area and recent '*near misses*' at the hospital. The Deputy State Coroner noted it is important that any feasibility study carefully review the most appropriate model for the local area, including whether it should be co-located with an existing health service or NSP, or established as a standalone facility. The Deputy State Coroner also held that there ought to be wide consultation to ensure community engagement and support.²⁴⁵
- 15.147 Consistent with these findings, Deputy State Coroner Grahame made the following recommendation: '*15. That NSW Health, in consultation with Liverpool Hospital, undertake a feasibility study regarding a supervised injecting space within the grounds of Liverpool Hospital.*'²⁴⁶
- 15.148 Although the recommendations above were made in the context of inquests into deaths relating to other substances, the Inquiry is of the view that they are also applicable to reducing ATS-related harm, given that many people in NSW inject ATS.²⁴⁷ As discussed above, 35% of people in NSW reported ATS as the most recent drug injected²⁴⁸ in 2018 and in the same year there were 15,107 visits to the MSIC to inject ATS.²⁴⁹ The prevalence of injecting among people who use ATS is discussed in Chapter 7.
- 15.149 The Inquiry finds that supervised drug consumption services should be allowed to operate in areas where there is an identified local need. To facilitate their operation, the DMT Act should be amended to remove the restriction permitting a single supervised drug consumption service (Uniting MSIC) to operate in NSW.

Integrating service delivery in NSW

- 15.150 The Inquiry has received evidence in support of integrated drug consumption services, co-located with other health services to provide support and improve accessibility for marginalised populations. Dr Jauncey, Uniting MSIC, said she prefers integrated and co-located services where possible, as a one-stop shop offers greater benefits to users and improves the likelihood of linking them with other treatments and supports.²⁵⁰
- 15.151 Integrated drug consumption services facilitate access to broader supports, provide opportunities for engagement and build familiarity and therapeutic relationships with healthcare services and professionals.²⁵¹ Dr Jauncey also said integrated models could help overcome barriers to services, including stigma.²⁵² This is discussed further in Chapter 17, with reference to the Portland Hotel Society in Canada.

- 15.152 Dr Jauncey said integrated services should be developed in consultation with the clients the service will engage, *'focusing on the needs of the people who will use the service is an essential element of service planning and all too often forgotten or neglected'*.²⁵³ Dr Kerry Chant, Chief Health Officer, NSW Ministry of Health, noted the importance of responses that consider local settings and provide more holistic services to address the factors that are leading to individual harms.²⁵⁴
- 15.153 The evidence to this Inquiry clearly demonstrates that holistic care is required to address the multifaceted needs of people who use drugs, as discussed in Chapters 3, 10 and 14. The Inquiry is persuaded by the evidence that integrated drug consumption services are the best model to deliver this care.

Vulnerable populations should have access to supervised drug consumption services

- 15.154 Pregnant women and young people aged 16 to 18 years are excluded from the MSIC. Evidence before the Inquiry identifies these groups as vulnerable populations who would benefit from accessing the MSIC's services, particularly through referrals to health, treatment and support services.²⁵⁵ The Inquiry heard that pregnant women and young people should be permitted access to the MSIC.²⁵⁶

Access by pregnant women

- 15.155 It is a statutory condition of the MSIC's licence that pregnant women are excluded from the service.²⁵⁷ However, the Inquiry has heard this exclusion may cause a range of harms to both the woman and her unborn child. The Inquiry received a substantial amount of evidence in support of allowing pregnant women to access the MSIC to reduce the risk of harm,²⁵⁸ including from the RACGP,²⁵⁹ the Australasian Chapter of Addiction Medicine of the Royal Australasian College of Physicians (RACP)²⁶⁰ and Uniting MSIC.²⁶¹ The Inquiry also heard that the current restriction prevents the exercise of clinical discretion, and that clinical discretion should be applied on a case-by-case basis to allow pregnant women access to the MSIC.²⁶² The Inquiry notes that access to the MSIC is also supported by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).²⁶³

Pregnant women are a vulnerable population

- 15.156 The possible harmful effects of ATS use in pregnancy include miscarriage, premature birth and stillbirth,²⁶⁴ multiple hospital admissions to manage complications, and cardiovascular collapse and seizures.²⁶⁵ Possible harmful effects for the child include stroke, heart failure or withdrawal as newborns.²⁶⁶ Infants exposed to ATS have been found to have lower birth weight than non-exposed infants²⁶⁷ and may experience cognitive problems, delays in motor development or long-term neurobehavioural disorders.²⁶⁸
- 15.157 The NSW Health Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period identify particular complexities for pregnant women who use ATS including polydrug use, disengagement from treatment services and coexisting mental health issues.²⁶⁹ The Inquiry heard that women who are pregnant and use drugs, including ATS, may be marginalised,²⁷⁰ stigmatised²⁷¹ and face barriers to accessing treatment.²⁷² In its submission to the Inquiry, RANZCP indicated that ATS use in pregnancy is associated with attending antenatal care less frequently than those who use other drugs.²⁷³

- 15.158 RANZCOG has noted that the incidence of methamphetamine use in pregnancy is likely to be increasing, with potential consequences for mothers and their newborns.²⁷⁴ The Inquiry heard that the demand for treatment of pregnant women at Kamira Drug and Alcohol Treatment Services in Wyong, NSW, has increased by more than 500% in two years,²⁷⁵ with nearly all the pregnant women seeking treatment there using crystal methamphetamine throughout their pregnancy.²⁷⁶

Excluding pregnant women from the MSIC puts them at risk of harm

- 15.159 The Inquiry heard evidence that denying pregnant women access to the MSIC puts them and their unborn children at risk of harm, including through lost opportunities for engagement with health and social supports.²⁷⁷
- 15.160 As the MSIC provides services only to people with pre-established patterns of injecting drug use, refusing pregnant women access may lead to harms including continued injection in unsafe, unsupervised environments.²⁷⁸ Uniting MSIC emphasised that pregnant women seeking access to the service have already obtained drugs with the intention of injecting them. The outcome of turning them away *‘is not that they do not inject – instead it is a perpetuation of their likely street based, unsanitary and unsupervised injecting, with all its inherent dangers’*.²⁷⁹
- 15.161 The Inquiry heard from the RACP’s Australasian Chapter of Addiction Medicine that the significant clinical concerns about drug use in pregnancy are even greater for women injecting unsupervised, and that excluding pregnant women from the MSIC *‘is likely to increase the potential harm to the individual and to the unborn child’*.²⁸⁰ RANZCOG has noted that the adverse impacts of hepatitis, HIV and overdose – harms mitigated by the MSIC’s services – are *‘even greater in pregnancy and it seems incongruous to deny pregnant women this important opportunity for harm minimisation’*.²⁸¹
- 15.162 NUAA submitted that refusing pregnant women access to the MSIC *‘forces them to inject in circumstances that are far less safe’*²⁸² and leads to their social exclusion and marginalisation.²⁸³ NUAA’s submission to the Inquiry described the account of one pregnant woman who was threatened while injecting in a doorway near the MSIC.

*‘Some guys from a nearby building site saw me and started yelling at me, calling me a crack whore mum. One jumped the fence and ran towards me with a length of wood in his hands while two others threw clumps of concrete at me ... I ran and got away but I am still amazed that they didn’t get the irony of wanting to bash me up for injecting when pregnant. My baby deserved the safety of MSIC even if people don’t think I did.’*²⁸⁴

Excluding pregnant women from the MSIC is not best practice

- 15.163 Best practice clinical guidelines note the importance of engaging pregnant women who use ATS in care early.²⁸⁵ NSW Health guidelines note that they are likely to be polydrug users and not engaged with AOD services and may require inpatient support to help them stop using ATS.²⁸⁶ In addition, the NSW Health Strategic Priorities 2019–20 identify reducing and minimising the harm associated with AOD use, particularly in pregnant women, as a priority.²⁸⁷
- 15.164 Evidence to the Inquiry also highlighted the importance of connecting pregnant women who inject drugs with health, treatment and social services as early as possible in their pregnancy,²⁸⁸ research has found that stopping methamphetamine use at any time during pregnancy improved birth outcomes.²⁸⁹

- 15.165 The Inquiry received evidence that pregnant women are especially motivated to stop their drug use²⁹⁰ but face barriers to treatment and support, including social stigma and difficulty accessing services.²⁹¹ In a 2016 letter to the Assistant Minister for Health, RANZCOG stated:

*'For some vulnerable women, attendance at the injecting centre may be the only occasion for constructive contact with a health care service. Given the special needs of pregnant women with substance abuse, the opportunity to engage with these women must not be missed. Every effort should be made to assist them with enrolling in suitable programs for both antenatal care and birth.'*²⁹²

- 15.166 Many harms to unborn children arise from pregnant women's comorbidities and poor engagement in preventive and obstetric care.²⁹³ The MSIC is recognised as a gateway for treatment, counselling and referral for people who use illicit substances.²⁹⁴ Allowing pregnant women access is an important opportunity to improve outcomes for them and their babies²⁹⁵ by linking them to support services that can identify and respond to these harms.²⁹⁶ Such services may include specialised antenatal services,²⁹⁷ counselling and discussion about contraception.²⁹⁸
- 15.167 Associate Professor Yvonne Bonomo, addiction medicine physician and Director of Melbourne's St Vincent's Hospital Department of Addiction Medicine, gave evidence to the Inquiry that excluding pregnant women from the MSIC is not best practice. In an expert report, she said pregnancy can often be the motivating factor to address ATS use *'and as much support as possible should be provided to the woman to support her with this'*, including through care and referrals at the MSIC.²⁹⁹
- 15.168 Dr van Beek, The Kirby Institute and formerly Uniting MSIC, gave evidence that refusing pregnant women access *'causes clinicians to seriously question whether they are meeting their duty of care to these particular high-risk clients'*.³⁰⁰ The exclusion of pregnant women has also been described as discriminatory.³⁰¹
- 15.169 Since the MSIC's inception, all the service's medical directors have advocated for women who are pregnant and injecting drugs to have access to the service.³⁰² The Australian Medical Association (NSW) said it is a matter for the relevant clinical experts.³⁰³ The Inquiry heard that clinical discretion should be applied on a case-by-case basis to allow pregnant women access to the MSIC³⁰⁴ and that developing a model of case-by-case assessment would be beneficial.³⁰⁵ The NSW Police Force told the Inquiry that it considers allowing pregnant women access to the MSIC to be a clinical matter.³⁰⁶
- 15.170 The evidence set out above demonstrates that pregnant women, including those who use ATS, would benefit from access to drug consumption facilities including the MSIC. Access should be permitted according to clinical advice, and guidelines and protocols developed to support the care and management of pregnant women and their unborn children attending such facilities, that take into account the potential harms of ATS use described above.

Access by young people

- 15.171 Section 36(1)(a) of the DMT Act provides that it is a statutory condition of a licence for an injecting centre that *'[no] child is to be admitted into that part of the centre that is used for the purpose of the administration of prescribed drugs'*. As a result, people under the age of 18 are excluded from accessing the MSIC for the purposes of administering a drug or accompanying an adult into the MSIC.³⁰⁷

- 15.172 The 2016 Statutory Review considered the exclusion of people under the age of 18 from the service.³⁰⁸ The Commissioner of Police and Secretary of the Ministry of Health, who oversee the MSIC and undertook the 2016 Statutory Review, did not recommend any changes to the age restriction due to an overriding concern that it could expose children to normalised drug taking behaviour, concerns regarding public perception that the government is condoning drug taking behaviour of young people and because only seven young people had attempted to use the service since 2010.³⁰⁹
- 15.173 The Inquiry received evidence that excluding young people from accessing the MSIC to administer drugs represents a lost opportunity for engagement with a vulnerable cohort of people who use drugs. The Inquiry did not receive any evidence about the exclusion of access for the purposes of accompanying an adult.
- 15.174 In its submission to the Statutory Review, Uniting MSIC stated that the benefits of permitting access to people under the age of 18 would include reducing injection in risky environments, preventing blood-borne virus transmission in a target cohort of the NSW Government Hepatitis C Strategy and providing access to harm reduction services and treatment for a vulnerable population.³¹⁰
- 15.175 In a statement to the Inquiry, Dr Martyn Lloyd-Jones, President of the RACP's Australasian Chapter of Addiction Medicine, expressed support for extending access to the MSIC for young people aged 16 to 18. He said excluding young people creates missed opportunities to engage them in holistic health and psychosocial supports and that it is *'illogical to exclude such highly vulnerable individuals from the very services which they may benefit from the most'*.³¹¹
- 15.176 Associate Professor Hespe, RACGP, told the Inquiry that as young people are less likely to see drug use as an issue or engage with a GP about substance use, facilitating *'non-judgmental patient-centred care'* for this vulnerable cohort is a priority.³¹²
- 15.177 In his evidence to the Inquiry about why the age limit on access to the MSIC should not be changed, Detective Acting Superintendent Cook, NSW Police Force, noted that national data suggest the age of uptake for methamphetamine use is 22.1, and that this increased between 2013 and 2016.
- 15.178 The average age of initiation into methamphetamine use is not an appropriate reason to deny harm reduction services to young people. Further, the number of people refused access is unlikely to be indicative of the total number of young people in the area who would use the MSIC given that the age restriction already in place may deter people under the age of 18 from attempting to access the service.
- 15.179 Detective Acting Superintendent Cook gave evidence that the NSW Police Force is concerned about legal and ethical considerations in allowing people aged 16 and 17 years access to the service. A similar concern was raised in the Statutory Review, where the Commissioner of Police and the Secretary of the Ministry of Health observed that the MSIC was not designed to deal with the medicolegal considerations raised if a child or young person were to access the centre, including with regard to child protection.³¹³ In submissions, the NSW Police Force raised an additional concern regarding *'the clinical and health considerations'* associated with allowing minors access to the MSIC, but did not articulate what those particular considerations might be.³¹⁴

- 15.180 Under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), mandatory reporting guidelines apply to a child, which is defined as a person under the age of 16.³¹⁵ That is, concerns around mandatory child protection reporting would not arise were young people aged 16 to 18 able to access the service. The Australasian Chapter of Addiction Medicine of the RACP expressed support for implementing mandatory reporting safeguards that reflect child protection legislation as part of its support for reducing the age limit on access to the MSIC.³¹⁶
- 15.181 Providing a clean, safe environment and opportunity to engage vulnerable young people who have pre-existing injecting patterns of drug use would achieve greater harm reduction benefits than refusing them access to the MSIC. Further, access would be permitted according to clinical assessment. The Inquiry notes in this context that NSPs allow people under the age of 18 to access sterile syringes for the purposes of injection.

Expanding drug consumption services to include smoking

- 15.182 The Inquiry received evidence in support of including smoking facilities as part of drug consumption services.³¹⁷ In her evidence to the Inquiry, Ms Hedrich, EMCDDA, explained how drug consumption service models have evolved to reflect changing patterns of drug use. Ms Hedrich said most services initially provided facilities for injection only. As clients transitioned from injecting to smoking after being encouraged to use less harmful routes of administration, a need emerged for inhalation facilities. According to Ms Hedrich: *'Not allowing the people who had changed their risk behaviour to use the same services they had been using before seemed unreasonable and many of the services then started to provide separate inhalation rooms.'*³¹⁸
- 15.183 These pragmatic rationales, combined with shifts in drug trends which resulted in a rise in drug smoking, led many services in Canada and Europe to include inhalation facilities in service provision.³¹⁹ Reflecting these changes in consumption patterns, European services provide approximately equal service capacity for smoking and injecting, while some facilities in the Netherlands provide significantly more capacity for smoking.³²⁰ There are 24 drug consumption services across the Netherlands, all of which offer inhalation facilities, and 19 which accommodate injecting.³²¹ Spain, Switzerland and Germany also provide inhalation facilities in their drug consumption services.³²²

Benefits of smoking services

- 15.184 Engaging people who smoke ATS through drug consumption services could facilitate earlier contact with health and social services that might not otherwise be accessible to them.³²³
- 15.185 As set out above, the majority of people who use ATS in NSW administer their drugs via inhalation. However, there are no services in NSW targeting people who smoke methamphetamine and existing services offer limited opportunities to engage with this cohort of people who use drugs. Uniting MSIC submitted that supervised inhalation facilities could create an opportunity to engage with this population of people who use ATS but who may not otherwise access healthcare services.³²⁴ Professor Ritter, DPMP, told the Inquiry that a supervised inhalation service would provide an opportunity to educate people to address the harms associated with ATS inhalation, including mental health and social harms.³²⁵

- 15.186 The Penington Institute submitted that drug consumption services that allow non-injection modes of administration, including smoking, would extend the harm reduction benefits currently provided by the MSIC – including overdose prevention and referrals to support services – to a broader population of people who use ATS.³²⁶ NUAA submitted that *‘allowing injecting but not inhaling in safer consumption sites does not make sense from a public health point of view’*,³²⁷ and that limiting services to injection only does not reflect consumption patterns.³²⁸
- 15.187 As discussed above, people who inhale ATS are at risk of similar harms to those who inject, except for blood-borne virus transmission and the injuries related to needle use, which are more likely to occur among people who inject drugs.³²⁹ Uniting MSIC noted that encouraging non-injecting routes of administration is increasingly accepted as being of public health importance, and providing safe smoking facilities would offer alternatives to *‘the far more dangerous route’* of injecting.³³⁰
- 15.188 The Inquiry also heard that providing a service that allows people to inhale drugs may help prevent the uptake of injecting practices and, potentially, facilitate a transition from injecting to smoking.
- 15.189 Ms Bourque gave evidence that inhalation services at ARCHES in Lethbridge, Canada provide an opportunity to prevent initiation into injecting, to transition from injecting to inhalation, or reduce injecting by administering drugs via inhalation.³³¹
- ‘[I]f we offered multiple modes of consumption, it would give people an opportunity to move to less intensive methods of consumption and potentially would help us or increase the chances that we could move them along the spectrum of care and increase quality of life.’*³³²
- 15.190 Data from ARCHES Lethbridge indicate that of the clients who started attending their service between February and May 2018 with injection-only practices, 6.4% of those who continued to attend the service in November 2018 transitioned to smoking-only practices, and 73.4% transitioned to a combination of injecting and smoking practices.³³³
- 15.191 Dr van Beek, The Kirby Institute and formerly Uniting MSIC, gave evidence that the most common reason for transition away from injecting was concern about vein damage and more general health concerns.³³⁴ Dr van Beek expressed the view that it would be necessary to closely monitor the risk of people who inhale transitioning to injecting as a result of attending a drug consumption facility that provided injection and inhalation services.³³⁵ However, she noted that facilities overseas have developed protocols to manage these risks.³³⁶ Dr Read, Kirketon Road Centre, also noted that facilities overseas have separate sections for inhalation and for injection to reduce cross over of these populations.³³⁷

Case study: ARCHES, Lethbridge, Canada

In February 2018, ARCHES opened a medically supervised consumption service for people over the age of 16 in response to drug-related public health and public order concerns in the Lethbridge area.³³⁸ It is the only service in North America to facilitate four routes of administration: injection, smoking, ingestion and intranasal.³³⁹ The provision of multiple modes of administration has various objectives, including encouraging less risky routes of administration, engaging with people who smoke, facilitating engagement with care and increasing quality of life for people who use drugs.³⁴⁰

ARCHES Lethbridge has approximately 663 visits per day, and more than 286,000 visits between establishment and August 2019.³⁴¹ Approximately 42% of visits are for the administration of methamphetamine.³⁴²

The service is available 24 hours a day, seven days a week, and is delivered by a range of medical professionals, including nurses, paramedics, addiction counsellors and harm reduction/social work specialists.³⁴³ Other services are integrated with the consumption services, including mental health support, indigenous-specific programs, nursing clinics, art and music therapy, prenatal care, drug court and diversionary programs.³⁴⁴

Since its establishment the service has:

- reduced public drug consumption
- reduced publicly discarded injecting equipment
- increased uptake of referrals to health and social services, including treatment
- not led to an increase in local crime
- reduced blood-borne virus transmission.³⁴⁵

- 15.192 The Inquiry heard evidence that local needs must guide the establishment of any new drug consumption service or changes to established services to permit the supervised inhalation of drugs. Dr Jauncey, Uniting MSIC, told the Inquiry that:

*'Kings Cross was the site of concentrated public drug injecting with extraordinarily high numbers of accidental heroin overdoses. Hence when MSIC was established the focus was on injecting as opposed to other routes of administration, and the primary aim was focused around stopping heroin overdose deaths. Where the local problems are different, the model of operation needs also to be different ... While we know that the majority of methamphetamine use across Australia is smoked rather than injected, nevertheless in Kings Cross the demand for inhalation of substances at MSIC has been low. As a result we have not needed to consider the addition of inhalation facilities, though of course this would be reviewed if demand dictated.'*³⁴⁶

- 15.193 Dr Harrod, NUAA, supported the provision of supervised inhalation services based on local need, but only in response to a 'careful needs assessment'.³⁴⁷
- 15.194 Dr Read, Kirketon Road Centre, was supportive of drug consumption rooms that include a facility for supervised inhalation of drugs 'when the local context dictated that's the most effective and most important way of reducing harm within that community'.³⁴⁸
- 15.195 Dr Jauncey, Uniting MSIC, expressed support for the expansion of drug consumption facilities in NSW according to local needs.³⁴⁹

Recommendation 51:

- A. That the *Drug Misuse and Trafficking Act 1985* (NSW) be amended to provide for supervised drug consumption services to be provided based on local need, including:
- to remove the restriction on the number of licences available
 - to allow facilities to provide for other routes of drug consumption, including inhalation
 - to allow access for young people aged 16 to 18, subject to clinical assessment.
- B. That pregnant women be eligible to access drug consumption rooms (including the Medically Supervised Injecting Centre) as clinically advised.

Recommendation 52:

That drug consumption rooms be integrated with services addressed to the broader health and psychosocial needs of people who use drugs.

Harm reduction at music festivals

- 15.196 Harm reduction interventions are important at music festivals due to factors that increase the likelihood of drug-related harms in these environments. Rates of illicit drug consumption, particularly MDMA, are likely to be higher among festival patrons; a survey conducted at a 2016 music festival found 60% of respondents had consumed MDMA in the past 12 months.³⁵⁰ The physiological effects of these substances, combined with environmental factors such as high temperatures and physical exertion, can increase the probability of adverse outcomes.³⁵¹
- 15.197 The music festivals held in NSW in 2018–19 that experienced serious drug-related harms were generally larger (8,000 patrons or more) offered high energy or electronic dance music and predominantly targeted people between 18 and 29 years.
- 15.198 Harm reduction guidelines for music festival organisers, and peer-based harm reduction services for patrons, are both used in NSW to reduce the risks of drug-related harm at music festivals.

Recommendations of the NSW Government's expert panel

- 15.199 In September 2018, the NSW Government convened an expert panel in response to increasing harms at music festivals, including two drug-related deaths at a music festival earlier that month.³⁵² The panel comprised NSW Chief Medical Officer Dr Kerry Chant, NSW Police Commissioner Mick Fuller and Chair of the Independent Liquor and Gaming Authority, Philip Crawford.
- 15.200 The panel considered options for improving music festival safety, including increasing penalties for drug supply, harm reduction strategies and community drug education.³⁵³ Substance testing was not considered by the panel. Substance testing is discussed later in this chapter.

- 15.201 Reporting in October 2018, the panel recommended developing a guide for health and harm reduction services at festivals, improved AOD harm reduction programs and messages for festival attendees, and a new ‘music festival’ licence with safety management plans tailored to the festival’s risk profile.³⁵⁴ It also recommended a trial of criminal infringement notices for the offence of possession of prohibited drugs, discussed further in Chapter 11, and a new offence of ‘*supply of drugs causing death*’.³⁵⁵
- 15.202 The NSW Government implemented several measures including a trial of the use of penalty notices for low-level drug possession at certain music festivals³⁵⁶ and the introduction of a criminal offence targeting drug dealers whose supply causes death.³⁵⁷ Additionally, the NSW Legislative Assembly introduced a music festival licensing scheme for certain ‘high-risk’ festivals; these licensing regulations were subsequently disallowed by the Legislative Council, as discussed below.
- 15.203 The government also expanded harm reduction through peer-based programs and a targeted social media campaign, and developed *Guidelines for Music Festival Event Organisers: Music Festival Harm Reduction* (the Music Festival Guidelines) to support event organisers to deliver safer music festivals.³⁵⁸ These guidelines include advice to organisers about how to mitigate the risks of drug-related harm to patrons by providing water, shade and chill-out spaces, onsite medical plans, harm reduction messaging and peer-based harm reduction services.³⁵⁹
- 15.204 The regulations establishing a licensing scheme for ‘high-risk’ music festivals were the subject of a 2019 Parliamentary Inquiry by the Legislative Council’s Regulations Committee (Regulations Committee). It heard the regulations caused concern within the music festival industry due to a lack of consultation, confusion about which festivals were captured by the scheme, how they were assessed and the financial costs to organisers. In August 2019, the Regulations Committee recommended the regulations be disallowed.³⁶⁰ On 26 September 2019, the regulations were disallowed by the Legislative Council.³⁶¹
- 15.205 The Inquiry notes that in November 2019, after the NSW Legislative Council voted to disallow the regulations,³⁶² Parliament passed the *Music Festivals Act 2019*. The Act requires music festival organisers of high-risk festivals to prepare and comply with safety management plans,³⁶³ and requires the responsible Minister to establish a music festival roundtable with government and industry stakeholders to meet at least four times a year.³⁶⁴ The safety management plan must include information about the health services and harm reduction initiatives the music festival organiser will provide.³⁶⁵
- 15.206 The Regulations Committee found that the development and continual improvement of the Music Festival Guidelines is a positive step in addressing AOD issues at music festivals. It recommended that the adoption of the Guidelines be discussed by the roundtable, and that the NSW Government take the findings and recommendations from the *NSW Coronial Inquest into Music Festival Deaths* to the roundtable for discussion before responding to the Coroner.³⁶⁶
- 15.207 The findings and recommendations arising from the *NSW Coronial Inquest into Music Festival Deaths*, and the NSW Government’s response to them, are discussed later in this chapter. The Inquiry notes that the Music Festival Guidelines were updated in December 2019 in response to the inquest. They now include more detailed information about arranging transfer of seriously unwell patients to hospital and recommendations to ensure medical protocols are in place for resuscitation procedures.³⁶⁷

Peer services

- 15.208 Peer-based harm reduction services are delivered by people with lived experience of drug use. They were formally embedded and expanded as part of the actions recommended by the Music Festival Guidelines.³⁶⁸
- 15.209 NSW Health funds DanceWize NSW to deliver harm reduction services at music festivals.³⁶⁹ DanceWize NSW delivers a specialised peer-led model, with more than 150 staff and volunteers.³⁷⁰ It was established in 2017 and later expanded under the Guidelines, delivering 14,000 peer education interventions and 1,500 care interventions at 22 festivals in 2018–19, half of them in regional areas.³⁷¹ An independent evaluation in 2018 noted effective engagement and positive harm reduction advice, while a 2019 rapid review found DanceWize NSW exceeded its expected performance.³⁷²
- 15.210 Coordinator of DanceWize NSW, Erica Franklin, gave evidence to the *NSW Coronial Inquest into Music Festival Deaths* that peer-based interventions engage young people in a way that schools, security, police, medical teams or counsellors generally do not.³⁷³
- 15.211 DanceWize NSW staff and volunteers undertake extensive training to deliver services including:³⁷⁴
- a care space for the provision of brief interventions, counselling, support and monitoring of people experiencing low to mid-range intoxication, including from ATS
 - an education space for the provision of harm reduction and health resources, and evidence-based information on topics including drugs, mental health, sexual health and response to assaults, polydrug combinations and service referrals
 - rovers who provide harm reduction advice, information and health resources, and identify patrons requiring assistance and support.
- 15.212 Participants at the Inquiry's Youth Roundtable described challenges in trying to access information to reduce drug-related harm and said they valued services such as DanceWize NSW that provide information at the point of consumption.³⁷⁵
- 15.213 Delivering her findings following the *NSW Coronial Inquest into Music Festival Deaths*, Deputy State Coroner Grahame recommended the continued funding and expansion of peer services. This recommendation, and the NSW Government's response, are set out below.

Other harm reduction strategies at music festivals

- 15.214 Dr Harrod, NUAA, told the Inquiry that people are using drugs before going to festivals (a practice known as 'preloading') and taking excessive doses, disregarding harm reduction messages about moderating drug use. Dr Harrod expressed the view that the presence of police and sniffer dogs is a significant factor in such situations, as '[y]ou can't really moderate your use or be sensible about it if you're taking it all at once to avoid detection'.³⁷⁶ Professor Nadine Ezard, Director of the National Centre for Clinical Research on Emerging Drugs (NCCRED) and Clinical Director of the Alcohol and Drug Service at Sydney's St Vincent's Hospital, gave evidence to the *NSW Coronial Inquest into Music Festival Deaths* that care must be taken to avoid policing strategies that inadvertently encourage consumption of drugs as a way of avoiding detection, with attendant risk of overdose.³⁷⁷ Policing strategies at music festivals are discussed in further detail in Chapter 19.

- 15.215 In Professor Ezard's opinion, substance testing is an appropriate harm reduction strategy for music festivals.³⁷⁸ The Inquiry received a large amount of evidence supporting onsite substance testing at music festivals, delivered in partnership with peer-based harm reduction services. This will be discussed further below.

Findings of the *NSW Coronial Inquest into Music Festival Deaths*

- 15.216 Harm reduction measures at music festivals were considered as part of the *NSW Coronial Inquest into Music Festival Deaths*. Deputy State Coroner Grahame made the following relevant recommendations at the conclusion of that inquest:³⁷⁹

'A6. That the Department of Premier and Cabinet facilitate a regulatory roundtable with the involvement of relevant State and Local government and key industry stakeholders, including the Department of Health, private health providers such as EMS Event Medical, NSW Ambulance and NSW Police, the Australian Festivals Association, harm minimisation experts and promoters, to ensure appropriate minimum standards for policing, medical services and harm reduction are mandated at music festivals.'

'A7. That in developing any new music festival regulations the Department of Premier and Cabinet, working with the Australian Festivals Association and other relevant stakeholders, give consideration to the submissions of the family of Joshua Tam'.

'B4. That the NSW Department of Health continues to fund and expand appropriate peer-delivered harm prevention and reduction services that are well received by patrons, for example, DanceWize.'

'B7. That the NSW Health Guidelines for Music festival Event Organisers: Music Festival Harm Reduction be amended to advise of an appropriate time frame and protocol for a private medical service provider to conduct a full evaluation, preferably with an independent consultant, in the event of a fatality involving a patient who they have treated.'

'B9. That the Department of Health continues to promote music festival guidelines that encourage the following initiatives, by explaining their significance in reducing the risk of drug-related harms and death:

- d. Free cold water at multiple stations throughout festivals.*
- e. Well ventilated chill-out spaces and the regular checking of ambient temperatures.*
- f. Additional activities to music to encourage chill out (particularly for longer festivals).*
- g. Involvement of artists in harm reduction messages.'*

- 15.217 The Inquiry supports these recommendations. The Inquiry notes that the NSW Government, in its response to the *NSW Coronial Inquest into Music Festival Deaths*, expressed support for each of them.

- 15.218 The Inquiry also notes that the NSW Government introduced amnesty bins at music festivals in December 2019, as a key part of its response to the recommendations. Amnesty bins allow music festival patrons to discard substances without fear of police prosecution.³⁸⁰

Substance testing

- 15.219 Substance testing services allow members of the public to anonymously submit samples of prohibited drugs for expert chemical analysis, including to identify the presence of contaminants and purity, where technology allows.³⁸¹
- 15.220 The evidence to the Inquiry indicates that most models of substance testing share similar features, including those offered internationally and employed in recent trials in the ACT:³⁸²
- A person submits a sample of a prohibited substance for testing.
 - Information about the substance to be tested is collected from the person submitting the sample (for example, what the person thinks the drug is).
 - The sample is analysed using one or more physical and chemical tests.
 - Information about the limitations of testing and a brief tailored health intervention is provided to the person intending to use the drug.
 - Test results are provided to the person intending to use the drug.
- 15.221 The results are interpreted and explained by an onsite expert, with feedback provided on the anticipated and actual results of the analysis in relation to substance content, drug purity (if tested) and whether harmful adulterants are present.³⁸³
- 15.222 Substance testing services aim to reduce harm by:
- delivering a brief intervention that involves the provision of education and information about risks³⁸⁴
 - providing information about the contents of the substance to reduce the risk of the person unintentionally ingesting an adulterated substance or a drug that is different to the one they originally intended to consume³⁸⁵
 - monitoring the drug market to identify novel and emerging substances and changes in trends to inform public health interventions (including public warning systems) and law enforcement.³⁸⁶
- 15.223 The benefits of substance testing are discussed in further detail below.
- 15.224 Potential outcomes from substance testing are that a person discards the drug, uses a smaller quantity of the drug or consumes the drug in a less harmful way – for example, by taking the drug in smaller amounts over a longer period of time or ensuring they drink enough water.³⁸⁷ There can also be an extended impact where the person passes on harm reduction information to others, such as their friends,³⁸⁸ or where substance testing results contribute to a public warning or public health response.

Services can be front-of-house or back-of-house

- 15.225 The predominant focus of research on substance testing, and of evidence to this Inquiry, has involved front-of-house services. Front-of-house, or public-facing models, are those in which the service interacts directly with the person who intends to consume the substance tested.³⁸⁹ Back-of-house services models are those that do not directly engage with the person intending to consume the substance, and are generally conducted for law enforcement or public health purposes.

- 15.226 The Inquiry heard evidence that some international front-of-house substance testing services communicate the results of the test directly and only to the person who submitted the sample for testing. Daan van der Gouwe, sociologist and drugs researcher at the Trimbos Instituut in the Netherlands, gave evidence that the Netherlands' Drugs Information and Monitoring System (DIMS) does not allow service clients to publish the results online because other people may be misinformed due to the many variations in batches of drugs. DIMS provides test results over the phone to the person who submitted the sample; they never provide written results to avoid the results being misused.³⁹⁰
- 15.227 The Inquiry heard evidence that some international substance testing services share the data obtained through the service with various stakeholders. For example, DIMS prepares separate annual reports for internal purposes and for the public and shares information with a board that includes staff from treatment services, the Ministry of Health and the Health Inspectorate. DIMS also shares information as part of its involvement in a European early warning system, in academic journals and with the EMCDDA.³⁹¹ When the need arises, information may be used by DIMS to issue a 'red alert' – a public warning mechanism – as discussed below.³⁹²
- 15.228 Back-of-house testing already operates in NSW, through NSW Health's Forensic and Analytical Science Service (FASS). FASS tests some drugs seized by the NSW Police Force for forensic purposes³⁹³ and blood samples collected by NSW Health for the clinical management of people admitted to intensive care for suspected overdose. However, the number of tests is limited; currently blood samples are sent for testing only when patients are not improving. NSW Health is still in the process of setting up surveillance through its intensive care units.³⁹⁴ Back-of-house models may also involve the testing of substances discarded in amnesty bins. The lack of direct public engagement means the benefits of back-of-house models are primarily associated with monitoring functions.
- 15.229 NSW Health and the NSW Police Force intend to conduct greater monitoring of the drug market through expanded analysis of drug seizures.³⁹⁵ The Inquiry notes that testing conducted by front-of-house services could enhance existing back-of-house testing in the same way. Such enhancements can and should complement a public-facing substance testing service.
- 15.230 Data collected from both models may inform public health messaging. This is discussed further in Chapter 21 and later in this chapter.

Types of testing

- 15.231 The Inquiry heard evidence about the broad range of substance testing methods available. They extend from simple, cheap and easily accessible reagent or colorimetric testing, which is comparatively unreliable, to highly sophisticated methods using expensive equipment operated by qualified technicians. These can yield more comprehensive information about the contents of a pill including the relative purity or dose of a drug in a sample.³⁹⁶
- 15.232 Accuracy, rapidity of test results and the extent to which the technology can provide quantitative information are relevant to the standard of substance testing that can be achieved. An additional consideration, relevant only to onsite testing models, is the stability of equipment within the environment where it will be deployed.³⁹⁷

Types of testing

- **Qualitative:** provides a positive or negative indication for the presence of a certain drug. An example is reagent testing, which uses colorimetric testing to determine the presence or absence of a particular substance.³⁹⁸ Colorimetric tests rely on simple chemical reactions and produce results that can be interpreted with the naked eye.³⁹⁹
- **Quantitative:** indicates a value for the amount of a substance in a given sample along a reference range, with some interpretation of results.⁴⁰⁰ An example is testing through gas chromatography mass spectrometry (GCMS), a comprehensive form of analysis provided in fixed-site locations and some onsite services used in festival settings.⁴⁰¹
- **Semi-quantitative:** provides an indication of quantity, for example, 'low', 'medium' or 'high', without providing the accuracy of fully quantitative testing.⁴⁰² An example is testing through Fourier-Transform Infrared Spectroscopy (FTIR), used onsite at festivals internationally and at the ACT trials in 2018 and 2019.⁴⁰³

The method of testing is determined by the type of equipment available.⁴⁰⁴

Technological capability

- 15.233 The use of appropriate technology to ensure accurate analysis is an important feature of substance testing. Factors specific to onsite services, such as environmental conditions and time constraints, may limit the type of equipment able to be deployed and the standard of analysis achieved.
- 15.234 The three testing methods most frequently discussed in the evidence to the Inquiry were:
- reagent or colorimetric testing
 - Fourier-Transform Infrared Spectroscopy
 - gas chromatography mass spectrometry.

Reagent or colorimetric testing

- 15.235 A number of substance testing services around the world use reagent testing; in some cases, it is only one of several methods used as part of a staggered testing process.⁴⁰⁵ Reagent testing produces a colour to identify whether or not the sample contains a particular substance⁴⁰⁶ and so provides only limited qualitative information. The Inquiry heard that the tests are not reliable with mixtures of substances and cannot identify adulterants.⁴⁰⁷ Dr Caldicott, Pill Testing Australia, informed the Inquiry that reagent testing is not fit for purpose, except perhaps as an initial screening test prior to further analysis.⁴⁰⁸

Fourier-Transform Infrared Spectroscopy (FTIR)

- 15.236 Each chemical compound has a unique infrared spectrum. FTIR testing uses a machine to identify the compounds in a sample by comparing the spectrum of the sample against the spectra of compounds documented in a library. Where the compounds in the sample have been documented in the library, the machine gives a score out of 1,000 to rate the quality of the match. If a compound has not been added to the library, the machine will identify the closest match.⁴⁰⁹ Dr Michelle Williams, research toxicologist, gave evidence to the *NSW Coronial Inquest into Music Festival Deaths* that, while there are suggestions that the nine libraries used by FTIR analysis contain 30,000 compounds, many of the libraries, such as cosmetics, polymers, fibres, proteins and kidney stones, are irrelevant in the context of substance testing; only one library – the Tictac Drug library – includes relevant compounds. At the time she gave her evidence, that library contained 430 compounds, 345 of which were new psychoactive substances and 25 of which were traditional ‘*drugs of abuse*’.⁴¹⁰
- 15.237 FTIR is able to provide information about the contents of a substance. However, FTIR is not able to identify a compound that has not been documented in the library, and is limited in its ability to provide information about how much of the compound is in the substance.⁴¹¹ The Inquiry heard that machines used to conduct FTIR are capable of being calibrated to provide semi-quantitative information, but that this is not the norm.⁴¹²

Gas chromatography mass spectrometry (GCMS)

- 15.238 The Inquiry heard that a testing method that combines spectrometry with chromatography, such as GCMS, is the current gold standard in forensic drug analysis. GCMS is able to detect a greater range of chemicals and can detect dosage to the milligram.⁴¹³ Therefore, machines that conduct GCMS are capable of providing comprehensive qualitative and quantitative information about the contents of a substance.

Evidence in relation to the various testing methods

- 15.239 In a statement to the *NSW Coronial Inquest into Music Festival Deaths*, toxicologist Andrew Leibie detailed the limitations of FTIR technology commonly used onsite at music festivals. Mr Leibie noted that FTIR is unable to detect newer psychoactive substances and polydrug mixes or determine substance concentration (purity) and dose, all of which are significant contributors to overdose.⁴¹⁴ The Inquiry heard evidence from consultant toxicologist Dr John Lewis, member of The International Association of Forensic Toxicologists and chairman of Standards Australia Committee CH-036, which governs the recommended practice for the collection, detection and quantitation of drugs of abuse in urine. He noted that toxic additives may not be identified if they are under the 5% to 10% impurity threshold required for detection by FTIR.⁴¹⁵
- 15.240 The first front-of-house pill testing trial in Australia was conducted by Pill Testing Australia in 2018 at the Groovin the Moo Festival in the ACT. Its success led to a second trial at Groovin The Moo in 2019. Both trials used FTIR analysis. The limitations of the technology were outlined to all patrons.⁴¹⁶
- 15.241 FTIR equipment can be calibrated to set a threshold or ‘*cut-off*’ score, to reflect the level of confidence in the reading.⁴¹⁷ In the absence of agreed standards in Australia, Pill Testing Australia set a conservative score of 750 as the threshold (or ‘*cut-off*’) for the 2018 ACT trial, as preparatory work showed that pure substances typically scored over 750.⁴¹⁸

- 15.242 It has been suggested that FTIR analysis *'failed to identify 53% of the drugs sampled'* in the 2018 ACT trial.⁴¹⁹ This is incorrect. What actually occurred is that 53% of the samples provided did not produce a result above the threshold score.⁴²⁰
- 15.243 Pill Testing Australia suggest that possible reasons for 53% of samples not yielding scores above the threshold may be that the major compound of the sample was one that had not been added to the library (i.e. it could not be matched) or the sample was an impure mixture of more than one compound.⁴²¹
- 15.244 Harm Reduction Australia noted that brief interventions provided to patrons by medical professionals and peers clearly communicated the limitations of FTIR analysis.⁴²² In evidence to the *NSW Coronial Inquest into Music Festival Deaths*, Dr Caldicott, the clinical lead for Pill Testing Australia, said FTIR analysis was suitable for a music festival environment as it is fast, robust and reliable, and can provide an approximate indication of substance purity. Dr Caldicott noted that more sophisticated technology was available but prohibited by legal constraints around handling of substances by the analyst.⁴²³
- 15.245 The Australian Criminal Intelligence Commission does not support onsite testing, noting the limitations of the technology, and submitted that comprehensive analysis of the content of the entire pill or tablet, which occurs in some European fixed-site locations, is *'the only type of testing which gives drug users a reliable indication of what they are consuming'*.⁴²⁴ Toxicologist Dr Lewis, similarly, gave evidence that he did not support an onsite testing service, but stated his support for fixed-site testing because of the capacity of technology available.⁴²⁵ The Australasian Chapter of Addiction Medicine of the RACP recognises the limitations of onsite pill testing technology but supports medically supervised trials in NSW, as discussed later in this chapter.

Onsite and fixed-site services

- 15.246 The Inquiry considered two front-of-house substance testing models, onsite and fixed site. Onsite testing involves services conducted at a temporary location such as a music festival.⁴²⁶ Fixed-site testing provides ongoing services at a permanent site.⁴²⁷

Onsite services

- 15.247 Onsite services operate in environments where people are likely to use drugs, including music festivals, parties and nightclubs.⁴²⁸ Access is confined to the people attending those venues and events. Of approximately 20,000 patrons at Canberra's Groovin the Moo festival in 2019, 234 participants used the onsite substance testing service.⁴²⁹ The outcomes of the 2019 Groovin the Moo pilot are discussed later in this chapter.
- 15.248 Dr Caldicott gave evidence that the substance testing conducted onsite by Pill Testing Australia occurs in the confines of the medical facility, removed from *'the hurly-burly'* atmosphere of the music festival, and that patrons have as much time as they want for the process.⁴³⁰
- 15.249 The Inquiry heard evidence that FTIR analysis can be effectively conducted onsite at music festivals. Dr Caldicott informed the Inquiry that technology capable of performing GCMS analysis may also be deployed at music festivals, but that the technology needs to be stable enough for Australia's environmental conditions.⁴³¹ Dr Caldicott gave evidence that a GCMS machine was deployed for the first time in the southern hemisphere and possibly the world at the second substance testing trial at Groovin the Moo,⁴³² but it was unable to be used on the day of the festival.⁴³³

- 15.250 Onsite services have the potential to engage people who engage in opportunistic drug use at festivals.⁴³⁴ In its submission to the Inquiry, St Vincent's Health Australia noted that health workers are not often given an opportunity to intervene immediately before people choose to take drugs.⁴³⁵ The Inquiry heard that onsite services may engage people who decide to take drugs at short notice on the day of an event, and who would not be reached by a fixed-site service.⁴³⁶
- 15.251 The potential for onsite services to engage people who may not be reached by fixed-site services is significant because research shows there are elevated levels of drug use at music festivals and similar events. A survey conducted in 2016 of 642 attendees at an Australian music festival found that 73.4% reported taking drugs, compared with 28.2% of the general young adult population.⁴³⁷ For MDMA, commonly known as ecstasy, almost 60% reported use in the previous 12 months, compared with 7% in the general age matched population.⁴³⁸
- 15.252 Onsite services enable prompt interventions in the immediate context of drug use,⁴³⁹ including by facilitating medical attention if required.⁴⁴⁰ They can also provide peer or health workers and other services with real-time information about the substances circulating at an event.⁴⁴¹
- 15.253 At the 2019 Groovin the Moo trial, patrons who had their substance tested were given a unique card with information about the result of the analysis, which could be vital information for treating clinicians in the event of the person requiring medical assistance.⁴⁴²

Case study: The Loop, United Kingdom

The Loop onsite substance testing service aims to reduce drug-related harm through:

- identifying drug market trends, drug use and substances of concern due to adulterations and high purity
- informing public health and clinical responses
- engaging with hard-to-reach populations to provide harm reduction advice, education and brief interventions
- providing an early warning system in partnership with police and health services.⁴⁴³

The Loop began operating in the UK in 2013, conducting back-of-house testing on discarded substances to inform law enforcement and onsite health services.⁴⁴⁴ Following six drug-related deaths at festivals, a need was identified to improve drug knowledge and education to reduce drug-related harms⁴⁴⁵ and in 2016 The Loop began an onsite, front-of-house substance testing trial.⁴⁴⁶ It included a 20-minute face-to-face health consultation delivered by a multidisciplinary medical team, providing education to inform consumption choices.⁴⁴⁷

The pilot evaluation found:

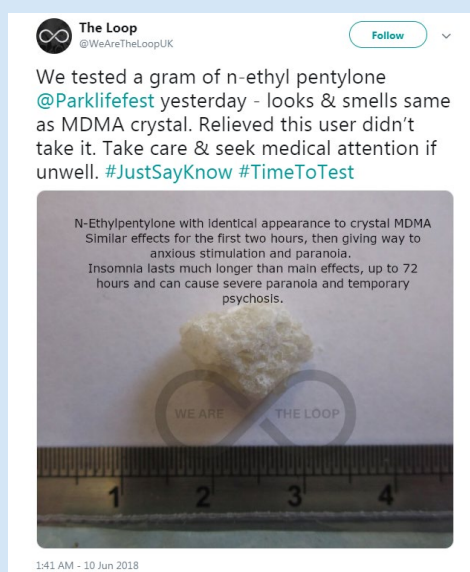
- Two-thirds of people disposed of substances in their possession when testing revealed the substance was not what they thought they had bought.
- More than 21% of people disposed of substances in their possession after obtaining the test result.
- There was positive behaviour change, including people moderating their doses and not mixing them with other substances.⁴⁴⁸

The service has expanded its festival and nightclub attendance following the successful pilot and has won awards for innovation and excellence.⁴⁴⁹ Services were expanded to 12 festival events in 2018 and have been supported by stakeholders including police, health and welfare organisations, festival and event organisers, researchers and politicians.⁴⁵⁰ Subsequent service evaluations, yet to be published, show similar outcomes to the initial pilot and demonstrate that alerts are leading to people discarding hazardous substances, preventing drug-related harms.⁴⁵¹

The service provides broader public health benefits by issuing alerts and warnings about identified substance risks and monitoring substances to inform law enforcement responses. The Loop is negotiating expansion into fixed-site locations. A recent alert issued by The Loop is shown in Figure 15.2, below.

The Inquiry notes that, in May 2018, The Loop introduced the UK's first community-based substance testing service.⁴⁵² In February 2019, Addaction, a UK drug, alcohol and mental health charity, was granted a licence by the UK Home Office for the purposes of conducting a community substance testing pilot, which took place for four days over four weeks in February to March 2019, and is pending evaluation; that pilot was a partnership between Addaction drug service, Hertfordshire University and The Loop.⁴⁵³ The Loop has applied for a government licence.⁴⁵⁴

Figure 15.2 The Loop alert⁴⁵⁵



Fixed-site services

- 15.254 Fixed-site substance testing services may be publicly accessible and permanently located in a community setting. They use highly sophisticated equipment to conduct accurate and comprehensive analysis.⁴⁵⁶ A fixed-site service does not operate under time constraints and provides a quieter environment for the delivery of brief health interventions.⁴⁵⁷
- 15.255 The comprehensive analysis used at fixed-site services takes time, delaying the communication of test results to the consumer.⁴⁵⁸ Australian research involving people who use drugs has found that 61% of those surveyed would use a testing service that required a one-week wait for results providing greater analytic reliability, while 80% would be willing to wait an hour.⁴⁵⁹

- 15.256 The Inquiry received evidence from DIMS that the benefits of fixed-site services over onsite services include that information about the risks of the drugs submitted can be provided in a quiet environment, with comprehensive information about the tested substance, including dose; and that there may be less time available for this at an event like a music festival.⁴⁶⁰ The Inquiry notes that front-of-house fixed-site services can be used by members of the public regardless of how and where a drug may be consumed. They can be used by people who use drugs in contexts other than music festivals, offering opportunities to engage with and provide brief interventions to a broader range of people in the community.
- 15.257 DIMS in the Netherlands is an example of how fixed-site services can be incorporated into an official policy response.⁴⁶¹

Case study: The Drugs Information and Monitoring System (DIMS), the Netherlands

DIMS is the world's most comprehensive substance testing service. It was established by the Ministry of Health in 1992 as a central coordinating agency for substance testing and national monitoring functions. Since 1999 its primary aim has been monitoring the illicit drug market and formalising a public health service response. Since 2002, testing services have been fixed site only, following concerns about condoning recreational drug use and the ability to deliver effective health interventions in a festival setting.⁴⁶²

National drug policy in the Netherlands accepts that drug use is unavoidable. It focuses on preventing and reducing harms to the individual and the broader community,⁴⁶³ including through DIMS substance testing. Fixed-site locations allow the use of more sophisticated analysis techniques and for people who use drugs to be engaged in a quiet setting without the queues or time pressures that may be present at festival settings.⁴⁶⁴

Objectives of the service include:

- providing monitoring functions to inform health and law enforcement responses, including through a national warning alert system
- engaging with people who use drugs to reduce harms through education and referrals to treatment where appropriate.⁴⁶⁵

The Netherlands is one of the only countries to use consumer-derived data sources to inform public health policy and law enforcement intelligence on production and manufacturing information.⁴⁶⁶ Data obtained through DIMS is compared with other data sources, including police seizures, to build a comprehensive understanding of the illicit drug market.⁴⁶⁷

Operation and governance

The DIMS network consists of 33 fixed-site drug checking services⁴⁶⁸ located across the country in prevention offices. Each service is governed in collaboration with local authorities through operational agreements, protocols and testing standards.⁴⁶⁹ The centralised DIMS bureau conducts all laboratory analysis, monitoring the market to identify health risks, while the services engage individuals for the purposes of prevention and harm reduction. This consultation is an important component of the intervention, providing opportunities to facilitate conversations with a hard-to-reach population.⁴⁷⁰

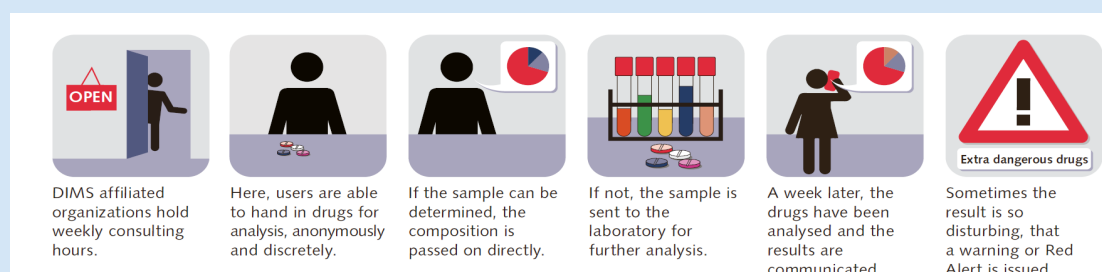
There is an official agreement with the Netherlands Public Prosecution Service that anyone in possession of illicit drugs when attending a substance testing service will not be arrested or prosecuted.⁴⁷¹

Testing process

DIMS services open at set times each week. People can anonymously attend, free of charge, to have substances assessed and receive education interventions from professional testers and peer educators.⁴⁷² Substances are submitted for an initial reagent test, then compared to the comprehensive database of previous chemical analysis. If the substance cannot be identified onsite it is sent for laboratory analysis with the results returned a week later.⁴⁷³ Approximately 300 samples are submitted weekly across the DIMS network, with more than 12,630 received in 2018. Most samples undergo further laboratory analysis.⁴⁷⁴

Additional information is captured for monitoring purposes, including details of purchase, intended setting of use and any observed adverse effects. All service patrons must sign a disclaimer acknowledging that DIMS cannot be held liable for health issues arising from substance use.⁴⁷⁵

The process for testing is described below:⁴⁷⁶



Red Alert System

When serious health risks are identified, DIMS can issue a red alert through channels including press releases, local prevention officers, the Red Alert app and internationally through the European early warning system. Adverse effects that do not meet this criterion are communicated through the DIMS website and the Red Alert app.⁴⁷⁷

These functions enable early communication about and rapid responses to the detection of new and hazardous substances to prevent adverse health outcomes. The value of the system was demonstrated in 2014 when a pill was identified which contained no MDMA but a potentially lethal dose of para-methoxymethamphetamine (PMMA). Overnight, a Red Alert campaign was issued. There were no reported deaths in the Netherlands from this pill but in the following fortnight, there were several deaths in the United Kingdom, which had no formal warning system.⁴⁷⁸

Substance testing operates in many jurisdictions worldwide

- 15.258 Many countries have implemented substance testing as a harm reduction measure. A 2017 review reported 31 services operating in 20 countries, including in Europe, the UK, the US, Canada and New Zealand.⁴⁷⁹ These services deliver a variety of fixed-site and onsite services.⁴⁸⁰ Research suggests the growth in these services may be due to the increasing prevalence of high potency pills, novel substances and associated harms.⁴⁸¹ Most services are funded through national or state governments.⁴⁸²
- 15.259 There have been few independent evaluations of substance testing services. A recent rapid review conducted for the NSW Ministry of Health noted that while 20 of the services reported some type of evaluation had been undertaken, many were internal, unpublished or not available in English.⁴⁸³

Groovin the Moo pill testing pilot, ACT

15.260 Conducted by Pill Testing Australia at the 2018 Groovin the Moo Festival in Canberra, the pilot was the first front-of-house pill testing trial in Australia. The service had various aims, including:⁴⁸⁴

- assessing the feasibility of onsite pill testing in Australia
- providing a health service to reduce the harms associated with drug use
- informing drug consumption behaviour through drug education
- reducing drug-related health presentations, ambulance callouts and police arrests
- obtaining data for public health and law enforcement purposes
- providing opportunities to build an evidence base through independent evaluation.

Criteria for the Groovin the Moo pill testing pilot, 2018

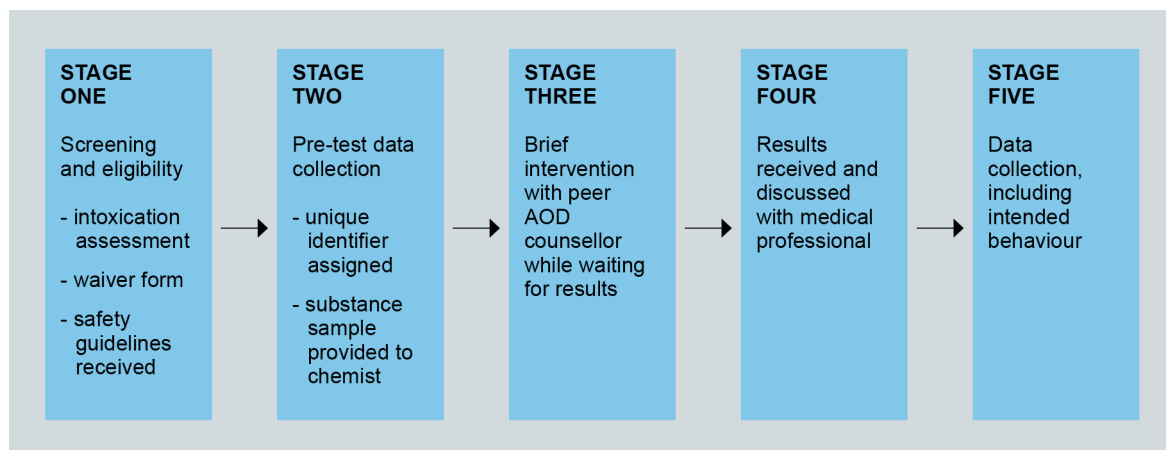
Criteria for the pill testing pilot were set by the ACT Government's inter-directorate Working Group on pill testing and were as follows:⁴⁸⁵

- The service should be established as a standalone service with close proximity to the medical area at the event.
- Technical staff who are undertaking the testing must be appropriately trained in the use of the pill testing equipment.
- Staff who are delivering advice and brief interventions about drug use must be trained in drug counselling.
- The pill testing equipment used must be able to reliably identify the major drug present in an unknown tablet or powder and potentially detect adulterants and/or substances that are unknown within an acceptable time period.
- The service should maintain regular communication with medical and ambulance personnel in the medical area and the event organiser to brief them on the results of pill testing; this may help inform medical procedures in the event of an overdose or other adverse event.
- The limitations of pill testing must be communicated to all patrons using the pill testing service, including that testing cannot guarantee the identification of all substances in a substance.
- Regardless of the pill testing result, each patron must be advised that drug taking is inherently unsafe and safe disposal is the best way to avoid risks to health.
- The service must provide an amnesty bin for safe disposal of drugs. These drugs must be destroyed onsite such that they cannot be reconstituted, and safely disposed of after the event by the service.
- The service must collect evaluative data, including but not limited to:
 - number of patrons attending the service
 - number of tests and brief interventions delivered
 - number of patrons who discarded their drug at the service
 - chemical content of each sample tested.

15.261 There are public and political concerns about increasing drug-related harms at Australian music festivals.⁴⁸⁶ In 2018 the ACT Government, ACT Health, ACT Police and Groovin the Moo Festival organisers supported the first government-sanctioned pill testing pilot to address these harms.⁴⁸⁷

- 15.262 It is important to note that a requirement of the trial was that the limitations of substance testing be communicated to all patrons using the service, including that testing cannot guarantee the identification of all substances in a sample. Regardless of the test result, each patron was to be advised that drug taking is inherently unsafe and safe disposal is the best way to avoid risks to health.
- 15.263 Following the success of the 2018 pilot, a second pilot was implemented at the 2019 festival. This second pilot was independently evaluated by the Australian National University to assess the feasibility of substance testing in Australia and its effectiveness for changing drug use behaviour.⁴⁸⁸ The results of that evaluation are discussed from paragraph 15.266.
- 15.264 Both pilots featured an onsite medically supervised pill testing model, co-located with medical facilities and delivered by medical staff and trained peers.⁴⁸⁹ The model encompassed five stages, including advice on service limitations and brief interventions and engagement with medical professionals and peer AOD counsellors. These stages are outlined in Figure 15.3.

Figure 15.3: Key stages of model⁴⁹⁰



- 15.265 Patrons accessing the service were required to sign a waiver acknowledging that no test can be completely reliable, no drug is safe, and the limitations of the testing service.⁴⁹¹

Figure 15.4: Groovin the Moo patron pill testing waiver form⁴⁹²

Patron Pill Testing Liability Waiver
To be signed by any patron before commencing pill testing.

I, the person signing this document **(I/me)**, agree that in consideration of receipt of the pill testing service carried out by Harm Reduction Australia **(HRA)** at the 'Groovin the Moo' festival **(Festival)** on 29 April 2018 at The University of Canberra **(Services)**, to release and discharge HRA, its employees, directors, contractors and volunteers and any other person connected with the provisions of the Services from any liability for personal injury or death suffered by me arising or connected in any way from the Services.

By signing I confirm having read and understood the contents of this waiver.

NAME: SIGN HERE DATE:

No test results regardless of findings:

- 1) Provides evidence of purity**
(Drugs are almost always adulterated)
- 2) Provides evidence of safety**
(no drug is completely safe, even if it is pure)
- 3) Provides evidence of dose**
(you never know how weak or strong the effects will be)
- 4) Provides information about how you will respond to the product being tested, today.**

I understand that the advice provided does not constitute any recommendation to consume drugs, and has been provided for the purposes of preventing drug related harm.

All drug use carries with it an inherent risk.

The only way to guarantee, 100%, that you are not harmed by consuming drugs is not to consume drugs.

Sample Number: Initial:

2018 pilot outcomes

- Analysis was conducted on 83 samples for 129 participants.⁴⁹³
- Two highly toxic chemicals, including N-ethylpentylone, were identified.⁴⁹⁴
- Brief interventions were delivered to 75% of service patrons.⁴⁹⁵
- As a result of the testing, 42% of service patrons reported that their drug taking behaviour would change.⁴⁹⁶
- Following the testing, 18% of patrons indicated they would either discard the drugs in the amnesty bins or were unsure what they would do due to the information provided.⁴⁹⁷

2019 pilot outcomes⁴⁹⁸

- The number of people using the service doubled compared with 2018, with 234 patrons entering the service and 170 samples analysed.
- MDMA was the predominant substance identified.
- Seven samples containing potentially lethal N-ethylpentylone were identified. All samples but one were discarded following education.
- All service patrons received health warnings and safety information.
- The trial was supported and recognised as a critical harm reduction measure by the ACT Government, Police and Health services.

Independent evaluation of the 2019 pill testing pilot

- 15.266 An external, independent evaluation of the 2019 ACT pill testing trial was conducted by researchers at the Australian National University, with financial support from ACT Health.⁴⁹⁹ The report of the evaluation was published on 10 December 2019. The purpose of the evaluation was to *'inform policymaking in the ACT and to contribute to evidence on pill testing in the Australian context'*.⁵⁰⁰ Developing a strong framework for future evaluations of pill testing services in Australia was identified as a further aim of the evaluation.
- 15.267 Seven data sources were used for the evaluation: pre- and post-testing surveys with the service participants; observational data; service data; follow-up interviews with participants; follow-up interviews with other stakeholders; and indicators derived from routinely collected administrative data.⁵⁰¹
- 15.268 A total of 234 pill testing patrons entered the service. Of these, 22 declined to enrol in the evaluation, 53 were excluded from the evaluation due to being under 18 years of age and one was excluded for knowingly presenting a sample of candy for testing, leaving 158 valid evaluation participants. Each of these completed a pre-test questionnaire and 147 also completed a post-test survey after receiving their test results and brief intervention.⁵⁰²
- 15.269 Eleven in-depth, semi-structured interviews were conducted in August and September 2019 with people who had participated in the service. The interviews were subsequently analysed using qualitative methods. The interview topics included basic demographics, expectations about drugs prior to testing, attitudes and drug-related behaviours prior to the festival, experiences of the pill testing service, and attitudes and behaviour soon after they left the pill testing service and in the following months.⁵⁰³
- 15.270 Six evaluation questions informed the design and implementation of the evaluation, set out below along with the key findings:⁵⁰⁴

How successfully was the program implemented, given its specific context?

15.271 The service was successfully implemented, particularly given limitations of context. A potentially harmful substance was identified. The pill testing information and brief interventions were valued by patrons. Misinterpretation of results based on a misunderstanding about what the test results could say about the purity of the samples tested were common, indicating consideration should be given to developing standardised explanatory language to deliver the drug testing results. Communication between the pill testing service, the ACT Ambulance Service, ACT Health, ACT Policing and the festival promoters enabled the successful implementation of the service.

To what extent was the program received positively by participants and by other key stakeholders?

15.272 The service was received positively by patrons and key stakeholders. No stakeholder reported concerns about the service and there was general support for continuing pill testing services in the ACT.

To what extent did the program result in participants' attitudinal and/or behavioural change related to illicit drug use?

15.273 Testing and the accompanying harm reduction brief interventions produced a number of positive results in participants' self-reported drug harm reduction knowledge, their trust of health providers and other written sources of harm reduction information, and stated behavioural intentions regarding drug use.

To what extent did the program produce valuable information about illicit drug availability in Canberra, and how did the authorities use that information?

15.274 The program produced valuable information about illicit drug availability in Canberra, including the identification of a substance previously unidentified in the ACT.

Did the program have any unintended consequences, either positive or negative? If so, what were they?

15.275 Stakeholders and patrons indicated aspects of the service could be improved, however none reported adverse, unintended consequences of the trial.

Should the program continue and, if so, what changes in the program and its contexts are desirable?

15.276 There was support for the development of further pill testing and harm reduction information services for people who use illicit drugs at festivals. Strengths that should be retained and some areas that ought to be improved were identified.

15.277 Some of the more specific findings of the evaluation of interest to the Inquiry are set out below.

Findings of the independent evaluation

15.278 Almost all participants positively rated their experience of the service, their confidence in the testing equipment, the quality of the information provided and the clarity of that information.⁵⁰⁵ Ninety-five per cent of the patrons reported that they would use a pill testing service again, were it available, and 98% would promote the pill testing service by telling others about the service.⁵⁰⁶

- 15.279 Patrons were also asked in the follow-up interviews about event-based versus fixed-site models of pill testing.⁵⁰⁷ The evaluators reported that there:
- ‘was no clear preference for one or the other and many advocated for both. Many saw the positives of providing pill testing services at events where people are likely to take drugs, yet also suggested that time taken out of a festival to attend a health service would be perceived negatively by some. Many saw the positives of providing fixed-site models in order to deliver services to others besides festival goers, noting that people use drugs in many environments other than festivals. However, it was also noted that, depending on where the service was located, the need to travel to attend such sites could present a barrier’.*⁵⁰⁸
- 15.280 Stakeholders were also asked their opinions about different models of pill testing services and reported positives and negatives for each. They identified as a positive of event-based services the *‘capacity to attract new, as well as more experienced, drug users who have never been to a health service before to talk about their drug use’*.⁵⁰⁹ The ability to provide services to a wider range of people who use drugs and the use of testing technology able to provide more specific details about substances were identified as positives of fixed-site services.⁵¹⁰
- 15.281 The service produced valuable information about illicit drug availability in Canberra, including the identification of N-ethylpentylone, which had not previously been identified in the ACT.⁵¹¹ The authorities used this information to notify patrons in the service, adjoining festival medical services and ACT Health when the substance was discovered. The proportion of tested drugs identified as MDMA was considerably higher in 2019 than in 2018, considered by a range of key stakeholders to be an important finding, confirming other sources of information about MDMA in the Canberra drug market at the time.⁵¹²
- 15.282 In terms of effects on patrons’ behaviour, 8% of the evaluation sample reported that they would discard the drugs they had tested.⁵¹³ Most patrons reported that they were not going to use more drugs (in amount or quantity) during the festival than they had intended before accessing the service and many reported an intention to adopt less risky drug consumption behaviour on the day, including using no drugs (7%), only alcohol (6%), or a lower amount or quantity of the drug (28%). Nineteen per cent stated that they planned to use the same amount as they intended before testing, and 8% stated that they would use more of the drug than originally planned, while 26% of patrons were not sure what they would do.⁵¹⁴
- 15.283 The results of the evaluation indicated a small but significant overall rise in patrons’ intention to use the tested drug between pre-test and post-test.⁵¹⁵ Patrons who entered the service with low intention to use and those who entered with high intention to use generally reported the same intention upon exiting the service. However, those patrons who indicated a 100% intention to use pre-test showed a significant decrease in likelihood of drug use from before testing to after receiving the service.⁵¹⁶
- 15.284 There was a small number of individuals in the high intention group (70 to 100% intention to use) who reported that they would not use the drug upon exiting the service. No patron changed their self-reported intention to use from low or medium to fully determined. However, there was a consistent and significant rise in intention to use the tested drug among the medium intention group (40 to 60% intention to use). That is, those who entered the service reporting a medium-level intention to use reported a higher inclination to use the tested drug upon leaving the service.⁵¹⁷ A small but significant increase was found in the intention to use the tested drug among participants who had taken an illicit drug (other than cannabis) in the past.⁵¹⁸

- 15.285 Gender was a consistent predictor of changes in intended consumption, with females being more likely than males to report an intention to use less drugs. Being told that the tested drug might be of higher strength was also associated with an increased likelihood of reporting an intention to use less drugs.⁵¹⁹
- 15.286 The statistics in relation to intention should be understood in the context of associated behavioural changes suggesting that patrons would be using their drugs in a way that reduced the risks of experiencing harm from the drugs.
- 15.287 Many of the patrons who participated in the follow-up interviews reported that the quantity of drugs they intended to use did not change after testing, as the drug was confirmed to be what they had expected. However, while many interviewees indicated that their intention to use did not change, their intention to engage in harm reduction behaviours increased. The reported behaviours included not taking all of the substance/s at once, increasing the amount of time between consumption of substances, and being aware of overexertion and hydration in order to reduce the potential harms of these drugs.⁵²⁰ The data collected from the follow-up interviews also suggested that many of the patrons interviewed understood that their tested substance was stronger than they were used to taking, an understanding that appeared to be directly related to their decision to alter their behaviours to reduce the potential harms of the drug.⁵²¹
- 15.288 The evaluation reported that the service could not assess purity, suggesting patrons misunderstood the results. However, Dr Caldicott, Pill Testing Australia, gave evidence that the equipment was calibrated to detect particular quantities of the drug,⁵²² suggesting that some indication of purity could be provided to patrons (for example, at least 150mg of MDMA).⁵²³
- 15.289 The Inquiry considers that the apparent misunderstanding relates to the way the test results were communicated. One of the reasons trials are run before implementation is to identify issues that need to be resolved. Steps can be taken to reduce this risk in a subsequent trial or on implementation.
- 15.290 The evaluators noted that, nevertheless, the apparent misunderstanding was linked to static or increased intention to consume the drugs tested, but also to uptake behaviours that could reduce the potential harms of drugs.⁵²⁴
- 15.291 The evaluators observed that limited evidence is available internationally on the long-term impacts of attending a pill testing service, largely due to the difficulty of following patrons longitudinally.⁵²⁵ When the 11 patrons who participated in the follow-up interviews were asked about whether their drug use had changed after attending the pill testing service, most reported some ongoing impact on drug use, limited by the availability of pill testing services more widely. Most also reported that they continued to use illicit drugs but remained concerned, or were more concerned, about the contents of their drugs and those drugs' potential impacts.⁵²⁶
- 15.292 In relation to information about drugs, the evaluators identified a dramatic increase in the proportion of respondents who reported that they would be willing to use healthcare providers (up from 14.6% in pre-test to 32.5% in post-test), brief intervention providers/peer counsellors (from 10.2% to 22.2%), home pill testing (from 8.9% to 20.6%) and written materials (from 12.2% to 22.2%) as their sources of information on drugs due to their experience of the pill testing service.⁵²⁷ Finally, as to sharing of test results, 108 of 118 patrons who knew others using the same drug reported that they were going to share the test results with other people who use drugs.⁵²⁸

15.293 The communication of results to others appears to have led to an overall decrease in use and reduced risk of harm, including where the results were misunderstood. In at least two instances, it appears to have led to changes in the behaviour of others that both reduced consumption and reduced harm.

15.294 The evaluators also made some observations about the need for future evaluation of pill testing services and other research, noting that:⁵²⁹

‘Some sections of the media, and some prominent opinion leaders, have stated that there is no, or little, evidence to support pill testing, but this is wrong. It reflects, at best, a lack of understanding of the nature of the evidence that underpins complex social interventions. Pill testing research reports, policy briefs, service descriptions and the like have been published, along with a small number of service evaluations, and many of these are listed in this report’s bibliography.

The existing research on, and evaluations of, pill testing services indicate support for it as a harm reduction intervention, but this body of work has notable limitations. Generally, evaluations have focused on descriptive measures of operational outputs such as number of drugs tested, number of brief interventions delivered, and contaminants found. A small but growing body of evidence is available on health service outcomes, such as changes in patron knowledge and changes in patrons’ self-reported behaviour. Still, few high-quality evaluations of pill testing services are being conducted and published. This reflects the fact that the people who have designed and conducted such services are generally based in small, inadequately funded, not-for-profits in Europe, and they have not had the capacity to engage professional researchers/evaluators to support their endeavors [sic]. It also reflects the significant methodological challenges in evaluating complex social interventions that aim to create positive behaviour change in the context of drug use. As such, much less is known about actual behavioural changes, impact on morbidity and mortality rates, utilisation by health and law enforcement agencies of information derived from testing, and drug market impacts, or process measures, such as feasibility, operational issues, program acceptability to key stakeholders, and costs.’

15.295 The evaluators stressed the importance of building evaluations into the design and operation of any future Australian pill testing services in order to address evidence gaps, and listed a number of areas where evidence is weak or missing:⁵³⁰

- the causal mechanisms that link pill testing interventions to changes in knowledge, attitudes and behaviour
- comparisons of the outcomes of different service delivery models
- the diffusion of information and behavioural change from pill testing, beyond those who present the substances for testing
- cost-effectiveness and cost benefit
- impacts in different settings and population groups
- regulatory frameworks
- impacts on drug markets
- impacts on health and wellbeing at the population level
- the outcomes of different models of policing at and in the vicinity of pill testing sites
- use of pill testing data for the purpose of law enforcement.

15.296 The results of the evaluation demonstrate that the substance testing service led to behavioural change that effectively reduced the risk of patrons experiencing drug-related harm, and in some cases reduced consumption, because drugs were discarded and because patrons consumed a smaller quantity of drugs.

Benefits of substance testing

15.297 The literature, submissions and evidence before the Inquiry identified numerous benefits of a substance testing service, including:

- the potential to identify potentially harmful contaminants or unexpected contents of drugs submitted for testing⁵³¹
- an opportunity to provide tailored health interventions and education to people who use drugs⁵³²
- an opportunity to monitor the illicit drug market.⁵³³

15.298 These are described in detail below.

Harmful contaminants or unexpected contents can be identified

15.299 Substance testing services can detect drugs containing toxic or novel adulterants in a sample, providing an opportunity to dissuade consumption of them and prevent people from experiencing their adverse effects.⁵³⁴ The Commonwealth Department of Health has previously stated pill testing services are likely to save lives by identifying toxic adulterants.⁵³⁵ The Inquiry also heard evidence of the importance of providing information about the quantity of the drug in a given substance.⁵³⁶ This information can be communicated to the individual intending to use the drug and may be used to inform broader public health alerts.

15.300 There is evidence that substances including paramethoxyamphetamine (PMA) and N-ethylpentylone are often sold as or added to MDMA.⁵³⁷ These substances are visually indistinguishable from MDMA and can cause serious harms, including fatal overdose.⁵³⁸ Dr Caldicott, Pill Testing Australia, gave evidence at the *NSW Coronial Inquest into Music Festival Deaths* that substance testing can identify the presence of those two substances. He said most people are accidentally exposed to those drugs while seeking ‘an MDMA-like experience’.

*‘The biological effects of the drug are far more dangerous than ... those you might see with MDMA. The problem is, of course, it doesn’t have the euphoric effect. And so when a young consumer consumes it, they might be left with the idea that it’s perhaps not as good a pill as they had intended. And therefore, they will re-dose or re-consume, obviously rapidly increasing the amount they are consuming. Alternatively, they might switch to a different type of pill’.*⁵³⁹

15.301 Drug Free Australia has suggested that by emphasising impurities and adulterations as the cause of harm, substance testing reduces public awareness of the harms associated with MDMA itself.⁵⁴⁰ Toxicologist Dr Lewis gave evidence that his concern is that it is the drug itself that causes harm:

*‘There’s been a lot of media and uninformed opinion out in the public about the additives, the toothpaste and the cement dust and all this sort of thing. There are additives; there are highly toxic materials, but I’m talking about ecstasy itself, purely and simply.’*⁵⁴¹

15.302 In each of the cases examined by the *NSW Coronial Inquest into Music Festival Deaths*, MDMA was ‘the major causal factor’ in the death.⁵⁴² A review of all MDMA-related deaths in Australia between 2000 and 2005 found no mention of adulterants in coronial findings, with MDMA or combined substance toxicity identified as the cause of harm in most cases.⁵⁴³

- 15.303 There is evidence before this Inquiry that substance testing services can reduce harms in relation to MDMA itself. Dr Caldicott stated that while the media focus is often on identifying exotic and unusual drugs, the *'real benefits'* of testing are associated with people who use MDMA *'because that's the overwhelming majority of people'*.⁵⁴⁴

*'There ... is this strange sort of perception that pill testing or drug checking doesn't work in the context of people who return a result for ecstasy or MDMA, and that actually couldn't be further from the truth. People who are advised ... [about their] sample of MDMA, that it may be of high purity, are then given the opportunity to sit down and have a long chat, either with a medical professional or a, a peer worker, about what that means to their health.'*⁵⁴⁵

- 15.304 However, the harms from impurities, including new psychoactive substances, should not be discounted. A recent review found that new psychoactive substances and/or hallucinogens were identified in 82 Australian deaths between 2007 and 2017, with 60% resulting from accidental drug toxicity.⁵⁴⁶ Further information about new psychoactive substances can be found in Chapter 1.
- 15.305 All but one of the patrons at the Groovin the Moo pill testing pilot who were told that their substance contained N-ethylpentylone and informed of its potential harms discarded their drugs.⁵⁴⁷
- 15.306 The Inquiry heard that testing of methamphetamine is generally not considered a high priority to protect against harms because it is rarely contaminated with other substances.⁵⁴⁸ However, in Canada there has recently been an alarming increase in the number of overdoses involving methamphetamine contaminated with fentanyl.⁵⁴⁹ The Inquiry heard that fentanyl is causing significant public health and social problems in North America, raising concerns in Australia's medical and law enforcement communities.⁵⁵⁰
- 15.307 The potential for such contamination is a factor in favour of substance testing services that offer the best opportunity to identify contaminants in a broad range of substances. The Inquiry heard that other jurisdictions have issued public health alerts when adulterants were detected in drugs submitted to substance testing services.⁵⁵¹ This is discussed further later in this chapter.

Substance testing engages consumers in brief harm reduction interventions

- 15.308 Substance testing services also function as a means of providing people with harm reduction information and education. Professor Michael Farrell, Director of NDARC, told the Inquiry that this includes information about what people are consuming and the associated risks, and offers the opportunity for people intending to use drugs *'to be discouraged from taking excessive amounts of tablets'*.⁵⁵² Although the objective of substance testing is not necessarily to stop drug use,⁵⁵³ the Inquiry heard it can discourage consumption and modify behaviour;⁵⁵⁴ people may use less, use more safely, reduce the variety of drugs consumed in a session or discard the drugs and not use them at all.⁵⁵⁵
- 15.309 Dr Caldicott said the analytical function of substance testing services can provide a *'hook'* to engage consumers in the brief intervention⁵⁵⁶ and said the *'true value'* of substance testing lay in the *'coupling of a face-to-face interaction with an analytical element'*.⁵⁵⁷ In evidence to the *NSW Coronial Inquest into Music Festival Deaths*, he noted that: *'Pill testing is about reducing harm through education ... people are provided with a range of information to help them make an informed decision about what they are about to do, understanding the risks better.'*⁵⁵⁸

15.310 This is significant because many people who use MDMA do so occasionally and their use is not problematic; a substance testing service provides a point of contact for a population that might not otherwise be linked with harm reduction services.⁵⁵⁹ Dr Caldicott noted that for most people, speaking with a medical professional or peer worker at a substance testing service is the first time they have engaged in a conversation about the risks to their health from taking drugs.⁵⁶⁰

15.311 This was consistent with evidence to the inquest by Dr Stephen Bright, Course Coordinator for Addiction Studies at Edith Cowan University. He said that *'pill testing in and of itself is simply a way to get people to have a discussion around their drug use'*.⁵⁶¹ He went on to observe that the accuracy of testing:

'...may not be as important as the interaction, the human interaction with another health care professional ... around 90% of people that access pill testing services are fairly naïve and young drug users that don't know a lot about drugs and they've never spoken to another health care professional before'.⁵⁶²

15.312 The nature of the brief intervention is guided by the substance tested and can be tailored to the individual.⁵⁶³ Dr Bright told the inquest that unless harm reduction messages identify risks that are specific to them, young people are likely to dismiss the information given to them. *'So it's very important that we individualise the information and tailor it for young people and make sure it's credible so they are able to utilise that information.'*⁵⁶⁴

15.313 Dr Caldicott also noted the significance of individualised interventions, saying:

'[T]he importance of the intervention is a discussion about the overall harm, and that includes not only the nature of the tablet itself, but the nature of what might be going on with the individual, with their comorbidities, with their pharmaceutical backgrounds'.⁵⁶⁵

15.314 Discussions during brief interventions may include explaining how and why the results may be inaccurate and providing information about how drugs are manufactured.⁵⁶⁶ In addition to being told about the risks and harms associated with drug use, people using the service are educated about what to do if they have an adverse reaction.⁵⁶⁷

15.315 The Inquiry heard evidence about how those interventions have been conducted in Australia and internationally. However, there is limited research as to their effectiveness.⁵⁶⁸

15.316 The positive outcomes identified in the independent evaluation of the second substance testing trial at Groovin the Moo in 2019 appear to be inextricably linked to the provision of both the testing results and the brief intervention.

'The experience of testing and the accompanying harm reduction brief interventions produced a number of positive results in terms of participants' self-reported drug harm reduction knowledge, their trust of health providers and other written sources of harm reduction information, and stated behavioural intentions regarding drug use'.⁵⁶⁹

15.317 As DanceWize noted in the evaluation report, *'that brief intervention is really, really crucial, because that's where you're kind of giving sense and context to the drug-testing results'*.⁵⁷⁰

- 15.318 The findings of the *NSW Coronial Inquest into Music Festival Deaths* noted *'it appears likely that each of the young people [who died] had limited knowledge about the potential dangers of MDMA or how to recognise the signs of distress'*.⁵⁷¹ The Deputy State Coroner noted the importance of connecting this *'hidden population'* with health messaging, including through onsite brief health interventions.⁵⁷²
- 15.319 The RACP submitted that patrons' ignorance of what their drugs contain is one of the key safety issues relating to drug use at music festivals. Combining illicit drugs with alcohol, heat and dehydration *'can increase the risk of accidental overdose or poisoning from unknown substances within the drug'*.⁵⁷³ The information provided by substance testing services includes information about those risks.
- 15.320 Dr Caldicott gave evidence that substance testing helps establish a relationship of trust with consumers, which is important because *'there is almost no relationship of trust between this ... generation or community and the people providing them with messages to stay safe'*.⁵⁷⁴
- 15.321 Several witnesses also identified the value of a peer component in brief interventions. Conversations with peer services facilitate personal discussions on a range of topics, from drug consumption to sexual health, that would not otherwise occur.⁵⁷⁵
- 15.322 DIMS indicated that it provided only a fixed-site service because of concerns around the ability to deliver the necessary health intervention in a busy festival environment.⁵⁷⁶ Dr Caldicott gave evidence disagreeing with any suggestion that the brief interventions could not be provided in that environment.⁵⁷⁷
- 15.323 Dr Lewis, toxicologist, suggested in his evidence that it may be possible to provide an intervention through other means, such as showing people a video on drug-related harms when they attend a festival.⁵⁷⁸ Dr Caldicott's evidence was that providing testing limited to reagent testing would not be sufficient, as it would not meet the *'due diligence'* of health professionals to provide the most accurate results appropriate to the circumstances, and would not give the individuals accurate information to the extent required for them to make an informed decision.⁵⁷⁹

Substance testing can help monitor emerging drugs of concern and drug markets

- 15.324 The monitoring function of substance testing is a potentially valuable adjunct to the work already being done in NSW to ensure timely identification of emerging drugs of concern and changing trends in the market. The information obtained through substance testing has potential benefits for public policy, health and law enforcement.
- 15.325 As discussed in Chapter 21, NCCRED has identified the development of a prompt response system for emerging drugs of concern as a priority for clinical research⁵⁸⁰ and has taken steps to develop such a system.⁵⁸¹ It is proposed that the system would collate information from existing sources. Professor Ezard, NCCRED, said information from a formal public substance testing service would assist the work of such a system,⁵⁸² and that contextualised information obtained from consumers at the point of testing would be *'enormously helpful'* in providing public health messaging and intervention to prevent adverse effects.⁵⁸³
- 15.326 The capacity to monitor substances purchased by consumers can help identify changing trends in the illicit drug market⁵⁸⁴ and facilitate the detection of emerging novel substances, contaminants, toxic substances and high purity substances.⁵⁸⁵ Substance testing also has the capacity to obtain up-to-date information about illicit drugs being used in particular locations and provides a further source of demographic data about consumers of illicit substances and other people at risk.⁵⁸⁶

- 15.327 Early detection of new and hazardous substances is beneficial from a public health and policy perspective as it enables relevant agencies to respond rapidly and effectively to new substances and their effects. Information from DIMS has demonstrated that psychostimulant markets are dynamic and new psychoactive substances and additives frequently emerge.⁵⁸⁷ The information obtained through substance testing services may assist clinicians to respond to emerging new psychoactive substances and support a public health-focused early warning system.⁵⁸⁸
- 15.328 Substance testing data from the DIMS monitoring system are used in this way. Data obtained through the DIMS network are compared with police seizure data to provide a comprehensive picture of the illicit drug market. The Netherlands is one of the only countries to use consumer-derived sources of information on the illicit drug market which, in addition to seized samples, can yield valuable intelligence about production and manufacturing to inform law enforcement strategies.⁵⁸⁹

Improving the monitoring of illicit drugs in NSW

- 15.329 In the *NSW Coronial Inquest into Opioid-related Deaths*, Deputy State Coroner Grahame found that monitoring programs to detect illicit fentanyl at venues such as the MSIC should be supported, to provide as much information as possible about the market and ensure the safety of people who use drugs.⁵⁹⁰ Accordingly, Deputy State Coroner Grahame recommended that NSW Health support a program of opioid monitoring to be available at venues including the MSIC and NUAA, noting it would provide data for planning, implementation and evaluation of public health practice.⁵⁹¹ Surveillance and information communication was also considered in the *NSW Coronial Inquest into Music Festival Deaths*, which recommended that the NSW Department of Health contribute to the Emerging Drugs Network of Australia (EDNA) by sharing information obtained through enhanced surveillance in emergency department and intensive care settings. EDNA is a nationwide collaboration of clinical toxicologists and emergency physicians using the National Poisons Network and Toxicology Specialist Advisory Group.⁵⁹²
- 15.330 The Inquiry supports this recommendation, recognising the public health utility of reducing the risks to the public posed by changing drug trends. The Inquiry notes that the NSW Government expressed support for this recommendation in its response to the *NSW Coronial Inquest into Music Festival Deaths*.
- 15.331 As discussed in Chapter 21, various initiatives are under way to improve illicit drug monitoring in NSW, including an enhanced partnership between NSW Health and the NSW Police Force to expand drug seizure testing⁵⁹³ and seed funding for EDNA to improve toxicological screening and information sharing.⁵⁹⁴
- 15.332 While these are useful methods to enhance the clinical and public health responses to drug-related harms, the Inquiry notes that their capacity to reduce harms is limited without the ability to communicate risks to people likely to consume drugs. The Inquiry heard there can be reservations about sharing this information with the public, for reasons including that it might prompt people to actively seek substances identified as highly potent.⁵⁹⁵ Dr Chant, NSW Chief Health Officer, said public warnings are not issued for all drugs detected ‘because of the unintended harms’.⁵⁹⁶ However, NCCRED submitted that communication with the public would enable harm reduction before the point of consumption and facilitate the provision of education directly to the consumer.⁵⁹⁷
- 15.333 The Inquiry notes that on 12 December 2019, NSW Health issued a public alert warning against the consumption of variable and high dose MDMA tablets/capsules circulating in NSW. The alert included photographs of two types of tablet identified as being high dose.⁵⁹⁸ On 28 December 2019, NSW Health issued another alert about MDMA pills found to contain double or triple the common dose.⁵⁹⁹

Concerns raised about substance testing

- 15.334 Despite the clear benefits of substance testing which are supported by a substantial amount of evidence, there is ongoing opposition to substance testing in NSW.
- 15.335 Professor Alison Ritter, DPMP, observed that proponents and opponents of substance testing have the common goal of wanting to save lives but differ in their views of how to achieve that goal: either by providing education and information on the drug intended for consumption or by preventing consumption.⁶⁰⁰

‘The question then becomes, “Well, what is the best way to save lives?” And this then becomes a debate about evidence. So the people who support pill testing will say, “Well, the best way to save lives is to provide people with better education, information and some information about the content of the drug that they intend to consume.” The opponents argue that the best way to save lives is to prevent drug use, is to say, “You should not use drugs”. And, probably, both things are true. You would save someone’s life if they don’t consume drugs, and you are more likely to save someone’s life if you give them education and information and support, and there’s not an evidence base that we could use to argue out which is better ... it then comes to whether you believe that drug use is a choice that people are allowed to make, and that’s the value position.’⁶⁰¹

- 15.336 Professor Ritter told the Inquiry that a position that relies only on preventing use is not consistent with a harm reduction approach. Nor is it consistent with a humane and pragmatic approach, or the human rights-based approach that is the foundation for international drug policy.⁶⁰²
- 15.337 In a recent analysis of the substance testing debate, Professor Ritter identified the arguments consistently raised in the public debate. They include:⁶⁰³
- that drugs are illegal and substance testing sends the wrong message
 - that there is no safe drug use, and substance testing gives people a false sense of security
 - that there is not enough evidence on substance testing.

‘Sending the wrong message’ about illegal drugs

- 15.338 Substance testing is often criticised as ‘*sending the wrong message*’ and condoning illegal drug use.⁶⁰⁴
- 15.339 Substance testing is a harm reduction measure, and current government drug policy recognises that harm reduction approaches do not condone drug use.⁶⁰⁵ Harm reduction is an entirely conventional approach to drug policy endorsed by state and Commonwealth governments.
- 15.340 The RACP told the Inquiry that the advice provided to people seeking substance testing ‘*does not condone drug taking, it simply enables ... better informed decisions*’.⁶⁰⁶ Gino Vumbaca, president of Harm Reduction Australia and convenor of Pill Testing Australia, gave evidence that: ‘*The better informed we are, the better decisions we generally make, and that’s true of drug users.*’⁶⁰⁷
- 15.341 As described in Chapter 11, the fact that drugs are illegal has clearly not been an effective deterrent and as the RACP submitted, the ‘*evidence shows that the moral message to abstain from taking drugs is not effective and that young people take drugs in large numbers*’.⁶⁰⁸

- 15.342 Mr Vumbaca told the Inquiry that when engaging with people at the testing service *'we're not saying it's okay to use drugs, and we're not trying to facilitate it. We're just saying, "We want you safe"'*.⁶⁰⁹
- 15.343 The Inquiry is satisfied that substance testing, as a measure that reduces harm, is consistent with Australia's harm minimisation policy as iterated in the National Drug Strategy, and that it does not 'send the wrong message' or condone drug use.

Testing provides 'a false sense of security'

- 15.344 Other arguments raised against substance testing are that there is no safe drug use, and substance testing provides people with 'a false sense of security'. The Inquiry notes that the NSW Government, in its response to the *NSW Coronial Inquest into Music Festival Deaths*, said that *'[y]oung people at music festivals should not be given a false sense of security'*.
- 15.345 The Inquiry heard from toxicologist Dr Lewis that substance testing may lead people to believe drugs are safe to take when that is not the case⁶¹⁰ and there is a risk that by testing for contaminants, testing does not adequately deal with the risks of the substance itself, including those relating to purity.⁶¹¹
- 15.346 As noted earlier, a review of all MDMA-related deaths between 2000 and 2005 found no mention of adulterants in coronial findings, with MDMA or combined substance toxicity identified as the cause of death in most cases.⁶¹² MDMA toxicity was the cause of four of the six deaths examined by the *NSW Coronial Inquest into Music Festival Deaths*, with another caused by complications from MDMA use and one by mixed drug toxicity (MDMA and cocaine).⁶¹³
- 15.347 Drug Free Australia has suggested that emphasising impurities and adulterants as the cause of harm results in reduced public consideration and awareness of the harms associated with MDMA, even in low doses.⁶¹⁴
- 15.348 Questions have been raised about how effective substance testing is in circumstances where chemical analysis confirms the substance is what the patron intends to consume. Dr Caldicott addressed these concerns in his evidence to the inquest, referring to the importance of brief interventions with patrons. He said that people who are advised that their sample may be high purity MDMA have the opportunity to discuss the potential implications for their health with a medical professional or peer worker.⁶¹⁵
- 15.349 Concerns have also been raised that technology used at music festivals does not have the capacity to yield accurate, comprehensive results. The ACIC submitted to the Inquiry that the technology used for substance testing in Australia, particularly in the ACT, is not sufficiently comprehensive.

*'[P]ills/tablets clandestinely manufactured for the illicit market have virtually no quality control, and consist of an illegal primary substance, which is potentially dangerous, and often a variety of other substances which also carry risk to the user. There is no guarantee that active substances will be uniformly distributed throughout a pill/tablet or that pills/tablets from the same batch will have consistent contents or combinations of contents ... Users are not receiving a comprehensive analysis of the content of the pill/tablet in its entirety, and hence may be lulled into a false sense of security.'*⁶¹⁶

- 15.350 However, the Inquiry heard that these limitations were discussed with people using the service at the ACT pilot. Dr Caldicott said:

*'The beauty of providing the pill testing process in front of them with a chemist beside us is that it gives us a very useful opportunity to briefly discuss with them how pills are manufactured, why it's not homogeneous in nature and how this could not – this might be an inaccurate result ... This greatly undermines their faith in the manufacturing process.'*⁶¹⁷

- 15.351 The Inquiry also heard that available technology is capable of checking the purity of a particular substance.⁶¹⁸ Further, information about the harms associated with purity can be provided to the person intending to take the drug,⁶¹⁹ even in the absence of accurate testing for purity. For example, patrons who attended the second substance testing trial at Groovin the Moo in 2019 reported an increase in behaviours that could reduce the potential harms of drugs, including changes in behaviour based on a misunderstanding (although incorrect) that their drugs were stronger or purer than expected.⁶²⁰ One female patron said:

*'Yeah, because they were quite strong, they said, "It can be harmful because of the strength that it is." ... Just to not take as much as I initially planned to, like, only take half a dose, just to be safe. ... So I only took half during the day, and then half during the night. ... Yeah, it was helpful. It was stuff I already sort of knew, but it was good to just hear it again sort of thing, like, stuff about just drinking a good, reasonable amount of water, and taking breaks and stuff like that.'*⁶²¹

- 15.352 The evidence to this Inquiry is that substance testing services educate people about the dangers of substance use through the provision of brief health interventions,⁶²² which communicate the risks of the substance identified and how to reduce harm if it is consumed.⁶²³ People are never told their drug is safe.⁶²⁴ Instead, Dr Caldicott said, they are told that if they wish to be 100% safe from illicit drugs then they should not consume any drugs. *'At no stage is it suggested that drugs are ever "safe" or "passed", or that any "green light" is being provided.'*⁶²⁵

- 15.353 As indicated earlier, the waiver form signed by people accessing the service at the Groovin the Moo pilot clearly stated that *'the advice provided does not constitute any recommendation to consume drugs, and has been provided for the purposes of preventing drug-related harm. All drug use carries with it an inherent risk. The only way to guarantee, 100%, that you are not harmed by consuming drugs is not to consume drugs.'*⁶²⁶

- 15.354 The RACP submitted that substance testing offers *'an opportunity for medical professionals to provide trusted face-to-face advice to young people about the risks of drug taking. The advice provided does not claim any substances to be "safe"'*.⁶²⁷ A recent global review of substance testing services found that a key feature of each is the opportunity to provide accurate information from health professionals, including the message that *'no drug is safe'*.⁶²⁸ Professor Nicole Lee, from the National Drug Research Institute, told the NSW Coronial Inquest into Music Festival Deaths: *'I think that having a pill testing service actually signals that taking drugs is potentially dangerous, and we will need to test them for that reason.'*⁶²⁹

- 15.355 When Dr Lewis was asked at the Inquiry whether his concern about the *'false sense of security'* could be dispelled by providing individualised information about the harms of taking MDMA, he said he *'couldn't argue against'* that conclusion.⁶³⁰

- 15.356 The Inquiry considers that an appropriate explanation of test results, together with an explanation about the limits of testing, will not give rise to a false sense of security. A recent evaluation of an onsite service in Portugal found 94.3% of service users reported they would not take the drug when testing yielded unexpected results.⁶³¹ The Inquiry heard there is no evidence to indicate that substance testing services in other countries encourage use, increase the prevalence of drug use or increase drug-related harms.⁶³²

There is sufficient evidence to support substance testing

- 15.357 The argument is often put that there is insufficient evidence to support substance testing as a harm reduction measure. For example, the NSW Government, in its response to the *NSW Coronial Inquest into Music Festival Deaths*, said that '[t]he Government is not satisfied that evidence exists demonstrating that pill testing is an effective tool for minimising drug harm'.⁶³³ The Police Commissioner submitted that neither onsite or fixed-site testing is supported 'given there is no science supporting what is a safe amount of drugs for an individual to consume'.⁶³⁴ However, should such a trial be introduced, the NSW Police Force would work collaboratively with other key agencies.⁶³⁵
- 15.358 The weight of the evidence received by this Inquiry and the international literature clearly support the conclusion that substance testing reduces harms.⁶³⁶
- 15.359 The independent evaluation of the second substance testing trial at Groovin the Moo in 2019 includes a discussion of the existing body of evidence.

*'Despite a range of pill testing services operating globally, the evidence base for pill testing is still developing and few independent evaluations have been published. From Europe, it appears that the introduction of pill testing has not increased drug use, uptake or drug-related deaths (Benschop, Rabes, and Korf 2002; Hungerbuehler, Buecheli, and Schaub 2011). Evidence suggests that pill testing can be useful for monitoring drug markets and identifying particularly dangerous or new psychoactive substances, and this information has been used to issue public alerts and bring about changes in drug markets (Brunt et al. 2017; Ontario Agency for Health Protection and Promotion and Leece 2017; Spruit 2001; Vidal Giné et al. 2017). Pill testing can also effectively engage with people who take drugs for the purposes of harm minimisation (Benschop, Rabes, and Korf 2002; Hungerbuehler, Buecheli, and Schaub 2011).'*⁶³⁷

- 15.360 The authors of the independent evaluation note that existing research and evaluations of substance testing have limitations, and that little is known about actual behavioural changes and impact on morbidity and mortality rates, among other things.⁶³⁸ However, they assert that statements that there is little or no evidence to support substance testing are 'wrong', and based on a misunderstanding of the nature of the evidence.⁶³⁹ The authors indicate that there are published reports, policy briefs, service descriptions, and a small number of service evaluations. They report that evaluations have focused on descriptive measures of operational outputs such as number of drugs tested, number of brief interventions delivered, and contaminants found, and that there is a small but growing body of evidence on health service outcomes, such as changes in patron knowledge and changes in patrons' self-reported behaviour.⁶⁴⁰
- 15.361 Experts acknowledge that substance testing is not a panacea.⁶⁴¹ However, as is clear from the evidence below, substance testing is one of a number of measures that can be employed to reduce drug-related harm.

- 15.362 Delivering her findings after the *NSW Coronial Inquest into Music Festival Deaths*, Deputy State Coroner Grahame said: *'Of course drug checking is not a magic solution to these tragic deaths. Of course its introduction will not guarantee further deaths will not occur. Drug checking is simply an evidence-based harm reduction strategy that should be trial[l]ed as soon as possible in NSW.'*⁶⁴²

Support for substance testing

Support from the people who use drugs

- 15.363 A recent survey of Australians who attend festivals and nightlife venues and consume drugs found 94% would use an onsite substance testing service and 85% would use a fixed-site service; only 36% supported a service that did not provide individual feedback.⁶⁴³ The Inquiry heard that people who use illicit drugs want information about substance content,⁶⁴⁴ and will act on harm reduction advice when provided.⁶⁴⁵ This evidence is consistent with relevant literature.⁶⁴⁶
- 15.364 The Inquiry heard evidence that there is high demand for substance testing capacity. In the absence of formal services, the sale of reagent testing kits has increased by more than 1,000% over three years.⁶⁴⁷ In the 2019 Ecstasy and Related Drugs Reporting System data, 36% of respondents stated they had tested their substances in the previous year, with 87% of those using personal colorimetric or reagent testing.⁶⁴⁸ Dr Caldicott gave evidence that Pill Testing Australia does not even use these tests as a screening tool, noting they are not fit for purpose, and that *'you might as well pick colours out of a hat'*.⁶⁴⁹ Similarly, Dr Lewis, toxicologist, gave evidence that colorimetric or reagent tests are *'very dangerous and ... very untrustworthy'*.⁶⁵⁰
- 15.365 The Inquiry heard that reagent testing is precluded from technology used by Pill Testing Australia due to concerns about the sensitivity of such tests.⁶⁵¹ Mr Vumbaca, Pill Testing Australia, described large disparities in the results that could be determined through a \$20 reagent test compared to the \$45,000 FTIR technology used by Pill Testing Australia.⁶⁵²
- 15.366 Dr Caldicott told the Inquiry that reagent tests have various limitations, including an inability to detect novel psychotropic substances when combined with MDMA, and no analysis of dose.⁶⁵³ Participants at the Youth Roundtable convened by the Inquiry acknowledged they were aware of the limitations of reagent testing but occasionally used them because they are *'better than nothing'*.⁶⁵⁴

Support from medical bodies

- 15.367 A number of professional medical and peak bodies including St Vincent's Health Australia, the Australian Medical Association (AMA), the RACP, the RACGP and the Australasian College for Emergency Medicine support the implementation of a substance testing pilot.⁶⁵⁵ Uniting NSW/ACT have previously approached the NSW Government to express support for a substance testing trial and to offer their expertise, resources and experience to find a way to respond to drug-related deaths at music festivals.⁶⁵⁶
- 15.368 St Vincent's Health Australia supports a trial of both onsite and offsite substance testing, to *'contribute to the development of a more solid evidence base concerning which interventions are the most successful in saving lives, challenging risky behaviours, and minimising damage, particularly in an Australian context'*.⁶⁵⁷ St Vincent's Health Australia submitted that any trial *'should provide highly trained healthcare workers with the opportunity to engage drug testing participants with information about the risks and harms associated with drug use, including offering a pathway to seeking treatment and further support if required'*.⁶⁵⁸

- 15.369 Both the federal and NSW branches of the AMA support substance testing trials *‘that might reduce harms and improve outcomes for users and society at large’*, as part of broader harm minimisation strategies and to develop evidence on the benefits and risks.⁶⁵⁹ The AMA notes that such trials should be appropriately funded, evaluated and controlled.⁶⁶⁰
- 15.370 The RACP, and its Australasian Chapter of Addiction Medicine, support evaluated pill testing trials in conjunction with other harm reduction measures *‘to keep people as safe as possible at music festivals’*.⁶⁶¹ The RACP said testing by appropriately skilled specialists can provide a range of harm reduction benefits, particularly through brief health interventions.⁶⁶² It noted that evidence from international services and the ACT pilot has shown that pill testing is an effective harm minimisation measure which *‘offer[s] an opportunity to provide trusted face-to-face advice to inform young people about the risks of drug taking’* and has utility for informing public health and law enforcement responses.⁶⁶³
- 15.371 The Inquiry heard that, on the advice of addiction medicine specialists in the College, the RACGP *‘fully supports the implementation of onsite drug-checking services’*.⁶⁶⁴ Associate Professor Hespe, RACGP, noted the high-quality international evidence of their efficacy and said such services allow *‘effective communication of the risks of substance use to individuals who would not otherwise engage in a substance-use conversation’*. Such an opportunity *‘can never be replicated within a practice setting’* and may facilitate referrals to appropriate services.⁶⁶⁵
- 15.372 The RACGP also supports fixed-site substance testing services, saying they would be likely to cater to people with more chronic drug dependence issues and could be integrated with other services to provide holistic care.⁶⁶⁶ Associate Professor Hespe said data obtained from such services about drug purity, contaminants and changing consumption patterns would enable GPs to manage patients more effectively.⁶⁶⁷
- 15.373 The Australasian College for Emergency Medicine supports a substance testing trial as part of a wider harm minimisation strategy, noting there is sufficient evidence *‘to support pill testing in the Australian environment. The results from the ACT trial in 2018 indicate that the support associated with the testing, as well as the test results, have a positive impact on a young person’s decision whether to use the pills they have with them’*.⁶⁶⁸

Recommendations of the NSW Coronial Inquest into Music Festival Deaths

- 15.374 As previously mentioned, substance testing at music festivals has been considered by the *NSW Coronial Inquest into Music Festival Deaths*. The evidence to that inquest has also been considered by this Inquiry.
- 15.375 In relation to substance testing, the Deputy State Coroner made the following recommendations to the NSW Department of Premier and Cabinet:⁶⁶⁹

‘A1. That the Department of Premier and Cabinet permits and facilitates Pill Testing Australia, The Loop Australia, or another similarly qualified organisation to run front-of-house medically supervised pill testing/drug checking at music festivals in NSW with a pilot date starting the summer of 2019–20.

A2. That the Department of Premier and Cabinet, working with NSW Health and NSW Police, fund the establishment of a permanent drug checking facility, similar to the Dutch model known as the DIMS.

A3. That the Department of Premier and Cabinet, working with NSW Health, research and support the development of technology to allow for the most sophisticated and detailed drug analysis to be made available on site at music festivals.

A4. That the Department of Premier and Cabinet, working with NSW Health, research and support the development of early warning systems at music festivals generally and arising from front-of-house and/or back-of-house drug checking.

A5. That the Department of Premier and Cabinet, working with the NSW State Coroner, NSW Police, FASS and NSW Health, develop protocols for the open sharing of information between these agencies regarding drug trends and monitoring of drug deaths.'

15.376 The following recommendation was made to the NSW Police Force.⁶⁷⁰

'C3. That, in the event of pill testing/drug checking facilities being operational at NSW music festivals, the Police Commissioner issue an operational guideline providing clear guidance to operational police as to how they are requested to exercise their discretion in regard to illicit drug use and possession at festivals. Such a Guideline should:

a. Identify the role of police as one of support and protection for otherwise law-abiding festival goers.

b. Request police not to take punitive action against people in possession of drugs for personal use, and to concentrate their operations on organised drug dealing, social disorder and other crimes.

c. Emphasise that while a primary part of policing at music festivals involves crowd control and enforcement of laws, it is part of good policing, and an objective at music festivals, to engage positively with festival goers wherever possible, to provide support and comfort where needed and to act to reduce or minimise harm.'

15.377 The Inquiry notes that a clear demand exists for substance testing, and prohibiting access to more comprehensive and expensive technology results in people seeking rudimentary and ineffective methods of analysis, without the accompanying provision of education. It would be better to provide services that use appropriate and sophisticated technologies and provide brief interventions, harm reduction advice and opportunities for behaviour change.

Fixed-site substance testing is warranted together with a trial of on-site substance testing

15.378 The evidence to this Inquiry clearly indicates that substance testing has the potential to reduce the harms associated with the use of ATS. Such testing has the demonstrated ability to reduce harms by providing:

- information about the substance itself, both directly to the person intending to consume that drug and through the provision of public warnings in appropriate circumstances
- an opportunity for education and health intervention, particularly to people who are unlikely to otherwise engage with harm reduction or health services
- a source of information for monitoring of illicit drug markets, with the associated public health and law enforcement benefits.

- 15.379 The conclusions of this Inquiry are consistent with the those reached by the *NSW Coronial Inquest into Music Festival Deaths* and with experts in the field, including Professor Alison Ritter, DPMP.⁶⁷¹
- 15.380 The matters raised in opposition to substance testing are not supported by the evidence to this Inquiry. An appropriately designed pilot would allow reservations about the operation of an on-site substance testing service and the scale of the impact of the service to be explored and identified. Any such trial should be designed so that its contribution to reducing drug-related harms can be evaluated.⁶⁷²
- 15.381 Substance testing services engage people who intend to use substances in a conversation about the risks and how to reduce the possible harms. The brief intervention facilitated through substance testing provides an opportunity to engage people before they consume any drugs and provide them with important individualised drug-related health advice, possibly for the first time, including that no drug use is safe.⁶⁷³
- 15.382 There is more than sufficient evidence before this Inquiry to support a recommendation that fixed-site substance testing be introduced and further, that on-site substance testing be trialled and evaluated in NSW as a harm reduction measure, and to complement other strategies to reduce ATS-related harms.

Features of a substance testing service

- 15.383 To achieve the benefits identified above a substance testing service should have the following features.

Services should be front-of-house to engage with people directly

- 15.384 The service should be front-of-house and include a brief intervention to provide the person accessing the service with health and harm reduction information. No witness or submission to the Inquiry proposed the development of a service without this component.
- 15.385 Dr Caldicott, Pill Testing Australia, told the Inquiry that '*the true value of pill testing*' is in combining face-to-face interactions with the test itself.⁶⁷⁴ Harm Reduction Australia supports only front-of-house testing services at both onsite and fixed locations, due to the direct communication and interaction offered to people who use them.⁶⁷⁵
- 15.386 A back-of-house service would provide some of the same benefits as a front-of-house service, but without the personalised health interventions that help inform people's decisions, and which are so significant in addressing the potential harms of drug use. For this reason, the Inquiry recommends a front-of-house service.

Fixed-site and onsite services

- 15.387 There appears to be no logical reason to limit substance testing to a fixed-site service; indeed, the Inquiry heard that onsite and fixed-site services are complementary.⁶⁷⁶ Providing both models would ensure a broad range of people can be reached, as well as supporting the monitoring function by allowing drugs to be tested from a broad range of settings.⁶⁷⁷

- 15.388 In its response to the recommendations of the *NSW Coronial Inquest into Music Festival Deaths*, the NSW Government stated that it does not support pill testing because:

*‘... it is not satisfied that evidence exists demonstrating that pill testing is an effective tool for minimising drug harm. The Deputy Coroner [sic] recorded MDMA toxicity as the major causal factor in all deaths examined by the inquest. Young people at music festivals should not be given a false sense of security’.*⁶⁷⁸

- 15.389 As set out in detail above, the work of the Inquiry has demonstrated that the bases articulated by the NSW Government for resisting a substance testing trial in NSW are without foundation. They are contradicted by the weight of the evidence received by this Inquiry, which has been significant.
- 15.390 The Inquiry concludes that there is a strong and compelling evidence base to support substance testing as an effective harm reduction measure used in conjunction with other harm reduction strategies.

Recommendation 53:

- A That the NSW Government establish a state-wide clinically supervised substance testing, education and information service, with branches at appropriate fixed-site locations, to:
- provide illicit drug market monitoring functions to inform public health and law enforcement responses, and
 - reduce drug-related harms through the provision, in conjunction with such testing, of appropriate health interventions, consumer education and information to members of the public.
- B That in addition, with a view to establishing an outreach capacity of the service to settings where there is a high risk of harm through illicit drug use, a trial be undertaken onsite at a music festival, and independently evaluated, to:
- provide illicit drug market monitoring functions to inform public health and law enforcement responses, and
 - reduce drug-related harms through the provision, in conjunction with such testing, of appropriate health interventions, consumer education and information to members of the public.

- 15.391 Brief intervention offered by substance testing services is of paramount importance. As noted above, there is limited research on the effectiveness of the brief interventions delivered as part of substance testing.⁶⁷⁹
- 15.392 The NSW Health Guidelines prepared in response to deaths at recent music festivals include guidance on various harm reduction approaches currently available to festival organisers.⁶⁸⁰ These include suggested harm reduction messages and opportunities for providing those messages. Similar guidelines for brief interventions delivered as part of a substance testing service would improve service delivery and identify and support best practice in delivering those interventions.

Recommendation 54:

That NSW Health develop evidence-based guidelines for the optimal delivery of brief interventions at substance checking services.

Conclusion

- 15.393 The Inquiry acknowledges the crucial role played by harm reduction measures within drug policy responses. There is evidence that current measures reduce injection-related harms and encourage engagement with the health system, including treatment services.⁶⁸¹
- 15.394 However, responses have not sufficiently adapted to meet the harms associated with smoking ATS, the most common method of administration. There is evidence that many people who smoke ATS are not receiving adequate harm reduction interventions and would benefit from advice, education and engagement with the broader health system.
- 15.395 The evidence is clear that targeted responses are required to reduce different harms⁶⁸² and engage a broader cohort of people who use ATS. The abundant and cogent evidence received by the Inquiry unquestionably supports a range of responses to ATS use, including NSPs, supervised drug consumption facilities, distribution of smoking equipment and substance testing at onsite and fixed-site locations.⁶⁸³
- 15.396 The Inquiry notes that there is a limited Australian evidence base for some of its recommended measures, such as substance testing, consumption services for people who smoke ATS and the provision of smoking equipment. Therefore a rigorous evaluation process should be developed to monitor the outcomes of such measures against their intended objectives: reducing drug-related harms and engaging people who use ATS for the purposes of education, information, brief interventions and links to health and social service supports.
- 15.397 Opportunities should be taken to extend services that have demonstrated success in reducing drug-related harms, such as NSPs and the MSIC, to a broader range of people who use ATS.
- 15.398 The Inquiry notes that effective partnerships and collaboration between facilitating agencies, including NSW Health and the NSW Police Force, are essential to implement these measures successfully.

References

- 1 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 6.
- 2 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 13.
- 3 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017); United Nations Chief Executives Board for Coordination (UNCED), *Summary of Deliberations* (18 January 2019) 13.
- 4 Craig Rodgers and Ingrid Van Beek, 'Chapter 8: Harm Reduction: Reducing the Harms from Drug Use' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 166-7.
- 5 Alison Ritter and Jacqui Cameron, 'A Review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs' (2006) 25 *Drug and Alcohol Review* 611, 611.
- 6 Susan Collins et al, 'Current Status, Historical Highlights, and Basic Principles of Harm Reduction' in G Alan Marlatt, Mary E Larimer and Katie Witkiewitz (eds), *Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviours* (Guilford Press, 2nd ed, 2012) 6.
- 7 Susan Collins et al, 'Current Status, Historical Highlights, and Basic Principles of Harm Reduction' in G Alan Marlatt, Mary E Larimer and Katie Witkiewitz (eds), *Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviours* (Guilford Press, 2nd ed, 2012) 6.
- 8 Susan Collins et al, 'Current Status, Historical Highlights, and Basic Principles of Harm Reduction' in G Alan Marlatt, Mary E Larimer and Katie Witkiewitz (eds), *Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviours* (Guilford Press, 2nd ed, 2012) 19; Alison Ritter and Jacqui Cameron, 'A Review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs' (2006) 25 *Drug and Alcohol Review* 611, 612.
- 9 Susan Collins et al, 'Current Status, Historical Highlights, and Basic Principles of Harm Reduction' in G Alan Marlatt, Mary E Larimer and Katie Witkiewitz (eds), *Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviours* (Guilford Press, 2nd ed, 2012) 6.
- 10 Susan Collins et al, 'Current Status, Historical Highlights, and Basic Principles of Harm Reduction' in G Alan Marlatt, Mary E Larimer and Katie Witkiewitz (eds), *Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviours* (Guilford Press, 2nd ed, 2012) 27.
- 11 Sydney (General) Hearing, Sydney, 9 May 2019, TS 270.10-14 (Dr Brett).
- 12 Harm Reduction Hearing, Sydney, Exhibit A, Tab 1, Statement of Alison Ritter, 13 September 2019, [6].
- 13 Uniting NSW/ACT, Submission No 95, 7 May 2019, 1.
- 14 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4249.29-40 (Dr Jauncey).
- 15 Neil Hunt, 'A review of the evidence-base for harm reduction approaches to drug use' (2003) *Forward Thinking on Drugs* 1; Harm Reduction Hearing, Sydney, 23 September 2019, TS 4224.1-4 (Dr Caldicott).
- 16 Robert J MacCoun, 'Toward a Psychology of Harm Reduction' (1998) 53(11) *American Psychologist* 1199, 1202-1203.
- 17 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 1.
- 18 Alex Wodak, *Demand Reduction and Harm Reduction* (Global Commission on Drug Policies, Working Paper, 2011) 8.
- 19 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 1.
- 20 Craig Rodgers and Ingrid Van Beek, 'Chapter 8: Harm Reduction: Reducing the Harms from Drug Use' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 166-167.
- 21 'Harm Reduction' *World Health Organization, Regional Office for Europe* (Web Page, 2020) <<http://www.euro.who.int/en/health-topics/communicable-diseases/hiv-aids/policy/policy-guidance-for-areas-of-intervention/harm-reduction>>.
- 22 Alison Ritter and Jacqui Cameron, Turning Point Alcohol and Drug Centre, University of Melbourne, *A systemic Review of Harm Reduction* (Drug Policy Modelling Project Monograph 6, 2005) 17.
- 23 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4305.19-32 (Dr Harrod).
- 24 Neil Donnelly and Nicole Mahoney, NSW Bureau of Crime Statistics and Research, *Trends in property and illicit drug crime around the Medically Supervised Injecting Centre in Kings Cross: 2012 update* (Issue Paper No 90, July 2013) 1; Dagmar Hedrich, Thomas Kerr and Francoise Duboise-Arber, European Monitoring Centre for Drugs and Drug Addiction, *Chapter 11: Drug consumption facilities in Europe and beyond*, (Monographs: Harm Reduction: evidence, impacts and challenges, 2010) 308; Craig Rodgers and Ingrid Van Beek, 'Chapter 8: Harm Reduction: Reducing the Harms from Drug Use' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 149-150, citing National Centre in HIV Epidemiology and Clinical Research, *Return on Investment 2: Evaluating the Cost Effectiveness of Needle and Syringe Programs in Australia* (Report, 2009).
- 25 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4196.1 (Professor McKetin); TS 4252.22-23 (Dr Jauncey).
- 26 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13A, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 12 July 2019, TS 373.8-17 (Dr Caldicott).
- 27 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4252.21-23 (Dr Jauncey).
- 28 See Harm Reduction Hearing, Sydney, 23 September 2019, TS 4252.34-37 (Dr Jauncey).
- 29 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4252.26-31 (Dr Jauncey); St Vincent's Health Australia, Submission No 127 (14 May 2019) 5.
- 30 NSW Branch of the Royal Australian and New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 8; Louisa Degenhardt et al, 'Estimating the number of regular and dependent methamphetamine users in Australia, 2002-2014' (2016) 204(4) *The Medical Journal of Australia* 1; Rebecca McKetin et al, 'Evaluating the impact of community-based treatment options on methamphetamine use: findings from the Methamphetamine Treatment Evaluation Study (MATES)' (2012) 107(11) *Addiction* 1998, 2004.
- 31 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4252.29-38 (Dr Jauncey).
- 32 References to footnotes in Table 15.1:
 - (a) Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 15.
 - (b) United Nations Office on Drugs and Crime, *Drug Policy and Results in Australia* (Report, October 2008) 24.
 - (c) Alison Ritter and Jacqui Cameron, Turning Point Alcohol and Drug Centre, University of Melbourne, *A systemic Review of Harm Reduction* (Drug Policy Modelling Project Monograph 6, 2005) 14.

- (d) European Monitoring Centre for Drugs and Drug Addiction, *Drug consumption rooms: an overview of provision and evidence* (Publication, June 2018) 2; Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (Report, February 2004).
 - (e) Caitlin Hughes, National Drug & Alcohol Research Centre, UNSW Sydney, *The Australian (illicit) drug policy timeline: 1985-2016* (Drug Policy Modelling Program, 2016) 60, 61.
 - (f) Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Fact Sheet, April 2019) 3.
 - (g) Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 16-18.
 - (h) Monica Barratt et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Profiles of drug checking services operating in 2017* (Drug Policy Modelling Program Bulletin No 24, 2018) 3-5, 7.
 - (i) Monica Barratt et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Profiles of drug checking services operating in 2017* (Drug Policy Modelling Program Bulletin No 24, 2018) 5-7.
 - (j) Caitlin Hughes, National Drug & Alcohol Research Centre, UNSW Sydney, *The Australian (illicit) drug policy timeline: 1985-2016* (Drug Policy Modelling Program, 2016) 58.
 - (k) Monica Barratt et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Profiles of drug checking services operating in 2017* (Drug Policy Modelling Program Bulletin No 24, 2018) 7-9.
 - (l) Caitlin Hughes, National Drug & Alcohol Research Centre, UNSW Sydney, *The Australian (illicit) drug policy timeline: 1985-2016* (Drug Policy Modelling Program, Resource, 2016) 55.
 - (m) Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 37, see also Eberhard Schatz and Marie Nougier, *Drug consumption rooms Evidence and Practice* (International Drug Police Consortium Briefing Paper, June 2012).
 - (n) Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 18-19.
 - (o) Monica Barratt et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Profiles of drug checking services operating in 2017* (Drug Policy Modelling Program Bulletin No 24, 2018) 10.
 - (p) Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 19.
 - (q) Caitlin Hughes, National Drug & Alcohol Research Centre, UNSW Sydney, *The Australian (illicit) drug policy timeline: 1985-2016* (Drug Policy Modelling Program, 2016) 43-44.
 - (r) Monica Barratt et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Profiles of drug checking services operating in 2017* (Drug Policy Modelling Program Bulletin No 24, 2018) 12, 14, 16.
 - (s) Vendula Belackova et al, 'Drug consumption rooms: A systemic review of the evaluation methodologies' (2019) 38(4) *Drug and Alcohol Review* 406, 407.
 - (t) Monica Barratt et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Profiles of drug checking services operating in 2017* (Drug Policy Modelling Program Bulletin No 24, 2018) 18-21.
 - (u) Pill Testing Australia, 'Second pill testing pilot in Canberra a success!' (Media release, 29 April 2019).
 - (v) 'A story of harm minimisation' *History of the Uniting Medically Supervised Injecting Centre* (Web Page) <<https://www.uniting.org/community-impact/uniting-medically-supervised-injecting-centre--msic/history-of-uniting-msic>>.
 - (w) Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 3.
- 33 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4309.34-4310.4 (Dr Harrod).
 - 34 Harm Reduction Hearing, Sydney, Exhibit A, Tab 18, Statement of Rebecca McKetin, 10 September 2019, [5].
 - 35 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4199.1-13 (Professor McKetin).
 - 36 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13A, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 12 July 2019, TS 373.8-10 (Dr Caldicott).
 - 37 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4225.24-26 (Dr Caldicott).
 - 38 Harm Reduction Hearing, Sydney, Exhibit A, Tab 8, Joint Statement of Tracey Burton and Marianne Jauncey to the *Coronial Inquest into Music Festival Deaths*, 3 June 2019, [31].
 - 39 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4169.35-4170.3 (Professor Ritter); Harm Reduction Hearing, Sydney, Exhibit A, Tab 8, Joint Statement of Tracey Burton and Marianne Jauncey to the *Coronial Inquest into Music Festival Deaths*, 3 June 2019, [31].
 - 40 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4169.37-40 (Professor Ritter).
 - 41 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4202.25-39 (Professor McKetin).
 - 42 National Drug & Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 18; see also Harm Reduction Hearing, Sydney, 23 September 2019, TS 4202.45-4203.10 (Professor McKetin).
 - 43 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4309.34-4310.4 (Dr Harrod).
 - 44 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4371.26-41 (Dr Read); 23 September 2019, TS 4202.12-17 (Professor McKetin).
 - 45 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4190.28-30 (Professor McKetin).
 - 46 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4371.40-41 (Dr Read).
 - 47 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4202.12-17 (Professor McKetin).
 - 48 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 15.
 - 49 Jenny Iversen et al, Kirby Institute, UNSW Sydney, *Needle Syringe Program Minimum Data Collection: (National Data Report, November 2016)* 3.
 - 50 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4441.33-34 (Dr Chant).
 - 51 Alison Ritter and Jacqui Cameron, Turning Point Alcohol and Drug Centre, University of Melbourne, *A systemic Review of Harm Reduction* (Drug Policy Modelling Project Monograph 6, 2005) 14.
 - 52 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4206.28-40 (Professor McKetin); TS 4268.28-34 (Dr Jauncey); 24 September 2019, TS 4310.6-16 (Dr Harrod); Harm Reduction Hearing, Sydney, Exhibit A, Tab 14A, Statement of Phillip Read, 17 September 2019, [26]; Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5-6; National Drug & Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 17; Penington Institute, Submission No 56 (May 2019) 21; Moree Hearing, Moree, 15 August 2019, TS 3017.15-3019.1 (D Kelly).
 - 53 Department of Health, Australian Government, *Eighth National HIV Strategy 2018-2022* (2018) 9.

- 54 Jenny Iversen et al, Kirby Institute, UNSW Sydney, *Needle Syringe Program Minimum Data Collection*: (National Data Report, November 2016) 3.
- 55 Alison Ritter and Jacqui Cameron, Turning Point Alcohol and Drug Centre, University of Melbourne, *A systemic Review of Harm Reduction* (Drug Policy Modelling Project Monograph 6, 2005) 14.
- 56 Sue Heard et al, Kirby Institute, UNSW Sydney, *Needle Syringe Program National Minimum Data Collection* (National Data Report, November 2018) 41.
- 57 Alison Ritter and Jacqui Cameron, Turning Point Alcohol and Drug Centre, University of Melbourne, *A systemic Review of Harm Reduction* (Drug Policy Modelling Project Monograph 6, 2005) 14.
- 58 Sue Heard et al, Kirby Institute, UNSW Sydney, *Needle Syringe Program National Minimum Data Collection* (National Data Report, November 2018) 41.
- 59 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4441.33-34 (Dr Chant).
- 60 Alison Ritter and Jacqui Cameron, Turning Point Alcohol and Drug Centre, University of Melbourne, *A systemic Review of Harm Reduction* (Drug Policy Modelling Project Monograph 6, 2005) 14.
- 61 Harm Reduction Hearing, Sydney, Exhibit A, Tab 14A, Statement of Phillip Read, 17 September 2019, [7].
- 62 Sue Heard et al, Kirby Institute, UNSW Sydney, *Needle Syringe Program National Minimum Data Collection* (National Data Report, November 2018) 41.
- 63 Jenny Iversen et al, Kirby Institute UNSW Sydney, *Needle Syringe Program Minimum Data Collection*: (National Data Report, November 2016) 1, 7-8.
- 64 Harm Reduction Hearing, Sydney, Exhibit A, Tab 14A, Statement of Phillip Read, 17 September 2019; Harm Reduction Hearing, Sydney, 24 September 2019, TS 4358.28-4260.5 (Dr Read).
- 65 Craig Rodgers and Ingrid Van Beek, 'Chapter 8: Harm Reduction: Reducing the Harms from Drug Use' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 149-50, citing National Centre in HIV Epidemiology and Clinical Research, *Return on Investment 2: Evaluating the Cost Effectiveness of Needle and Syringe Programs in Australia* (Report, 2009).
- 66 Craig Rodgers and Ingrid Van Beek, 'Chapter 8: Harm Reduction: Reducing the Harms from Drug Use' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 148.
- 67 Alison Ritter and Jacqui Cameron, Turning Point Alcohol and Drug Centre, University of Melbourne, *A systemic Review of Harm Reduction* (Drug Policy Modelling Project Monograph 6, 2005) 19.
- 68 Alison Ritter and Jacqui Cameron, Turning Point Alcohol and Drug Centre, University of Melbourne, *A systemic Review of Harm Reduction* (Drug Policy Modelling Project Monograph 6, 2005) 19.
- 69 Craig Rodgers and Ingrid Van Beek, 'Chapter 8: Harm Reduction: Reducing the Harms from Drug Use' in Alison Ritter, Trevor King and Nicole Lee (eds), *Drug Use in Australian Society* (Oxford University Press, 2nd ed, 2017) 149; Norah Palmateer et al, 'Evidence for the effectiveness of sterile injecting equipment provision in preventing hepatitis C and human immunodeficiency virus transmission among injecting drug users: a review of reviews' (2010) 105(5) *Addiction* 844, 844.
- 70 Sue Heard et al, Kirby Institute, University of New South Wales, *Needle Syringe Program National Minimum Data Collection* (National Data Report, November 2018) 41.
- 71 Louise Geddes, Jenny Iversen and Lisa Maher, Kirby Institute, UNSW Sydney, *New South Wales Needle and Syringe Program Enhanced Data Collection* (Report, July 2018) 14.
- 72 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4441.33-34 (Dr Chant); National Drug & Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 17-18; The Public Defenders, Submission No 12 (29 April 2019) 4; Harm Reduction Australia, Submission No 37 (5 May 2019) 2; Mental Health Commission of NSW, Submission No 119 (May 2019) 6; Australian Medical Association, Submission No 121 (14 May 2019) 5.
- 73 Louise Geddes, Jenny Iversen and Lisa Maher, Kirby Institute, UNSW Sydney, *New South Wales Needle and Syringe Program Enhanced Data Collection* (Report, July 2018) 14.
- 74 Harm Reduction Hearing, Sydney, Exhibit A, Tab 14A, Statement of Phillip Read, 17 September 2019, [17].
- 75 Louise Geddes, Jenny Iversen and Lisa Maher, Kirby Institute, UNSW Sydney, *New South Wales Needle and Syringe Program Enhanced Data Collection* (Report, July 2018) 14; Sue Heard et al, Kirby Institute, UNSW Sydney, *Australian Needle Syringe Program Survey National Data Report 2014-2018: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees* (July 2019) 2-3.
- 76 Louise Geddes, Jenny Iversen and Lisa Maher, Kirby Institute, UNSW Sydney, *New South Wales Needle and Syringe Program Enhanced Data Collection* (Report, July 2018) 40.
- 77 Dubbo Hearing, Dubbo, 5 June 2019, TS 1547.22-47 (McMillan).
- 78 Louise Geddes, Jenny Iversen and Lisa Maher, Kirby Institute, UNSW Sydney, *New South Wales Needle and Syringe Program Enhanced Data Collection* (Report, July 2018) 40.
- 79 See, for example, Harm Reduction Hearing, Sydney, 25 September 2019, TS 4399.4-14 (Bourque); Lynne Leonard et al, "'I inject less as a I have easier access to pipes'" Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed' (2008) 19(3) *International Journal of Drug Policy* 255, 257.
- 80 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4399.4-14 (Bourque).
- 81 Lynne Leonard et al, "'I inject less as a I have easier access to pipes'" Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed' (2008) 19(3) *International Journal of Drug Policy* 255, 257.
- 82 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4403.32-36 (Professor Kerr).
- 83 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4403.32-36 (Professor Kerr).
- 84 Lynne Leonard et al, "'I inject less as a I have easier access to pipes'" Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed' (2008) 19(3) *International Journal of Drug Policy* 255, 256.
- 85 Lynne Leonard et al, "'I inject less as a I have easier access to pipes'" Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed' (2008) 19(3) *International Journal of Drug Policy* 255, 256.
- 86 Lynne Leonard et al, "'I inject less as a I have easier access to pipes'" Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed' (2008) 19(3) *International Journal of Drug Policy* 255, 257.
- 87 Lynne Leonard, Emily DeRubeis and Nicholas Birkett, City of Ottawa Public Health, *Safer Crack Use Initiative* (Evaluation Report, 2006) 7.
- 88 Lynne Leonard, Emily DeRubeis and Nicholas Birkett, City of Ottawa Public Health, *Safer Crack Use Initiative* (Evaluation Report, 2006) 9, 11-12.
- 89 Lynne Leonard, Emily DeRubeis and Nicholas Birkett, City of Ottawa Public Health, *Safer Crack Use Initiative* (Evaluation Report, 2006) 7.

- 90 Lynne Leonard et al, "I inject less as a I have easier access to pipes" Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed' (2008) 19(3) *International Journal of Drug Policy* 255, 260.
- 91 Lynne Leonard, Emily DeRubeis and Nicholas Birkett, City of Ottawa Public Health, *Safer Crack Use Initiative* (Evaluation Report, 2006) 7-8.
- 92 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4403.32-41 (Professor Kerr).
- 93 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4404.28-40 (Professor Kerr).
- 94 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4404.36-40 (Professor Kerr).
- 95 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4206.28-40 (Professor McKetin); TS 4268.28-34 (Dr Jauncey); 24 September 2019, TS 4310.6-16 (Dr Harrod); Harm Reduction Hearing, Sydney, Exhibit A, Tab 14A, Statement of Phillip Read, 17 September 2019, [26]-[27]; Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5; NSW Council of Civil Liberties, Submission No 70 (7 May 2019) 6-7.
- 96 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 3, 12.
- 97 A Peacock et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Australian Drug Trends 2019: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews* (Report, 2019) 74.
- 98 Sydney (General) Hearing, Sydney, 9 May 2019, TS 267.45-46 (Dr Brett).
- 99 Sydney (General) Hearing, Sydney, 9 May 2019, TS 267.8-11 (Dr Brett); Harm Reduction Hearing, Sydney, 24 September 2019, TS 4310.28-29 (Dr Harrod); TS 4370.22-24 (Dr Read); 23 September 2019, TS 4192.1-6 (Professor McKetin); Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid Van Beek, 16 September 2019, [4].
- 100 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [7].
- 101 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid van Beek, 16 September 2019, [3], [8].
- 102 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid van Beek, 16 September 2019, [8].
- 103 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid van Beek, 16 September 2019, [3]-[6], [8].
- 104 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4368.36-39 (Dr Read).
- 105 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4370.20-24 (Dr Read).
- 106 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4369.5-12 (Dr Read).
- 107 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5; NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 15; Harm Reduction Hearing, Sydney, 24 September 2019, TS 4310.45-4311.13 (Dr Harrod).
- 108 Moree Hearing, Moree, 15 August 2019, TS 3018.39-3019.15 (D Kelly).
- 109 Moree Hearing, Moree, 15 August 2019, TS 3018.44-3019.1 (D Kelly).
- 110 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 15.
- 111 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4311.4-10 (Dr Harrod).
- 112 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4311.11-13 (Dr Harrod).
- 113 Harm Reduction Hearing, Sydney, Exhibit A, Tab 18, Statement of Rebecca McKetin, 10 September 2019, [13].
- 114 Harm Reduction Hearing, Sydney, Exhibit A, Tab 18, Statement of Rebecca McKetin, 10 September 2019, [9].
- 115 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4201.40-43 (Professor McKetin).
- 116 See Lynne Leonard et al, "I inject less as a I have easier access to pipes" Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed' (2008) 19(3) *International Journal of Drug Policy* 255, 257.
- 117 Harm Reduction Hearing, Sydney, Exhibit A, Tab 19B, Statement of Michael Cook, 25 September 2019 [3].
- 118 *Drug Misuse and Trafficking Act 1985* (NSW) s 11.
- 119 *Drug Misuse and Trafficking Act 1985* (NSW) s 11A.
- 120 The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 14; ACON, Submission No 77 (May 2019) 25.
- 121 National Drug & Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 18.
- 122 National Centre for Clinical Research into Emerging Drugs, Submission No 123 (14 May 2019) 5.
- 123 Antonia Karlsson et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Crystal methamphetamine use, routes of administration and use of commercial pipes among people who inject drugs in Australia* (Drug Trends Bulletin Series, 2019).
- 124 Amy Prangnell et al, 'Declining rates of health problems associated with crack smoking during the expansion of crack pipe distribution in Vancouver, Canada' (2017) 17(163) *BMC Public Health* 1, 2; Carol Strike and Tara Marie Watson, 'Education and equipment for people who smoke crack cocaine in Canada' (2017) 14(1) *Harm Reduction Journal* 1; Antonia Karlsson et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Crystal methamphetamine use, routes of administration and use of commercial pipes among people who inject drugs in Australia* (Drug Trends Bulletin Series, 2019).
- 125 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 10.
- 126 Antonia Karlsson et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Crystal methamphetamine use, routes of administration and use of commercial pipes among people who inject drugs in Australia* (Drug Trends Bulletin Series, 2019).
- 127 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5.
- 128 ACON, Submission No 77 (May 2019) 25.
- 129 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4168.37-42 (Professor Ritter).
- 130 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 15.
- 131 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 46, 'Updated Court Data', Tab 7, Response of NSW Bureau of Crime Statistics, BOCSAR dated 30 August 2019, to Request for Information dated 23 July 2019.
- 132 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4268.29-34 (Dr Jauncey).
- 133 *Drugs Misuse and Trafficking Act 1985* s 11A.
- 134 *Drug Misuse and Trafficking Act 1985* (NSW) s 36A; NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016).
- 135 European Monitoring Centre for Drugs and Drug Addiction, *Drug consumption rooms: an overview of provision and evidence* (Publication, 2018) 4.
- 136 Vendula Belackova et al, 'Drug consumption rooms: A systemic review of the evaluation methodologies' (2019) 38(4) *Drug and Alcohol Review* 406.
- 137 European Monitoring Centre for Drugs and Drug Addiction, *Drug consumption rooms: an overview of provision and evidence* (Publication, June 2018) 1.

- 138 Dagmar Hedrich, Thomas Kerr and Francoise Duboise-Arber, European Monitoring Centre for Drugs and Drug Addiction, *Chapter 11: Drug consumption facilities in Europe and beyond* (Monographs: Harm Reduction: evidence, impacts and challenges, 2010) 308.
- 139 European Monitoring Centre for Drugs and Drug Addiction, *Drug consumption rooms: an overview of provision and evidence* (Publication, June 2018) 2.
- 140 Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 7.
- 141 European Monitoring Centre for Drugs and Drug Addiction, *Drug consumption rooms: an overview of provision and evidence* (Publication, June 2018) 2.
- 142 'A story of harm minimisation' *History of the Uniting Medically Supervised Injecting Centre* (Web Page) <<https://www.uniting.org/community-impact/uniting-medically-supervised-injecting-centre--msic/history-of-uniting-msic>>.
- 143 European Monitoring Centre for Drugs and Drug Addiction, *Drug consumption rooms: an overview of provision and evidence* (Publication, June 2018) 2.
- 144 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4385.22-9 (Charvet).
- 145 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4385.22-9 (Charvet).
- 146 'A story of harm minimisation' *History of the Uniting Medically Supervised Injecting Centre* (Web Page) <<https://www.uniting.org/community-impact/uniting-medically-supervised-injecting-centre--msic/history-of-uniting-msic>>.
- 147 Vendula Belackova et al, 'Drug consumption rooms: A systemic review of the evaluation methodologies' (2019) 38(4) *Drug and Alcohol Review* 406, 407.
- 148 Vendula Belackova et al, 'Drug consumption rooms: A systemic review of the evaluation methodologies' (2019) 38(4) *Drug and Alcohol Review* 406, 407.
- 149 Dagmar Hedrich, Thomas Kerr and Francoise Duboise-Arber, European Monitoring Centre for Drugs and Drug Addiction, *Chapter 11: Drug consumption facilities in Europe and beyond* (Monographs: Harm Reduction: evidence, impacts and challenges, 2010) 311-312.
- 150 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [8].
- 151 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4277.42-47 (Hedrich).
- 152 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4407.41-43 (Professor Kerr).
- 153 Dagmar Hedrich, Thomas Kerr and Francoise Duboise-Arber, European Monitoring Centre for Drugs and Drug Addiction, *Chapter 11: Drug consumption facilities in Europe and beyond*, (Monographs: Harm Reduction: evidence, impacts and challenges, 2010) 308.
- 154 Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 7; Harm Reduction Hearing, Sydney, 24 September 2019, TS 4278.1-4 (Hedrich).
- 155 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4408.10-12 (Professor Kerr).
- 156 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4408.14-18 (Professor Kerr).
- 157 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4408.17-18 (Professor Kerr); 23 September 2019, TS 4257.46-4258.4 (Dr Jauncey).
- 158 Vendula Belackova et al, 'Drug consumption rooms: A systemic review of the evaluation methodologies' (2019) 38(4) *Drug and Alcohol Review* 406, 407.
- 159 Harm Reduction Hearing, Sydney Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [6].
- 160 Penington Institute, Submission No 56 (May 2019) 21.
- 161 St Vincent's Health Australia, Submission No 127 (14 May 2019) 28.
- 162 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [8].
- 163 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4407.45-4408.6 (Professor Kerr).
- 164 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4407.36-40 (Professor Kerr).
- 165 Dagmar Hedrich, Thomas Kerr and Francoise Duboise-Arber, European Monitoring Centre for Drugs and Drug Addiction, *Chapter 11: Drug consumption facilities in Europe and beyond*, (Monographs: Harm Reduction: evidence, impacts and challenges, 2010) 320.
- 166 Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 27; See, for example, Nicolas Clark, 'Despite bad press, injecting room is doing what it was designed for', *The Age* (Online, 15 April 2019) <<https://www.theage.com.au/national/victoria/despite-bad-press-injecting-room-is-doing-what-it-was-designed-for-20190415-p51e9v.html>>.
- 167 See, for example, Gillian Kolla et al, (2010) 'Risk creating and risk reducing: Community perceptions of supervised consumption facilities for illicit drug use', (2017), 19 (1-2), *Health, Risk & Society* 91, 92, 2; Jo Kimber, Kate Dolan and Alex Wodak, 'Survey of drug consumption rooms: service delivery and perceived public health and amenity impact' (2005) 24 (1) *Drug and Alcohol Review*, 21, 21.
- 168 Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 27.
- 169 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4278.39-40 (Hedrich).
- 170 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4256.34-4257.13 (Dr Jauncey).
- 171 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4407.24-25 (Professor Kerr).
- 172 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4278.24-28 (Hedrich).
- 173 Dagmar Hedrich, Thomas Kerr and Francoise Duboise-Arber, European Monitoring Centre for Drugs and Drug Addiction, *Chapter 11: Drug consumption facilities in Europe and beyond*, (Monographs: Harm Reduction: evidence, impacts and challenges, 2010) 322-323.
- 174 Neil Donnelly and Nicole Mahoney, NSW Bureau of Crime Statistics and Research, *Trends in property and illicit drug crime around the Medically Supervised Injecting Centre in Kings Cross: 2012 update* (Issue Paper no 90, July 2013) 1.
- 175 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4278.35-40 (Hedrich).
- 176 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4408.20-22 (Professor Kerr).
- 177 NSW Government, Submission No 143 (2019) 17.
- 178 Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 11.
- 179 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4260.8-17 (Dr Jauncey).
- 180 NSW Government, Submission No 143 (2019) 17.

- 181 Sara Woods, European Harm Reduction Network, The Netherlands, *Drug Consumption Rooms in Europe: Organisational Review* (Report, 2014) 24.
- 182 Sara Woods, European Harm Reduction Network, The Netherlands, *Drug Consumption Rooms in Europe: Organisational Review* (Report, 2014) 24.
- 183 The actual count of operational DCRs is higher, noting the exclusion of those operating in housing projects and heroin assisted treatment programs due to limitations of access.
- 184 Anouk de Gee et al, Trimbos Instituut, *Drug Consumption Rooms in the Netherlands: 2018 Update* (Report, 2019) 23.
- 185 Anouk de Gee et al, Trimbos Instituut, *Drug Consumption Rooms in the Netherlands: 2018 Update* (Report, 2019) 13, 23.
- 186 Anouk de Gee et al, Trimbos Instituut, *Drug Consumption Rooms in the Netherlands: 2018 Update* (Report, 2019) 7.
- 187 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4387.33-35 (Charvet).
- 188 Anouk de Gee et al, Trimbos Instituut, *Drug Consumption Rooms in the Netherlands: 2018 Update* (Report, 2019).
- 189 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4387.36-38 (Charvet).
- 190 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4388.24-28 (Charvet).
- 191 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4388.42 (Charvet).
- 192 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4389.33-37 (Charvet).
- 193 NSW Health, 'Prevention, brief and early interventions and harm minimisation', *Alcohol and other drugs Programs* (Web Page, 14 September 2017) <<https://www.health.nsw.gov.au/aod/programs/Pages/prevention.aspx>>.
- 194 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 2.
- 195 Ingrid Van Beek, 'The Sydney Medically Supervised Injecting Centre: A Clinical Model' (2003) 33(3) *Journal of Drug Issues* 625, 627.
- 196 Ingrid Van Beek, 'The Sydney Medically Supervised Injecting Centre: A Clinical Model' (2003) 33(3) *Journal of Drug Issues* 625, 627.
- 197 Ingrid Van Beek, 'The Sydney Medically Supervised Injecting Centre: A Clinical Model' (2003) 33(3) *Journal of Drug Issues* 625, 628.
- 198 Caitlin Hughes, National Drug & Alcohol Research Centre, UNSW Sydney, *The Australian (illicit) drug policy timeline: 1985-2016* (Drug Policy Modelling Program, 2016) 43.
- 199 *Drug Misuse and Trafficking Act 1985* (NSW) s 36E.
- 200 *Drug Misuse and Trafficking Act 1985* (NSW) s 36B; NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 4.
- 201 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [6].
- 202 Ingrid Van Beek, 'The Sydney Medically Supervised Injecting Centre: A Clinical Model' (2003) 33(3) *Journal of Drug Issues* 625, 627-628.
- 203 NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 5-6; Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [6]; KPMG, *Further Evaluation of the Medically Supervised Injecting Centre during its extended Trial period 2007-2011* (Final Report, 14 September 2010); MSIC Evaluation Committee, *Final report of the evaluation of the Sydney Medically Supervised Injecting Centre* (2003); Ingrid Van Beek, 'The Sydney Medically Supervised Injecting Centre: A Clinical Model' (2003) 33(3) *Journal of Drug Issues* 625; Neil Donnelly and Nicole Mahoney, NSW Bureau of Crime Statistics and Research, *Trends in property and illicit drug crime around the Medically Supervised Injecting Centre in Kings Cross: 2012 update* (Issue Paper no 90, July 2013) 1.
- 204 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [6].
- 205 NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 6.
- 206 NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 14.
- 207 NSW Government, Submission No 143 (2019) 16-17.
- 208 NSW Government, Submission No 143 (2019) 17.
- 209 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [6].
- 210 Neil Donnelly and Nicole Mahoney, NSW Bureau of Crime Statistics and Research, *Trends in property and illicit drug crime around the Medically Supervised Injecting Centre in Kings Cross: 2012 update* (Issue Paper no 90, July 2013) 1.
- 211 KPMG, *Further Evaluation of the Medically Supervised Injecting Centre during its extended Trial period 2007-2011* (Final Report, 14 September 2010) 171.
- 212 See, for example, Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21-22; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 8; The Public Defenders, Submission No 12 (29 April 2019) 4; St Vincent's Health Australia, Submission No 127 (14 May 2019) 27-28; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 15-16; Penington Institute, Submission No 56 (May 2019) 18-21.
- 213 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 4; Harm Reduction Hearing, Sydney, 23 September 2019, TS 4250.13-17 (Dr Jauncey).
- 214 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4250.13-17 (Dr Jauncey).
- 215 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4255.12-13 (Dr Jauncey).
- 216 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 8.
- 217 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 3-4.
- 218 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 6, 8; Positive Life NSW and HIV/AIDS Legal Centre, Submission No 82 (7 May 2019) 5-6; Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 4-7; St Vincent's Health Australia, Submission No 127 (14 May 2019) 27-28; NSW Council of Civil Liberties, Submission No 70 (7 May 2019) 6-7; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21-22.
- 219 *Drug Misuse and Trafficking Act 1985* (NSW) s 36A.
- 220 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4276.31-37 (Hedrich).
- 221 See, for example, St Vincent's Health Australia, Submission No 127 (14 May 2019) 27-28; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21-22; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 8-9; The Public Defenders, Submission No 12 (29 April 2019) 4; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 15-16; Penington Institute, Submission No 56 (May 2019) 18-21.
- 222 Royal Australasian College of Physicians, Submission No 47 (May 2019) 8; Positive Life NSW and HIV/AIDS Legal Centre, Submission No 82 (7 May 2019) 5; Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May

- 2019) 4-7; St Vincent's Health Australia, Submission No 127 (14 May 2019) 27-28; NSW Council of Civil Liberties, Submission No 70 (7 May 2019) 6-7; Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21-22.
- 223 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [8].
- 224 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4259.29-33 (Dr Jauncey).
- 225 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [10].
- 226 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4368.5-23 (Dr Read).
- 227 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4393.46-4394.4 (Bourque).
- 228 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4391.23-25 (Bourque).
- 229 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4394.4-7 (Bourque).
- 230 Lismore Hearing, Lismore, 14 May 2019, TS 709.22-33 (Dr Helliwell).
- 231 Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21.
- 232 Moree Hearing, Moree, 15 August 2019, Exhibit A, Tab 9, Statement of Roslyn Laws, 30 July 2019, [13].
- 233 George Christopher Dertadian and Stephen Tomsen, 'The case for a second safe injecting facility (SIF) in Sydney' (2019) *Current Issues in Criminal Justice* 1, 9.
- 234 George Christopher Dertadian and Stephen Tomsen, 'The case for a second safe injecting facility (SIF) in Sydney' (2019) *Current Issues in Criminal Justice* 1, 9.
- 235 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4260.26-31 (Dr Jauncey).
- 236 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4367.30-44 (Dr Read); Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) 21-22.
- 237 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 6-7.
- 238 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4260.26-9 (Dr Jauncey).
- 239 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4367.30-44 (Dr Read).
- 240 NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 11.
- 241 Closing submissions on behalf of the NSW Police Force, 11 November 2019, [75].
- 242 *Inquest into the death of DB, JD, DC, RG, AH and AB* (Findings of Deputy State Coroner Grahame, 1 March 2019) 42-43.
- 243 *Inquest into the death of Alan Bugden and Amaru Bestrin* (Findings of Deputy State Coroner Grahame, 17 December 2019) [214]-[216].
- 244 *Inquest into the death of Alan Bugden and Amaru Bestrin* (Findings of Deputy State Coroner Grahame, 17 December 2019) [212]-[213].
- 245 *Inquest into the death of Alan Bugden and Amaru Bestrin* (Findings of Deputy State Coroner Grahame, 17 December 2019) [217]-[219].
- 246 *Inquest into the death of Alan Bugden and Amaru Bestrin* (Findings of Deputy State Coroner Grahame, 17 December 2019) [227].
- 247 See Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 2-3.
- 248 Louise Geddes, Jenny Iversen and Lisa Maher, Kirby Institute, UNSW Sydney, *New South Wales Needle and Syringe Program Enhanced Data Collection* (Report, July 2018) 14.
- 249 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 8.
- 250 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [10].
- 251 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4449.4-21 (Maynard).
- 252 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [7].
- 253 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [10].
- 254 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4436.38-41 (Dr Chant).
- 255 For example, Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 4-5, 20-25; Harm Reduction Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September 2019, [5]; NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019); Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [8].
- 256 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5; Harm Reduction Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September 2019, [5].
- 257 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 4-5; NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 3.
- 258 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 15.
- 259 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [8].
- 260 Harm Reduction Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 9 September 2019, [5].
- 261 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 4-5.
- 262 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid Van Beek, 16 September 2019, [7].
- 263 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 30-31.
- 264 NSW Health, *Clinical Guidelines for the Management of Substance Use During the Pregnancy, Birth and the Postnatal Period*, (Summary Document, October 2014) 19.
- 265 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 13.
- 266 NSW Health, *Clinical Guidelines for the Management of Substance Use During the Pregnancy, Birth and the Postnatal Period*, (Summary Document, October 2014) 19.
- 267 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Expert report of Associate Professor Yvonne Bonomo, 17 September 2019, [11].
- 268 NSW Health, *Clinical Guidelines for the Management of Substance Use During the Pregnancy, Birth and the Postnatal Period*, (Summary Document, October 2014) 19; The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Substance use in pregnancy* (Guidelines, March 2018) 9.
- 269 NSW Health, *Clinical Guidelines for the Management of Substance Use During the Pregnancy, Birth and the Postnatal Period*, (Summary Document, October 2014) 19.
- 270 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 15.
- 271 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 13 December 2019, [8].

- 272 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [8]; Tendered in
Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Associate Professor Yvonne Bonomo, 17 September 2019, [11].
- 273 NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 13.
- 274 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Substance use in pregnancy* (Guidelines, March 2018) 9.
- 275 East Maitland Hearing, East Maitland, 20 June 2019, TS 2124.10-38 (Hewett).
- 276 East Maitland Hearing, East Maitland, Exhibit A, Tab 25, Statement of Catherine Hewett, 14 June 2019, 2.
- 277 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 4-5, 20-25; Harm Reduction
Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September 2019, [5]; NSW Users and AIDS
Association, Submission No 137 (undated, received 25 May 2019); Drug Policy Modelling Program, UNSW Sydney, Submission No
57 (7 May 2019) 15.
- 278 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 2; Uniting Medically Supervised Injecting
Centre, Submission No 117 (undated, received 10 May 2019) 5; Harm Reduction Hearing, Sydney, Harm Reduction Exhibit A, Tab
52, Statement of David Martyn Lloyd Jones, 10 September 2019 [5].
- 279 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5.
- 280 Harm Reduction Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September 2019, [5], 5.
- 281 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 30.
- 282 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 2.
- 283 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 11.
- 284 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 11.
- 285 NSW Health, *Clinical Guidelines for the Management of Substance Use During the Pregnancy, Birth and the Postnatal Period*
(Summary Document, October 2014), 19; NSW Health, *NSW Health Strategic Priorities 2019-20* (Publication, June 2019) 7, 10.
- 286 NSW Health, *Clinical Guidelines for the Management of Substance Use During the Pregnancy, Birth and the Postnatal Period*,
(Summary Document, October 2014) 19.
- 287 NSW Health, *NSW Health Strategic Priorities 2019-20* (Publication, June 2019) 7, 10.
- 288 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Associate Professor Yvonne Bonomo, 17 September
2019, [11]; The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Substance use in pregnancy*
(Guidelines, March 2018) 9; NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7
May 2019) 3.
- 289 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Substance use in pregnancy* (Guidelines,
March 2018) 9.
- 290 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [8].
- 291 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Associate Professor Yvonne Bonomo, 17 September
2019, [11].
- 292 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 30-31.
- 293 Harm Reduction Hearing, Sydney, 23 September 2019, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September
2019, [5].
- 294 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 30.
- 295 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 30-31.
- 296 Harm Reduction Hearing, Sydney, 23 September 2019, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September
2019, [5].
- 297 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5.
- 298 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 24.
- 299 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 682, Report of Associate Professor Yvonne Bonomo dated 17
September 2019, [11].
- 300 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid Van Beek, 16 September 2019, [7].
- 301 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 15.
- 302 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 4-5.
- 303 Harm Reduction Hearing, Sydney, Exhibit A, Tab 51, Statement of Kean-Seng Lim, 6 September 2019, [5].
- 304 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid Van Beek, 16 September 2019, [7].
- 305 Harm Reduction Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September 2019, [5].
- 306 Harm Reduction Hearing, Sydney, Exhibit A, Tab 19B, Statement of Acting Superintendent Michael John Cook 25 September 2019,
[8].
- 307 NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 7.
- 308 NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 1-16.
- 309 NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 8.
- 310 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 21-22.
- 311 Harm Reduction Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September, [5].
- 312 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [8].
- 313 NSW Government, *Report on the Statutory Review of Part 2A of the Drugs Misuse and Trafficking Act 1985* (NSW) (2016) 8.
- 314 Closing submissions on behalf of the NSW Police Force, 11 November 2019, [76].
- 315 *Children and Young Persons (Care and Protection) Act 1998* s 3.
- 316 Harm Reduction Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd Jones, 10 September 2019, [5].
- 317 The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 14; Penington Institute, Submission No 56 (May 2019) 20-21;
Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5-6; NSW Users and AIDS
Association, Submission No 137 (undated, received 25 May 2019) 11-12.
- 318 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4275.44-4276.15 (Hedrich).
- 319 European Harm Reduction Network, *Drug consumption rooms in Europe: Models, best practice and challenges* (Report, 2014) 13.
- 320 Sara Woods, European Harm Reduction Network, The Netherlands, *Drug Consumption Rooms in Europe: Organisational Review*
(Report, 2014) 17.

- 321 Anouk de Gee et al, Trimbos Instituut, *Drug Consumption Rooms in the Netherlands: 2018 Update* (Report, 2019) 18.
- 322 Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, *European report on drug consumption rooms* (February 2004) 20.
- 323 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4260.3-17 (Dr Jauncey); 25 September 2019, TS 4397.38-44 (Bourque).
- 324 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5.
- 325 Harm Reduction Hearing, Sydney, Exhibit A, Tab 1, Statement of Alison Ritter, 13 September 2019, [10].
- 326 Penington Institute, Submission No 56 (May 2019) 20-21.
- 327 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 12.
- 328 NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 11.
- 329 Harm Reduction Hearing, Sydney, Exhibit A, Tab 18, Statement of Rebecca McKetin, 10 September 2019 [4].
- 330 Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 5; See also Harm Reduction Hearing, Sydney Exhibit A, Tab 50, Statement of Ingrid van Beek, 16 September 2019 [4]; Harm Reduction Hearing, Sydney, 24 September 2019, TS 4372.26-30 (Dr Read).
- 331 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4394.9-16 (Bourque).
- 332 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4394.13-15 (Bourque).
- 333 Harm Reduction Hearing, Sydney, Exhibit A, Tab 49, ARCHES Lethbridge, *Interim Report: 28 February 2018 to 15 December 2018*, 9, 10.
- 334 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid van Beek, 16 September 2019, [3].
- 335 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid van Beek, 16 September 2019, [9].
- 336 Harm Reduction Hearing, Sydney, Exhibit A, Tab 50, Statement of Ingrid van Beek, 16 September 2019, [9].
- 337 Harm Reduction Hearing, Sydney, Exhibit A, Tab 14A, Statement of Phillip Read, 17 September 2019, [31].
- 338 'Supervised Consumption Services' ARCHES Lethbridge, (Web Page) <<https://lethbridgearches.com/get-help-scs/>>; Harm Reduction Hearing, Sydney, 25 September 2019, TS 4391.19 (Bourque).
- 339 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4391.23-6 (Bourque).
- 340 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4394.4-16 (Bourque).
- 341 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4391.17-22 (Bourque).
- 342 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4391.45-47 (Bourque).
- 343 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4391.28-34 (Bourque).
- 344 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4398.4-39 (Bourque).
- 345 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4392.18-26 (Bourque).
- 346 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019 [10]; see also Harm Reduction Hearing, Sydney, 23 September 2019, TS 4266.25-45 (Dr Jauncey).
- 347 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4312.12-27 (Dr Harrod).
- 348 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4374.14-21 (Dr Read).
- 349 Closing Submissions on behalf of Uniting Medically Supervised Injecting Centre, 1 November 2019, 1.
- 350 NSW Health, *Guidelines for Music Festival Event Organisers: Music Festival Harm Reduction* (December 2019) 4.
- 351 NSW Health, *Guidelines for Music Festival Event Organisers: Music Festival Harm Reduction* (December 2019) 4-5.
- 352 NSW Government, *Keeping People Safe at Music Festivals: Expert Panel Report* (October 2018) 2.
- 353 NSW Government, *Keeping People Safe at Music Festivals: Expert Panel Report* (October 2018) 2.
- 354 NSW Government, *Keeping People Safe at Music Festivals: Expert Panel Report* (October 2018) 1, 7-13.
- 355 NSW Government, *Keeping People Safe at Music Festivals: Expert Panel Report* (October 2018) 1, 13.
- 356 NSW Health, *Guidelines for Music Festival Event Organisers: Music Festival Harm Reduction* (December 2019) 1-29.
- 357 *Crimes Act 1900* (NSW) s 25C.
- 358 NSW Government, Submission No 143 (2019) 17-18.
- 359 NSW Health, *Guidelines for Music Festival Event Organisers: Music Festival Harm Reduction* (December 2019) 1-29.
- 360 Legislative Council Regulations Committee, Parliament of NSW, *Liquor Amendment (Music Festivals) Regulation 2019 and the Gaming and Liquor Administration Amendment (Music Festivals) Regulation 2019* (Report, 28 August 2019) vii-viii.
- 361 New South Wales, *Parliamentary Debates*, Legislative Council, 26 September 2019, 4-17.
- 362 See the Legislative Council Regulations Committee, Parliament of NSW, *Liquor Amendment (Music Festivals) Regulation 2019*.
- 363 *Music Festivals Act 2019* (NSW) s 5.
- 364 *Music Festivals Act 2019* (NSW) s 13.
- 365 *Music Festival Act 2019* (NSW) s 6(1)(f).
- 366 Legislative Council Regulations Committee, Parliament of NSW, *Liquor Amendment (Music Festivals) Regulation 2019 and the Gaming and Liquor Administration Amendment (Music Festivals) Regulation 2019* (Report, 28 August 2019) ix-x.
- 367 NSW Health, *Guidelines for Music Festival Event Organisers: Music Festival Harm Reduction* (December 2019) 21-24.
- 368 NSW Health, *Guidelines for Music Festival Event Organisers: Music Festival Harm Reduction* (December 2019) 15-18.
- 369 'Music Festival Harm Reduction', NSW Health (Web Page, 11 July 2019) <<https://www.health.nsw.gov.au/aod/Pages/music-festival-harm-reduction.aspx>>.
- 370 'About us', *Dancewize NSW* (Web Page) <<https://www.dancewizenw.org.au/about-us>>.
- 371 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 9-10.
- 372 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 99, Response of NSW Health dated 29 August 2019, to Request for Information dated 5 July 2019, 10.
- 373 Harm Reduction Hearing, Sydney, Exhibit A, Tab 81A, Statement of Erica Franklin, 28 June 2019, [9].
- 374 Harm Reduction Hearing, Sydney, Exhibit A, Tab 81A, Statement of Erica Franklin, 28 June 2019, [6].
- 375 Youth Roundtable (Private), Sydney, 1 April 2019, TS 20.36-21.1; 22.16-30; 24.27-42 (P4, P7, P1, P3).
- 376 Sydney (General) Hearing, Sydney, 8 May 2019, TS 182.6-27 (Dr Harrod).

- 377 Harm Reduction Hearing, Sydney, Exhibit A, Tab 15, Statement of Nadine Ezard to the Coronial Inquest into Music Festival Deaths, 31 May 2019, [5].
- 378 Harm Reduction Hearing, Sydney, Exhibit A, Tab 15, Statement of Nadine Ezard to the Coronial Inquest into Music Festival Deaths, 31 May 2019, [5].
- 379 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam and Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 135-137.
- 380 NSW Government, Detailed Summary of Response to the *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam and Alexandra Ross-King* (Response, 11 December 2019) 12-13; NSW Government, 'Drug amnesty bins for music festivals,' (Media Release, 11 December 2019).
- 381 Fiona Measham, 'Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking' service' (2019) 67 *International Journal of Drug Policy* 102.
- 382 See Monica Barratt et al, Drug Policy Modelling Program, UNSW Sydney, *Global review of drug checking services operating in 2017* (Bulletin No 24, 2018) 3-4, 6-7; Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison (2011) 3(9) *Drug Testing Analysis* 621, 622-623; Gino Vumbaca et al, Pill Testing Australia, *Report on the 2nd ACT GTM Pill Testing Pilot: a Harm Reduction Service* (August 2019) 8-9, 11-12; Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 2-3, 10.
- 383 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4325.34-4326.4 (van der Gouwe); Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 2-3, 10.
- 384 Monica Barratt et al, Drug Policy Modelling Program, UNSW Sydney, *Global review of drug checking services operating in 2017* (Bulletin No 24, 2018) 6.
- 385 Harm Reduction Hearing, Sydney, Exhibit A, Tab 95C, Claudine Lyons Consulting, *Drug Checking Models: Revised Rapid Review - Prepared for NSW Ministry of Health* (Report, July 2019), 5; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 8-9.
- 386 Harm Reduction Hearing, 24 September 2019, TS 4279.43-46 (Pirona).
- 387 Harm Reduction Hearing, Sydney, Exhibit A, Tab 1, Statement of Alison Ritter, 13 September 2019, [11].
- 388 Harm Reduction Hearing, Sydney, Exhibit A, Tab 1, Statement of Alison Ritter, 13 September 2019, [11].
- 389 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4218.6-9 (Vumbaca).
- 390 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4327.41-4328.3 (van der Gouwe).
- 391 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4328.8-25 (van der Gouwe).
- 392 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4328.33-38 (van der Gouwe).
- 393 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4423.11-29 (Dr Chant).
- 394 Harm Reduction Hearing, Sydney, Exhibit A, Tab 95.1, *Coronial Inquest into Music Festival Deaths*, 19 September 2019, TS 1317.49-1318.38 (Dr Chant).
- 395 Harm Reduction Hearing, Sydney, Exhibit A, Tab 19B, Statement of Acting Superintendent Michael John Cook, 25 September 2019, [6].
- 396 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4218.17-4219.25 (Dr Caldicott).
- 397 See Harm Reduction Hearing, Sydney, 23 September 2019, TS 4220.39-4221.5 (Dr Caldicott).
- 398 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4219.1-8 (Dr Caldicott).
- 399 Harm Reduction Hearing, Exhibit A, Tab 101, Lane Harper, Jeff Powell, Em M Pijl, 'An overview of forensic drug testing methods and their suitability for harm reduction point-of-care services' (2017) 14(52) *Harm Reduction Journal* 1, 9.
- 400 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4219.8-11 (Dr Caldicott).
- 401 Monica Barratt et al, Drug Policy Modelling Program, UNSW Sydney, *Global review of drug checking services operating in 2017* (Bulletin No 24, 2018) 4.
- 402 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4219.13-14 (Dr Caldicott).
- 403 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13B, *Coronial Inquest into Music Festival Deaths*, 10 September 2019, TS 970.1-971.23 (Dr Caldicott); Monica Barratt et al, Drug Policy Modelling Program, UNSW Sydney, *Global review of drug checking services operating in 2017* (Bulletin No 24, 2018) 4.
- 404 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4219.23-7 (Dr Caldicott).
- 405 Harm Reduction Hearing, Sydney, Exhibit A, Tab 95C, Claudine Lyons Consulting, *Drug Checking Models: Revised Rapid Review - Prepared for NSW Ministry of Health*, (Report, July 2019), 4, 10.
- 406 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4218.27-36 (Dr Caldicott); TS 4326.39-41 (van der Gouwe); see also Harm Reduction Hearing, Sydney, Exhibit A, Tab 19, Expert Opinion of John Lewis produced for the *Coronial Inquest into Music Festival Deaths*, 27 May 2019, [2].
- 407 Harm Reduction Hearing, Sydney, Exhibit A, Tab 19, Expert Opinion of John Lewis produced for the *Coronial Inquest into Music Festival Deaths*, 27 May 2019, [2]; see also Harm Reduction Hearing, Sydney, 23 September 2019, TS 4241.32-36 (Dr Caldicott).
- 408 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4226.17-34 (Dr Caldicott).
- 409 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [5].
- 410 Harm Reduction Hearing, Sydney, Exhibit A, Tab 53A, *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam and Alexandra Ross-King*, Lidcombe, 12 September 2019, TS 1176.36-1177.20; Tab 55, Statement of Michelle Williams, 3-4.
- 411 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [5].
- 412 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4220.21-34 (Dr Caldicott).
- 413 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [5].
- 414 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 701, Brief of Evidence – Volume 24, Tab 75, Statement of Andrew Leibie to the *Coronial Inquest into Music Festival Deaths*, 22 June 2019, 4-5.
- 415 Harm Reduction Hearing, Sydney, Exhibit A, Tab 19, Expert Opinion of John Lewis produced for the *Coronial Inquest into Music Festival Deaths*, 27 May 2019 [2].

- 416 Harm Reduction Hearing, Sydney, Exhibit A, Tab 108, Pill Testing Australia, *Report on the 2nd ACT GTM Pill Testing Pilot: A Harm Reduction Service* (August 2019) [12]. See also T Makkai et al Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: A Harm Reduction Service* (June 2018) 1, 12.
- 417 Gino Vumbaca, 'Harm Reduction Australia and Pill Testing Australia: A message to all parliamentarians (Media Release, 2 September 2019).
- 418 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 14, 20, 22.
- 419 See Drug Free Australia, 'Onsite pill testing was unable to identify most drugs' (Media Release, 21 July 2019).
- 420 Gino Vumbaca, 'Harm Reduction Australia and Pill Testing Australia: A message to all parliamentarians (Media Release, 2 September 2019).
- 421 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 20.
- 422 Gino Vumbaca, 'Harm Reduction Australia and Pill Testing Australia: A message to all parliamentarians (Media Release, 2 September 2019).
- 423 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [5].
- 424 Australian Criminal Intelligence Commission, Submission No 149 (7 June 2019) 28.
- 425 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4343.35-4344.4 (Dr Lewis).
- 426 Harm Reduction International, *Drug Checking Services: Global State of Harm Reduction* (Briefing Paper, 2018) 2.
- 427 European Monitoring Centre for Drugs and Drug Addiction, *An Inventory of on-site pill testing interventions in the EU* (Scientific Report, 2001) 1, 11; Harm Reduction Hearing, Sydney, 23 September 2019, TS 4208.30-4 (Professor McKetin).
- 428 Harm Reduction International, *Drug Checking Services: Global State of Harm Reduction* (Briefing Paper, 2018) 2.
- 429 Harm Reduction Hearing, Sydney, Exhibit A, Tab 108, Pill Testing Australia, *Report on the 2nd ACT GTM Pill Testing Pilot: A Harm Reduction Service* (August 2019) 7.
- 430 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4230.26-8 (Dr Caldicott).
- 431 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4221.1-5 (Dr Caldicott).
- 432 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [5].
- 433 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4220.5-9 (Dr Caldicott).
- 434 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4231.24-7 (Vumbaca).
- 435 St Vincent's Health Australia, Submission No 127 (14 May 2019) 30).
- 436 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4231.124-27 (Vumbaca).
- 437 Niamh Day et al, 'Music festival attendees' illicit drug use, knowledge and practices regarding drug content and purity: a cross sectional survey' (2018) 15(1) *Harm Reduction Journal* 1, 4.
- 438 Niamh Day et al, 'Music festival attendees' illicit drug use, knowledge and practices regarding drug content and purity: a cross sectional survey' (2018) 15(1) *Harm Reduction Journal* 1, 4.
- 439 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4232.36-4233.8 (Dr Caldicott); 24 September 2019, TS 4326.14-16 (van der Gouwe).
- 440 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4231.16-22 (Dr Caldicott).
- 441 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4316.38-42 (Dr Harrod).
- 442 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4240.28-41 (Dr Caldicott and Vumbaca).
- 443 'On-site Drug Safety Testing' *The Loop* (Web Page) <<https://wearetheloop.org/testing>>.
- 444 Harm Reduction Hearing, Sydney, Exhibit A, Tab 53B, *Coronial Inquest into Music Festival Deaths*, 19 September 2019, TS 1360.17-44 (Professor Measham); Fiona Measham, 'Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking' service' (2019) 67 *International Journal of Drug Policy* 102.
- 445 Royal Society for Public Health, *Drug safety testing at festivals and night clubs* (Report, June 2017) 1.
- 446 Fiona Measham, 'Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking' service' (2019) 67 *International Journal of Drug Policy* 102, 104.
- 447 Harm Reduction Hearing, Sydney, Exhibit A, Tab 53B, *Coronial Inquest into Music Festival Deaths*, 19 September 2019, TS 1362.4-9 (Professor Measham).
- 448 Fiona Measham, 'Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking' service' (2019) 67 *International Journal of Drug Policy* 102, 106.
- 449 'About Us' *The Loop* (Web Page) <<https://wearetheloop.org/about-the-loop>>.
- 450 Monica Barratt et al, Drug Policy Modelling Program, UNSW Sydney, *Global review of drug checking services operating in 2017* (Bulletin No 24, 2018) 6-7; Harm Reduction Hearing, Sydney, Exhibit A, Tab 53B, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 19 September 2019, TS 1364.44-1365.8 (Professor Measham).
- 451 Harm Reduction Hearing, Sydney, Exhibit A, Tab 53B, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 19 September 2019, TS 1368.20-26 (Measham).
- 452 Harm Reduction Hearing, Sydney, Exhibit A, Tab 53B, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 19 September 2019, TS 1372.38-1373.1 (Professor Measham).
- 453 Harm Reduction Hearing, Sydney, Exhibit A, Tab 53B, *Coronial Inquest into Music Festival Deaths*, 19 September 2019, TS 1372.38-1373.1 (Professor Measham); Tab 53C, Report of Amira Guirguis to the *Coronial Inquest into Music Festival Deaths*, 27 May 2019, 5.
- 454 Tom Tilley, 'Could this wheelee bin be the solution to the pill testing stalemate?', *ABC News* (online, 8 November 2019) <<https://www.abc.net.au/news/2019-09-17/a-solution-to-the-pill-testing-stalemate/11511652>>; 'Testing Times', *Foreign Correspondent* (Australian Broadcasting Corporation, 2019) 00:17:00-00:17:30 <<https://www.abc.net.au/foreign/testing-times/11520778>>.
- 455 @WeAreTheLoopUK, Twitter (The Loop) (Twitter, 10 June 2018, 6.41pm GMT) <https://twitter.com/WeAreTheLoopUK/status/1005731716575715328?ref_src=twsrc%5Etfw>.
- 456 Australian Criminal Intelligence Commission, Submission No 149 (7 June 2019) 27-28; Tibor Brunt, European Monitoring Centre for Drugs and Addiction, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges* (Background

- Paper, 30 October 2017); 7; Harm Reduction Hearing, Sydney, Exhibit A, Tab 19, Expert Report of John Lewis, 29 August 2019, 4-6.
- 457 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4230.26-8 (Dr Caldicott).
- 458 Tibor Brunt, European Monitoring Centre for Drugs and Addiction, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges* (Background Paper, 30 October 2017) 7, 10.
- 459 Monica J Barratt et al, 'Pill testing or drug checking in Australia: Acceptability of service design features' (2018) 37(2) *Drug and Alcohol Review* 37, 226, 227.
- 460 Harm Reduction Hearing, Sydney, Exhibit A, Tab 36, Annexure 3 - Trimbos Instituut, 'The Drugs Information and Monitoring System (DIMS): Factsheet on drug checking in the Netherlands', April 2019, 10.
- 461 Monica Barratt et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Profiles of drug checking services operating in 2017* (Drug Policy Modelling Program Bulletin No 24, 2018) 1.
- 462 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 3.
- 463 Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison (2011) 3(9) *Drug Testing Analysis* 621, 621.
- 464 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 10.
- 465 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 3.
- 466 Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison (2011) 3(9) *Drug Testing Analysis* 621, 628-629.
- 467 Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison (2011) 3(9) *Drug Testing Analysis* 621, 628-630.
- 468 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4325.13-14 (van der Gouwe).
- 469 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 3-4.
- 470 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 11.
- 471 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 4, citing College van Procureurs-Generaal, maart 2002, reg.nr. 20021004.
- 472 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4325.15-23, 4325.44-4326.8 (van der Gouwe); Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison (2011) 3(9) *Drug Testing Analysis* 621, 622.
- 473 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4326.33-47 (van der Gouwe).
- 474 Daan van der Gouwe, Trimbos Instituut, *Annual Report 2018: Drug Information and Monitoring System (DIMS)* (2019) 2; Harm Reduction Hearing, Sydney, 24 September 2019, TS 4326.25-47 (van der Gouwe).
- 475 Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison (2011) 3(9) *Drug Testing Analysis* 621, 623-624.
- 476 Daan van der Gouwe, Trimbos Instituut, *Annual Report 2018: Drug Information and Monitoring System (DIMS)* (2019) 1.
- 477 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 8.
- 478 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 9.
- 479 Monica Barratt et al, Drug Policy Modelling Program, UNSW Sydney, *Global review of drug checking services operating in 2017* (Bulletin No 24, 2018) 2, 4.
- 480 Monica Barratt et al, Drug Policy Modelling Program, UNSW Sydney, *Global review of drug checking services operating in 2017* (Bulletin No 24, 2018) 4.
- 481 Adam R Winstock et al, *Global Drug Survey (GDS) 2019 Key Findings Report* (16 May 2019).
- 482 Monica Barratt et al, Drug Policy Modelling Program, UNSW Sydney, *Global review of drug checking services operating in 2017* (Bulletin No 24, 2018) 7.
- 483 Harm Reduction Hearing, Sydney, Exhibit A, Tab 95C, Claudine Lyons Consulting, *Drug Checking Models: Revised Rapid Review - Prepared for NSW Ministry of Health*, (Report, July 2019) 6.
- 484 Harm Reduction Hearing, Sydney, Exhibit A, Tab 108, Pill Testing Australia, *Report on the 2nd ACT GTM Pill Testing Pilot: A Harm Reduction Service* (August 2019) 7-9.
- 485 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 12.
- 486 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 1.
- 487 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 1.
- 488 Harm Reduction Hearing, Sydney, Exhibit A, Tab 108, Pill Testing Australia, *Report on the 2nd ACT GTM Pill Testing Pilot: A Harm Reduction Service* (August 2019) 10.
- 489 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the Coronial Inquest into Music Festival Deaths, 26 June 2019, [5].
- 490 See T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 8-12.
- 491 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 33.
- 492 See T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 33.
- 493 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 8-9.
- 494 St Vincent's Health Australia, Submission No 127 (14 May 2019) 30.

- 495 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 29.
- 496 St Vincent's Health Australia, Submission No 127 (14 May 2019) 30.
- 497 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 25-26.
- 498 Harm Reduction Hearing, Sydney, Exhibit A, Tab 108, Pill Testing Australia, *Report on the 2nd ACT GTM Pill Testing Pilot: A Harm Reduction Service* (August 2019) 7.
- 499 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 8.
- 500 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 8.
- 501 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 9.
- 502 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 9.
- 503 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 9.
- 504 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 8, 44.
- 505 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 26.
- 506 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 27.
- 507 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 27.
- 508 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 27.
- 509 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 28.
- 510 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 28-29.
- 511 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 37.
- 512 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 37.
- 513 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 31.
- 514 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 31.
- 515 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 32.
- 516 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 32.
- 517 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 32.
- 518 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 32.
- 519 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 32.
- 520 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 33.
- 521 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 33.
- 522 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4220.24-34 (Dr Caldicott).
- 523 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [7].
- 524 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 34.
- 525 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 34.
- 526 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 34.
- 527 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 35.
- 528 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 36.
- 529 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 42.
- 530 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 42.
- 531 Harm Reduction Hearing, Sydney, Exhibit A Tab 15, Statement of Nadine Ezard to the *Coronial Inquest into Music Festival Deaths*, 31 May 2019, [5]; Laura Smit-Rigter and Daan van der Gouw, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 3.

- 532 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [3]; Harm Reduction Hearing, Sydney, 23 September 2019, TS 4224.9-43 (Dr Caldicott); 24 September 2019, TS 4279.34-4280.9 (Pirona); Tab 15, Statement of Nadine Ezard *Coronial Inquest into Music Festival Deaths*, 31 May 2019, [5]; Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 3; Harm Reduction Hearing, Sydney, Exhibit A, Tab 7, Statement of Alison Ritter to the *Coronial Inquest into Music Festival Deaths*, 21 May 2019, 2; Harm Reduction Hearing, Sydney, Exhibit A, Tab 9, Statement of Gino Vumbaca to the *Coronial Inquest into Music Festival Deaths*, 12 May 2019, 1,2,5.
- 533 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4325.25-26 (van der Gouwe); TS 4279.43-46 (Pirona); Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (2019) 3; Harm Reduction Hearing, Sydney, Exhibit A, Tab 7, Statement of Alison Ritter to the *Coronial Inquest into Music Festival Deaths*, 21 May 2019, 4.
- 534 Andrew Groves, 'Worth the test?' Pragmatism, pill testing and drug policy in Australia,' (2018) 15(2) *Harm Reduction Journal* 1, 2-3.
- 535 Tom Gotsis, Chris Angus, and Lenny Roth, 'Illicit drug use and possession: Current policy and debates' (Briefing Paper No 4, NSW Parliamentary Research Service, August 2016) 55, citing the Department of Health and Ageing, *Drug Testing Kits: Detailed discussion paper on social, health and legal issues* (2005) 32.
- 536 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4227.17-27 (Dr Caldicott).
- 537 Monica Barratt and Rachel Sutherland, National Drug & Alcohol Research Centre, UNSW Sydney, *Paramethoxyamphetamine (PMA)* (Fact Sheet, 2016).
- 538 Harm Reduction Hearing, Sydney, Exhibit A, Tab 108, Pill Testing Australia, *Report on the 2nd ACT GTM Pill Testing Pilot: A Harm Reduction Service* (August 2019) 12.
- 539 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13A, *Coronial Inquest into Music Festival Deaths*, 12 July 2019, TS 370.9-16 (Dr Caldicott).
- 540 Drug Free Australia, *Why have pill testing when most ecstasy deaths are from normal doses of MDMA?* (Report, 2019) 1, 3, 33.
- 541 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4341.32-37 (Dr Lewis).
- 542 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King*, (Findings of Deputy State Coroner Grahame, 8 November 2019) [66].
- 543 Sharlene Kaye, Shane Darke and Johan Dufflou, 'Methylenedioxymethamphetamine (MDMA) related fatalities in Australia: Demographics, circumstances, toxicology and major organ pathology' (2009) 104(3) *Drug and Alcohol Dependence* 254.
- 544 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13A, *Coronial Inquest into Music Festival Deaths*, 12 July 2019, TS 372.48, 373.8 (Dr Caldicott).
- 545 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13A, *Coronial Inquest into Music Festival Deaths*, 12 July 2019, TS 372.50-373.6 (Dr Caldicott).
- 546 Shane Darke, Sharlene Kaye and Johan Dufflou, 'Characteristics and circumstances of death related to new psychoactive stimulants and hallucinogens in Australia' (2019) 204 *Drug and Alcohol Dependence* 1.
- 547 Harm Reduction Hearing, Sydney, Exhibit A, Tab 108, Pill Testing Australia, *Report on the 2nd ACT GTM Pill Testing Pilot: A Harm Reduction Service* (August 2019).
- 548 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4208.40-4209.34 (Professor McKetin).
- 549 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4409.24-29 (Professor Kerr); 24 September 2019, TS 4299.36-38 (Professor Ezard).
- 550 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4302.12-38 (Professor Ezard); Australasian Chapter of Addiction Medicine of the Royal College of Physicians, Preliminary Submission No 85 (31 January 2019) 1.
- 551 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4281.26-29 (Pirona); 24 September 2019, TS 4328.33-4329.11 (van der Gouwe).
- 552 Sydney (General) Hearing, Sydney, 7 May 2019, TS 44.4-5 (Professor Farrell).
- 553 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4280.19-22 (Pirona).
- 554 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4231.42-4233.12 (Vumbaca and Dr Caldicott), TS 4240.7-26 (Vumbaca and Dr Caldicott); Penington Institute, Submission No 56 (May 2019) 19.
- 555 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [7]; Harm Reduction Hearing, Sydney, Exhibit A, Tab 7, Statement of Alison Ritter to the *Coronial Inquest into Music Festival Deaths*, 21 May 2019, 3.
- 556 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4224.21-31 (Dr Caldicott).
- 557 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4217.32-33 (Dr Caldicott).
- 558 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [3].
- 559 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4326.6-12 (van der Gouwe).
- 560 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13A, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 12 July 2019, TS 373.8-16 (Dr Caldicott).
- 561 Harm Reduction Hearing, Sydney, Exhibit A, Tab 72A, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 19 July 2019, TS 936.30-31 (Dr Bright).
- 562 Harm Reduction Hearing, Sydney, Exhibit A, Tab 72A, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 19 July 2019, TS 936.31-36 (Dr Bright).
- 563 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4224.1-7 (Dr Caldicott); 24 September 2019, TS 4316.17-34 (Dr Harrod).
- 564 Harm Reduction Hearing, Sydney, Exhibit A, Tab 72A, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 19 July 2019, TS 928.4-6 (Dr Bright).
- 565 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4224.1-4 (Dr Caldicott).
- 566 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4242.32-37 (Dr Caldicott).
- 567 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [3].

- 568 Harm Reduction Hearing, Sydney, Exhibit A, Tab 95C, Claudine Lyons Consulting, *Drug Checking Models: Revised Rapid Review - Prepared for NSW Ministry of Health*, (Report, July 2019), 5-6; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 8-9.
- 569 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 44.
- 570 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 22.
- 571 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) [47].
- 572 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) [58].
- 573 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 8-9.
- 574 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4225.6-28 (Dr Caldicott).
- 575 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4226.1-9 (Dr Caldicott).
- 576 Laura Smit-Rigter and Daan van der Gouwe, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019) 7, 10.
- 577 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4229.24-4230.33 (Dr Caldicott).
- 578 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4341.9-14 (Dr Lewis).
- 579 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4226.17-4227.8 (Dr Caldicott).
- 580 Harm Reduction Hearing, Sydney, 24 September 2019, T 4289.34-42 (Professor Ezard).
- 581 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4289.46-4293.37 (Professor Ezard).
- 582 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4297.42-4298.20 (Professor Ezard).
- 583 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4298.20-4299.42 (Professor Ezard).
- 584 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4297.42-4298.44 (Professor Ezard); St Vincent's Health Australia, Submission No 127 (14 May 2019) 31.
- 585 See, for example, Laura Hondebrink, et al, 'Monitoring new psychoactive substances (NPS) in the Netherlands: Data from the drug market and the Poisons Information Centre' (2015) 147 *Drug and Alcohol Dependence* 109; Harm Reduction Hearing, Sydney, 24 September 2019, TS 4281.15-29 (Pirona); St Vincent's Health Australia, Submission No 127 (14 May 2019) 31.
- 586 European Monitoring Centre for Drugs and Drug Addiction, *An Inventory of on-site pill testing interventions in the EU* (Scientific Report, 2001) 11, 15.
- 587 Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison (2011) 3(9) *Drug Testing Analysis* 621, 622.
- 588 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4279.34-4280.4, 4281.15-29 (Pirona); 23 September 2019, TS 4238.35-4239.2 (Dr Caldicott).
- 589 Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison (2011) 3(9) *Drug Testing Analysis* 621, 628-629.
- 590 *Inquest into the death of DB, JD, DC, RG, AH and AB* (Findings of Deputy State Coroner Grahame, 1 March 2019) 37, [158].
- 591 *Inquest into the death of DB, JD, DC, RG, AH and AB* (Findings of Deputy State Coroner Grahame, 1 March 2019) 43, [13].
- 592 Harm Reduction Hearing, Sydney, Exhibit A, Tab 73, Joint Report of David McCutcheon and Jessamine Sodersrom to the *NSW Coronial Inquest into Music Festival Deaths* dated 28 June 2019, 9.
- 593 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4423.22-45 (Dr Chant).
- 594 Harm Reduction Hearing, Sydney, Exhibit A, Tab 73, Joint Report of David McCutcheon and Jessamine Soderstrom, 28 June 2019, 11-12.
- 595 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4405.14-19 (Professor Kerr).
- 596 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4424.12-24 (Dr Chant).
- 597 National Centre for Clinical Research on Emerging Drugs, Submission No 123 (14 May 2019) 7.
- 598 NSW Health, 'Drug warning – Variable dose and high dose MDMA tablets/capsules' (Media Release, 12 December 2019) <<https://www.health.nsw.gov.au/aod/Pages/drug-warning-mdma.aspx>>.
- 599 NSW Health, 'Warning over deadly "LEGO" ecstasy pills', (Media Release, 28 December 2019) <https://www.health.nsw.gov.au/news/Pages/20191228_00.aspx>.
- 600 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4171.1-36 (Professor Ritter).
- 601 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4171.11-23 (Professor Ritter).
- 602 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4171.36-44 (Professor Ritter).
- 603 Alison Ritter, 'Making drug policy in summer- drug checking in Australia as providing more heat than light' (2019) *Drug and Alcohol Review*, *Australian Professional Society on Alcohol and other Drugs* 1.
- 604 See, for example, Harm Reduction Hearing, Sydney, Exhibit A, Tab 7, Statement of Alison Ritter to *Coronial Inquest into Music Festival Deaths*, 21 May 2019, 10.
- 605 Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 6.
- 606 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 9.
- 607 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4232.32-34 (Vumbaca).
- 608 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 9.
- 609 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4245.43-45 (Vumbaca).
- 610 Harm Reduction Hearing, Sydney, Exhibit A, Tab 19, Expert Report of John Lewis to the *Special Commission of Inquiry into the Drug 'Ice'*, 29 August 2019, 6.
- 611 Harm Reduction Hearing, Sydney, Exhibit A, Tab 19, Expert Report of John Lewis prepared to the *Special Commission of Inquiry into the Drug 'Ice'*, 29 August 2019, 4, 5.
- 612 Sharlene Kaye, Shane Darke and Johan Dufou, 'Methylenedioxymethamphetamine (MDMA) related fatalities in Australia: Demographics, circumstances, toxicology and major organ pathology' (2009) 104(3) *Drug and Alcohol Dependence* 254.

- 613 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 132-134.
- 614 Drug Free Australia, *Why have pill testing when most ecstasy deaths are from normal doses of MDMA?* (Report, 2019) 1, 13.
- 615 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13A, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 12 July 2019, TS 373.3-6 (Dr Caldicott).
- 616 Australian Criminal Intelligence Committee, Submission No 149 (undated, received 4 July 2019) 28.
- 617 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4242.32-37 (Dr Caldicott).
- 618 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4220.21-34 (Dr Caldicott); Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [7]; Tab 95C, Claudine Lyons Consulting, *Drug Checking Models: Revised Rapid Review - Prepared for NSW Ministry of Health*, (Report, July 2019) 29; Tab 100, Tibor M Brunt et al, 'Drug testing in Europe: monitoring results of the Trans European Drug Information (TEDI) project' (2017) 9 *Drug Testing and Analysis* 188, 190; Tab 101, Lane Harper, Jeff Powell and Em M Piji, 'An overview of forensic drug testing methods and their suitability for harm reduction point-of-care services' (2017) 14(52) *Harm Reduction Journal* 3.
- 619 Harm Reduction Hearing, Sydney, Exhibit A, Tab 1, Statement of Alison Ritter, 13 September 2019, [11].
- 620 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 34.
- 621 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 22.
- 622 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4281.42-4282.2 (Pirona).
- 623 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4281.42-4282.2 (Pirona).
- 624 Harm Reduction Hearing, Sydney, Exhibit A, Tab 71, Statement of Stephen Bright to the *Coronial Inquest into Music Festival Deaths*, 27 May 2019, [2].
- 625 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [5].
- 626 T Makkai et al, Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (June 2018) 33.
- 627 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 9.
- 628 Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 17.
- 629 Harm Reduction Hearing, Sydney, Exhibit A, Tab 53A, *Coronial Inquest into Music Festival Deaths*, Lidcombe, 12 September 2019 (Professor Lee) TS 1145.17-18.
- 630 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4341.44-4342.1 (Dr Lewis).
- 631 Helena Valente et al, 'Evaluation of a drug checking service at a large scale electronic music festival in Portugal' (2019) 73 *International Journal of Drug Policy* 88, 88.
- 632 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4282.4-11 (Pirona); Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 7-8.
- 633 NSW Government, *NSW Government response to the Coroner's Inquest into the deaths of six patrons of NSW music festivals* (Table, received 11 December 2019) 1.
- 634 Closing submissions on behalf of the NSW Police Force, 11 November 2019, [70].
- 635 Harm Reduction Hearing, Sydney, Exhibit A, Tab 19B, Statement of Michael Cook, 25 September 2019, [2].
- 636 See, for example, Australian Medical Association (NSW), Submission No 121 (14 May 2019) 5; Harm Reduction Hearing, Sydney, Exhibit A, Tab 51, Statement of Kean-Seng Lim, 6 September 2019, 2, 3; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 9; Harm Reduction Hearing, Sydney, Exhibit A, Tab 52, Statement of David Martyn Lloyd-Jones, 10 September 2019, [5]; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [6]; Australasian College for Emergency Medicine, Submission No 52 (May 2019) 5; NSW Young Lawyers Criminal Committee, Submission No 124 (12 May 2019) 4; The Public Defenders, Submission No 12 (12 April 2019) 4; St Vincent's Health Australia, Submission No 127 (14 May 2019) 29; Uniting NSW/ACT, Submission No 95 (7 May 2019) 2-4; National Drug & Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 17-18; NSW Users and AIDS Association, Submission No 137 (undated, received 25 May 2019) 13-14; Alcohol and Drug Foundation, Submission No 78 (7 May 2019) 22-23; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 16-17; Penington Institute, Submission No 56 (May 2019) 18-21; National Drug Research Institute, Curtin University, Submission No 48 (May 2019) 8; Harm Reduction Australia, Submission No 37 (5 May 2019) 2; Robin Butterfield et al, 'Drug checking to improve monitoring of new psychoactive substances in Australia' (2016) 204(4) *Medical Journal of Australia* 144, 145; Joseph Palamar and Monica Barratt, 'Prevalence of reagent test-kit use and perceptions of purity among ecstasy users in an electronic dance music scene in New York City' (2018) 38(1) *Drug and Alcohol Review* 42, 48; Tibor Brunt, European Monitoring Centre for Drugs and Addiction, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges* (Background Paper, 30 October 2017); Fiona Measham, 'Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking; service'' (2019) 67 *International Journal of Drug Policy*, 102; Tibor M Brunt and Raymond J M Niesink, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results and international comparison' (2011) 3(9) *Drug Testing Analysis* 621; Laura Smit-Rigter and Daan van der Gouw, Trimbos Instituut, *The Drugs Information and Monitoring System (DIMS)* (Factsheet, April 2019); Helena Valente et al, 'Evaluation of a drug checking service at a large scale electronic music festival in Portugal' (2019) 73 *International Journal of Drug Policy* 88, 88.
- 637 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 6.
- 638 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 42.
- 639 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 42.
- 640 Anna Olsen, Gabriel Wong and David McDonald, Australian National University, *ACT Pill Testing Trial 2019: Program evaluation* (Report, December 2019) 42.
- 641 Harm Reduction Hearing, Sydney, Exhibit A, Tab 68, Statement of Robert Page to the *Coronial Inquest into Music Festival Deaths* (22 May 2019), [3]; Tab 71, Statement of Stephen Bright, Statement to the *Coronial Inquest into Music Festival Deaths* (27 May 2019) 9.
- 642 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam, Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) [517].
- 643 Monica J Barratt et al, 'Pill testing or drug checking in Australia: Acceptability of service design features' (2018) 37(2) *Drug and Alcohol Review*, 226, 227.

- 644 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4224.29-30 (Dr Caldicott); TS 4232.27-42 (Vumbaca); 24 September 2019, TS 4316.36-37 (Dr Harrod).
- 645 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4240.13-23 (Dr Caldicott).
- 646 Joseph Palamar and Monica Barratt, 'Prevalence of reagent test-kit use and perceptions of purity among ecstasy users in an electronic dance music scene in New York City' (2018) 38(1) *Drug and Alcohol Review* 42; Fermin Fernandez-Calderon et al, 'Harm reduction strategies related to dosing and their relation to harms among music festival attendees who use multiple drugs' (2019) 38(1) *Drug Alcohol Review* 55.
- 647 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4241.23-25 (Dr Caldicott).
- 648 Amy Peacock et al, National Drug & Alcohol Research Centre, UNSW Sydney, *Drug checking ("pill testing") and behavioural responses by people who use drugs in Australia* (Drugs Trends Bulletin Series, 2019).
- 649 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4226.27, 4218.17-25 (Dr Caldicott).
- 650 Harm Reduction Hearing, Sydney, 24 September 2019, TS 4353.45 (Dr Lewis).
- 651 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4218.22-25 (Dr Caldicott).
- 652 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4218.18-21 (Gino Vumbaca).
- 653 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4241.35-36 (Dr Caldicott).
- 654 Youth Roundtable (Private), Sydney, 1 April 2019, TS 41.12 (P4).
- 655 Harm Reduction Hearing, Sydney, Exhibit A, Tab 51, Statement of Kean-Seng Lim, 6 September 2019, 2, 3; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 9; Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [6]; Australasian College for Emergency Medicine, Submission No 52 (May 2019) 5; St Vincent's Health Australia, Submission No 127 (14 May 2019) 29-31.
- 656 Uniting NSW/ACT, Submission No 95 (7 May 2019) 2.
- 657 St Vincent's Health Australia, Submission No 127 (14 May 2019) 29.
- 658 St Vincent's Health Australia, Submission No 127 (14 May 2019) 30.
- 659 Harm Reduction Hearing, Sydney, Exhibit A, Tab 51, Statement of Kean-Seng Lim, 6 September 2019, 2, 3.
- 660 Harm Reduction Hearing, Sydney, Exhibit A, Tab 51, Statement of Kean-Seng Lim, 6 September 2019, 2.
- 661 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 8.
- 662 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 9.
- 663 The Royal Australasian College of Physicians, Submission No 47 (May 2019) 9.
- 664 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [6].
- 665 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [6].
- 666 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [6].
- 667 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 641, Statement of Charlotte Hespe, 9 October 2019, [6].
- 668 Harm Reduction Hearing, Sydney, Exhibit A, Tab 53, Statement of Chris Trethewy, 29 August 2019, [10].
- 669 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam and Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 135.
- 670 *Inquest into the deaths of six patrons of NSW music festivals, Hoang Nathan Tran, Diana Nguyen, Joseph Pham, Callum Brosnan, Joshua Tam and Alexandra Ross-King* (Findings of Deputy State Coroner Grahame, 8 November 2019) 138.
- 671 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4178.31-4179.7 (Professor Ritter); Harm Reduction Hearing, Exhibit A, Tab 7, Statement of Alison Ritter to the *Coronial Inquest into Music Festival Deaths*, 21 May 2019, 3.
- 672 See St Vincent's Health Australia, Submission No 127 (14 May 2019) 29.
- 673 Harm Reduction Hearing, Sydney, Exhibit A, Tab 12, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 26 June 2019, [5].
- 674 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4217.33-34 (Dr Caldicott).
- 675 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4218.6-9 (Vumbaca).
- 676 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4231.10-14 (Vumbaca).
- 677 Harm Reduction Hearing, Sydney, Exhibit A, Tab 7, Statement of Alison Ritter to the *Coronial Inquest into Music Festival Deaths*, 21 May 2019, 5.
- 678 NSW Government, *NSW Government response to the Coroner's Inquest into the deaths of six patrons of NSW music festivals* (Table, received 11 December 2019) 1.
- 679 Harm Reduction Hearing, Sydney, Exhibit A, Tab 95C, Claudine Lyons Consulting, *Drug Checking Models: Revised Rapid Review - Prepared for NSW Ministry of Health* (Report, July 2019) 29.
- 680 Harm Reduction Hearing, Sydney, Exhibit A, Tab 82, Submission of Kerry Chant to the *Coronial Inquest into Music Festival Deaths*, 31 May 2019, 8.
- 681 Harm Reduction Hearing, Sydney, 25 September 2019, TS 4409.43-4410.5 (Professor Kerr); KPMG, *Further Evaluation of the Medically Supervised Injecting Centre during its extended Trial period 2007-2011* (Final Report, 14 September 2010) X-XI; Harm Reduction Hearing, Sydney, Exhibit A, Tab 7A, Statement of Marianne Jauncey, 16 September 2019, [6-7].
- 682 Harm Reduction Hearing, Sydney, Exhibit A, Tab 13B, Statement of David Caldicott to the *Coronial Inquest into Music Festival Deaths*, 11 September 2019, 992.8-19.
- 683 See, for example: Sydney (General) Hearing, Sydney, 9 May 2019, TS 270.13-26 (Dr Brett); Mental Health Commission of NSW, Submission No 119 (May 2019) 6; St Vincent's Health Australia, Submission No 127 (14 May 2019) 28-33; Australian Medical Association, Submission No 121 (14 May 2019) 5; Justice Action, Submission No 100 (7 May 2019) 9-10; Uniting Medically Supervised Injecting Centre, Submission No 117 (undated, received 10 May 2019) 1-14; The Shopfront Youth Legal Centre, Submission No 92 (7 May 2019) 14; Drug Policy Modelling Program, UNSW Sydney, Submission No 57 (7 May 2019) 15-17; The Royal Australasian College of Physicians, Submission No 47 (May 2019) 8-9; Penington Institute, Submission No 56 (May 2019) 18-21; The Public Defenders, Submission No 12 (29 April 2019) 4; NSW Council of Civil Liberties, Submission No 70 (7 May 2019) 6-7.

