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

committed to preventing tragedy that arises from illicit drug policy

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CALL FOR THE INITIATION IN THE AUSTRALIAN CAPITAL TERRITORY OF HEROIN ASSISTED TREATMENT TO UNDERPIN THE RELEASE OF VULNERABLE PRISONERS, IMPROVE MENTAL HEALTH AND PROTECT THE ACT POPULATION FROM COVID-19

BACKGROUND PAPER

By Bill Bush

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By Bill Bush

> I think every government needs to look in every corner, every nook and cranny of the country and say where is vulnerable because if you don't find it first the virus will find it for you.
> (*Dr Dale Fisher ABC 7:30 report Monday 27 April. Dr Fisher is an Australian infectious disease physician who is professor of medicine at the National University of Singapore. He is working for the World Health Organization in leading Singapore's response to the coronavirus including its sudden resurgence attributed to migrant workers*.)

I. ABSTRACT

The ACT's overcrowded prison along with other prisons across the country are particularly vulnerable to an outbreak of SARS-CoV-2 virus. The health status of the prison population is poor with physical and mental health problems. As elsewhere, the ACT prison population is characterised by co-occurring substance dependency and other mental health issues. It is acknowledged that people with mental health problems are warehoused in prisons as de facto modern day mental health institutions. People with mental health conditions are at high risk of becoming drug users, a small proportion of whom will become dependent and at risk of resorting to property crime to support their habit. Sourcing their drug supply will also bring them under the influence of a criminal peer group and otherwise intensify risk factors for crime like unemployment, poverty, homelessness and alienation from their families. Their processing as criminals leads them into prison where the harsh, untherapeutic prison environment will further intensify their mental health problems and the very risk factors that led them into prison.

Adjusting drug policy to remove the threat of criminal sanctions over drug users is the surest way of reducing the flow of people into prison and the accelerated release of those from prison. The quickest and most effective way of doing this is by introducing enhanced treatment options superior to methadone and other pharmacotherapies that are currently available in Australia. Heroin assisted treatment (HAT) provides that option. Eight trials of it have taken place demonstrating its superiority to methadone in retaining in treatment patients who had consistently failed to be benefited

by methadone. Patients were stabilised and reintegrated into society. It is also shown to be one of the the most effective crime reduction measures ever tried.

A Cochrane review of the trials of HAT has confirmed the benefits of the intervention and promotion of a heroin trial by the Carnell government of the ACT in the 1990s as a response to then epidemics of heroin addiction, blood-borne diseases, property crime and drug overdose deaths. In the last three months of 2019 clinics for the treatment have been opened in Middlesbrough in the north of England and Glasgow in response to outbreaks of HIV among injecting drug users.

While most attention is on the impact of crystal, the stimulant, it is opiates, whether illicit or from misuse of powerful prescription analgesics, that remain the main factor in overdose deaths. Justice Health encourages ACT prisoners to become inducted onto existing pharmacotherapies but there is a high attrition rate with those who are released not continuing on the program.

HAT is shown to increase the general well-being and mental health of drug users and combat the stigma and isolation which intensifies much mental illness.

The article includes remarks on the possible benefits of hybrid hydromorphone comparable to HAT and on the likely benefit of HAT on reducing the grossly disproportionate incarceration of indigenous Canberrans and ends with remarks on the ineffectiveness and indeed crime enhancing influence of imprisonment and comparison of the ACT incarceration rate with overseas jurisdictions which to some extent have rolled out HAT.

II. Introduction

1. In the words of the British-based World Prison Brief, "The coronavirus pandemic presents formidable challenges for prisons worldwide – challenges they will struggle to meet, with potentially grave consequences for the health of prisoners, prison staff, their families, and all of us." It is only a matter of time before the SARS-CoV-219 virus epidemic infects overcrowded Australian prisons wreaking death on those with compromised health detained inside them and serving as a hotbed of infection into the broader community. In the words of the World Health Organization: "the risk of rapidly increasing transmission of the disease within prisons or other places of detention is likely to have an amplifying effect on the epidemic, swiftly multiplying the number of people affected." Deaths from the virus have already occurred in prisons in the United Kingdom, United States and Brazil. *The Guardian* reports that it is suspected that five recent suicides in six days in prisons in England and Wales are linked to the pausing of programs and confinement in cells of prisoners for 23 hours in the day.

2. A Second Open Letter of 20 March calls for the early release of vulnerable populations including women, Aboriginal and Torres Strait Islanders, the elderly

and people detained for “non-violent drug offences”. The letter also refers to the disproportionate effect of the virus “on vulnerable populations over-represented in prisons” including “people from low socio-economic backgrounds; people experiencing homelessness; and people with disabilities”. The last includes the majority in prison suffering from mental health conditions. Fear of infection has produced unrest and even riots.

3. Such vulnerable people should be released. This step should be complemented by measures to reduce the flow of people into prisons. This paper describes how these objectives can be achieved without compromising, and indeed by enhancing, community safety by changing laws to address the reason why so many find themselves in prison. The paper argues that these results can be achieved by changing our drug laws in ways that numerous other countries have already done.

4. The criminal law and policies have been changed in the past in response to earlier epidemics like HIV and hepatitis C when Australian drug policies moved from one that relied upon the sanctioning by the criminal law of users as the first line of defence to the policy of harm minimisation which sought a balance between its three arms of supply reduction (principally law-enforcement), demand reduction such as education and harm reduction involving actions that reduced the harm to those who, in spite of all, continued to use drugs. It was in this third limb that Australia led the world at that time in permitting sterile syringes (previously outlawed).

III. Heroin assisted treatment as a response to a SARS-CoV-2-like situation faced by the Carnell government

5. It was in the context of this flux that the then Chief Minister of the ACT, Formerly a pharmacist put the weight of her government behind the development of a trial of heroin assisted treatment. Her advocacy and that of her health Minister, independent Michael Moore, succeeded bringing on board the federal government the health Minister of which, happily, was a medical doctor, Dr Wooldridge. The state governments were persuaded to approve it. A number had interests that needed to be accommodated: Tasmania grew opium poppies and, under the trial developed by the National Centre for Epidemiology and Population Health of the ANU, Victoria and New South Wales would be required to participate in later phases of the trial.

6. The Federal Cabinet approved the proposal (the Commonwealth would have to permit the importation of heroin) but all was undone on 19 August 1997 when on the insistence of the Prime Minister, Mr Howard, the Cabinet approval was countermanded. The Prime Minister, Mr Howard, countermanded that trial[1] on

1. Alex Wodak, The heroin trial 10 years on: how politics killed hope, *Crikey*: Wednesday, 22 August 2007 at http://www.ffdlr.org.au/commentary/docs/Herointrial10yearson.htm.

the ground that "heroin prescription might be linked with more permissive attitudes to illegal drug use, encouraging use especially among young people."[2]

A. Health and social crises facing the Carnell government

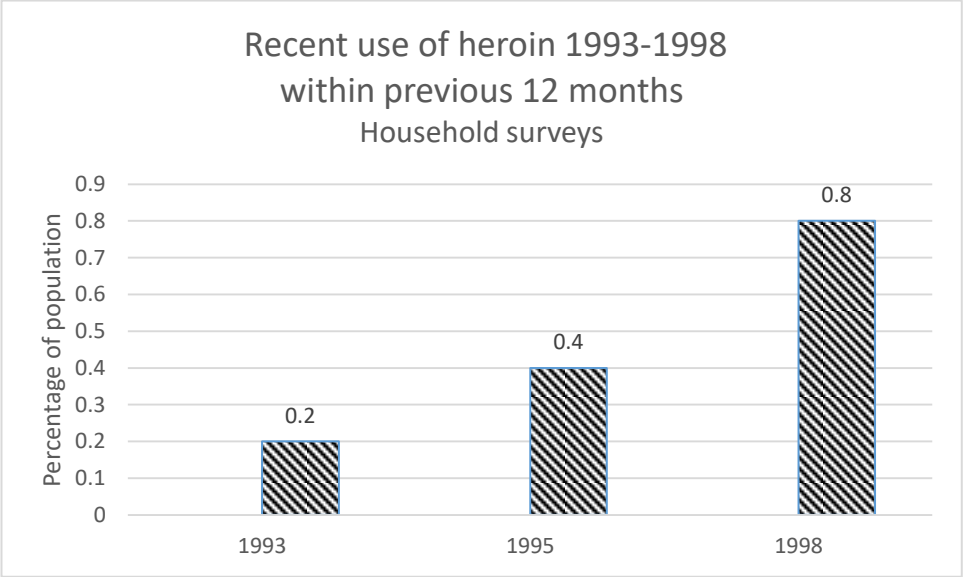
7. The predicament that Kate Carnell faced up to was a fourfold epidemic:

- an epidemic of heroin use;
- an epidemic of blood-borne diseases in particular of HIV (AIDS) and the recently isolated hepatitis C virus both of which are easily spread by injecting drug use, which was the main form of administration of heroin and for which, like SARS-CoV-2 at the moment, there existed no cure or vaccination;
- an epidemic of opioid overdose deaths from heroin use; and finally
- an epidemic of crime associated with the increasing heroin use.

8. There were reasons to think that heroin assisted treatment would help control these four.

B. Growth in heroin use

9. The household survey showed that heroin use quadrupled between 1993 and 1998.



C. HIV/Aids

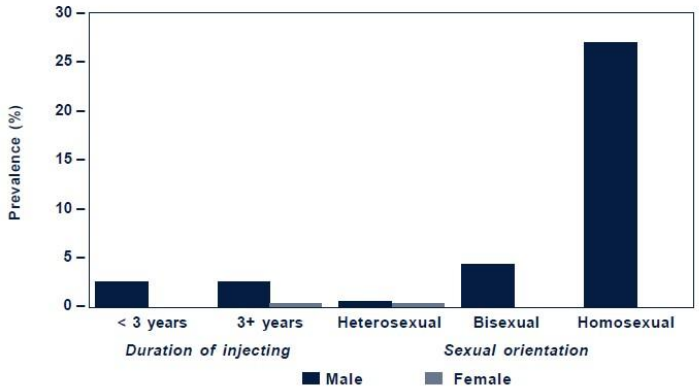
10. By the end of 1996 it was "estimated that there were 11,080 people living with HIV infection in Australia . . . ."

> "HIV prevalence has been very low (less than 0.6%) in both men and women seen at metropolitan sexual health centres in 1992-1996 who identified themselves as injecting drug users (Figure 15). HIV

2. Gabriele Bammer, Anja Dobler-Mikola, Philip M. Fleming, John Strang, Ambros Uchtenhagen, The Heroin Prescribing Debate: Integrating Science and Politics, *Science* vol. 284, issue 5418, pp. 1277-1278, 21 May 1999

prevalence in people attending needle and syringe exchanges has also remained low (less than 3%) except among men who identified themselves as either bisexual (4%) or homosexual (26%) (Figure 16)."[3]

Figure 16 HIV prevalence in people seen at needle and syringe exchanges, 1996, by duration of injecting drugs and sexual orientation



11. While the prevalence of HIV was low among injecting drug users, it was feared that injecting drug use, particularly in prisons where sterile syringes were not available, would be a vector by which the disease could spread into the community as was happening in some countries.

1. Hepatitis C virus

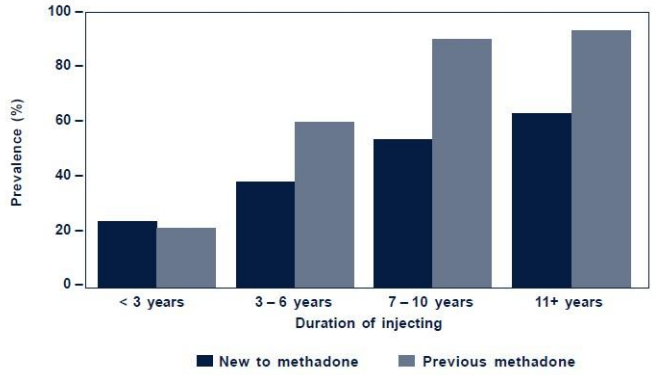
12. The number of hepatitis C diagnoses increased from 4116 in 1991 to 9060 in 1996. The first national report in 1997 on these diseases noted that:

> "HCV prevalence in people attending needle and syringe exchanges was very high, with an overall level of 65%. HCV prevalence was strongly related to duration of injecting in both males and females with levels of over 70%in people who have injected for three years or longer, though HCV prevalence was already high (around 30%) in men and women who had been injecting for less than three years. "The strong relationship between HCV prevalence and increasing duration of injecting was also seen in people tested on entry to methadone treatment (Figure 18)."[4]

[3]. National Centre in HIV Epidemiology and Clinical Research, *HIV / AIDS and related diseases; annual surveillance report 1997* (National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, NSW. 1997) pp.17-18 at https://kirby.unsw.edu.au/sites/default/files/kirby/report/SERP_1997-Annual-Surveillance-Report.pdf

4. The same.

Figure 18 HCV prevalence in people seen at methadone clinics, 1996, by duration of injecting and history of methadone treatment



"Reuse of equipment for injecting illicit drugs has been an infrequent mode of HIV transmission in Australia, but transmission of hepatitis C infection is occurring at very high rates in people who inject drugs."

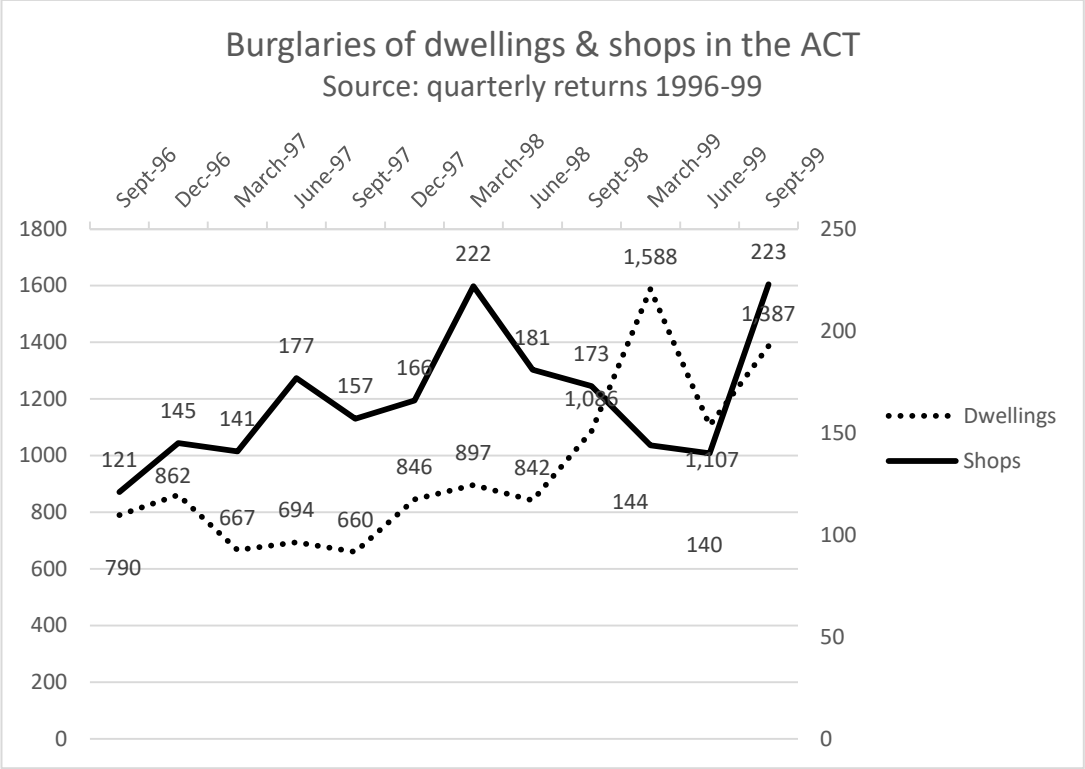
2. Property crime

13. "Dependent opioid users are . . . more likely to be criminally active"[5] ACT criminal justice quarterly statistics for burglary of dwellings doubled between 1996 and 2000 (790 in September 1996; 1422 in June 2000). Burglary from shops also doubled in that period. In the 13 years up to that time "property crime, of which stealing accounts for half, increased by 89%"[6] "those charged with the property offence are more likely to report they are dependent on heroin (37%) and either cocaine (2.7% or amphetamine (10.3%)."[7]

5. Karen Toohey, Gabrielle McKinnon, & Ingrid Osmond, *Review of the opioid replacement treatment program at the Alexander Maconochie Centre: Report of the ACT Health Services Commissioner*, (ACT Human Rights Commission, March 2018) p.9 at https://www.parliament.act.gov.au/__data/assets/pdf_file/0009/1185057/Alexander-Maconochie-Centre-Review-of-the-Opioid-Replacement-Treatment-Program.pdf visited 2/06/2020.

6. Satyanshu Mukherjee, Debbie Neuhaus & John Walker, *Crime and justice in Australia* (Australian Institute of Criminology, Canberra, 1990) p. 7.

7. Toni Makkai, *Illicit drugs and crime,* Adam Graycar & Peter Grabosky (eds), *The Cambridge handbook of Australian criminology* (Cambridge University Press, 2002) chapt. 6, pp. 110-125 at p. 120.



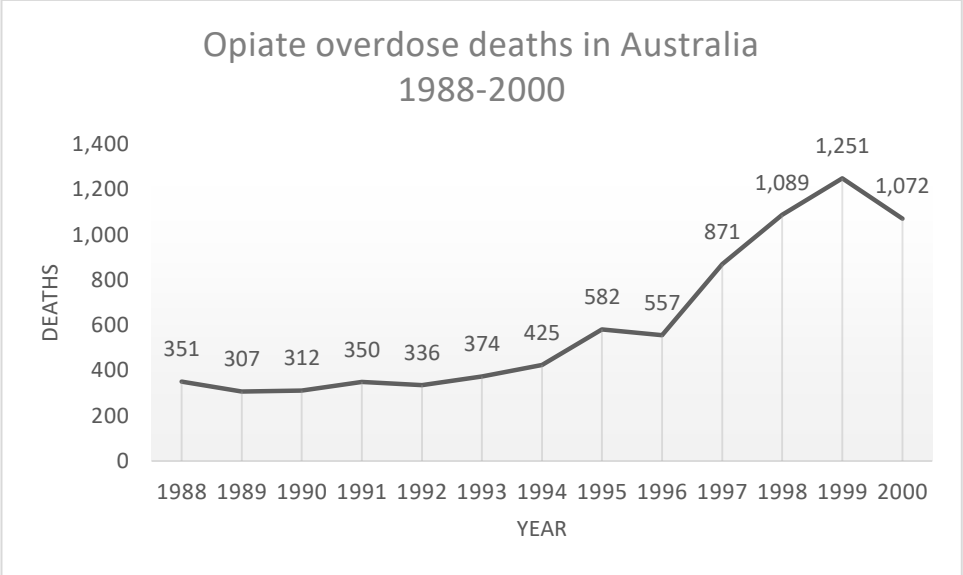
14. The then Labor leader of the Opposition, Rosemary Follett, spoke in support of the proposed heroin trial in terms of the crime that it might ameliorate:

> " . . . the use of heroin has led to an increase of crime in our community - crime against the person, crimes of violence, and crime against property. Our entire community is at greater risk because there are people in our community who choose to use this substance illegally. Our whole community is at greater risk of burglary, greater risk of mugging, greater risk of theft, and so on. So the cost in terms of crime in our community ought not to be discounted."[8]

3. Explosion of opiate overdose deaths

15. Overdose deaths more than tripled from 350 in 1991 to 1,251 in 1999.

8. *Hansard,* 27 February 1996.



D. The nightmare of worst-case scenarios:

16. The prevalence of HIV/AIDS in Australia including prisons may have been low in the early 1990s but it was feared that unless more effective measures of harm reduction were taken that then fatal infection could spread from intravenous drug users into the community. Intravenous users of heroin were congregated in prisons. On public health grounds there was therefore an imperative to reduce the concentration of this vulnerable population in a prison environment where injecting drug use was rife but without access to sterile syringes. In other countries and as with HCV in Australia, blood-borne diseases are "pervasive among IV drug users, who are dramatically over-represented in correctional institutions."[9] The United States National Commission on AIDS commented in 1991 that "by choosing mass imprisonment as the federal and state governments' response to the use of drugs, we have created a *de facto* policy of incarcerating more and more individuals with HIV infection."[10] The actuality of the foregoing health and social crises was ground enough for the Carnell government to promote radical measures but the nightmare was that worse was on the cards if the government did nothing to counter the growth in heroin use.

1. HIV/Aids

17. Lithuania

"In Latvia it is estimated that prisoners comprise a third of the country's HIV-positive population, and that a fourth of all HIV-positive persons in Latvia were infected while in prison.14 In Lithuania, in May 2002 the number of new HIV-positive test results among prisoners found in a two-week period equalled all the

9. TM Hammett. *AIDS in Correctional Facilities: Issues and Options*. 3rd ed.Washington, DC: US Department of Justice, 1988, at 26 quoted in Rick Lines, Ralf Jürgens, Glenn Betteridge, Heino Stöver, Dumitru Laticevschi, Joachim Nelles, Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience (2004 Canadian HIV/AIDS Legal Network)

10. Quoted in Lines et al., cited above, p. 10.

cases of HIV identified in the entire country during all of the previous years combined."[11]

18. Canada

"During the mid-1990s, the Canadian city of Vancouver experienced an HIV outbreak on an unprecedented scale among people who inject drugs. "At its peak, the rate of new infections reached 18 per 1,000 person-years, comparable to incidence rates seen in parts of sub-Saharan Africa. Up to 25% of the city's population of people who inject drugs became infected." [12]

19. Scotland

During 2015, a total of 47 cases of HIV were diagnosed among people who inject drugs in Glasgow, of whom 43 share the same strain (subtype C). This represents an almost fivefold increase on the previous annual average of 10 new infections, with laboratory testing indicating recent transmission in the majority of cases. There have been 13 further cases of HIV among people who inject drugs diagnosed during 2016 to date. Transmission appears to be predominantly via injecting drug use, though a degree of sexual transmission cannot be ruled out. Such an outbreak is unusual in an area such as Glasgow which provides a range of prevention services, including low-threshold access to sterile injecting equipment, opioid substitution therapy, sexual health services, and HIV treatment. Most of those affected are male, with relatively long histories of injecting drug use."[13]

20. Russia

260 prisoners contracted HIV in a Russian correctional colony in 2001

2. Tuberculosis

21. In an article entitled *Prisons in Post-Soviet Russia Incubate a Plague Scientific American* reported that "Between 1991 and 2001 the incidence of TB in Russia's prisons reached a staggering 7,000 cases per 100,000 inmates. According to one estimate, prisoners made up 25 percent of all new cases in the nation. In this oil-rich province [, Western Siberia] with just over a million inhabitants, the prison TB rate reached the equivalent of 4,000 cases per 100,000 inmates, with nearly one of every 11 cases proving fatal."[14]

22. According to the World Health Organisation "The prison environment is often conducive to tuberculosis transmission and rates may be higher than in the

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11. Quoted in Lines et al., cited above, p. 6.
12. NHS Greater Glasgow & Clyde, "Taking away the chaos": the health needs of people who inject drugs in public places in Glasgow city centre (NHS Greater Glasgow and Clyde, 2016) p. 15 at https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf visited 25/04/2020.
13. The same, p. 12.
14. Merrill Goozner, Prisons in Post-Soviet Russia Incubate a Plague (*Cook*, August 25, 2008) at https://www.scientificamerican.com/article/prison-plague-post-soviet-russia/.

general population. Furthermore, tuberculosis is increasingly associated with HIV/AIDS, so that the presence of HIV-infected prisoners may increase the risk of tuberculosis transmission. Vigorous application of WHO guidelines on HIV infection and AIDS in prisons efforts are therefore needed "to reduce the risks related to the environment (e.g., by improving ventilation, reducing overcrowding, and providing adequate nutrition); to detect cases of tuberculosis as early as possible through screening for tuberculosis on entry and at regular intervals during imprisonment, and through contact tracing; and to provide effective treatment."[15]

3. Botulism

23. Scotland

December 2014 – December 2015

• 26 cases resident in NHSGGC [NHS Greater Glasgow & Clyde), of whom 2 died

• 44 cases and 4 deaths across Scotland as a whole among public injecting drug users in 2014 – 15[16]

4. Anthrax

24. Scotland

December 2009 – December 2017

• 35 cases resident in NHSGGC, of whom 9 died – a serious infectious disease among people who inject drugs in Glasgow

• 119 cases and 14 deaths across Scotland as a whole [17]

5. Clostridium novyi

25. Scotland

April – August 2003

• 55 cases resident in Glasgow or surrounding areas, of whom 19 died

• 60 cases and 23 deaths across Scotland as a whole

Many of the cases "were identified to be part of a core group of particularly chaotic drug users with close links to the city centre and its drug scene." [18]

6. Soft tissue and Staphylococcus aureus bloodstream infections

Scotland

26. "Serious bacterial and fungal infections remain a significant hazard among people who inject drugs. Among clients accessing injecting equipment provision services in Scotland during 2013-2014, 28% had experienced an abscess, sore or

15. WHO guidelines on HIV infection and AIDS in prisons (WHO Global Programme on AIDS, First printed 1993) pp. 7-8.

16 NHS Greater Glasgow & Clyde, (2016) p. 46

17 The same.

18 The same.

open wound during the past year33. A large outbreak of soft tissue infections occurred among people who inject drugs in Edinburgh during 2014 and 2015, with many of those affected requiring prolonged hospitalisation and surgical intervention. NHSGGC [NHS Greater Glasgow & Clyde] are also currently investigating an apparent increase in Staphylococcus aureus bloodstream infections among people who inject drugs in Glasgow during the last year." [19]

27. The government's response to the current SARS-CoV-2 emergency should be informed by reflection on what might have been had the ACT in Australia proceeded with the trial of heroin assisted treatment. Switzerland, facing a public health emergency and scandal from heroin use in cities like Zürich, embarked on the heroin trial that the ACT was prevented from having. In doing so it was guided by the careful designed work that went into the design of the ACT trial.

E. Methadone

28. Methadone is an artificial opiate which, as a pharmacotherapy can address a number of the critical issues that faced the ACT government in the 1990s. It " . . .was introduced into Australia [as a treatment for heroin dependence] in 1969.

1. Australian endorsement of methadone

29. Methadone Maintenance Treatment (MMT) was endorsed by State, Territory and Commonwealth Governments as an appropriate and useful treatment for heroin dependence at the launch of the National Campaign against Drug Abuse in 1985." (Commonwealth Department of Health).
Pharmacotherapies like methadone are known to:

- retain "patients in treatment;
- decrease heroin use better than treatments that do not utilise opioid replacement therapy"[20]; and
- reduce offending among opiate dependent drug users.[21]

2. Methadone and crime reduction

30. Opiate Replacement Therapies like methadone aim ". . . to provide stability for the client, to reduce risks of overdose and other health and social

19 The same.

20. R.P. Mattick, C. Breen, J. Kimber, M. Davoli, "Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence", Cochrane Database of Systematic Reviews 2003, Issue 2. Art. No.: CD002209. DOI: 10.1002/14651858.CD002209 at http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002209/pdf_fs.html

21 John C. Ball & Alan Ross, The effectiveness of methadone maintenance treatment: patients, programs, services, and outcomes (Springer-Verlag, New York, Berlin &c, 1991) table 10.4, p. 202 and Maree Teesson et. al., (2003) *Twelve month outcomes from the treatment of heroin dependence: findings from the Australian Treatment Outcome Study (ATOS), New South Wales* (Technical report no. 191, National Drug and Alcohol Research Centre, University of New South Wales, Sydney) p. 21.

harms, and encourage positive lifestyle changes which may eventually allow a client to successfully achieve abstinence from opioid use."[22]

31. Crime reductions accompanying methadone maintenance treatment have been carefully assessed in a lot of studies. Even so, offending behaviour of patients is shown to decline while in opiate maintenance treatments. For example, a large-scale outcome study of methadone maintenance treatment involving six methadone maintenance programs, two in each of Baltimore, Philadelphia and New York, over a three-year period between 1985 and 1987 found that methadone maintenance had "a dramatic impact" on crime among the 388 patients who remained in treatment:

> "The reduction of crime associated with retention in methadone maintenance . . . appeared impressive. The study sample had an extensive criminal history prior to entering methadone: a total of 4,723 arrests, with a mean of nine arrests for the 86% of the sample who had been arrested. Sixty-six per cent of the group had spent some time in gaol, 36% having been incarcerated for two years or more. Although these figures indicate extensive criminal involvement, they seriously underestimate criminal activity which is better estimated by self-reported crime.
>
> "The sample admitted to 293,308 offences per year during their last period of addiction. Among those who admitted committing criminal acts, each person committed an average of 601 crimes per year (range 1 to 3,588), and had committed criminal offences on an average of 304 days per year during their last addiction period. After entry to methadone, the number of self-reported offences declined to 50,103 crimes per year and the mean number of 'crime days' per year decreased from 238 in the year prior to entry to 69 crime days during the early months of methadone maintenance. The number of crime days continued to decline with the number of years spent in treatment. In terms of the number of crimes committed, the reduction during methadone maintenance was 192,000 offences per year. As [the authors of the study] remark, such a substantial reduction in criminal activity among heroin users is usually only achieved by incarceration".[23]

32. More recently according to a large Australian evaluation of pharmacotherapies for opioid dependence:

> "Property crime was reported at baseline by a significantly greater proportion of Heroin Users (20%) than Methadone Patients (5%), as was drug dealing (23% vs. 8% respectively); fraud (8% vs. 2% respectively); and violence (3% vs. 1% respectively).

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22. *Review of the opioid replacement* (2018) cited above p. 10 at https://www.parliament.act.gov.au/__data/assets/pdf_file/0009/1185057/Alexander-Maconochie-Centre-Review-of-the-Opioid-Replacement-Treatment-Program.pdf.

23. Jeff Ward, Richard P. Mattick and Wayne Hall, *Key issues in methadone maintenance treatment* (National Drug and Alcohol Research Centre, University of New South Wales Press Ltd, 1992) p.35.

33. Criminal behaviour among Heroin Users was halved at the three month follow-up. Their average monthly expenditure on heroin decreased from $2,611 at baseline to $572 at three-month follow-up, consistent with the decreases in heroin use"[24]

3. Buprenorphine /Suboxone

34. Buprenorphine was introduced in Australia in the 1990s to supplement methadone as an opioid agonist or opioid substitution treatment. It is taken as a regular dose to remove the need for illicit opioids such as heroin, or in the treatment of pharmaceutical opioid dependence and is also commonly prescribed to treat chronic pain.[25]

35. Suboxone is a fixed combination of buprenorphine (a partial μ-opioid receptor agonist) with naloxone (an opioid antagonist) in a 4:1 ratio. The addition of naloxone to buprenorphine is expected to decrease the intravenous abuse of buprenorphine, because when taken sublingually, absorption of naloxone is minimal, however it can rapidly precipitate opioid withdrawal when injected.[26]

36. In the ACT prison: "Methadone (in the form of biodone) is the preferred medication for Opiate Replacement Therapy (ORT). Buprenorphine (in the form of Suboxone) is only available for limited periods to manage withdrawal on entry and shortly before release to reduce risk of overdose in the community. A short trial of Suboxone maintenance was conducted at the AMC but was ceased due to allegations of widespread diversion."

4. Inadequacy of methadone and buprenorphine

37. There was thus strong evidence of the efficacy of methadone as a pharmacotherapy that stabilised heroin dependent drug users to the extent that it was regarded as "the gold standard" for opiate treatment. But it clearly was insufficient to allay the serious health and social challenges facing the ACT government in the 1990s and which moved it to propose a trial of heroin assisted treatment for the many opiate dependent drug users for whom methadone did not help. Methadone has a bad name among many opiate dependent drug users. To be effective patients are required to take a "holding dose" which effectively means that they are required to add a dependency on methadone to their dependency on heroin. This was something that many did not want to do given that for many it is harder to overcome a methadone dependency than a heroin one.

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24. Mattick RP, Digiusto E, Doran CM, O'Brien S, Shanahan M, Kimber J, Henderson N, Breen C, Shearer J, Gates J, Shakeshaft A and NEPOD Trial Investigators, *National Evaluation of Pharmacotherapies for Opioid Dependence: Report of Results and Recommendations*. (National Drug and Alcohol Research Centre, Sydney, 2001 pp. 4 & 41.

25 National Drug and Alcohol Research Centre, *What is buprenorphine?* (UNSW, Sydney) at https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Buprenorphine.pdf.

26. Canadian Agency for Drugs and Technologies in Health, Suboxone Versus Methadone for the Treatment of Opioid Dependence: A Review of the Clinical and Cost-effectiveness at https://pubmed.ncbi.nlm.nih.gov/24716256/.

38. Methadone may have unpleasant side effects. As stated above, it is addictive. Like other opiates it is a 'drying' drug and can cause constipation and reduced saliva production. Long term effects can include tooth decay from reduced saliva and loss of libido. Methadone can be harmful for people with kidney and liver diseases.[27] Further drawbacks associated with methadone arise from the restrictive, demeaning and alienating regime often prescribed for its dispensation. Moreover, it is not effective for some heroin dependents and can itself produce a fatal overdose unless administered carefully under medical supervision. No wonder that methadone is sometimes referred to as "liquid manacles".

39. The bad reputation of methadone among many drug users is reflected in the large fall rate from the Opiate Replacement Therapy (ORT) program of the ACT prison as reported by the ACT Health Services Commissioner:

> " . . . it appears that there is a high attrition rate for participation in ORT on release into the community. Figures provided by Justice Health indicate that in 2016-17, 74% of detainees referred to building 7 on release took up that referral but that three months post release only 33% of this 74% were still receiving their opioid maintenance at Building 7. This is only a slight improvement from 2015-16 where 78% of released detainees commenced initially but only 21% of this group had continued in treatment at Building 7 after three months. It was not possible to obtain reliable data beyond three months post release."[28]

40. For many methadone therefore fails a crucial test of any drug treatment, namely its capacity to retain in treatment dependent drug users thus enabling them to stabilise their life and reintegrate into society.

41. The risks of buprenorphine appear similar but slightly less than those of methadone:

> "As with other prescription drugs, buprenorphine can suppress respiration resulting in fatal overdoses; however, buprenorphine is known to have less effect on respiration compared with other opioids. Buprenorphine can also cause sedation, though this is thought to be less than with methadone . . . Withdrawal from long-term use of buprenorphine may produce some symptoms similar to those experienced through withdrawal from other opioids, such as heroin or morphine. However, symptoms tend to be milder than for heroin or other opioids, such as methadone withdrawal."[29]

27. Australia, Department of Human Services and Health, *Handbook for medical practitioners and other health care workers on alcohol and other drug problems* (Australian Government Publishing Service, Canberra, 1994) p. 46

28. *Review of the opioid replacement* (2018) cited above p. 44.

29. National Drug and Alcohol Research Centre, *What is buprenorphine?* Cited above.

IV. Heroin assisted treatment shown to address the failings of methadone

42. The shortcomings of methadone inspired search for treatments that would engage the substantial number of dependent heroin users who were unable to engage with that or any other treatment. It seemed counter intuitive to consider heroin as a treatment for the addiction that it caused. The European Monitoring Centre for Drugs and Drug Addiction explained why that approach commended itself:

> "Why do we need to utilise such a potentially controversial treatment approach, if other treatments already exist and are approved, and have the same therapeutic objectives? The answer is that there remains a substantial minority of patients who fail to benefit from these treatments and for whom we may need to consider more intensive and alternative forms of treatment. For those patients who repeatedly fail with existing orthodox treatments, are they just 'untreatable' or might we be able to devise alternative and/or more intensive treatments which enable them to achieve the gains that have, thus far, been unattainable?"[30]

43. " . . .[T]he proportion of the opiate dependent population reached through this modality [methadone] rarely approaches 50%. . . . It cannot be assumed that all or even the majority of opiate users want methadone."[31] A substantial number of those not reached through methadone have a long history of failure to engage with methadone and other and other treatments. These people have typically lost faith in their capacity to break out of their long-term addiction, demoralised with little expectation of experiencing conventional rewards in life. It is thus postulated that for these people, heroin assisted treatment is "much more reinforcing than oral methadone or buprenorphine"[32] and so has a far greater capacity to attract and retain this hard to reach population.

44. Stymied, after the Howard government's veto of its trial of heroin assisted treatment, the ACT handed the baton to Switzerland which drew heavily upon the preparatory work in designing its own trial. The admission criteria for the Swiss trial selected precisely those for whom methadone did not work. Participants needed to be of:

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30. John Strang, Teodora Groshkova and Nicola Metrebian, EMCDDA insights: New heroin-assisted treatment: recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond (EMCDDA, 2012) at http://www.emcdda.europa.eu/system/files/publications/690/Heroin_Insight_335259.pdf visited 18/04/2020.

31. Richard Hartnoll, Epidemiological problems, in *Heroin-assisted treatment: work in progress* edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 347-64 at p. 358.

32. James Bell, Vendula Belackova, Nicholas Lintzeris, Supervised Injectable Opioid Treatment for the Management of Opioid Dependence, *Drugs* (2018) 78:1339–1352; *Drugs*. 2018 Sep;78(13):1339-1352 at p. 1,341. doi: 10.1007/s40265-018-0962-y.at https://pubmed.ncbi.nlm.nih.gov/30132259/ visited 17/05/2020..

- of a minimum age of 20,
- have had a minimum duration of daily heroin consumption of two years,
- have had negative outcome of at least two previous treatments; and
- have documented social and/or health deficits as a consequence of their heroin dependence.[33]

45. The trial was undertaken in the context of the AIDS and hepatitis epidemics for which injecting drug use was a principal pathway.

- in 1989 45% of all new transmissions among men of IV infection were caused by drug injections and 53% among women;
- more than 40% of registered HPV infections in Switzerland were accounted for by IV drug users; and
- about 60% of registered hepatitis C infection were detected among IV drug consumers.[34]

46. In 1980 there had been an evaluation of heroin maintenance in a controlled trial in the United Kingdom.[35] The Swiss trial inspired a series of studies that took place in six other countries within the next decade (namely: Belgium, Canada, Germany, The Netherlands, Spain, and a second one in the United Kingdom).

> "In response to the need for providing treatment options for illicit opioid users resistant to available therapeutic opioid maintenance interventions with generally established effectiveness (e.g., oral methadone maintenance treatment [MMT] and oral buprenorphine maintenance treatment [BMT]) and an increasing focus on the public order challenges related to un- or ineffectively treated heroin addiction, half a dozen countries (Canada, Germany, The Netherlands, Spain, Switzerland, and United Kingdom) have embarked on the experimental implementation of medical "heroin-assisted treatment" (HAT) initiatives over the past decades."[36]

47. A Cochrane review of trials in six countries (including Belgium) concluded:

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33. Martin Killias, Marcelo Aebi and Denis Ribeaud, "Key findings concerning the effects of heroin prescription on crime" p. 112 in *Heroin-assisted treatment: work in progress* edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 193-98

34. Thomas Steffen, Reduction of infectious diseases in a medically controlled heroin prescription programme (PROVE) p. 110 at in *Heroin-assisted treatment: work in progress* edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 109-16.

35. Hartnoll RL. Evaluation of heroin maintenance in controlled trial. *Archives of General Psychiatry* 1980;37:877-84

36 Benedikt Fischer, Eugenia Oviedo-Joekes, Peter Blanken, Christian Haasen, Jürgen Rehm, Martin T. Schechter, John Strang, and Wim van den Brink, Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics, *J Urban Health.* 2007 Jul; 84(4): pp. 552–562 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/

> "Five studies compared supervised injected heroin plus flexible dosages of methadone treatment to oral methadone only and showed that heroin helps patients to remain in treatment, and to reduce use of illicit drugs".[37]

48. An overview published in 2006 of the "largely positive" outcome of five trials concluded to that point noted that:

> "there is a mounting onus on the realm of politics to translate the—largely positive—data from completed HAT science into corresponding policy and programming in order to expand effective treatment options for the high-risk population of illicit opioid users."

49. In the light of these positive results Denmark in 2010 initiated heroin assisted treatment and in October and November 2019 clinics providing for that treatment were opened in Middlesbrough and Glasgow respectively.

1. Drop in Heroin use.

50. Addicted heroin users commonly engage in drug dealing to their drug using peers. This practice is seen as a more honourable course to raise money to support their habit than scamming family and friends and engaging in property crime. The Swiss trial brought about a large reduction in drug trafficking offences which disrupted the retail pyramid drug market. The rate of self-reported reduction by those on the Swiss trial in selling of "hard" drugs was 92% and there was a 76% reduction in selling "soft" drug (principally cannabis). This self-report was confirmed by reports of reduced police contact. There was a 78% reduction in use and possession of heroin, a 57% reduction in use or possession of cannabis and a 57% reduction in trafficking offences. These changes occurred within the first six months of the trial and extended to 24 months.[39]

51. It is fair to conclude that Australia would have substantially reduced the explosion of heroin use that it experienced throughout the 1990s.

2. Reduced transmission of blood-borne viruses.

52. An account of the impact of the heroin assisted program on infectious diseases summarises the results in the following terms:

> " . . . the cohort [of 1035 participants in the program] showed an incidence rate of 0.9% for HIV during the first six months. There are only 11 new cases. Therefore, no clear trend could be found. For hepatitis we found an incidence rate of 10% for both hepatitis B and C during the first half year of treatment. Progress and analysis over 30 months showed that in patients remaining in treatment the relative risk of new viral hepatitis infections was cut in half the first check on progress after six months was compared with

37. Ferri M, Davoli M, Perucci CA, Heroin maintenance for chronic heroin-dependent individuals (Review), *Cochrane Database of Systematic Reviews* 2011, Issue 12. Art. No.: CD003410.

38. The same.

39. Killias, Aebi and Ribeaud (2005) cited above, pp. 196-97.

later checks. New infections occurred more often among young patients and those consuming cocaine."

53. Lithuania and Russia provide examples of HIV infection exploding from prisons into the community. In Lithuania in 2002, almost 300 new cases of HIV were identified in a correctional facility through sharing of drug injection equipment. 260 prisoners contracted HIV in a Russian correctional colony in 2001 (Lines et. al. 2004, p. 6). The same could happen here unless the biggest incubator of blood borne viruses in the ACT is not closed down by deploying the full range of proven preventative measures.

3. Far fewer Deaths

54. The Swiss trial of heroin assisted treatment came close to eliminating the risk of overdose deaths among the 1,146 patients on the program. Only two of these died of an overdose though not as result of the prescribed narcotics. One death occurred during treatment and one after dropping out. In all 36 deaths occurred, the majority after the patient left the program producing a mortality rate for the cohort per treatment year of 1% which was within the range of the mortality rate within the community at large. A higher mortality rate had been expected in view of the considerable impairment of health of the participants on admission.[40]

4. Crime reduction

55. "This reduction in crime was verified in three ways: from self-report, reduction in police contacts and reduction in victimisation of those on the trial (victimisation being a recognised proxy for criminal activity).

56. A consistent finding from this series of randomised trials is of the substantial improvement in health and well-being of the patients receiving SIH compared with those provided with oral methadone treatment. This improvement includes, in particular, a major reduction in the extent of continued injecting of 'street' heroin, improvements in general health, psychological well-being and social functioning, as well as major disengagement from criminal activities (such as acquisitive crime to fund continued use of 'street' heroin and other street drugs).

40. Uchtenhagen, A. et al. (1999) cited above. pp.73-74.

57. Table 1: Prevalence and incidence rates of self-reported criminality after one year of treatment compared to the time before admission (reference. Six months, N=305[41]

Table 1: Prevalence and incidence rates of self-reported criminality, after one year of treatment in the programme, compared to the time before admission (reference period of 6 months, N=305).

offence type	prevalence rates				incidence rates			
	before	after	p	drop	before	after	p	drop
serious property offences[1]	11.2	0.7	<.001	94%	0.388	0.007	<.001	98%
other property offences[2]	39.9	17.4	<.001	56%	7.238	0.954	<.001	87%
selling «soft« drugs	26.3	12.5	<.001	52%	8.960	2.162	0.001	76%
selling «hard« drugs	46.9	8.2	<.001	83%	25.297	2.030	<.001	92%
assault[3]	1.0	1.0	ns	ns	0.017	0.016	ns	ns

[1] burglary, muggings, robbery, pick-pocketing
[2] thefts, shoplifting, receiving or selling stolen property
[3] with or without weapon

58. Table 2: Prevalence and incidence of rates of self-reported victimisations after one year of treatment compared to the time before admission to the program (N=604)[42]

offence type	prevalence rates				incidence rates			
	before	after	p	drop	before	after	p	drop
robbery	11.5	4.7	<.001	59%	0.273	0.084	<.001	69%
assault	3.6	2.7	ns	–	0.036	0.043	ns	–
sexual offences	1.7	1.4	ns	–	0.092	0.013	ns	–
fraud with drugs	55.3	16.0	<.001	71%	4.465	0.572	<.001	87%
thefts	23.0	13.0	<.001	43%	0.792	0.180	<.001	77%
theft of bicycle	14.1	9.7	.096	31%	0.201	0.128	.063	36%

.41. Martin Killias, Marcelo Aebi and Denis Ribeaud, "Key findings concerning the effects of heroin prescription on crime" p. 195 in *Heroin-assisted treatment: work in progress* edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 193-98.

[42]. The same.

59. Table 3: Incidence raised of police contact, by offence type, period of six months before and after admission to the program (N equal 604)[43]

offence type	*before*	*after*	drop	*p**
violent and sex offences	0.023	0.022	4%	ns
shoplifting	0.164	0.078	52%	<.01
burglary	0.041	0.013	68%	<.02
robbery / mugging	0.012	0.002	83%	.06
trespassing	0.028	0.007	75%	<.02
theft of vehicles	0.048	0.020	58%	<.03
other theft and property offences[1]	0.139	0.033	76%	<.01
other criminal code offences[2]	0.023	0.007	70%	<.01
traffic offences	0.040	0.013	68%	ns
use or possession of cannabis	0.131	0.056	57%	<.01
use or possession of heroin	0.689	0.149	78%	<.01
use or possession of cocaine or ecstasy	0.285	0.132	54%	<.01
use or possession of other or several substances	0.166	0.025	85%	<.02
drug trafficking	0.119	0.051	57%	<.01
offences to other laws[3]	0.017	0.005	71%	.07
overall incidence rate	*1.924*	*0.613*	68%	*<.01*

* t test for paired samples, two-tailed significance
1 including receiving stolen property and forgery
2 including fare dodging
3 including searches

60. Swiss researchers observed that " . . . The decrease has been particularly strong for serious property crime and drug trafficking."[44] Contrary to expectations, heroin prescription tended to decline as did the use of other (i.e. not prescribed drugs).

61. The foregoing tables record large reduction in drug trafficking offences. This reduction appears to have disrupted the retail drug distribution system. As mentioned above, a follow up study published a decade later suggests this disruption contributed to a decline in recruitment of new drug users.

62. While beyond the scope of the trial of heroin assisted treatment, on a population wide basis, street robberies, a crime typically committed by dependent drug users dropped in both the city and Canton of Zürich by about 70%.[45]

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[43]. Killias, Aebi & Ribeaud (2005) cited above p. 196.

[44] Martin Killias, Marcelo Aebi and Denis Ribeaud, "Key findings concerning the effects of heroin prescription on crime" in *Heroin-assisted treatment: work in progress edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen* (Verlag Hans Huber, Bern etc, 2005) p. 194.

[45]. The same, p. 197.

The German trial of heroin assisted treatment recorded comparable reductions in crime by participants in the program:

> "Illegal activities, according to EuropASI formulation of involvement in illegal activities in the last 30 days, decreased [by 2/3] in the first year of treatment, without a further decline in the second year."[46]

Delinquency which "decreased decreased rapidly ". . . was associated closely with the decline of illicit drug use and vanished procuring pressure."[47]

5. Reduction in illicit drug use

63. Contradicting the fear that motivated refusal in 1997 of the Howard government of the Carnell government's proposal for a heroin trial, the treatment produced a reduction in drug use. This was evident doing during the three-year trial in the large reduction noted above in drug dealing offences. There was understandably a quick and big reduction in use of illicit heroin. Participants on the heroin trial reported a dramatic reduction in use of heroin in the first six months of treatment and in the following six-month period a further, albeit less pronounced, progression was found. This reduction extended to other drugs too. Cocaine consumption as reported by the patients and corrected for urine samples also showed a marked progressive tendency to reduction.[48] Decrease in consumption of illicit heroin and cocaine "reduces the risk of continued contacts with the drug market".[49] While "illicit heroin and cocaine use regressed rapidly and markedly, benzodiazepine use decreased only slowly alcohol and cannabis consumption hardly declined at all. In a minority of patients, the continued regular use of cocaine (5%) and benzodiazepines (9%) even after 18 months of treatment remains a difficult therapeutic problem to manage."[50] The study went on to note that "reduction in trafficking of hard drugs is particularly important as hard drug users play an important role in the recruitment of new consumers."[51] This impact was confirmed by a later study of the canton of Zurich carried out a decade after the trial ended and while heroin prescription had become a standard treatment:

> "The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%"[52]

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46. At baseline at baseline 69.9% of the participants had been involved in illegal activities in the previous 30 days. At the end of 12 months this had sunk to 23.4%. Verthein, U., Bonorden-Kleij, K., Degkwitz, P Christoph Dilg , Wilfried K. Köhler , Torsten Passie , Michael Soyka , Sabine Tanger , Mario Vogel & Christian Haasen (2008), 'Long-term effects of heroin-assisted treatment in Germany', *Addiction* 103, pp. 960–966.

47. The same.

48. Uchtenhagen, A. Dobler-Mikola, T. Steffen, F. Gutzwiller, R. Blättler & S. Pfeifer, *Prescription of narcotics for heroin addicts* vol. 1 *main results of the Swiss national Cohort Study* p. 6 (Karger, Basel, Freiburg, Paris &c, 1999) p. 55.

49. The same, p. 58.

50. The same, p. 5.

51. The same, p. 67.

52. Carlos Nordt & Rudolf Stohler, "Incidence of heroin use in Zurich, Switzerland: a treatment case register analysis" in *The Lancet*, vol. 367, pp. 1,830-34 (3 June 2006).

6. Superiority to methadone alone

64. The assessment of heroin assisted treatment in The Netherlands and elsewhere considered combined treatment with heroin and methadone of people with chronic, therapy-resistant opiate dependency. It found that the treatment was safe:

> "The treatment is more effective than in the case of methadone alone. The physical and mental health, as well as social functioning improve, including a reduction of crime."[53]

65. The German trial reported a 73% reduction in illegal drug use for those receiving heroin assisted treatment compared to just 51.5% for those on methadone.[54]

66. According to a survey by the European Monitoring Centre for Drugs and Drug Addiction there was "A consistent finding from this series of randomised trials is of the substantial improvement in health and well-being of the patients receiving [supervised injectable heroin treatment] SIH compared with those provided with oral methadone treatment."[55]

B. Hydromorphone

67. Hydromorphone is an opioid used as a potent painkiller. Trials in Canada have shown that injectable hydromorphone produces results comparable to heroin assisted treatment among so-called "treatment refractory opioid dependent individuals". A 2010 pilot study compared the "treatment response with injectable hydromorphone [with] diacetylmorphine [pharmaceutical-grade heroin]." The result pointed to "Hydromorphone [being] similarly safe and effective as diacetylmorphine as opioid-agonist substitution treatment."[56] A further double-blind controlled trial in Vancouver comparing hydromorphone and heroin found "no statistically significant differences in treatment retention between the double-blind and open-label treatment periods, suggesting that patients can be successfully attracted and retained in treatment with open-label hydromorphone."[57] More

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53. J.E.E. Verdurmen, A.P.M. Ketelaars, M.W. van Laar, *The Netherlands National Drug Monitor: Fact Sheet Drug Policy* (Trimbos Institute, Utrecht, [2005]) p. 20 http://www.trimbos.nl/Downloads/Programmaas/NDM/Factsheetdrugsbeleid-2005DEF%20Engels.pdf.

54. Christian Haasen, Uwe Verthein, Peter Degkwitz, Juergen Berger, Michael Krausz and Dieter Naber, Heroin-assisted treatment for opioid dependence; Randomised controlled trial, *British Journal of Psychiatry*, Heroin-assisted treatment for opioid dependence: Randomised controlled trial, *British journal of Psychiatry* (2007), vol. 191, no. 55 pp. 55-62, table 2.

55. Strang, Groshkova and Metrebian (2012), cited above pp. 160-61.

56. Oviedo-Joekes E, Guh D, Brissette S, Oviedo-Joekes E, Guh D, Brissette S, et al. Double-blind injectable hydromorphone versus diacetylmorphine for the treatment of opioid dependence: a pilot study. *J Subst Abuse Treat* 2010; 38: 408–11.

57. Eugenia Oviedo-Joekesa, Heather Palisa, Daphne Guh, Kirsten Marchanda, Suzanne Brissettec, Scott Harrisond, Scott MacDonald, Kurt Lock , Aslam H. Anis , David C. Marsh, Martin T. Schechter, Treatment with injectable hydromorphone: Comparing retention in double blind and open label treatment periods, *Journal of Substance Abuse Treatment,* vol 101, pp.50-54, June 1, 2019.

serious adverse effects have been reported for heroin assisted treatment than for hydromorphone. These have mostly concerned respiratory depression associated with the heroin. All such events were treated successfully. It is advised that

> "Due to the risk of respiratory depression or epileptic seizures, patients should be observed for at least 15 minutes after heroin injections in a facility with first-aid resources (qualified staff, including a physician, and first-aid equipment)."[58]

68. A subsequent trial comparing adverse events associated with the same two treatments concluded that "When injectable hydromorphone and diacetylmorphine are individually dosed and monitored, their opioid-related side effects, including potential fatal overdoses, are safely mitigated and treated by health care providers."[59] A 2016 report of a trial in British Columbia that confirmed that hydromorphone was comparable in efficacy to heroin treatment observed that some variation in adverse effects in favour of hydromorphone between those pharmacotherapies reinforces the need for " . . . a patient-centered approach that offers a choice of opioids, as is the standard of practice in other clinical areas, such as palliative care."[60] In the midst of an opioid overdose epidemic, injectable options are timely to reach a very important minority of people who inject street opioids and are not attracted to other treatments.

69. Inexplicably the current ACT drug strategy did not retain a commitment found in the earlier ones to "support researchers to seek funding to participate in a clinical research trial of hydromorphone in the ACT."[61] In spite of the apparent equivalence of efficacy of hydromorphone and diacetylmorphine [heroin], this paper urges the clinical adoption of the latter for the reason that it is more studied and implemented than hydromorphone. Undoubtedly hydromorphone should be considered though if heroin is considered impracticable.

70. The failure to retain reference in the current ACT drug strategy to heroin assisted treatment and hydromorphone is all the more inappropriate in the light of the approval of a National Health and Medical Research Council grant signed off by the Commonwealth Health Minister Greg Hunt of a trial of hydromorphone

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58. Reimer, J., Verthein, U., Karow, A., Schäfer, I., Naber, D. and Haasen, C. (2011), 'Physical and mental health in severe opioid-dependent patients within a randomised controlled maintenance treatment trial', *Addiction* 106, pp. 1647–1655.

59. Eugenia Oviedo-Joekes, Suzanne Brissette, Scott MacDonald, Daphne Guha, Kirsten Marchand, Salima Jutha, Scott Harrison, Amin,Janmohamed, Derek Z.Zhang, Aslam H. Anis, Michael Krausz, David C.Marsh, Martin T.Schechter, Safety profile of injectable hydromorphone and diacetylmorphine for longterm severe opioid use disorder in Drug and Alcohol Dependence 176 (2017) 55–62.

60 Oviedo-Joekes E, Guh D, Brissette S, Marchand K1, MacDonald S, Lock K, Harrison S, Janmohamed A, Anis AH, Krausz M, Marsh DC, Schechter MT, Hydromorphone Compared with Diacetylmorphine for Long-term Opioid Dependence: A Randomized Clinical Trial. *JAMA Psychiatry*. 2016 May 1;73(5):447-55.

61. ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 at http://www.atoda.org.au/wp-content/uploads/2017/09/ACT-Alcohol-Tobacco-and-Other-Drug-Strategy-2010-2014.pdf visited 6/2/2020.

under the direction of Professors James Bell, Alison Ritter and Carla Treloar and others of the University of New South Wales.

> "Implementation of time-limited parenteral[62] hydromorphone in people with treatment-resistant injecting opioid use disorder: Feasibility, acceptability, and cost."[63]

This trial was approved in 2019, after the release in December 2018 of the current ACT drug strategy.[64]

71. In the light of the many practical difficulties in the way of the initiation of heroin assisted treatment in Australia, not least the approval of the Commonwealth government and New South Wales and Victorian governments if it is to be imported through those states, hydromorphone may be the more practicable option even though the weight of evidence attested by numerous trials and a Cochrane review favours heroin assisted treatment.

V. Secondary beneficial outcomes of heroin assisted treatment

72. The National Health Service paper that formed the basis for the decision to institute late last year Heroin Assisted Treatment in Glasgow summarises the benefits in the following terms: "Randomised controlled trials from a number of countries have demonstrated that, for this group, heroin-assisted treatment can have both individual and social benefits in terms of retention in treatment, decreased illicit drug use, reduced criminal activity and incarceration and, potentially, reduced mortality. There is also evidence – including from the UK – that heroin-assisted treatment is cost-effective from a societal perspective. Although relatively small numbers of people are eligible for heroin-assisted treatment, the health and social harms they experience, the costs they incur, and their lack of benefit from other treatments, provide strong clinical and economic arguments for its provision."[65]

1. Reductions in risk factors for crime and illicit drug use

73. Regarded by the law as criminals, dependent illicit drug users are quintessentially stigmatised and marginalised from society. These are injecting drug users with a bundle of adverse health and social factors that have " . . . come to be known as severe and multiple disadvantage: homelessness, offending,

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62. Administered or occurring elsewhere in the body than the mouth and alimentary canal. In other words, injectable hydromorphone.

63. National Health and Medical Research Council, 2018 Partnership Projects Third Call for Funding Commencing in 2019 at https://www.nhmrc.gov.au/sites/default/files/documents/attachments/grant%20documents/Partnership-third-call-2019.pdf visited 01/06/2020.

64. ACT Health Directorate, *ACT Drug Strategy Action Plan 2018-2021: A Plan to Minimise Harms from Alcohol, Tobacco and Other Drug Use* (ACT Health Directorate, Canberra, 2018) at https://health.act.gov.au/about-our-health-systempopulation-health/act-drug-strategy-action-plan

65. NHS Greater Glasgow & Clyde, p. 66, (2016) cited above.

chronic poverty, and previous trauma. Such factors are inextricably linked to health, and must be directly addressed if any response to public injecting is to succeed."[66]

74. "The ultimate goal of treatment is thus not just . . ." to help those affected overcome dependence" but also to "be fully reintegrated into society."[67] Re-integration is also the acknowledged objective of opiate replacement therapy within the ACT prison:" The overarching aim of treatment is to provide stability for clients on release, to allow them to participate in employment and other activities and to minimise the legal, health and social harms associated with the use of illicit drugs."[68] The "marked improvements in social functioning" attributed to heroin assisted treatment[69] 'improved in all the intervention groups with heroin groups having slightly better results."[70]

75. The Swiss trial recorded that:

> "The patient's housing situation rapidly improved and stabilised (there was in particular no longer any homelessness).
>
> "Fitness for work improved considerably; permanent employment more than doubled (from 14 to 32%), unemployment fell by more than half (from 44 to 20%); the remainder lived on allowances or any regular employment or engaged in housework.
>
> "Debts during the treatment period were constantly and substantially reduced.
>
> "A third of the patients who depended on welfare on admission required no further support; on the one hand, others now required welfare (as result of the loss of illicit income).
>
> "Contact with drug addicts and the drug scene decline massively but was not adequately replaced by new social contacts during the observation period." [71]

The improvement social integration and reduction of risk factors for crime ascertained German trial of Heroin Assisted Treatment showed comparable improvements:

> "The social situation improved markedly during the 2-year treatment (Table 3). The housing situation stabilized and the proportion of subjects in

66. The same, p. 72.

67. Bammer *et al*., (1999) cited above.

68. Review of the opioid replacement treatment (2018) cited above, p.43

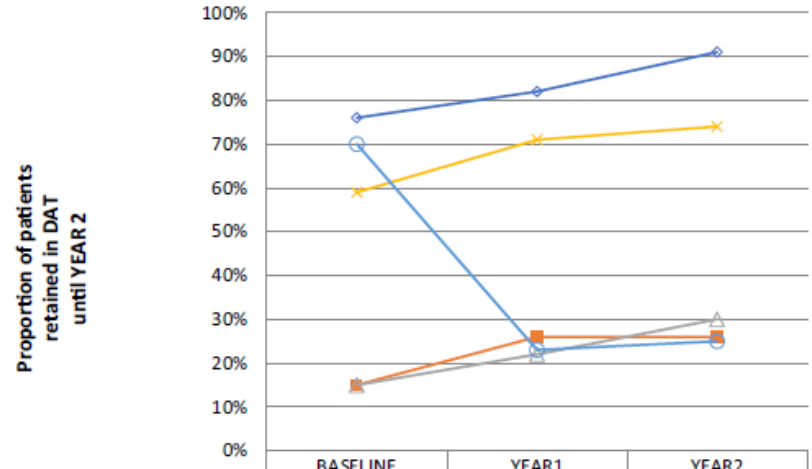
69. Transform Drug Policy, Foundation, Heroin-assisted treatment in Switzerland (ND) at https://transformdrugs.org/heroin-assisted-treatment-in-switzerland-successfully-regulating-the-supply-and-use-of-a-high-risk-injectable-drug/ visited 17/04/2020.

70. Ferri, Davoli & Perucci (2011) cited above

71. Uchtenhagen, A*. et al.* (1999) cited above. p. 6.

employment increased. Drug-free contacts, i.e. leisure activities in the company of people without drug or alcohol problems, increased and leisure behaviour generally improved."[72]

These improvements are summarised following graph:[73]



	BASELINE	YEAR1	YEAR2
Stable housing	76%	82%	91%
Employment	15%	26%	26%
Drug-free social contacts	15%	22%	30%
Leisure activities	59%	71%	74%
Illegal activities	70%	23%	25%

Fig. 2 Significant impact of DAT on participants' social outcomes over 2 years (German study—Verthein et al. [49])

76. These improvements in social deficits characteristically shared by people who end up in prison are translatable into reductions in acknowledged risk factors for crime.[74] To the social deficits can be other added other risk factors like chronic illness and psychiatric disorders that the trials of heroin assisted treatment were also shown to ameliorate. This means that more effective drug treatment that heroin assisted treatment offers reinforces the crime reduction influence of that treatment. With improved social integration there is less incentive to engage in property crime to finance drug habits.

2. Mental health

77. The Swiss trial saw substantial improvements in the mental condition of participants in the trial conducted over three years of heroin assisted treatment more than 40% of whom " . . . were in a poor mental condition on admission. Need

72. Verthein, Bonorden-Kleij, & Degkwitz, et al. (2008), cited above.

73 Bell, Belackova, & Lintzeris (2018) cited above p. 1,347

74. National Anti-crime Strategy, *Pathways to prevention: developmental and early intervention approaches to crime in Australia; Full report* (Attorney-General's Dept, Canberra, 1999) p. 136 at http://www.ag.gov.au/agd/www/rwpattach.nsf/viewasattachmentPersonal/%28E24C1D4325451B61DE7F4F2B1E155715%29~no6_fullreport.pdf/$file/no6_fullreport.pdf visited 24/11/2011

for psychiatric treatment reported by the attending physicians was greater than the need for physical treatment."[75]

> "The general state of mental health improved on average, and the need for treatment was estimated to be slightly lower compared to the status on admission.
>
> "In particular, depression and other affective disorders became less frequent, which is not the case for schizophrenic conditions. Of the schizophrenic psychoses, diagnosed at the outset (N = eight), five stayed on the program for at least 18 months. This matched the mean retention rate in the program, in contrast to high dropout rates of dual diagnosis patients in general.
>
> "Affective disorders required psychiatric treatment considerably less often after the second month in the program. The same applies to personality disorders and other behavioural disturbances. The corresponding data for schizophrenia showed no reduced need for treatment."[76]

78. Comparable improvements in mental health were measured in the first year of the trial in Germany comparing oral methadone with of heroin assisted treatment. The mental health of those recruited was very poor:

> "Almost 70 points (T value) on the Global Severity Index of SCL-90-R [Symptom Checklist] (inclusion criterion was a minimum of 60 points) indicate a high average degree of mental strain. 30% even reach the highest score of 80 points. In external assessment by the Global Assessment of Functioning Scale (GAFS), axis V of the DSM-IV, patients reached only an average score of 53 to 54 points. Accordingly, the clinical global assessment concerning the existence of a mental disease ranges from "moderate," to "distinctly ill". To fit to the study patients had attempted suicide at least once."[77]

79. Improvements in mental health were assessed utilising Symptom Checklist 90 (SCL-90) which is a widely applied self-assessment instrument for a broad range of mental disorders that assesses the subjective symptom burden in patients with mental disorders:

75. Uchtenhagen *et al.* (1999) cited above, p. 44.

76. The same p.51

77. Dieter Naber, The German model project for heroin assisted treatment of opioid-dependent patients – multi-centre, randomised, controlled treatment study; clinical study report of the first study phase (Centre for Interdisciplinary Addiction Research of Hamburg University, January 2006) p. 23 at http://www.heroinstudie.de/H-Report_P1_engl.pdf visited 20/05/2020

> "The development of mental symptoms took a parallel course: the SCL-90 score of heroin patients dropped from 76.3 at baseline to 55.1, methadone patients, the SCL score "only" dropped from 72.7 to 62.1 points." [78]

80. There was a "marked deterioration" in mental health during a trial of two-months when trial treatments were withdrawn.[79] A further research report specifically focusing on the outcomes of the German trial that compared heroin assisted treatment with oral methadone in seven treatment centres noted that:

> "The course of mental distress, as measured by the SCL-90-R, . . . decreased in both groups; the decrease was greater in the heroin group, and, again, within this group it was greater in completers compared to dropouts. Similarly, psychosocial functioning, as measured by the GAF [Global Assessment of Functioning], improved. The initial score improved in both groups, but it was better in the heroin group; in this case, completers of both the heroin and methadone groups benefited more than their respective dropouts."[80]

3. Physical health

81. Physical afflictions are also common among people experiencing mental health problems not to mention among the large co-occurrence of substance dependency and other mental health issues. In the first month of treatment of the Swiss trial "30 abscesses were diagnosed in a subsample of 147 patients. After one year, only one absence per month was diagnosed." After 18 months the Swiss trial found that 18 6% of patients had good health compared to 79% on admission that those with poor physical health declined from 21% on admission to 14% after 18 months.[81] The German trial of heroin assisted treatment used the Opiate Treatment Index [OTI] health scale to measure the improvement in physical health of participants as well as the Symptom Checklist 90 to measure the improvement in mental health. The outcomes are reflected in the following charts:[82]

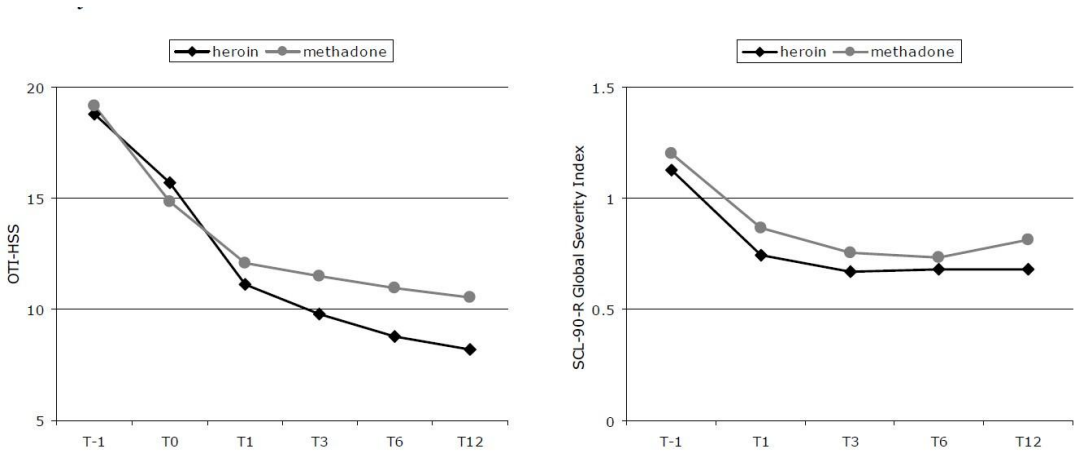
78. The same, p.22 & also table. 7.2, p. 70 at http://www.heroinstudie.de/H-Report_P1_engl.pdf visited 20/05/2020

79. The same, p. 23.

80. Reimer et al. (2011), cited at p. 1651.

81. Uchtenhagen, A. et al. (1999) cited above. pp. 48 & 49.

82. Naber, The German model project for heroin assisted treatment (2006), figure 7.2, p. 80.



82. In another report on the German trial the improvement in physical health was summarised the following terms:

> Physical health, as measured by the OTI–HSS, improved in both treatment groups, although the improvement was more pronounced in the heroin group, and within the heroin group it was more pronounced in completers compared to dropouts. Development of the nutritional status (BMI) and the KPS[83] resembled OTI–HSS data; BMI and KPS improved in both treatment groups and the improvement was again more pronounced in the heroin group, and within the heroin group more pronounced in completers compared to dropouts (Table 3). A pathological electrocardiogram (total n = 582) was present in 20.4% of patients at baseline; this decreased to 17.7% (of n = 339) at follow-up in the heroin group and increased to 21.8% (of n = 243) in the methadone group (the group difference was not statistically significant). The frequencies of pathological echocardiograms decreased in the heroin group and increased in the methadone group.[84]

83. The situation regarding blood-borne viruses to which injecting drug users are particularly exposed discussed below at VI.2 (p. 34).

84. A review of multiple trials concluded that "Patients receiving SIH [supervised injectable heroin treatment] treatment achieved gains in physical and mental health . . ." What is more "available evidence suggests added value of SIH alongside supplementary doses of methadone for long-term treatment-refractory opioid users".[85]

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83. KPS stands for Karnofsky Performance Status which is a standard way used to determine a patient's prognosis and changes in a patient's ability to function.

84. Reimer et al. (2011), cited above at p. 1,651.

85. Strang, Groshkova and Metrebian (2012), cited above p. 12.

VI. Where would the ACT be now if the Australian heroin trial had gone ahead?

85. It is fair to conclude that had the Australia heroin trial gone ahead and, in the light of positive results on a par with those from Switzerland and other countries, been implemented, the landscape of illicit drug use, health, crime and corrections in Australia would be very different from what it has turned out to be.

86. This part will consider the likely impact on the preoccupations facing the ACT government when it moved to establish a heroin trial in the mid-1990s when, to recapitulate, it was facing four epidemics: One of heroin use; a second of blood-borne diseases; a third of opioid overdose deaths and finally an epidemic of crime associated with the increasing heroin use.

87. Let us speculate on the situation that the ACT (and in some cases Australia as a whole could) could reasonably have found itself in had it proceeded with the trial and implemented it.

88. Heroin assisted treatment has produced bountiful dividends that, transposed to an Australian context, will be outlined – benefits like reduced homelessness, poverty and less mental illness bolster social cohesion and reinforce community well-being.

> "The chaos and instability of addiction is a major barrier to better health among [the] population [of injecting heroin users who have failed to benefit from opiate replacement therapies like methadone], . . . Prescribed injectable heroin would be a welcome addition to existing opioid substitution therapies."[86]

89. In the context of the current pandemic, the ACT community would not be as at high risk as it is now from Covid19 virus spreading within and beyond the vulnerable prison population and would have reaped other health and social benefits.

1. Heroin use

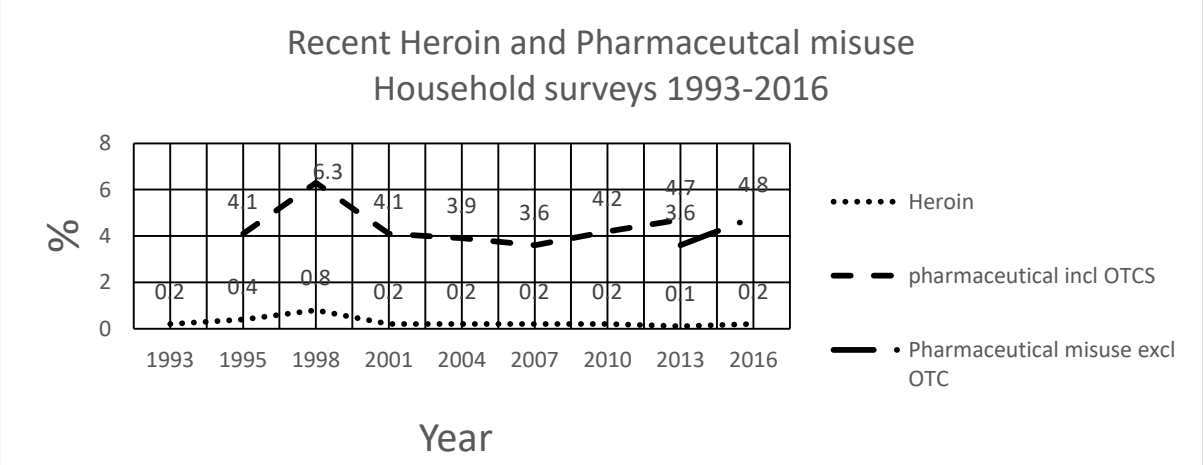
90. Heroin use reach its apex in 1998 when the household survey recorded that 0.8% of the population had used it within the previous 12 months. It was probably higher in the following year but had sunk back to merely 0.2% when the next household survey was conducted in 2001 after the onset of the heroin drought at the end of 2000. Subsequent household surveys have reported that its use has remained fairly stable but opiate misuse has not declined and has indeed expanded. Rather than heroin a lot of the population is turning to pharmaceuticals opiates, often in search of pain relief.

91. In 2018 the ACT Health Services Commissioner described this trend in the following terms:

> "While there has been a decline in the use of heroin in the Australian community since 2010, in favour of drugs such as methamphetamine (ice),

86. NHS Greater Glasgow & Clyde, (2016) cited above p.74

this has been counterbalanced by increasing rates of addiction to prescription opioids such as oxycontin, tramadol and endone, reflecting significant shifts in practice in the use of opioids for pain relief. Australian opioid dispensing episodes increased from 500,000 prescriptions in 1992 to 7.5 million prescriptions in 2012 and it is now apparent that the ongoing use of these medications can lead to dependency and misuse. There is a higher prevalence of misuse of prescription medication amongst female prisoners, with just over one quarter of women in prison reporting misuse of analgesics/painkillers (27% of women compared with 11% of men)."[87]



92. The 2016 household survey noted that: "The majority of people misusing pharmaceutical analgesics and opioids bought them from a pharmacy (52%) and about 1 in 5 obtained it with a prescription or by doctor shopping." Measures to tighten up on these practices are known to drive people seeking pain relief to access the black market for those medications and also for heroin. The resurgence in opiate overdose deaths discussed below is tragic evidence of this trend. The ACT would clearly be in a far better position to ameliorate this situation were the medical profession to have a greater range of treatments options including the capacity to prescribe heroin or hydromorphone. Heroin used to be widely prescribed in Australia until stocks ran out after the Commonwealth prohibited its import in 1953. It is still a widely prescribed analgesic in the United Kingdom for severe pain.

93. The profile of non-medical opiate use and new drugs like the stimulant methamphetamines may have come into fashion but heroin misuse remains a principal drug used by people sentenced to prison: "Lifetime heroin use is up to 10 times higher in the prison population and prisoners are 20 times more likely to inject drugs than the general population."[88]

2. Blood-borne diseases

94. Viral hepatitis remains a major public health concern. 182,144 people in Australia are living with chronic hepatitis C and 226,612 with chronic hepatitis B. There were 10,537 notifications of hepatitis C in Australia and 66 liver transplants due to chronic hepatitis C or hepatitis C related hepatocellular carcinoma (liver

87. Review of the opioid replacement (2018) cited above p. 11.

88. Review of the opioid replacement (2018) cited above p. 10

cancer). An estimated 584 deaths were attributed to hepatitis C. An estimated 584 death were attributed to hepatitis C and 428 deaths attributable to hepatitis B during 2016-2017.[89]

95. 'No cases of HIV have been detected in prison entrants in the NPEBBV&RBS [National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey] since 2007."[90]

> "The prison population is especially at risk of hepatitis C infection, due to the high proportion of people in custody with a history of injecting drug use (IDU), the at-risk behaviours associated with illicit and injecting drug use, including needle-sharing, and other at-risk behaviours, such as amateur tattooing and violence that can lead to blood-to-blood contact. People in prison often come from marginalised groups, where medical care in the community is unavailable or not accessed, so are at risk of having undiagnosed hepatitis C before prison." [91]
>
> "Prison clinics are an ideal place to detect and treat people with undiagnosed hepatitis C. In recent years, new medications for hepatitis C have led to an enormous increase in the treatment rate of people in prison with hepatitis C."[92]

96. 22% of prison entrants are hepatitis C positive but the availability of new direct-acting antiviral treatment mean it is much less of a problem than it was in the 1990s. A 2018 review by the ACT Health Commissioner reported a striking improvement in the prevalence of hepatitis C among inmates:

> "ACT Health have informed us that in 2010 approximately 30% of detainees at the AMC were Hepatitis C positive. In July 2017, with the support of Hepatitis C treatment made available through the Pharmaceutical Benefits Scheme (PBS) in 2016, those figures have reduced to less than 2 percent."[93]

97. While acknowledging that, prisons remain a fertile ground for the contraction and spread of blood-borne diseases. This is because of the extent of injecting drug use, the reuse of syringes that goes on within prisons and the refusal of most governments, prison administrations and corrections officers to countenance the provision of sterile syringes that have helped control the spread of these infections in the community.

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89. Hepatitis Australia, *Hepatitis Statistics* (2019) at https://www.hepatitisaustralia.com/hepatitis-statistics visited 16/04/2020.

90. Australian Institute of Health and Welfare, *The health of Australia's prisoners 2018* (30 May 2019, Cat. no. PHE 246. Canberra: AIHW) p. 56 at https://www.aihw.gov.au/getmedia/2e92f007-453d-48a1-9c6b-4c9531cf0371/aihw-phe-246.pdf.aspx?inline=true.

91. The same, p. 49.

92. The same, pp. 51-52.

93. *Review of the opioid replacement* (2018) cited above p. 49 at http://hrc.act.gov.au/wp-content/uploads/2018/03/ORT-Report-Final-Ready-to-Print.pdf visited 27/04/2020.

98. The Burnett Institute 2010 evaluation of the ACT prison described the extent of injecting drug use in the following terms:

> "Nearly one third reported ever injecting drugs at the AMC and approximately one quarter reported injecting drugs in the past four weeks and that the last time they injected drugs was in prison. Of those that reported injecting in the past four weeks, approximately equal proportions reported injecting less than weekly or weekly or more often."[94]

99. The 2016 health and well-being survey recorded that "Among all respondents, over one-quarter of respondents reported ever injecting heroin (27%) and meth/amphetamines (28%) in prison."[95] The boredom of prison life fosters drug seeking behaviours[96] that is reflected in the prison adage: "a day off your mind is a day off your time."[97]

100. The confronting reality of injecting drug use in prison is described in an AIVL working paper:

> "Syringes are rented out from person to person and reused many times. It is common place for needles to be sharpened on match boxes and other suitable surfaces and if one is lucky enough to have clean injecting equipment then it is heavily guarded and is often the focus of stand over tactics."

101. The health and financial benefits of the needle/syringe programs were assessed in the Commonwealth Government report *Return on Investment in Needle and Syringe Programs in Australia*. That showed clearly that "NSPs are effective in reducing the incidence of both HIV and Hepatitis C and that they represent an effective financial investment by Government."

102. The retreatment of people who have become reinfected with hepatitis C comes at a huge cost to the Pharmaceutical Benefits scheme. "The direct acting antiviral medications are among of the most expensive oral medications in history, with wholesale acquisition prices ranging from $417 (Glecaprevir-pibrentasvir) to $1,125 per day (Ledipasvir-sofosbuvir). . . . For example, the wholesale acquisition cost of a 12-week course of Sofosbuvir is $84,000 and the estimated production cost is $68 to $136.[98]

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94. Stoové, M., Kirwan, A. (2010). External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre. (Burnet Institute: Melbourne) April 2011 p. 125

95. Young J.T., van Dooren, K., Borschmann R., & Kinner S.A. (2017), *ACT Detainee Health and Wellbeing Survey 2016: Summary results.* ACT Government, Canberra, ACT. p. 42 & p. 43 at https://stats.health.act.gov.au/sites/default/files//2016%20ACT%20Detainee%20Health%20and%20Wellbeing%20Survey%20Report.pdf.

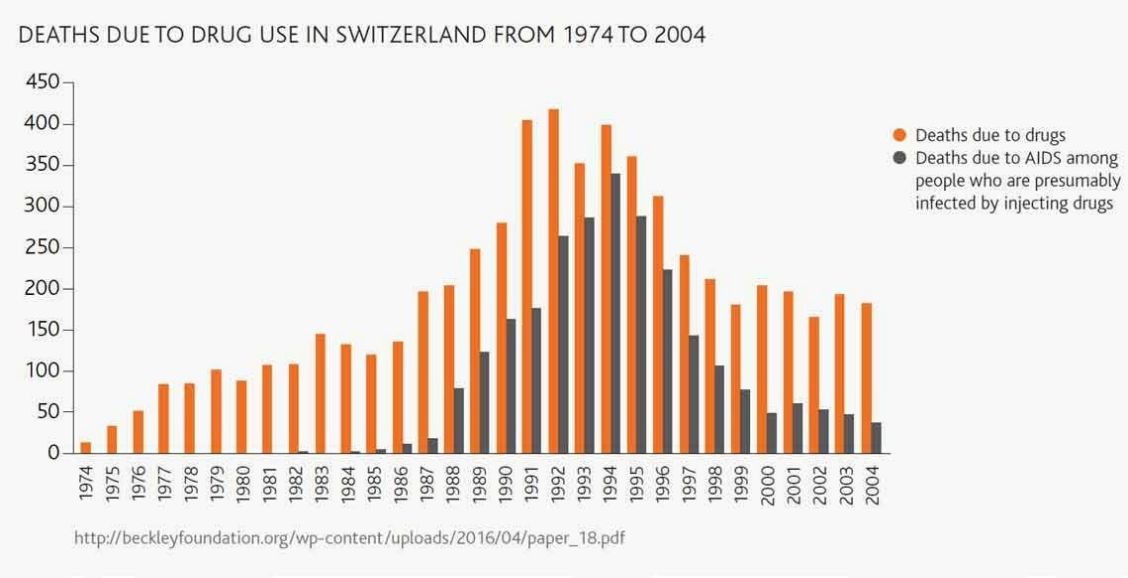
96. The same, p.3 & 12.

97. The same, pp. 24, 25 & 47.

98. Sophie L. Woolston, H. Nina Kim, Cost and Access to Direct-Acting Antiviral Agents (Hepatitis C Online, last Updated: May 31st, 2018) at

3. Opiate overdose deaths

103. The Swiss trial of heroin assisted treatment came close to eliminating the risk of overdose deaths among the 1146 patients on the program. Only two of these died of an overdose though not as result of the prescribed narcotics. One death occurred during treatment and one after dropping out. In all 36 deaths occurred, a majority of which did so after the patient left the program producing a mortality rate for the cohort per treatment year of 1% which was within the range of the mortality rate within the community at large. A higher mortality rate had been expected in view of the considerable impaired health of the participants on admission.[99]



104. Since Switzerland introduced its program in the mid 1990's deaths due to drug use and deaths due to AIDs among drugs addicts have declined steadily.[100]

105. It is reasonable to deduce that had the proposal of the ACT government prevailed and heroin assisted treatment introduced in Australia that there would not have been anything like the number of opiate overdose deaths. In 2016 there were 1,225 such deaths which was higher than the previous peak in 2000 when 1,072 died. Even applying the same 1% death rate experienced in Switzerland to the sum of Australian opiate deaths since 1998, it is fair to say that 17,327 lives might well have been saved had the Howard government not vetoed the heroin trial in 1997.

106. The increase of opiate overdose deaths in recent years owes much to prescription opioids "opiate-based analgesics including codeine, oxycodone and morphine, and synthetic opioid prescriptions including tramadol, fentanyl and methadone."

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https://www.hepatitisc.uw.edu/go/evaluation-treatment/cost-access-medications/core-concept/all visited 27/04/2020

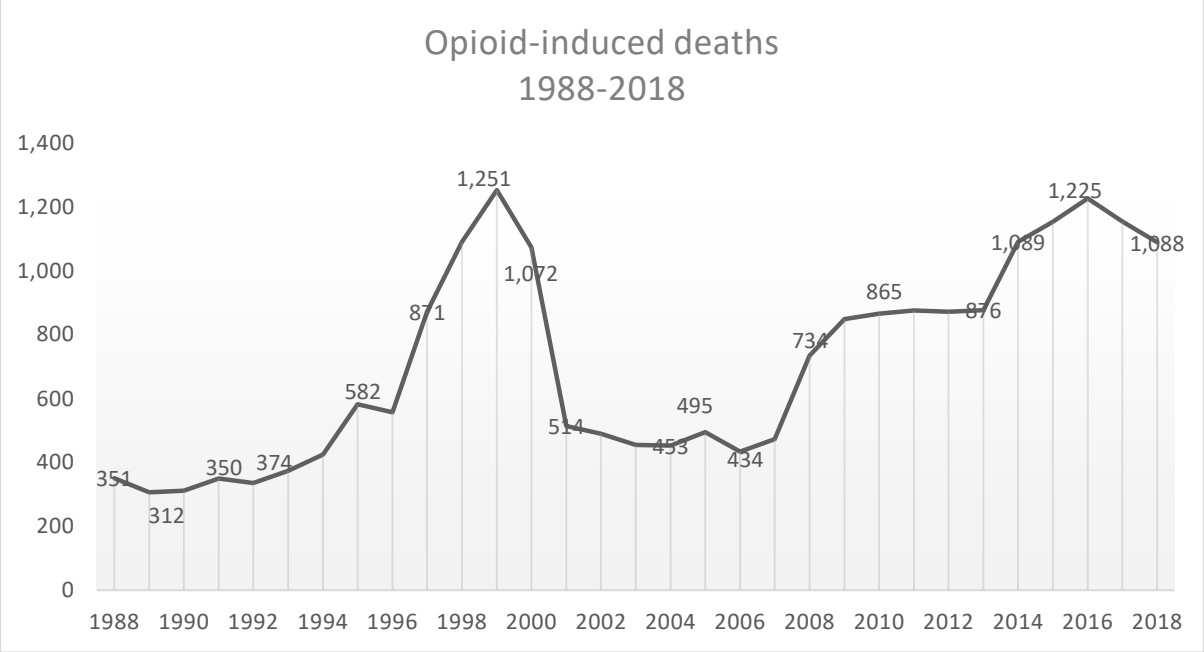
99. Uchtenhagen *et al.* (1999) cited above, pp. 73-75.

100. Transform Drug Policy Foundation, (ND) cited above.

107. Many of the people now dying have become addicted while seeking relief from chronic pain. The response of our political leaders to this complex challenge will, if anything compound the problem. Without large expansion of pain treatment, the response of our political leaders to this complex challenge will, if anything compound the problem. Without large expansion of pain treatment tightening up procedures to clamp down on doctor shopping tends to drive desperate people who have become addicted to pain medications to source their continuing supply from the criminal black market.

108. Moreover, the profile people dying from opiates has changed. The Australian Bureau of statistics noted that "In 2016, an individual dying from a drug induced death in Australia was most likely to be a middle aged male, living outside of a capital city who is misusing prescription drugs such as benzodiazepines or oxycodone in a polypharmacy (the use of multiple drugs) setting. The death was most likely to be an accident.

109. "This profile," the Bureau continued, "is quite different from that in 1999, where a person who died from a drug induced death was most likely to be younger (early 30s) with morphine, heroin or benzodiazepines detected on toxicology at death."



110. In these respects Australia is following on the heels of the epidemic of addiction and deaths in the United States from prescription medication where it is assessed as a phenomenon with economy wide ramifications:

> "Participation in the labor force has been declining for prime age men for decades, and about half of prime age men who are not in the labor force (NLF) may have a serious health condition that is a barrier to work. Nearly half of prime age NLF men take pain medication on a daily basis, and in nearly two-thirds of these cases they take prescription pain medication. Labor force participation has fallen more in areas where relatively more

opioid pain medication is prescribed, causing the problem of depressed labor force participation and the opioid crisis to become intertwined."[101]

111. A concomitant of this opioid crisis has been a rash of "'deaths of despair' [alcohol, suicide, and accidental poisonings]" among prime-age males the highest rates being in counties which "had an average prime-age male participation rate of 73 percent in 2014, compared to 88 percent for the prime-age male population across the country."[102]"

4. Crime reduction

112. The reduction in property crime reviewed above by participants in the Swiss trial of heroin assisted treatment was in the region of 90%. A leading criminologist concluded that "heroin treatment constitutes without doubt one of the most effective measures ever tried in the area of crime prevention."[103]

113. The Cochrane review of eight studies of heroin trials was a little less forthright but still positive: "Results on criminal activity and incarceration were not possible to be pooled but where the outcome were measured results of single studies do provide evidence that heroin provision can reduce criminal activity . . ."104 The review of the European Monitoring Centre for Drugs and Drug Addiction included among the "consistent findings" of the Swiss and other trials a " . . . major disengagement from criminal activities (such as acquisitive crime to fund continued use of 'street' heroin and other street drugs) . . ."[105]

114. One can add to these enhancement of other crime reduction factors brought about by assisted treatment: big reductions in drug dealing by those on the program – and hefty reduction in dealing hard drugs.

5. Imprisonment

115. In 1965 which was when drug law enforcement began to be ramped up, the Australian incarceration rate as a whole was 71.64 per 100,000.[106] The Productivity Commission now report it to be 171.5. Unlike the United States which is seeing a distinct downturn since a peak of 755 in 2008, the Australian rate continues to rise.[107] The situation in the United States is attributable in part to a

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101. Alan B. Krueger, "Where Have All the Workers Gone? An Inquiry into the Decline of the U.S. Labor Force Participation Rate" (Brookings Papers on economic activity, BPEA Conference draft, September 7-8, 2017) at https://www.brookings.edu/wp-content/uploads/2017/09/1_krueger.pdf visited 10/9/17

102. The same.

103. Translation from Martin Killias, Marcelo F. Aebi, Denis Ribeaud & Juan Rabasa, Rapport final sur les effets de *la prescription de stupéfiants sur la délinquance des toxicomanes*, 3rd ed. (Institut de police scientifique et de criminologie, Lausanne, September 2002) p.80.

104. Ferri, Davoli & Perucci (2011), cited above.

105. Strang, Groshkova & Metrebian (2012), cited above, p. 161.

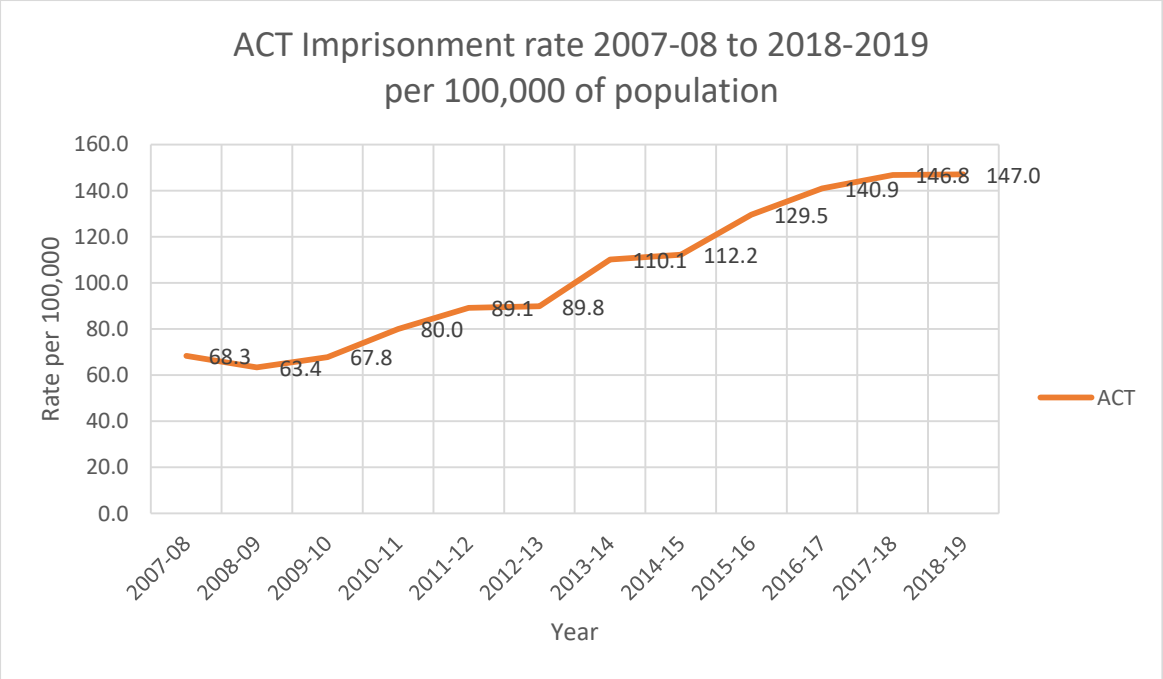
106. Adam Graycar & Peter Grobosky eds, *The Cambridge handbook of Australian criminology* (Cambridge UP, 2002) table 1.3, p. 16.

107. https://books.google.com.au/books?id=2xFYQLiLlSUC&pg=PA105&lpg=PA105&dq-=Prison+population+rate+and+composition,+and+occupancy+level,&source=bl&ots=nq8m

perception that the rate of incarceration is financially unsustainable.[108] The decline which followed the Global Financial Crisis and a 2011 order of the Supreme Court to reduce overcrowding.[109]

116. While the imprisonment rate in the ACT is substantially less than for Australia as a whole, its increase represents a shattering of the vision for a human rights compliant, rehabilitative correctional institution that guided the decision for the territory to establish in 2008 its own prison rather than continuing to transport prisoners to New South Wales. This vision was reflected in according it the name of the great 19th-century penal reformer, Alexander McConachie.

117. Measured by the number of people per 100,000 in the population, the incarceration rate in the ACT has shot up in the decade from 2009–10 when a mere 67.8 Canberrans found themselves behind bars. This had grown to 147 in 2018–19, an increase of 117%. Since the ACT prison was officially opened on 11 September 2008 the ACT rate of incarceration has increased by 132%. In terms of numbers: "the prison commenced operations in 2009. Since that time the prison population at AMC has expanded rapidly, from 158 detainees in July 2009 to 441 in 2016 and the prison has increased its capacity from approximately 270 to 539 through the addition of new accommodation units."[110]



W9DrMn&sig=ACfU3U2DJfLTnSM_-lLHiWkhZmPqyh8Fgg&hl=en&sa=X&ved=2ahUKEwiNsYPz1L7oAhWIILcAHQdjBg0Q6AEwAHoECAkQAQ#v=onepage&q=Prison%20population%20rate%20and%20composition%2C%20and%20occupancy%20level%2C&f=false

108. Jacobson *et al., op.cit*. p. 12.

109. David Biles, No Excuse for complacency: bar problems with jail systems in Australia pale by comparison, the US reminds us of the mistakes to avoid, *The Canberra Times,* Monday,May 7, 2012 p 9

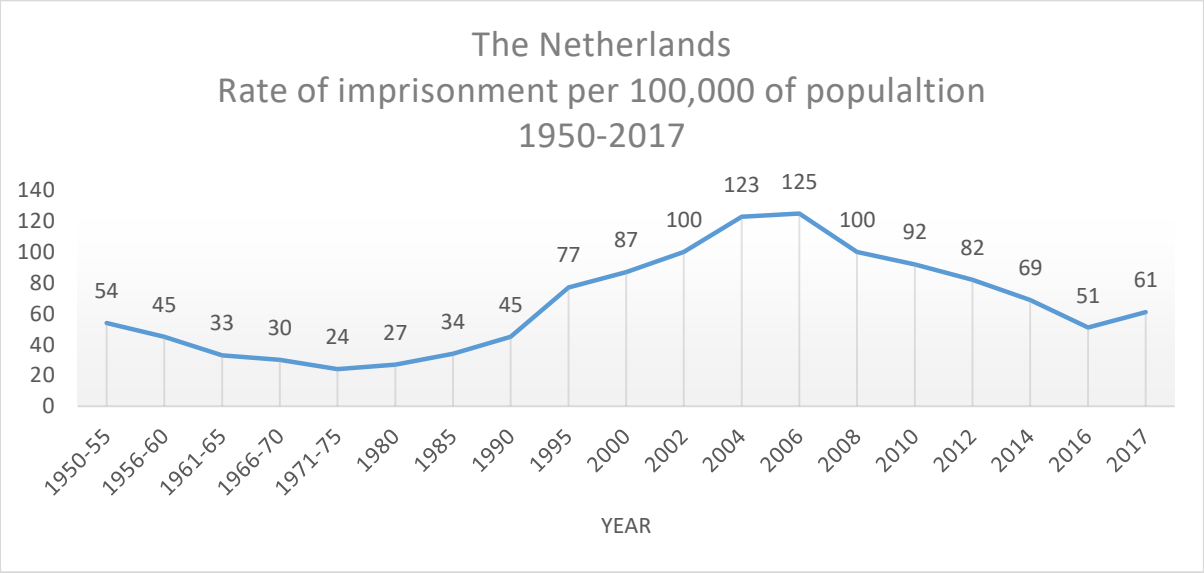
110. *Review of the opioid replacement treatment* (2018) cited above, p.13

SOURCE: Productivity Commission (2020): 8A Corrective services — Data tables contents table 8A.5 at https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/justice/corrective-services/rogs-2020-partc-section8-data-tables.xlsx & : Productivity Commission, Report on government services 2018, corrective services, Table 8A.5.

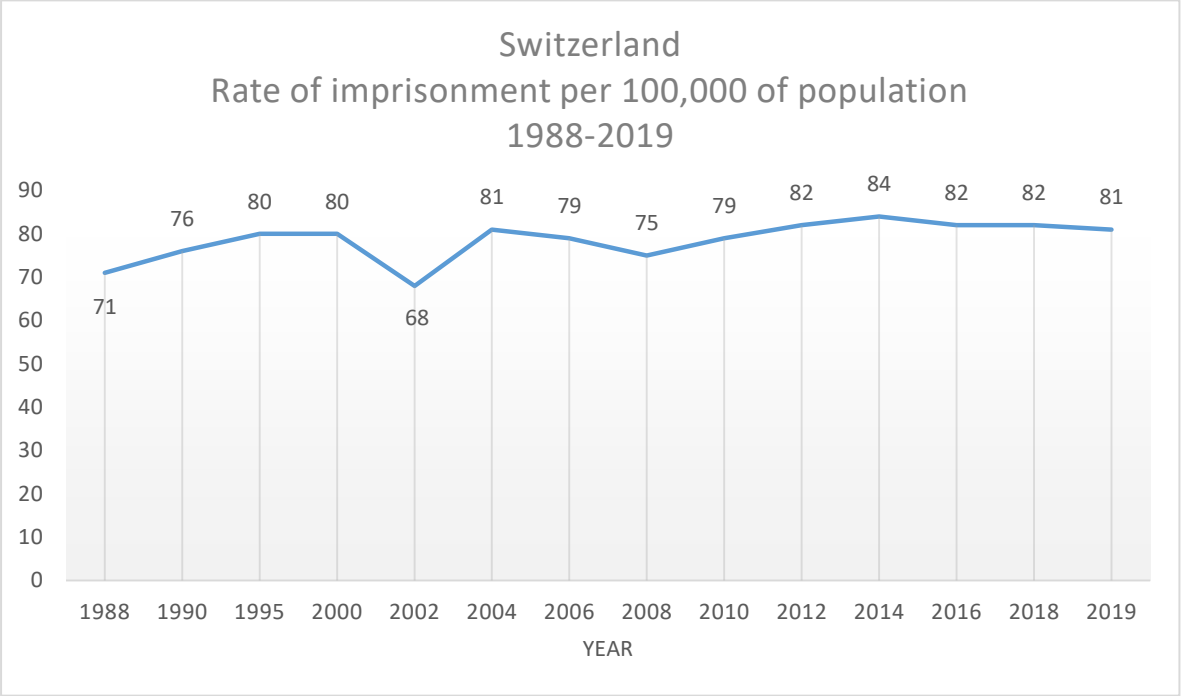
118. It is not easy to draw comparisons between the ACT and the imprisonment rate in overseas jurisdictions. This is because of the multitude of societal factors that bear upon the level of crime and the administration of the justice system. These factors include the demography, the extent that drug treatment services are rolled out across the community and attitude of the media and the community towards crime and punishment. Subject to the foregoing caveats it is still instructive to compare the ACT with other jurisdictions which have taken a somewhat less punitive attitude to drug use. Set out below is, therefore, information on the rate of imprisonment in The Netherlands, Switzerland, Germany, Denmark, Canada, British Columbia and the United Kingdom all of which have adopted to some extent heroin assisted treatment. A significant British development occurred in Scotland in November 2019, when a clinic providing the treatment was opened in Glasgow in Scotland with the aim of treating "20 patients with the most severe, long-standing and complex opioid problems in its first year, and 40 in the second year." This followed hot on the heels of a similar clinic in Middlesbrough.

119. Noted are the percentage difference in the rate of these jurisdictions compared to that of the ACT as well is the number of detainees that that difference represents. The following data are taken from the World Prison Brief at https://www.prisonstudies.org/highest-to-lowest/prison-population-total:

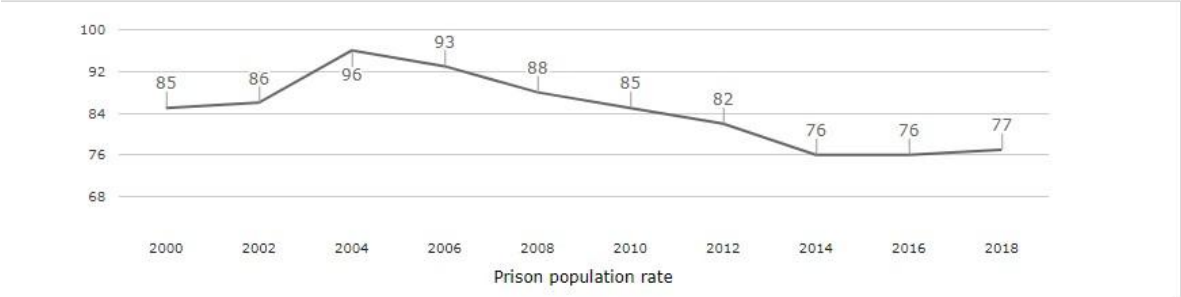
120. Netherlands: 61 per 100,000 = 41% of the ACT imprisonment rate translating to 277 fewer detainees



121. Switzerland: 81 = 55% of the ACT imprisonment rate translating to 212 fewer detainees



122. Germany: 77 = 52% of the ACT imprisonment rate translating to 225 fewer detainees



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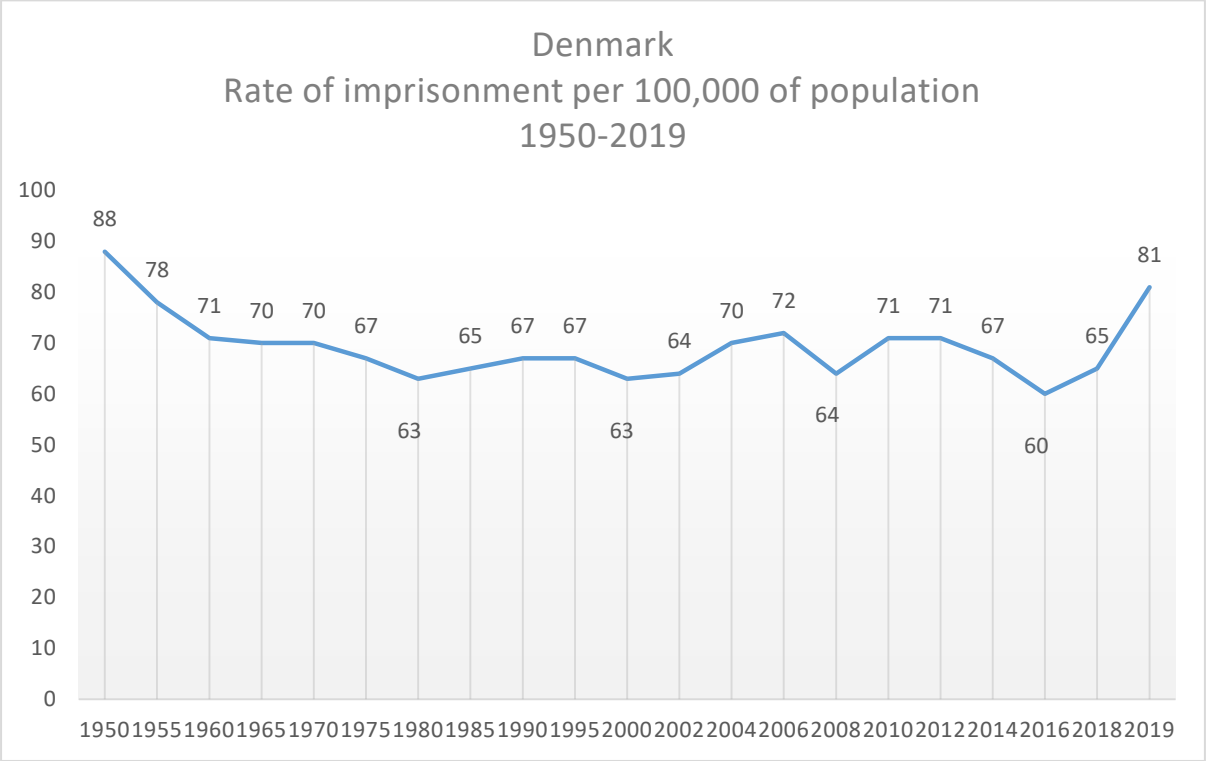
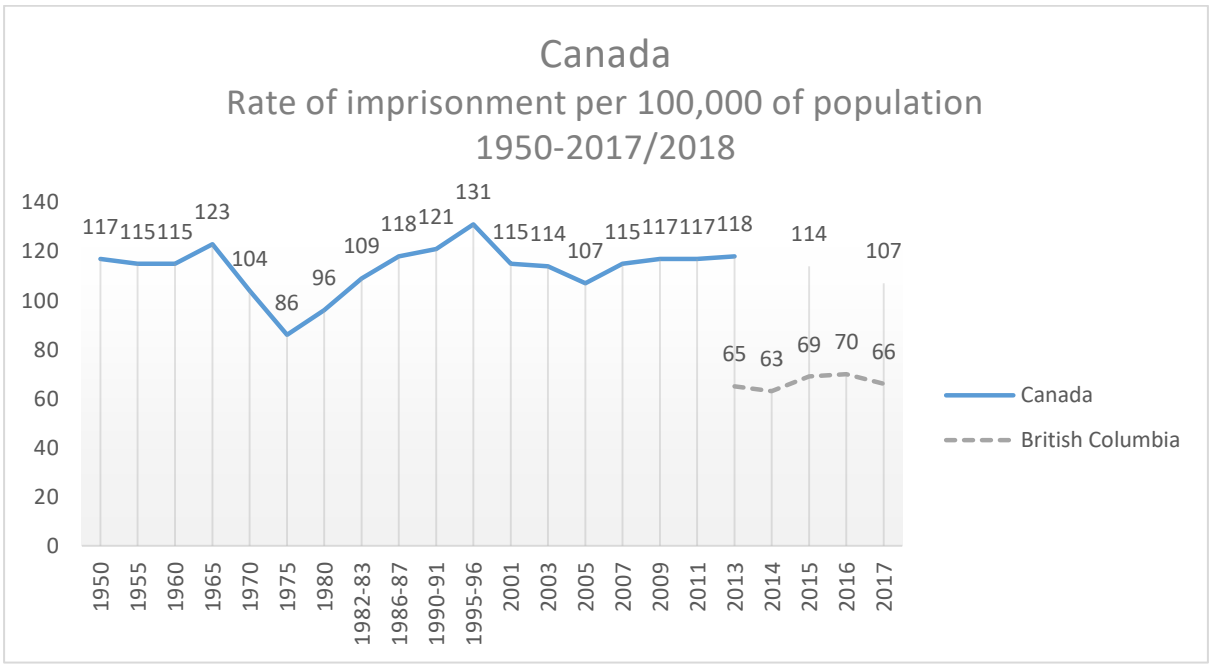
111. *World Prison Brief* data at https://www.prisonstudies.org/country/germany

123. Denmark: 81= 55% of the ACT imprisonment rate translating to 212 fewer detainees



124. Canada: 107 = 76% of the ACT imprisonment rate translating to 113 fewer detainees

British Columbia: 66 = 44.9% of the ACT imprisonment rate translating to 261 fewer detainees



SOURCE: *World Prison Brief* data for Canada as a whole; British Colombia imprisonment rates are taken from *Adult correctional statistics in Canada*, a series beginning with that of 2013/2014 to 2017/2018.

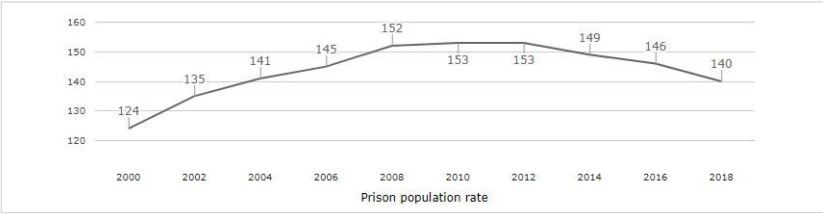
125. The imprisonment rates reported in the *Adult correctional statistics in Canada series do not appear to correspond with those in the World Prison Brief.* The 2015/2016 issue commented that:

> *"*In 2015/2016, there were on average 120,568 adult offenders on a given day, in either custody or in a community program1 (Table 1) among the 11 reporting provinces and territories for which both custody and community data were available. This represents a rate of 438 offenders per 100,000 adult population, a decrease of 3% from the previous year and a decline of 16% compared to 2011/2012."

126. Participants in a Canadian ministerial review in 2016[112] of the criminal justice system highlighted the decline in imprisonment in the youth justice system over the past twenty years.

> "Many participants felt the successful approaches in the youth justice system could also apply to the adult criminal justice system.
>
> . . .The drop was steepest in British Columbia. Its government began funding better community-based alternatives to custody. The number of youth in custody fell, so custody centres closed. That freed up money for better programming, which led to lower caseloads for community staff."

127. United Kingdom: England & Wales: 140 = 95% of the ACT imprisonment rate



128. The imprisonment rate in Scotland (140) is the same as in England and Wales.

129. In November 2019, a clinic providing the treatment was opened in Glasgow in Scotland with the aim of treating "20 patients with the most severe, long-standing and complex opioid problems in its first year, and 40 in the second year."

130. The United Kingdom has long permitted the prescription of heroin for the treatment of opiate addiction though the numbers who have been able to access it had been very small. As of about 15 years ago around 450 patients are prescribed heroin in Britain.[113] Just as used to be the case in Australia, heroin is a widely prescribed analgesic in the United Kingdom for severe pain. In October 2019 a

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112 Jody Wilson-Raybould, What we heard - Transforming Canada's criminal justice system: Message from the Minister, circa2016, at https://www.justice.gc.ca/eng/rp-pr/other-autre/tcjs-tsjp/p1.html.

113. Nicola Metrebian, a research fellow at Imperial College London, quoted in "Handouts fix drug crime" in http://www2.swissinfo.org/sen/swissinfo.html?-siteSect=2251&sid=6001767&cKey=1123755067000 visited 22/3/2007.

clinic permitting the medically supervised supervision of heroin injection was opened in Middlesbrough. The numbers receiving heroin assisted treatment in England and Wales and Scotland are too small to have any detectable impact on the rate of crime and imprisonment.

B. Secondary beneficial outcomes of heroin assisted treatment

131. What, might, one asks, is the purpose of providing heroin to treat those addicted to the same substance? The answer is clear when one looks for benefits well beyond the narrow confines of medical treatment for an addiction:

> "In fact, the answer to this question is remarkably similar to the answer for other medication-based treatments — it is the quitting of use of 'street' heroin, alongside other improvements in physical and psychological well-being, as well as the disengagement from any criminal activity and broader social integration."114

1. Reductions in risk factors for crime and illicit drug use

2. Social integration

132. The Cochrane review of trials comparing the extent that heroin assisted treatment promoted social integration came out firmly in favour of treatments involving heroin:

> "Social functioning improved in all the intervention groups with heroin groups having slightly better results. If all the studies comparing heroin provision in any conditions vs any other treatment are pooled the direction of effect remain in favour of heroin."115

133. A similar intervention in Canberra has the ability to reduce the social deficits of both the existing crowd of prisoners and the population likely to take their place who in the words of the Public Health Association of Australia " . . . have poorer health than the general community, with particularly high levels of mental health issues, alcohol and other drug misuse, and chronic conditions. They are a vulnerable population with histories of unemployment, homelessness, low levels of education and trauma."116

134. The 2010 inmate survey confirmed the applicability to the ACT of this description:

> "A majority of the participants came from a socially disadvantaged background. Thirty-eight per cent of participants were placed in care before 16 years of age; 19% of participants had either parent incarcerated when he/she was a child (Table 3); 42% of participants had spent some time in juvenile justice when they grew up; 68% of participants were excluded from

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114. P. 160.

115. Ferri, Davoli & Perucci (2011) cited above p.1

116. Public Health Association of Australia, *Prisoner health background paper (*Deakin ACT, October 2017) at https://www.phaa.net.au/documents/item/2579 visited 21/04/2020.

school; only 47% of participants were employed six months prior to imprisonment: and 6% had never been employed."[117]

135. The 2016 survey[118] confirmed and expanded upon this picture of disadvantage:

In care: 23% of a smaller sample of participants had been "in care before 16 years of age";

Removal from family: "Twenty-three respondents (24%) reported that they had been removed from their family for one month or more. Sixty percent of these respondents reported that they had been placed in institutions; and few reported placements with other family members."

Parent incarcerated: 21% of them had a parent who was incarcerated when participant was a child

Juvenile detention: "One-quarter (25%) of non-Indigenous respondents indicated that had ever experienced custody in Bimberi or Quamby, compared with 61% of Indigenous respondents." Quamby operated until 2006 when Bimberi replaced it. The survey added that "Respondents with a history of juvenile detention reported being in juvenile detention on a median of 4 occasions (range 1 to 50). Non-Indigenous respondents reported slightly more episodes of juvenile detention compared with Indigenous respondents (median of 4.5 vs. 4.0 occasions, respectively)."

Education: "Respondents indicated that they had spent fewer than 10 years (mean ±standard deviation (SD)) 9.6 years (±1.7) (range 5 to 12 years) at school. Indigenous respondents left school at a mean age of 14.3 years (±1.4); non-Indigenous respondents left school at a mean age of 15.7 years (±1.8).

Exclusion from school: "Nearly two-thirds of respondents (64%) reported that they had never been expelled from school. Of those who reported being expelled, the first expulsion occurred at a mean age of 12.3 years (±3.3)."

Employment: "44% reported employment in the six months prior to prison."

Victimhood of crime: "Nearly three-quarters of respondents (73%) reported that they had ever been a victim of crime; over half (56%) were a victim of person-based crimes and 37% of property-based crimes (Table 2.1.2)."

Housing: "Approximately one in five of respondents (21%) reported unstable accommodation in the four weeks prior to their current incarceration (Table 2.2.1)."

136. More effective drug treatment as exemplified by trials of heroin assisted treatment facilitates social reintegration of troubled young people who typically fill the ACT prison. The adoption of such treatment here can be reasonably expected to reduce the flow of people into the prison and to facilitate the release of many

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117. ACT Health, *2010 ACT Inmate Health Survey: Summary results* (Canberra 2011) p.71

118. Young *et al.* (2017) cited above.

already inside it. In blunt terms better drug treatment can turn off the tap and drain away much of the problem.

3. The quick return of heroin assisted treatment

137. The benefits of heroin assisted treatment manifest themselves quickly. In the Swiss heroin trial there was a marked decrease in those on the program committing offences "in the first six months of treatment . . . And in the second six months there was a further reduction."[119] A recent review of different studies noted that "Most improvement occurs within the first 6–12 months of SIOT, improvements plateau at 2 years, and at follow-up a degree of improvement is sustained."[120] The report of the Swiss trial records improvements within a matter of months in a large range of metrics: in accommodation, employment social contact and mental health. Of mental health the study tracked depression, anxiety/delusion and aggressive acting-out: "follow-up analysis over 18 months showed a reduction in depressive syndrome is. Anxiety and delusional syndrome is also diminished markedly as did aggressive acting-out. The decrease in depressive symptoms occurred primarily in the first 12 months of treatment and then remained stable. The decrease in anxiety and delusional symptoms was continuous and extended beyond the first 12 months of treatment. The decrease in aggressive behaviour also showed further improvement after 12 months of treatment."[121]

VII. Mental health problems

138. "Mental health problems are " . . . a strong risk factor for future offending in adults. There is emerging evidence that adult onset offending may be directly associated with adult-onset mental health problems, particularly schizophrenia and bipolar disorders."[122]

139. People with mental health conditions are aggregated in prisons. The 2016 health and well-being survey of ACT detainees found that over half of respondents (54%) reported that they had received one or more mental health diagnoses in their lifetime. Twenty-one respondents (21%) indicated that they had ever been admitted to a psychiatric unit or ward in a hospital, including 14% of Indigenous and 24% of non-Indigenous respondents.

140. The majority of participants had other mental health issues. About 70% of them had a formal psychiatric assessment at some time in their lives. Among those being assessed, 27% were told that they had Attention Deficit Hyperactive Disorder. Further, a notable portion of the participants (40%) had suicidal thoughts. Among those who had suicidal thoughts, 69% of them had attempted

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119 Uchtenhagen, A. et al. (1999) cited above. p. 67.

120. James Bell, Vendula Belackova, Nicholas Lintzeris, Supervised Injectable Opioid Treatment for the Management of Opioid Dependence, *Drugs* (2018) 78:1339–1352; Drugs. 2018 Sep;78(13):1339-1352 at p. 1349.

121. The same pp. 52-53.

122. Queensland Productivity Commission, *Imprisonment and recidivism, final report*, vol. 1 (2019) cited above,p. 61 and p. 62.

suicide. About 62% of the participants had experienced a head injury where they became unconscious

141. The draft report this of the Commonwealth Productivity Commission in the course of its current investigation into mental health records that:

> "People with mental illness are overrepresented in every part of the justice system. Among police detainees, around 43% of males and 55% of females were reported to have a previously diagnosed mental disorder; while around 40% of prison entrants have been told they have a mental health disorder at some stage in their life (including substance use disorder) — double the rate of the non-prison population. Mental illness is particularly common among female prisoners, and at a much higher level among those Aboriginal and Torres Strait Islander people who are in prison."

142. The Australian Institute of Health and Welfare stresses the much higher prevalence of mental illness in prisons than in the community at large:

> "Mental health conditions, particularly severe conditions, are over-represented in the prison population. For example, the prevalence of psychosis in a London prison population was found to be more than 20 times that of the general community, and almost 70% of people in prison had more than one mental health disorder".

143. This is confirmed in the ACT context by the 2016 health and well-being survey of ACT detainees which found that over half of respondents (54%) reported that they had received one or more mental health diagnoses in their lifetime. Twenty-one respondents (21%) indicated that they had ever been admitted to a psychiatric unit or ward in a hospital, including 14% of Indigenous and 24% of non-Indigenous respondents.

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1. Co-occurrence of substance dependency and other mental health issues

146. The crossover between substance dependency and other mental health conditions is so common that the ground-breaking Senate Select Committee on Mental Health in 2006 termed it “the expectation not the exception”.[123] That Committee lamented that:

> “Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system.”[124] (Senate Mental Health (2006)).
>
> “Population estimates indicate that more than one-third of individuals with an AOD use disorder have at least one comorbid mental health disorder; however, the rate is even higher among those in AOD treatment programs. Additionally, there are a large number of people who present to AOD treatment who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder”[125].

147. The Queensland Productivity Commission inquiry into imprisonment and recidivism heard that mental illness is among a cluster of risk factors that "increases chances of offending and imprisonment. Risk factors arise from many sources, including birth related events, mental health, personal relationships and substance use. Queensland research shows that both offenders and prisoners are likely to have had mental health issues and/or a history of child neglect story of child neglect."[126]

148. “A systematic literature review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia found rates ranging from 47% to 100%. In addition, a large number of people who present for substance use treatment display symptoms of mental disorders, while not meeting the full criteria for a diagnosis of a disorder.”[127]

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123. Senate 2006: Senate, Select Committee on Mental Health, *A national approach to mental health: from crisis to community,* First report (March 2006) chapt. 14.

124. The same §2.29.

125. Marel C, Mills KL, Kingston R, Gournay K, Deady M, Kay-Lambkin F, Baker A, Teesson M (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* (2nd edition). (Commonwealth Department of Health, Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales) p. xi.)

126. Queensland Productivity Commission, Imprisonment and recidivism, final report, vol. 1 (August 2019) p. 58 at https://qpc.blob.core.windows.net/wordpress/2020/01/FINAL-REPORT-Imprisonment-Volume-I-.pdf visited 02/05/2020.

127. Productivity Commission, Mental Health*, Draft Report (Productivity Commission, October 2019*, volume 1) p. 324 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf visited 02/06/2020.

149. "For young people aged 10-24 years, alcohol and other drug (AOD) use are the leading causes of the total burden of disease in males (8.2% and 2.0%, respectively), and alcohol and iron deficiency in females (3.4% and 1.0%, respectively)."[128]

150. "As a whole, mental and substance use disorders make up 12% of the total health loss in Australia, behind cancer, cardiovascular diseases, and musculoskeletal conditions (AIHW 2019c). However, they represent the second highest proportion of years lived with disability in Australia (figure 2.9)."[129])

2. Those with the most complex needs end up in prison

151. Those with a high co-occurrence of substance dependency and other mental health issues often become enmeshed in the criminal justice system. This is the cohort of "consumers with the most complex mental health needs" (draft report vol. 1, p. 27) whose difficulties the Productivity Commission notes "can be more profound . . ., due to additional stigma and discrimination" (p. 625). It is the co-occurrence that elevates the risk of offending, reoffending and return to prison. A 2010 American study found that:

> "those with a co-occurring psychiatric and substance use disorder presented with a substantially higher risk of multiple incarcerations over a 6-year period compared to prisoners with psychiatric disorders alone or substance use disorders alone."[130]

Relying upon an extensive survey of the prison population in New South Wales the NSW Law Reform Commission mentions that "it would appear that the rate of mental health impairment in prisoners is more than triple the rate in the general population, with the rate of over-representation varying, in some cases significantly, depending on the actual mental health impairment concerned. For example, the rate of psychosis in sentenced and reception prisoners is much greater than the apparent rate in the general population – possibly as much as 21 times the rate in the general population."[131] "Research comparing community and prison samples in the UK found that the weighted prevalence of psychosis in prisons is 10 times greater than that of the general population."[132]

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128. Orygen, The National Centre of Excellence in Youth Mental Health,and headspace, *Submission to the Productivity Commission's Inquiry into Mental Health*, April 2019, p.3.

129. PC, Mental Health Draft Report, (2019) vol. 1, cited above, p.153.

130. As summaried in Artemis Igoumenou, Constantinos Kallis, Nick Huband, Quazi Haque, Jeremy W. Coid & Conor Duggan, Prison vs. hospital for offenders with psychosis; effects on reoffending, *The Journal of Forensic Psychiatry & Psychology*, v. 30 no.6, pp. 939-958, (7 Aug 2019) p. 940.

131. NSW Reform Commission, People with cognitive and mental health impairments in the criminal justice system: Diversion, Report 135 (June 2012) p.90 at https://www.lawreform.justice.nsw.gov.au/Documents/Publications/Reports/Report-135.pdf.visited 25/04/2020.

132. Igoumenou *et al,*cited above, p.939.

152. Drug prohibition underpinned by the criminal law has criminalised mental ill health producing an epidemic of imprisonment of people with co-occurring substance dependency and other mental health conditions.

> Forensic hospitals receive an ever-increasing share of the mental health budget. Even so, most mentally ill offenders do not get the benefit of such sustained and comprehensive rehabilitation, and are instead crowded into our new asylums, the prisons, where the prevalence of schizophrenia is at least 10 times that of the wider community.[133]

153. It has been evident to forensic psychiatrists for many years that " . . . the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing. In one of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995".[134] Substance abuse problems among persons with schizophrenia increased from 8.3% in 1975 to 26.1% in 1995.[135]

154. The large-scale co-occurrence of substance dependency and other mental health conditions complicates the treatment of both conditions and life of the people experiencing both. This complication is intensified by the fact that the same mutually reinforcing correlates constitute risk factors for mental illness,[136] drug dependency,[137] crime and imprisonment[138] creating a knot of complexity and

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133. Olav Nielssen, Patrick McGorry, David Castle and Cherrie Galletly, The RANZCP guidelines for Schizophrenia: Why is our practice so far short of our recommendations, and what can we do about it? at *Australian & New Zealand Journal of Psychiatry* 2017, Vol. 51(7) 670–674 at https://www.pc.gov.au/__data/assets/pdf_file/0003/238260/sub037-mental-health-attachment2.pdf visited 26/04/2020.

134. Paul E Mullen, Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services (2001) p.17 at http://crg.aic.gov.au/reports/mullen.pdf visited 02/06/2020.

135. Cameron Wallace, Paul E. Mullen & Philip Burgess, "Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders" in *American Journal of Psychiatry*, vol. 161, pp. 716-727 (2004).

136. Commonwealth Department of Health and Aged Care, *Promotion, prevention and early intervention for mental health-a monograph* (Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, 2000) at https://familyconcernpublishing.com.au/wp-content/uploads/2013/12/PPEiMentalHealth2000.pdf visited 13/11/2018.

137. Penny Mitchell, Catherine Spooner, Jan Copeland, Graham Vimpani, John Toumbourou, John Howard and Ann Sanson, *The role of families in the development, identification, prevention and treatment of illicit drug problems: commissioned by the NHMRC for the Strategic Research Development Committee's National Illicit Drug Strategy Research Program* (National Health and Medical research Council, 2001) at https://test1.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds8.pdf visited 21/04/2020.

138. National Anti-crime Strategy, *Pathways to prevention: developmental and early intervention approaches to crime in Australia; Full report* (Attorney-General's Dept, Canberra, 1999) at researchgate.net/publication/43493789_Pathways_to_Prevention_Development_and_Early_Intervention_Approaches_to_Crime_in_Australia.

dysfunction dauntingly hard to disentangle. The Productivity Commission's 2019 draft report reflects upon this interplay:

> People with dual diagnosis commonly experience poorer physical health, greater levels of disability and increased risk of suicidal behaviours than those with substance use disorders only (Prior et al. 2017). In addition, clients presenting with comorbid mental health conditions often have a variety of other family and social problems, such as housing, employment, welfare and legal problems (Marel et al. 2016, p. xi). This can lead to social isolation and higher levels of distress for their families and carers (VIC DHHS nd).[139]

3. Overcrowded condition of Australian prison

155. The annual Reports by the Commonwealth Productivity Commission on Government Services charts the extent to which Australian prisons are overcrowded. Its Report on Government Services Table 8A. has it that the ACT prison utilisation is 110.5% thus exceeding its design capacity. This is better than New South Wales that incarcerate's the largest number of prisoners in the country (the latest reported figure of 122.9% is for 2016-17) but more crowded than Queensland (105.5%).

156. The impacts of the crowded conditions in the ACT are reflected in reports of the ACT Inspector of Correctional Services.[140] He writes that overcrowding compounds the difficulty of managing the complexity of the sole ACT prison population that must accommodate males and females and prisoners of all classifications: "overcrowding at the AMC is placing pressure on the ability of ACTCS to make accommodation placements that address individual needs." (p. 39). For example," significant overcrowding limits the ability of AMC management to ensure older detainees can access an appropriate physical space" (p. 97). The situation is worse for women than for men. Women are now accommodated " . . .in a former male high security unit while male protection detainees occupy the Women's Community Centre cottages." This, the inspector commented, "is unsatisfactory". The women are disadvantaged with regard to access to green space, recreation opportunities, employment, and reintegration programs and their proximity to men's units exposes them to verbal harassment and abuse. The ACT government needs to find a quick and effective solution to this problem (p.21).

4. The unhealthiness of prison environment for people with mental illness and other disabilities.

157. Jail populations are made up of many suffering from different disabilities – far more than the 18% estimate for the community at large. They include people

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139. PC, Mental Health Draft Report, (2019) vol. 1, cited above p. 324 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf visited 02/06/2020.

140. ACT Inspector of Correctional Services, Report of a review of a correctional centre, *Healthy prison review of the Alexander Maconochie Centre 2019 (*ACT Inspector of Correctional Services, Canberra 2019) at https://www.ics.act.gov.au/__data/assets/pdf_file/0007/1429495/191120-OCIS-AR-Final-Web-Version.pdf visited 28/03/2020

with acquired brain injury, and those suffering from a substance dependency as well as other mental health conditions. The 30% of the ACT prison population who have a disability[141] have a hard time there.

158. A detainee survey found that:
44% (n=71) reported that their needs arising from a disability are 'rarely' or 'never' met
28% (n=71) reported being discriminated against by other detainees and that
39% (n=72) reported being discriminated against by staff

159. The Inspector commented:

> "The experience of having a disability in detention can vary widely and be very significant. For example, there may be physical accessibility issues; limitations around understanding prison routine and instructions; barriers to fully participating in programs, education and work; a risk of increased social isolation; increased vulnerability to bullying, harassment and physical or sexual violence; difficulty coping with prison conditions resulting in co-morbidity with mental health disorders and other physical conditions; and behavioural responses or actions resulting from not understanding rules and expectations that are punished as discipline breaches."[142]

160. "Prison culture can be scary and threatening. The rules by which we live in the community often mean nothing in the prison environment."[143] Scary and threatening the ACT prison certainly is with highest rate of prisoner on prisoner violence in any prison system in the country at 3.51 "serious assaults" per 100 prisoners (defined as requiring overnight hospitalisation or ongoing medical treatment) and 9.09 other assaults (defined as causing physical injury not requiring overnight hospitalisation et cetera)[144] this renders derisory the professed commitment of Corrective Services to rehabilitation. The ACT prison is not a safe place. All too often it re-traumatises people for whom traumatisation earlier in their life contributed mightily to their incarceration.[145] There were no reports of assaults by prisons on staff.

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141. "Nationally there are estimates that as much as 50%[76] of detainees have a disability compared with around 18% in the general population" The same, p. 95

142. The same, p. 96.

143. Australian Injecting & Illicit Drug Users League (AIVL), Discussion paper: Prison-Based Syringe Exchange Programs (PSE Programs), Canberra, revised May 2008 p.6 at http://www.aivl.org.au/wp-content/uploads/2018/05/prison-based-syringe-exchange-programs-aivl-position-paper-2008.pdf visited 17/04/2020.

144. Productivity Commission (2020), Report on Government Services 2020: 8A Corrective services — Data tables contents, table 8A.17 at https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/justice/corrective-services/rogs-2020-partc-section8-data-tables.xlsx visited 28/03/2020..

145. See, for example the high level of domestic violence experienced within 12 months prior to incarceration, Table 2.6.27, 56% had been the victim of "person-based" crime, table 2.1.2

161. Forensic Psychiatrists like Prof. Dr Paul Mullen, Clinical Director, Victorian Institute of Forensic Mental Health, writes that the experience of prison compounds mental health problems:

> "Mental disorders and intellectual limitations are frequently constructed by staff and prisoners alike as a sign of vulnerability and vulnerable is not a safe label to wear in prison. Those who do seek mental health treatment are at risk of being seen by staff as attempting to evade the rigours of prison, and by fellow prisoners as weak and unacceptably alien. Prisons and jails are intended to be punishing and they provide hard and unforgiving environments which often amplify distress and disorder."[146]

5. Imprisonment compounds mental health and other harms of inmates

162. The processes of the criminal justice system are singularly inappropriate, ineffective and harming of people with schizophrenia who, because of drug laws, are increasingly incarcerated:

> "Prisons are our new asylums. There are about 1600 psychiatric hospital beds in NSW and between 900 and 1000 people with schizophrenia in prison at any one time. Prisons are cheaper, but the length of stay is greater, and they are very inefficient places to provide care. Moreover, the imprisonment of people with schizophrenia is often due to the failure of community care, and the interface between prison and the community does little to stop the door from revolving."[147]

163. Indeed, prisons are just about the worst place for people with mental health problems to be. In the words of a review by the University of London Institute for Criminal Policy Research:

> "'It has long been recognised that psychological harm can result from the loss of liberty, separation from family and community, deprivation of autonomy and material deprivation – all factors that characterise imprisonment. The often traumatic experience of being taken into custody (for the first time, in particular) can exacerbate pre-existing mental illness and can propel people with mental health vulnerability into violence, substance abuse, self-harm and even suicide. People with existing mental

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and 1/4 had been removed from their family (*ACT Detainee Health and Wellbeing Survey 2016* cited above).

146. Paul E Mullen, Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services (2001) p.36 at http://crg.aic.gov.au/reports/mullen.pdf visited 26/04/2020.

147. Olav Nielssen, Submission to Productivity Commission mental health enquiry, submission 37 of 17 March 2019 at https://www.pc.gov.au/__data/assets/pdf_file/0009/238257/sub037-mental-health.pdf visited 22/04/2020.

> health conditions have been found to be more likely to be involved in violence, victimisation and prison rule infractions (Fazel et al, 2016)."[148]

164. Heroin assisted treatment holds out the real prospect of stopping or at least slowing that revolving door.

165. Prisons inflict not just the intended harm of deprivation of liberty, but also aggravate many of the problems that were a factor in people being sent to prison in the first place. Not least among these is the presence of illicit drugs. These are present in prison to such an extent that non-drug users are known to commence drug use while in prison: "prison environments have been identified as sites of injection initiation".[149]

6. Prison undermines the capacity of people to flourish in the community

166. The fracturing of community links to family, friends, employment and other protective factors follows from arrest and incarceration. This disruption bears particularly keenly on people with mental illness making it all the more difficult for them to reintegrate into the community. While noting that prisons amplify distress and disorder, Dr Mullens notes that some thrive under a prison regime:

> "Equally however they provide remarkably predictable environments with clear rules and limited but well delineated roles. Some mentally disordered individuals thrive in this world stripped of the contradictions and complexities of the outside world. Sadly thriving in total institutions is rarely conducive to coping in the community."[150]

167. The views about predictability gel with evidence before the Victorian Ombudsman:

> "Upon release, [prisoners] return to homelessness and re-entry to prison is a pretty good option when you have a clean bed, three meals, a job and your mates! The difficulty of reassimilation into an unwelcoming community is overwhelming for [people] who are suffering severe anxiety with depression, from years of trauma and incarceration."

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148 Catherine Heard, Towards a health-informed approach to penal reform? Evidence from ten countries (Institute for Criminal Policy Research, University of London, London, June 2019) at https://www.prisonstudies.org/sites/default/files/resources/downloads/icpr_prison_health_report.pdf visited 6/2/2020.

149. Dan Werb, R. N. Bluthenthal, G. Kolla, C. Strike, A. H. Kral, A. Uusküla & D. Des Jarlais, "Preventing Injection Drug use Initiation: State of the Evidence and Opportunities for the Future" *Journal of Urban Health,* vol. 95, issue no.1, pp 91–98, February 2018, at https://link.springer.com/article/10.1007/s11524-017-0192-8 visited 4/5/2019 and Gore SM, Bird AG, Ross AJ. "Prison rites: starting to inject inside", *BMJ*.;311(7013):1135–6, 1995.

150. The same. Paul E Mullen, Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services (2001) at http://crg.aic.gov.au/reports/mullen.pdf visited 02/06/2020

7. Stigma and social exclusion

168. The harm reduction element of Australia's and the ACT's professed policy of harm minimisation seeks to improve the health and social exclusion of people who continue to use illicit drugs. Critics of harm reduction measures like NSP programs, peer support and opiate replacement therapies see them as normalising and thus encouraging drug use. At the root of drug policy is thus a tension: there is a tendency in some quarters to view the intended stigma and isolation that is fostered by the criminal nature of drug use as therapeutically desirable in so far as it deters people from becoming drug users. The truth is rather the reverse. Stigma forms and often insurmountable barrier between healthcare providers and people with co-occurring mental health conditions that include substance dependency.

169. People suffering from a substance dependency and another mental health issue tend to be snared by this dynamic. A qualitative study of patients at the Crosstown clinic in Vancouver that administers heroin assisted treatment illustrates how that pharmacotherapy helped break down on the part of both provider and patient the obstacle in the way of understanding and respectful care without which effective medical care is likely to be ineffective. It comes down to a question of trust:

> "Trust issues [are] rooted in participants' prior experiences of discrimination in the healthcare system related to their use of street opioids.
>
> > "[My iOAT (Injectable opioid agonist treatment) doctor] treats people with respect and dignity, which is huge. [For] many years in my life, I've been 'the junkie'… Looked down on by people in that [healthcare] field, no matter where or what their position was. I don't get that there [at Crosstown Clinic]… The staff is amazing... I really feel like each and every one of them cares." (N10)
>
> "As participants' trust in healthcare providers grew, they discovered that staff also had "a lot of understanding….A lot more understanding than the average person" (N24)."[151]

Such judgemental and marginalising attitudes were also evident in some community reactions to the AIDS epidemic. At its outset, HIV disease settled among socially devalued groups, and as the epidemic has progressed, AIDS has increasingly been an affliction of people who have little economic, political, and social power."[152] Most of the public injecting drug users in Glasgow who contracted HIV around 2015 were ". . . male, with relatively long histories of injecting drug use . . . Most report[ed] multiple social vulnerabilities, including unemployment, homelessness, and offending. The combination of these factors is

151. Kirsten Marchand, Julie Foreman, Scott MacDonald, Scott Harrison, Martin T. Schechter, and Eugenia Oviedo-Joekes, Building healthcare provider relationships for patient-centered care: A qualitative study of the experiences of people receiving injectable opioid agonist treatment, *Subst Abuse Treat Prev Policy*. 2020.

152. Albert R. Jonsen and Jeff Stryker, *The social impact of AIDS in the United States*, (National Academy Press, Washington, D.C. 1993) p. 9.

often referred to as severe and multiple disadvantage (SMD) and is increasingly recognised as a powerful marker for ill health and social exclusion."[153]

170. The intensification of the marginalisation of people with mental illnesses unrelated to substance misuse is thus fostered by the community perception of co-occurrence:

> "Stigma around AOD use remains considerably higher than for mental health issues, and lack of understanding about what treatment entails or fear of judgement result in many young people not seeking help or disclosing an AOD issue to a clinician to ensure a timely and effective treatment approach is taken to respond to the comorbidity."[154]

171. The law's labelling of drug users as criminals intensifies the disempowering and marginalising stigma that impedes their recovery including access to services: family and peer group engagement that is vital for reintegration. The stigma around drug use makes the work of both the AOD and mental health sector so much more difficult. "Service users and providers alike spoke of stigma as a powerful barrier to accessing much needed services among this population. Many people with active or former injecting drug use described a need for more person-centred care, and wanting more input into decisions about their care. We were struck by the strength and value of the existing peer network for people in recovery, and by the opportunities for empowerment, engagement, and harm reduction that a similar network could offer for people who inject drugs."[155]

172. In its submission to the Productivity Commission, Anglicare stressed the vital importance for health and well-being of social connection: "

173. Disengagement and isolation from families, society flow from the stigma and marginalisation of drug users: "clients presenting with comorbid mental health conditions often have a variety of other family and social problems, such as housing, employment, welfare and legal problems. This can lead to social isolation and higher levels of distress for their families and carers (VIC DHHS nd).

174. Anglicare Australia recommends that the Commission acknowledge the importance of social connection and attention to the social determinants of health and well-being:

> "Social connection and networks go beyond the family, and are also important pillars of our wellbeing. Here, the design of our lived environment and policy settings can have a direct impact on social connection, and there

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153. NHS Greater Glasgow & Clyde, "Taking away the chaos": the health needs of people who inject drugs in public places in Glasgow city centre (NHS Greater Glasgow and Clyde, 2016) p.12 at https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf visited 25/04/2020.

154. PC, Mental Health Draft Report, (2019) vol. 1, cited above, p.331

155. Anglicare, Care dignity respect change hope: submission to the Productivity Commission Inquiry into "The Social and economic benefits of improving mental health". April 2019, Submission 376, p. 11.

> is a role for government at a population level. . . . (sub. 376 Anglicare Australia)
>
> • Reflects on population level government policy settings that impact the social determinants of health in its draft report;
>
> • Acknowledges the role of these settings in creating risks such as chronic stress, which significantly increases peoples' vulnerability to developing widespread mental illnesses such as anxiety and depression; and
>
> • Make recommendations that capture well-documented changes to government policy settings such as increases to government income payments, and the provision of social housing, which would significantly reduce this negative impact to many people's mental health. [156]

175. There are qualitative reports of heroin assisted treatment reducing stigma and alienation. The major theme reported by respondents in a qualitative study was carried out during the final months of the trial of supervised injectable opioid treatment (SIOT) in Spain:

> "was that patients and family members saw SIOT as "medicalization" of heroin use. Instead of a drug which controlled their lives, it became a medication. Respondents apparently saw this as positive, as reducing stigma. Family members commented that they looked on their affected member as 'chronically ill' and not as 'addicts' once they were in SIOT."[157]

176. There is an ambivalence by some dependent heroin users towards the medicalisation implicit in heroin assisted treatment:

> "Some perceive medicalization as helpful, but resent being in treatment. For some, medicalization takes the fun out of using heroin."[158]

Attitudes like this help explain why many drug users receiving the treatment move to other treatments and abstinence. In other words, heroin assisted treatment is not the sticky flytrap that it often made out to be by opponents. Rather, treatment helps participants stabilise their life and facilitate social reintegration.

8. Inadequacy of prison health services

177. Even the best intended and well-resourced prison health service is handicapped providing health services to a prison population whose health needs are very high. Reviews of the ACT Inspector of Correctional Services and the Health Services Commissioner[159] give a sense of the obstacles in the way of

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156. Anglicare, Care dignity respect change hope: submission to the Productivity Commission Inquiry into "The Social and economic benefits of improving mental health". April 2019, Submission 376, pp. 11-12

157. James Bell, Vendula Belackova, Nicholas Lintzeris, Supervised Injectable Opioid Treatment for the Management of Opioid Dependence, Drugs (2018) 78:1339–1352; Drugs. 2018 Sep;78(13):1339-1352 at p. 1348.

158. The same.

159. *Review of the opioid replacement* (2018) cited above.

adequate health treatment. The delivery of healthcare in prisons is a demanding and time-consuming exercise given the congregation within the stressful environment of prisons of people with manifold mental and physical health conditions.

178. Qualitative research associated with the Crosstown clinic in Vancouver[160] that allows heroin assisted treatment described as iOAT [Injectable opioid agonist treatment] illustrates the transformative environment facilitated by that intervention that empowers and facilitates opiate dependent people with a history of failed engagement on an adversarial basis with health services to address multiple health and social problems in their lives.

> Reduced street opioid use was the most consistent initial iOAT goal and outcome described. . . . Some participants credited this outcome to how well the medication suppressed cravings and withdrawal (e.g., "*I actually feel it and it gets me better*" (N28)). Others reflected that the accompanying financial or social costs of street acquired opioid use were no longer worth the "risk", because "*I risk my freedom every time I do it* [use street heroin]" (N25). Narratives about "freedom" were also rooted in participants' goals to disconnect from the "*constant struggle*" (N23) of daily street opioid use that was "*extremely anxiety inducing*" (N11). Participants attributed this struggle and anxiety to: "*living a day ahead because you don't want to wake up sick*" (N30); "*spend[*ing*] our lives chasing the drug, or the money...there's no time for anything else, but your addiction*" (N07); and "*having to steal sometimes in order to support that habit*" (N11). Being able to disconnect from this struggle and anxiety brought an increasing sense of "*stability*", "*having a life*", *normalcy*" and "cook". These outcomes carried subjective meanings, including regular sleep, food in the cupboard, money left at the end of the month, being able to attend a movie or a concert, and reconnecting with family.
>
> Within narratives of "stability", participants defined positive changes to health functioning (e.g., "*weight gain*", "*eating and sleeping better*"). Generally, participants felt they were taking better care of their health by prioritizing treatment for chronic conditions that had been neglected over the years (e.g., Hepatitis C treatment, dental and vision, medications and counselling for depression and anxiety). Such health outcomes were primarily discussed in relation to the delivery of holistic care that was part of this iOAT setting. Examples of how these outcomes arose further emphasized that building relationships (especially feeling supported, accepted, and understood) was fundamental to these outcomes. For instance, when the nurse practitioner took the extra time to go over a participant's health history, this "*got me thinking more in terms of what do I need to just feel good for today, what can I do to make my future better, you know? Yeah, taking care of my pap tests, my breast exams and both my mom and grandma had breast cancer*" (N04).

160. Kirsten Marchand, Julie Foreman, Scott MacDonald, Scott Harrison, Martin T. Schechter, and Eugenia Oviedo-Joekes, Building healthcare provider relationships for patient-centered care: A qualitative study of the experiences of people receiving injectable opioid agonist treatment, *Subst Abuse Treat Prev Policy*. 2020.

179. The stigma associated with criminality flowing from illicit drug use compounding stigma associated with mental illness (see part VII.7 p.56) in the harsh demeaning prison environment renders it immensely difficult if not impossible to deliver person centred care known to be necessary for the healing of these vulnerable people. Research identifies the following ingredients of effective care of this vulnerable and troubled population:

- trust between participants and healthcare providers in contrast to the participants' history of discrimination in the healthcare system as users of illicit drugs;
- an understanding and respectful attitude of healthcare providers towards participants;
  - "a positive therapeutic relationship was fundamental to experiencing care was *meeting me where I am*."
- an open-minded and respectful communication style of healthcare workers with participants;
- a sense of safety of participants to speak up about their needs and preferences and willingness of healthcare providers to heed those preferences;
  - this approach is in contrast to the common experience of drug users that their views are dismissed: ""[My doctor] doesn't listen, and [she/he] just does what [she/he] wants to do… [she/he] still tries to push methadone on me…I tried to go up on my dose a couple of times in the past and [my doctor] wouldn't let me, like [she/he] said 'you gotta do this first."
- the discovery by participants of their own self-reported outcomes
- the aggregation in one place of health and other support services
  - "centralized care was closely aligned with participants' needs. As one participant explained, '*when you are trying to get some order in their life…you can't have [us] going all over the place and that, to have it all in one hub, it's right there man*"
- receipt of tailored comprehensive care
- encouragement of participants to take responsibility
- encouragement of a sense of agency in participants to invest in their own care
  - encouragement of participants to take responsibility for their own lives. Participants emphasized that holistic care be delivered in a manner that encouraged clients to '*have the responsibility to invest in [our] own lives'* (N10).'
  - When healthcare providers took time to understand the evolving needs of their patients and were presented with information in an unbiased manner, they gained an increased sense of empowerment.

180. All these elements go towards the goal of person centred care. As the following paragraphs shows it is nigh on impossible to realise that objective in either the prison environment or in the mandatory directive context of the ACT's drug court and its so-called "therapeutic jurisprudence". Government thinking must go further than the slogan that drug policy is a health rather than a criminal issue.

181. All told, the obstacles in the way of the provision of health services within prisons commensurate with the needs of inmates renders it extremely hard if not practically impossible to honour the human rights principle of equivalence under which prisoners "should have access to the same standard of care available to people outside prisons."[161] The counterpoint to this view is put forward by the Australian Medical Association ". . . that prison offers an opportunity to access disadvantaged groups who are normally hard to reach in the community. This access provides an opportunity to address health inequalities including drug, alcohol and tobacco use, primary health care access and mental health care treatment."[162] A strong case can be made that these advantages are neutralised and undermined by prison environments. The New South Wales coroner observed that the "poorly coordinated and planned mental health care of Jonathan Hogan, a young Wiradjuri man at the Junee Correctional Centre contributed to him taking his own life. "He had a history of substance abuse and [earlier] a psychiatrist had "formed the opinion that he had paranoid schizophrenia . . . and on his intake the jail staff knew that he had previously been on medication for depression and schizophrenia and had a history of self-harming."[163]

The Inspector of Correctional Services in his 2019 Healthy Prison Review[164] did, for example, mention some of the obstacles at the ACT prison:

- only one psychologist position at the AMC to provide general (as opposed to forensic) psychological service to some 500 detainees. This staffing level is grossly inadequate and must be addressed as a matter of urgency.
- A prevailing atmosphere of "lethargy and boredom" in part contributed to by the absence of meaningful work.

182. Challenges adverted to by the Health Services Commissioner included:

> reconciling the tension between the health needs of detainees to which the prison health services accord priority with the security priorities of corrective services. This manifests itself in:
>
> i. the unavailability to Justice Health of the level of specialist mental health staff sufficient to treat the high concentration of people detained in the prison with mental health conditions. The Health Services

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161. ACT Human Rights Commission, Human Rights Audit on the Conditions of Detention of Women at the Alexander Maconochie Centre A Report by the ACT Human Rights and Discrimination Commissioner April 2014 pp. 130-31 at https://hrc.act.gov.au/wp-content/uploads/2015/02/HRC-Womens-Audit-2014.pdf visited 24/04/2020.

162 The same, p. 108 and similar wishful thinking of PC, Mental Health Draft Report, (2019) vol. 1, cited above p. 601 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf visited 02/06/2020.

163 *The Canberra Times,* 13 May 2020, p. 8.

164. ACT Inspector of Correctional Services, Report of a review of a correctional centre, Healthy prison review of the Alexander Maconochie Centre 2019 (ACT Inspector of Correctional Services, Canberra 2019) at https://www.ics.act.gov.au/__data/assets/pdf_file/0007/1429495/191120-OCIS-AR-Final-Web-Version.pdf visited 28/03/2020.

Commissioner did not compare the ACT prison to the Adult Mental Health Unit at the Canberra Hospital or to Dhulwa Mental Health Unit;

ii. rejection at the instance of corrections of Suboxone on the ground that it can be more easily diverted than methadone. “A short trial of Suboxone maintenance was conducted at the AMC but was ceased due to allegations of widespread diversion”;[165]

iii. rejection by corrections officers and prison administration of the introduction of a needle and syringe program to guard against the spread of blood-borne diseases.[166]

iv. Impediments in the sharing of information relevant to the health needs of inmates;[167]

v. The prisoner/warder mindset inculcates distrust and impedes corrective services staff fulfilling their fiduciary responsibilities for the well-being of prisoners in matters like supporting medication rounds and observing detainees in the course of their safe induction onto the methadone [168]

vi. inadequacy of premises for the health service to meet the needs of a much larger number of prisoners: “the Hume Health Centre facility has not been expanded since commencement, placing strain on health services and facilities which were not designed for the current number of detainees.”[169]

vii. constraints imposed by prison routines on the ready access of health service staff to detainees and of detainees to health service staff.[170] These constraints can lead to irregular dosing times, failure to note and react to overdoses, inadequate observation and monitoring of detainees being inducted onto pharmacotherapies like methadone,[171] inadequate support for detainees wishing to cease opioid pharmacotherapy and the ready flow of health information.

viii. the unavailability and absence of capacity to administer Naloxone to reverse overdoses. “Naloxone (a medication which blocks the effects of opioids to reverse overdose and is available for peer use in the community) is not available to be administered in the event of an overdose. We understand that currently, if an overdose occurs after-hours, when health staff are not onsite, naloxone could not be administered until paramedics arrive at the AMC to treat a detainee who has overdosed.”[172]

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165. Review of the opioid replacement (2018) cited above p.13

166. The same, pp. 48-49.

167. The same, p.23.

168. The same, pp.12 & 29.

169. The same, p. 13.

170. The same, pp.13,15 & 30.

171. The same, p. 30.

172. The same, p. 31.

ix. the risk of detainees receiving pharmacotherapies being stood over to divert those pharmacotherapies to fellow prisoners.[173] "In the prison environment diverted methadone is a tradeable commodity and the illicit supply of diverted methadone can place other detainees at real risk of harm and overdose."

x. constraints on a prison based health service securing the cooperation of Corrections and other services in putting in place *after care services for discharged detainees*. As well as drug treatment,
after care services should include social support services. "In addition to drug dependence treatment needs, many ex-prisoners have housing and financial difficulties and in some instances psychiatric problems. They may be released to either poor family support or deeply dysfunctional families and friends. For this reason, aftercare cannot be limited to drug treatment but needs to include social support services."[174] In England and Wales "patients discharged from hospitals but not subjected to the Care Programme Approach (CPA). The CPA mandates that the patients are subject to a package of care including regular reviews by their clinical team (including Care Coordinator, Social Worker and Consultant Psychiatrist) focusing not only on their mental state but also on risk prediction and management." In comparison it is not the norm for prisoners with mental health diagnoses, to be followed up by community mental health services.[175]

VIII. Indigenous incarceration in the ACT

183. The Productivity Commission makes the point that "Many Aboriginal and Torres Strait Islander people experience high levels of distress — for example, one in three adults report having experienced high or very high distress in a recent four week period."[176] It then traces a pathway that leads a hugely disproportionate number of indigenous Australians to prison:

> "Disadvantage and psychosocial stress often go hand in hand, and pose a concurrent risk to people's health. Among other things, inadequate housing, a lack of employment, high rates of incarceration or insufficient education opportunities are sources of disadvantage for Aboriginal and Torres Strait Islander people that may lead to psychological distress. Entrenched poverty amongst Aboriginal and Torres Strait Islander people is recognised as a 'significant underlying factor' that contributes to self-destructive behaviour, intentional self-harm and suicide."

184. Social exclusion follows from these experiences. Incarceration further marginalises all those struggling with the chaotic experience of co-occurring

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173. The same, p. 36

174. The same, p. 43.

175. Igoumenou *et al,*cited above, p.951.

176. Productivity Commission, Mental Health*, Draft Report (Productivity Commission, October 2019*, volume 2) p. 831 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume2.pdf visited 24/04/2020

substance dependency and other mental health issues whether they be indigenous or non-indigenous Australians. In other words, incarceration intensifies and compounds the very problems that led to imprisonment. It is a bond of suffering with non-indigenous people battling substance dependency and other mental health problems but is that much keener for indigenous Australians because they are marginalised in the land of their ancestors. Stan Grant writes:

> "I interviewed one Australian criminologist who said that the rates of imprisonment are 'unbelievable'. But we believe it. To us it is all too real. The same criminologist told me that we are locked up for crimes that would see other Australians walk free. He said it isn't because there is rampant crime in black communities. Indigenous people murder and rape at half the rate of the general population, and commit drug crime about eight times less. But once locked up indigenous people begin a spiral of reoffending in jail. Over and over people are trapped in a cycle of violence, drugs and alcohol, mental illness, sexual abuse, unemployment and abject poverty."[177]

185. "The NSW Health Aboriginal Mental Health and Wellbeing Policy cites the high prevalence of grief, trauma and loss in Aboriginal communities, as well as a rate of suicide and self harm that is at least twice the national rate. It has been reported that the rate of mental illness in these communities is affected by "socio-cultural, socio-economic and socio-historical factors"[178]

186. The Queensland Productivity Commission heard that "The overlap between offending, child protection and prisoners . . . larger for Aboriginal and Torres strait islander people [around 60 per cent] than non-Indigenous people and larger for women than men. It is most severe for Indigenous women—three-quarters of Indigenous female prisoners have had a mental health episode, been in child protection, or both."[179] "This research emphasises that offending is strongly connected to a history of child maltreatment and mental health admissions. This connection is even stronger for prisoners, who on average exhibit more harmful or more frequent offending than offenders generally."[180]

187. In his address to the Legislative Assembly on 24 August 2004 on the ACT prison then being planned, The Chief Minister said that indigenous prisoners then constituted approximately 9 per cent of the ACT prison population which at that the time were all transported to New South Wales to serve their sentence. He termed this level to be unacceptable. How much less acceptable is the situation 14 years on when, according to the Productivity Commission, indigenous Canberrans now constitute 23% of the ACTs own prison?

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177. Stan Grant, *talking to my country* (HarperCollins, Sydney, 2017) p.106.

178. NSW Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: Diversion*, Report 135 (June 2012) p.17 at https://www.lawreform.justice.nsw.gov.au/Documents/Publications/Reports/Report-135.pdf visited 25/04/2020.

179. Queensland Productivity Commission, Imprisonment and recidivism, final report, vol. 1 (2019) cited above, p. 62 and p. xliii

180.. The same.

188. In 2018-19 in the ACT the crude imprisonment rate for the Aboriginal and Torres Strait Islander population was 3,398.6 offenders per 100,000 relevant adult population, compared with 112.2 for the non-Indigenous population. After adjusting for differences in population age structures, the rate per 100 000 Aboriginal and Torres Strait Islander population in 2018-19 was 1,602.5, compared with a rate of 107.6 for the non-Indigenous population. Therefore, after taking into account the effect of differences in the age profiles between the two populations, the ACT indigenous corrections rate is 14.9 times greater than for the non-Indigenous population. Rates that do not take age profile differences into account are almost 18.9 times greater (only Western Australia, at 19 times, is worse). In 2004 the Chief Minister could claim indigenous imprisonment rate was lower than the national average.

189. The gross overrepresentation of indigenous people in the ACT prison make all the more pointed comments of the Productivity Commission in its draft report on Mental Health[181]:

> "The incarceration of Aboriginal and Torres Strait Islander people, its causes and devastating effects have been the subject of a number of inquiries and Royal Commissions, the most recent being the ALRC inquiry in 2017. . . . A large proportion of those incarcerated are diagnosed with mental illness and cognitive disabilities (section 16.2).
>
> > 'The issues pertaining to the needs of prisoners with mental illnesses and/or cognitive impairment are amplified for Aboriginal and Torres Strait Islander offenders given their significant overrepresentation in the criminal justice system.'"

190. The ACT Health Services Commissioner has pointed out that to address this disturbing inequality "it is vital that all aspects of treatment of Aboriginal and Torres Strait Islander detainees meet their cultural needs and support their rehabilitation."[182])

191. In the context of SARS-CoV-2 virus, the large number of indigenous Australians in prison evokes the historical memory of widespread death of aborigines from diseases introduced by the European invaders.

> " . . . Aborigines had had no opportunity to acquire immunity or to evolve genetic resistance [to European-introduced germs.] Within a year of the first European settlers arrival at Sydney, in 1788, corpses of aborigines who have died in epidemics became a common sight. The principal recorded

181. PC, Mental Health Draft Report, (2019) vol. 1, cited above p. 628 at https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf

182. Review of the opioid replacement (2018) cited above p.27.

> killers were smallpox, influenza, measles, typhoid, typhus, chickenpox, whooping cough, tuberculosis and syphilis."[183]

192. Australia as a whole has replicated albeit to a more modest degree the stratospheric levels of imprisonment in the United States with more than 2 million Americans incarcerated at a rate of 655 per 100,000. This has been attributed to zealous drug law enforcement of that country's prohibitionist policies.

> "Harsher sentencing of drug offences was a key development, in the context of the US government's 'war on drugs' as declared by President Nixon in 1971 – with the consequence that admissions for drug offences accounted for almost one-third of all admissions to state and federal prisons over the period 1993 to 2009."[184]

193. "Indigenous people entering prison were more than twice as likely as Indigenous people in the community."[185]

194. "Indigenous prison entrants (56%) were more likely than non-Indigenous prison entrants (38%) to report they had been in prison in the previous year." (p.112).

195. "In 2018, Indigenous prison entrants (56%) were 1.5 times as likely as non-Indigenous prison entrants (38%) to report they had been incarcerated in the previous 12 months. This gap had increased between 2015 and 2018. In 2015, less than half (45%) of Indigenous prison entrants said they had been in prison in the previous year, compared with 38% of non-Indigenous entrants (Figure 14.2).

196. "This means that, in 2018, two of the most vulnerable groups in the prison population—women and Indigenous people—were more likely to report a history of incarceration in the last 12 months than they had in previous years. These groups also showed poorer health outcomes than men and non- Indigenous people in the prison system." (ibid).

IX. The ineffectiveness of Prisons

197. The NSW Law Reform Commission quoted with approval an important British study to the effect that "prison is a high-cost intervention which is ineffective in reducing subsequent offending."[186] Mentioned in the section above on mental health is another British study that compared "matched pairs of adult males with psychosis (schizophrenia or delusional disorder)" released from prison with those released from mental health hospitals. This study found that" males with psychosis

183. Jared Diamond, *Guns, germs and steel: a short history of everybody for the last 13,000 years* (Vintage, London, 1998) P 320.

184. Jessica Jacobson, Catherine Heard and Helen Fair, *Prison evidence of its use and over-use from around the world* (Institute for Criminal Policy Research, London 2017) p. 11 at https://www.prisonstudies.org/sites/default/files/resources/downloads/global_imprisonment_web2c.pdf

185. AIHW, The health of Australia's prisoners (2019), cited above p. 97

186. NSW Law Reform Commission (2012), cited above, p.39.

released from prisons had a hazard of reoffending nearly 3 times the one of their matched" controls with psychosis discharged from hospitals. [187]

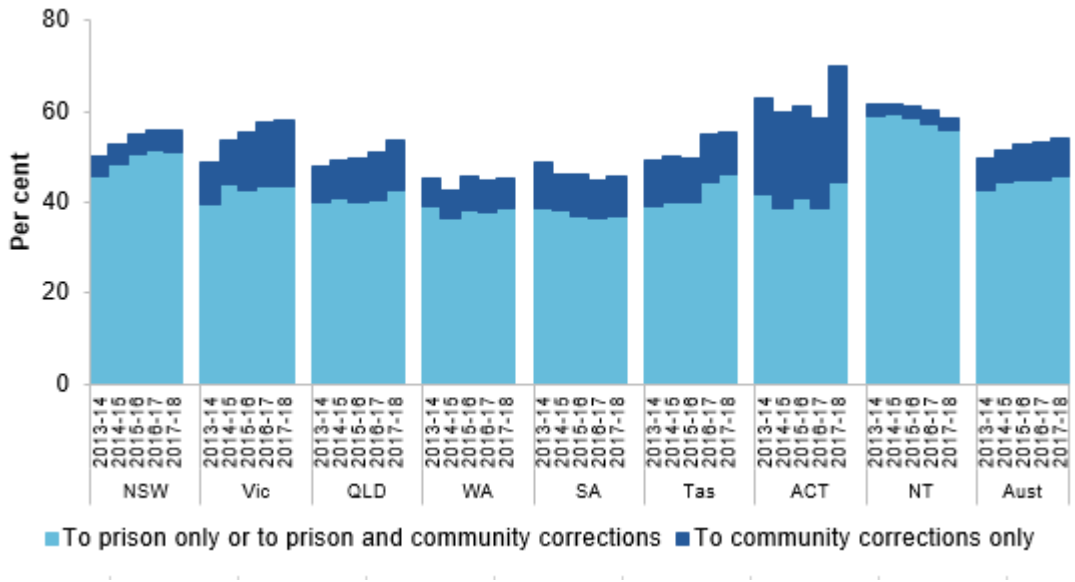
A. There is a high churn of people in and out of prison

198. People spend on average only 5.9 months in the ACT prison[188] and there is continual contact between prison staff and inmates which means, from a public health point of view, detainees are not isolated from the community not protected from infections circulating in the community.

B. Recidivism

199. The Sentencing Advisory Council of Victoria reports in 2015–16 44.2% of prisoners returned to prison within two years and 69.9% returned to corrective services. This is consistent with the 2019 Report on Government Services of the Productivity commission that includes the following chart of rates of return of released prisoners to corrective services. It shows rates of return to prison on a par with other jurisdictions but reflects an effort to reduce the rate of incarceration in the ACT, in the form of a relatively large rate of return to community corrections.

Figure C.3 Prisoners returned to corrective services with a new correctional sanction within two years of release (per cent)[a, b]



a See table CA.4 for detailed footnotes and caveats. **b** Rates for a financial year relate to prisoners released two years prior to that reporting period who returned within two years of their release date.

200. Most people who find themselves in prison sentenced for a relatively short period so that they will soon re-enter the community. For example "although the

187. Igoumenou *et al,*cited above,p.946.

188. Michael Moore & Melanie Walker, *Balancing access and safety Meeting the Challenge of Blood Borne Viruses in Prison: report for the ACT Government into implementation of a Needle and Syringe Program at the ACT's prison, the Alexander Maconochie Centre* (Public Health Association of Australia, Canberra, 19 July 2011) p. 11.

average sentence length in Victoria is three years, more than a quarter of Victoria's prisoner population, or 26.2 per cent are serving a sentence of less than one year."

201. In its draft report on mental health the Productivity Commission has noted that:

> "the majority of prisoners with mental illness spend relatively short periods of time in custody before returning to the community, inadequate healthcare in prisons and poor transition support services are likely to raise the burden on the community healthcare system and increase recidivism."

The inquiry into recidivism of the Queensland Productivity commission made a similar point about imprisonment increasing the burden on the mental health system in the community:

> "These indirect costs [of imprisonment] can include forgone employment, as well as higher rates of unemployment, social exclusion, homelessness and poor mental health following release."[189]

202. According to the Bureau of Statistics the median sentence length for defendants sentenced to custody in a correctional institution in 2015–16 remained unchanged compared with 2014–15 at:

- 30 months for the Higher Courts; and
- 6 months for the Magistrates' Courts and Children's Courts

C. Imprisonment increases crime

203. There is a persuasive string of evidence that imprisonment actually increases rather than reduces crime. Dr Don Weatherburn director of the NSW Bureau of Crime Statistic and Research reported in a 2010 study that "There is no evidence that prison deters offenders convicted of burglary or non-aggravated assault. There is some evidence that prison increases the risk of offending amongst offenders convicted of non-aggravated assault." He added as a caveat that "further research with larger samples is needed to confirm the results."

204. In that same paper Dr Weatherburn reviewed the research literature on the deterrent effect of imprisonment. The results were mostly equivocal. He went on to consider Australian studies. These did point to imprisonment increasing the risk of reoffending:

- A 1974 study of seven categories of offence from the probation register of the NSW Department of Child Welfare found recidivism "to be higher after detention for all but two offences: 'behaviour problems' and 'take and use motor vehicle."
- A 1996 study of a large group of convicted juveniles in New South Wales. The results of his study suggested that those subject to a custodial penalty "were more likely to reoffend".

189. Queensland Productivity Commission, *Imprisonment and recidivism, final report*, vol. 1 (2019) cited above, p.xxi.

- A 2009 study of juveniles comparing two groups of juveniles, one subject to a custodial penalty and the other not, "found no significant effect of detention on risk of re-offending."
- Another 2009 study in which also Weatherburn was involved looked at adult offenders and concluded that "Prison was found to exert no effect on time to re-offend amongst those who had not previously served time in custody. Offenders who had previously served time in custody, however, actually re-offended more quickly if they received a prison sentence than if they received a suspended sentence."

205. In the light of the insights from this research, why on earth should we, without fundamental reform to it, persevere with an institution that fails so cruelly and miserably and at such cost to achieve its objectives? That we do persevere with our prison invites one to reflect on the part that sadism and masochism play in shaping public policy. Justice Reinvestment initiatives stand as some recognition of the irrationality in the present course.[190]

X. Conclusion

206. Heroin assisted treatment would have substantially ameliorated the explosion of heroin use that Australia experienced throughout the 1990s.

207. There would have been a far reduced burden of disease from hepatitis C than was able to be achieved merely by measures such as needle/syringe programs in the community and harm reduction measures like provision of condoms and bleach in prisons.

208. Property crime and other crime particularly associated with addiction to illicit drugs would have been much less that it is now.

209. Above all there would not have been anything like the thousands of heroin overdose deaths that occurred in Australia in the latter years of the 1990s and subsequently up to the present with the renewed availability of that drug and the growth of opiate dependence from prescription painkillers.

210. There would not have been an epidemic of so-called "deaths of despair" like suicide that are fostered by the stigmatisation and marginalisation of dependent drug users.

211. There would not be as much overcrowding of ACT prisons as there is and it may even have been unnecessary for the ACT to establish its own prison.

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[190]. Matthew Willis and Madeleine Kapira, Justice reinvestment in Australia: A review of the literature AIC reports Research Report 09 (Australian Institute of Criminology, Canberra,2018) at file:///C:/Users/Bill/Downloads/rr09_justice_reinvestment_in_australia_160518_0.pdf visited 02/06/2020.C:\Users\Bill\Downloads\rr09_justice_reinvestment_in_australia_160518_0.pdf