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**Submission to the Ministerial Council on  
Drug Strategy**

**Australia's National Drug Strategy  
Beyond 2009**

**February 2010**

## Introduction

The Australian Injecting & Illicit Drug Users League (AIVL) is the peak national organisation for the state and territory drug user organisations and represents people who use/inject illicit drugs and drug treatment consumers on issues of national significance. AIVL's current members are:

- **NSW** - NSW Users & AIDS Association (NUAA);
- **ACT** – Canberra Alliance for Harm Minimisation and Advocacy (CAHMA);
- **VIC** – Harm Reduction Victoria (formerly VIVAIDS);
- **TAS** – Tasmanian Council on AIDS, Hepatitis and Related Diseases (TASCAHRD)
- **SA** – South Australian Voice of IV Education (SAVIVE)
- **WA** – Western Australian Substances Users Association (WASUA);
- **NT** – Territory Users Forum (TUF)
- **QLD** – Queensland Injectors Health Network (QuIHN) and Queensland Intravenous AIDS Association (QuIVAA).

As a peer-based organisation, AIVL and its member groups are run by and for people who use/have used illicit drugs and for this reason represent an important perspective in the National Drug Strategy – Beyond 2009 Consultation. AIVL would like to thank the Ministerial Council on Drug Strategy (MCDS) for the opportunity to provide a submission to this important consultation process for illicit drug users and those in drug treatment.

For consistency, our submission utilises the 'core principles' outlined in the Consultation Paper and then follows with specific responses to the questions listed under each of the sub-headings under 'Emerging issues and new developments'.

## A Consistent Approach

While AIVL does not contest that a "consistent approach" has been maintained across the Australian drug strategies over an extended period of time, we would like to question whether:

1. the principle of harm minimisation as the basis of Australia's drug strategies is one of its "greatest strengths"; and
2. that *Australia's* harm minimisation approach is "increasingly accepted internationally as a humane and pragmatic approach to drug issues".

The Consultation Paper appears somewhat dismissive of calls to review the "harm minimisation" terminology and basically relegates these calls to, at best, a 'side-issue'. In reality however, AIVL believes nothing could be further from the truth. Many stakeholders within the alcohol & other drugs (AOD) sector feel strongly that a complete review of this terminology is well overdue and the continued use and application of the harm minimisation approach (as it is defined by the Australian Government) is creating confusion and uncertainty both within the sector and beyond (Miller, 2009).

We would like to stress that in questioning the use of the terminology "harm minimisation" as it is defined by the Australian Government, we are not by extension questioning the centrality of a harm minimisation approach (as it is more broadly

understood and defined) to Australia's next National Drug Strategy (NDS). Indeed this apparent tension is at the heart of why many within the sector are calling for change. As an organisation AIVL has been operating within the licit and illicit drugs areas for over 20 years. This timeframe has allowed us to watch the development of conflict and confusion in relation to the term "harm minimisation" first hand. Prior to 1985 Australia was in-step with the international community in that terms such as "harm reduction" and "harm minimisation" were used interchangeably. "Harm Reduction/Minimisation" did not include supply or demand reduction activities but rather had a complete focus on strategies and approaches to reduce or minimise drug related harm.

With the election of the Howard Government, Australia took the steps of developing its own 'unique' policy framework to underpin all activity in relation to licit and illicit drugs in Australia. This new framework appropriated the term "harm minimisation" and reframed it completely to act as an overarching term. Harm minimisation was no longer interchangeable with harm reduction. It now stood for a three pronged approach that included supply reduction, demand reduction and harm reduction. Although this may have appeared to be a logical and clear reframing of the policy approach from a Government perspective, the problem is that the Government did not articulate the rationale for this change properly within the AOD sector or the general community and it did not change the fact that every other country in the world was still using "harm reduction" and "harm minimisation" interchangeably.

Subsequently despite the 'consistent' use of the term "harm minimisation" as the organising principle for the NDS, it has led to anything but consistency at the level of on-the-ground implementation. The review of the current strategy highlights the 'inconsistencies' that have been caused through the 'consistent' use of imprecise and confusing terminology. Miller states that:

*"A considerable amount of ideological baggage is now associated with it (harm minimisation). Rather than being a useful tool for communicating a complex idea, 'harm minimisation' has become a slogan, along with such terms as 'harm prevention', 'harm maintenance' and 'zero tolerance'."*

(Miller, 2009)

When Professors Single and Rohl conducted their landmark evaluation of the NDS in 1997, there was no doubt that they believed the goal and focus of harm minimisation was to reduce drug related harm. They emphasised that harm minimisation represented the "middle ground" whereby even if stakeholders in the sector and the broader community could not agree on policy approaches to the prevention of drug use per se, at least the harm minimisation approach represented the opportunity to foster meaningful alliances to support the 'shared' goal of reducing drug related harm (Single & Rohl, 1997).

Although some may argue that the harm minimisation approach with its three pillars is designed to create alliances to achieve shared goals, the fact remains that while supply reduction and demand reduction are part of the harm minimisation approach there is no possibility of reaching shared goals among the key stakeholders. By including supply and demand reduction in the harm minimisation approach, it ceases being a source of common ground and becomes an ideological and political battlefield over the merits of having the prevention of drug use as the primary strategic goal rather than having a primary focus on reducing drug related harm.

The use of the overarching terminology of “harm minimisation” has also led to a significant confusion and disagreement about what range of activities constitute ‘supply reduction’, ‘demand reduction’ and ‘harm reduction’ respectively. Despite the terminology being used for over a decade, those working in the AOD sector, let alone people in the general community frequently do not fully understand the meaning of the terms. This results in AOD sector workers making claims of undertaking harm reduction activities when in fact their efforts are focused on the prevention of drug use per se, not the reduction of drug related harm for those who are in active drug use.

The use of the overarching terminology of “harm minimisation” has also resulted in law enforcement professionals claiming that their supply reduction activities are by association, harm minimisation activities. This not only creates confusion in the international context where harm reduction and harm minimisation are still interchangeable, but also raises the question of how legislation and policies that are specifically aimed at criminalising and frequently incarcerating a highly marginalised group within the community can possibly be classified as ‘minimising drug related harm’.

For these reasons, AIVL recommends the removal of “harm minimisation” as the overarching terminology in future national drug strategies. AIVL believes the use of this term is misleading and confusing. It suggests that the core focus of Australia’s drug policy approach is on reducing or minimising drug related harm when in fact the balance of investment is heavily weighed against harm reduction activities in favour of supply and demand reduction. The three pillars of supply reduction, demand reduction and harm reduction would remain but would need to be clearly defined so as to remove current confusion about these distinct approaches.

In addition, AIVL recommends that the new overarching framework or organising principle for the NDS should simply be to “reduce harms associated with problematic drug use” – that is drug use that results in health problems not drug use that is defined as ‘problematic’ merely because it is deemed illegal. This would allow for recognition of the role of non-problematic drug use in society while still providing an appropriate strategic response to the areas where harms are occurring from problematic use. It would also ensure a more balanced approach to the use of available resources in that funding can be directed to specific areas and issues (through the 3 pillar approach) based on need and best outcomes rather than on the most accepted ideological response.

Finally, AIVL also believes that a shift to a focus on ‘reducing harms associated with problematic drug use’ will also allow for a range of broader health and social factors to be addressed under the aegis of the NDS rather than having an almost exclusive focus on the prevention of drug use per se. Such broader issues could include stigma and discrimination, homelessness, multiple health conditions incl. BBVs, primary health care, consumer participation, cultural diversity and developing a supportive legislative and policy environment that is conducive to health and wellbeing, etc.

### **Evidence Informed Practice**

AIVL supports the NDS being underpinned by a strong evidence based that is always informed by the best available evidence and practice. While it is hard to disagree with such a statement and this sentiment is certainly expressed within the current NDS,

AIVL is concerned about the degree to which this sentiment is implemented in practice. For example, the current level of investment across the three pillars of supply, demand and harm reduction disproportionately favours law enforcement and prevention initiatives as opposed to harm reduction measures (Moore, 2008).

Internationally and within Australia there is overwhelming evidence to support the effectiveness and cost effectiveness of harm reduction approaches (IHRA, 2008). Indeed the evidence supporting one of the main harm reduction strategies in the Australian context – needle & syringe programs – shows that NSPs have already saved almost \$1.3 billion in health costs in the short term and even more over the longer term (NCHECR, 2009). Further, evidence also shows that despite the current investment in NSP, at least 50 percent of all injections are occurring with used needles & syringes (NCHECR, 2009). Together the above findings make for compelling evidence by any measure, yet we have not seen an increase in investment in NSP to address the unacceptably high rates of reusing of injecting equipment. It seems just from this one example (and there are many more) that policy and practice is not always being informed by the evidence base.

The other issue that AIVL believes is important to take into consideration is that although we support basing policy and practice on available evidence, we are also concerned to ensure that in the rush to apply the evidence we do not lose the opportunity for innovation. There are many examples in the AOD and BBV sectors that demonstrate that without a commitment to innovation and willingness to act in the absence of available evidence, certain highly effective approaches would never have been implemented. Needle and syringe programs in the community are an example in the Australian context. Needles and syringe programs in prisons and heroin prescription programs in the community and in prisons are further examples in countries other than Australia. In the area of illicit drugs in particular the need to act to address an emerging issue in a timely manner can mean having to design and implement programs without a strong available evidence base.

The reasons why there are gaps in the evidence base particularly in relation to illicit drugs is due to the fact that in 2009 despite having a framework of national research centres of expertise, we do not have a comprehensive sentinel surveillance system for monitoring current and emerging issues in illicit drugs generally and injecting drug use in particular. There are two main annual national research projects focusing on illicit and injecting drug users in the IDRS/EDRS and the Annual NSP Survey. While these projects do tell us basic information about a relatively small number of illicit and injecting drug users in Australia, AIVL does not believe they can provide the level of information needed to allow for evidence-based policy and program planning. The main reasons for this is that both studies despite being annual are basically national 'snapshots' using a relatively small sample of self-selecting respondents recruited from a small sample of self-selecting sites. These sampling and methodology issues greatly restrict the value and application of the findings for the larger population of illicit and injecting drug users in Australia.

The lack of strategic investment in Australian illicit drug research means that too often the results of relatively small studies are inappropriately used as the 'evidence base' to inform large scale changes to policy and practice within the AOD sector. This results in findings based on the self-reported comments of a small number of drug users being taken out of context or over-stated to a dangerous degree. In this regard, while AIVL fully supports evidence informed policy and practice we caution against over-stating or using available data out of context, while at the same time

discourage an over-reliance on having all the evidence before taking action particularly on emerging issues. This is a balancing act but both considerations need to be taken into account within the NDS.

## Partnerships

The Consultation Paper states that: *“Cross-sectoral partnerships are essential to coordinating resources and effort, enlisting skills, experience and expertise, and bringing people together to work collectively toward the common goal of reducing drug-related harm”* (DoHA, 2009). While AIVL fully supports the concept of partnership and collaborative effort, there is and always has been a visible absence of people who use illicit drugs (particularly injecting drug users) and drug treatment consumers in the NDS and the processes through which it is implemented. For example AIVL as the peak national organisation representing drug users and treatment consumers has never been actively included in or consulted on the work of the IGCD and have been excluded from the Australian National Council on Drugs (ANCD) for the past 10 years.

In the past 20 years, despite a lack of acknowledgement of the central role of affected communities in the NDS, AIVL has been consistently expected to provide the ‘drug user’ and ‘treatment consumer’ perspective to large numbers of committees, steering groups, resource development processes, conferences and forums. The lack of a formal acknowledgement of the importance of the consumer perspective within the policy framework however has meant that AIVL receives no resourcing from DoHA to undertake this role.

This lack of formal involvement and partnership with affected communities has been a feature of the NDS over many years despite the fact that during this time many international and Australian governments and organisations have publicly confirmed the value of community/consumer involvement. As far back as 1994, the Commonwealth Department of Human Services and Health in *Better Outcomes for Australians* stated that *“...Involving the community in decision making about their own health, as well as the planning and management of health services is integral to effective health promotion and illness prevention...”* (CDHSH, 1994).

In this context, AIVL believes it is essential for the NDS to review its current approach and ensure a much greater level of inclusion of, visibility for and partnership with illicit drug users, treatment consumers and their representative organisations. The available literature cites many benefits and successful outcomes from consumer participation in health services. In broad terms it is stated by the National Resource Centre for Consumer Participation in Health (NRCCPH) that the successes of consumer participation include:

- improvements in the quality of health care;
  - improvements in health outcomes;
  - more appropriate public policy;
  - better use of public funds;
  - better understanding and targeting of consumer issues and needs;
  - increased consumer control over health and health services; and
  - improved communication between service providers and consumers.
- (NRCCPH 2004)

The role of injecting drug users and drug user organisations has also been acknowledged throughout the international and Australian literature in relation to blood borne virus (BBV) prevention, treatment and care including HIV and hepatitis C. Indeed, strong and effective partnerships between governments, researchers, health professionals and affected communities have been a hallmark of the Australian response to BBVs in particular HIV and hepatitis C. In this context, people who inject drugs have been prioritised not only as an 'at-risk' population and thereby a focus of initiatives to prevent BBV transmission, but as a genuine partner with critical skills and expertise to bring to all aspects of the national strategic response.

With the national strategies for BBVs the role of peer education has been acknowledged as one of the main ways that people who use and inject illicit drugs gain access to information on safer injecting, harm reduction and access to services including drug treatment services. The main reason for the effectiveness of peer education in relation to illicit drug use issues is that it draws on the trust, credibility and relationships between peers. The majority of people who inject drugs interviewed for the recent National Hepatitis C Needs Assessment conducted by Hepatitis Australia stated that peer education and information produced by drug user organisations were their main and most trusted sources of information on hepatitis C and other BBVs (Richmond, 2009).

In this regard, AIVL is seeking the formal inclusion of drug users and treatment consumers as partners in all aspects of the NDS and across key priority action areas including:

- peer education in relation to harm reduction and drug information;
- consumer participation in drug treatment settings;
- drug user & consumer involvement in the development of supportive legislative and policy frameworks;
- affected community engagement in all areas of national drug research; and
- consultation and partnership with peer-based drug user organisations all aspects of the national response to illicit drugs and related issues.

In addition, while AIVL supports the concept of building broader links particularly in line with the Government's social inclusion agenda, we are concerned about shifting the focus to building new partnerships when there is still a need to ensure key stakeholders such as illicit drug users and treatment consumers are genuinely 'at the table'. That said, we would support the inclusion of expertise and organisations on issues such as human rights, health promotion, law reform, social policy, health literacy and cultural diversity.

Finally AIVL has a range of concerns about the increasing focus on mental health within the AOD sector. Rather than a partnership approach to ensuring mental health issues are addressed appropriately within the AOD area, it increasingly feels as though the AOD sector is being 'incorporated' into mental health. While AIVL acknowledges that appropriate partnerships with mental health are an essential part of a responsive and ethical AOD sector, we are concerned about the impact of broad generalisations about the mental health of 'all illicit drugs users' or 'most people on opioid pharmacotherapies' on our community. Many years ago AOD treatment was almost exclusively managed as a mental health issue though consultant psychiatrists and mental health institutions. For good reasons there was a move to shift AOD treatment into the community sector at least in part to de-stigmatise drug treatment for those who access it.

As part of this shift back towards mental health, AIVL has also noticed the increasing inclusion of terms and language from the mental health and disability sectors that do not necessarily have relevance for drug policy and services. One example of this is the increasing use of the term “carers” alongside “consumers” in discussions about consumer participation and involvement in the AOD sector. While a small number of people with problematic alcohol and other drug use issues may have physical and/or mental comorbidities that require carer support, this is not the case for the majority of AOD consumers. Indeed we would suggest that the concept has no relevance in relation to tobacco cessation and in AIVL’s experience, little or no relevance for people on opioid pharmacotherapies. While AIVL acknowledges that anxiety and depression is an issue for many opioid pharmacotherapy consumers, these issues are also widespread in the general adult population, and in any event, rarely result in people requiring ‘carers’ in the clinical sense.

AIVL is also concerned about the increasing links being made between treatment for illicit drug use and mental health at both a policy and service delivery level. We are concerned that these associations are resulting in the wholesale adoption of language and practices that may be well suited to clinical services in psychiatric care and disability but are not only inappropriate but potentially harmful in relation to treatment for illicit drug use. AIVL is concerned that the inclusion of ‘carers’ in what should be consumer participation and advocacy models can at best act as a distraction from the real priorities, but at worst, can act as a barrier to consumer involvement. For these reasons, AIVL would encourage a careful consideration of the potential benefits and disadvantages of including ‘carers’ in the language of the NDS or associated policies and documents.

### **A coordinated, integrated approach**

While AIVL supports the NDS as a higher level document to articulate key principles and priorities we also believe the strategy needs to be measurable and accountable and therefore should include performance related outcomes linked to the principles and priorities identified. In this regard we envisage a document that as a minimum articulates:

- key underlying principles;
- high level priorities;
- specific goals for implementation;
- how resources will be allocated; and
- key performance/outcome indicators.

In relation to key underlying principles, AIVL believes the NDS could benefit from the inclusion of a number of key concepts that have not been addressed or sufficiently addressed in previous strategies.

#### **a) Consumer Participation:**

In May 1985 a petition of reform was addressed to the Federal Health Minister. This petition called for a formal system of public participation to be built into the national health system. A review of community participation was conducted by the Department of Health in 1985–86. The review recommended that a health forum be established with representation from community and consumer groups to provide a consumer perspective on

health issues. It is this action that established the Consumers' Health Forum (CHF) and funds were made available within the 1986–87 budget to support its establishment. The Consumer Health Forum stated that;

*“Consumer participation is well recognised by many politicians, policy makers and service planners. Although considerable gains have been made in many areas for the benefit of health consumers, the need for effective consumer participation is not universally accepted.”* (CHF, [www.chf.org.au/our\\_chf/history.asp](http://www.chf.org.au/our_chf/history.asp))

This statement has great resonance for people who use illicit drugs and those accessing drug treatment services. Within many other areas of healthcare, consumer participation is valued and seen as a crucial component of health care provision. Within harm reduction and drug treatment services however there is still a great deal of work to be done to ensure consumer participation is not only valued but viewed as a standard aspect of quality service provision.

The available literature cites many benefits and successful outcomes from consumer participation in health services. In broad terms it is stated by the National Resource Centre for Consumer Participation in Health (NRCCPH) that the successes of consumer participation include:

- improvements in the quality of health care;
- improvements in health outcomes;
- more appropriate public policy;
- better use of public funds;
- better understanding and targeting of consumer issues and needs;
- increased consumer control over health and health services; and
- improved communication between service providers and consumers (NRCCPH 2004).

The evidence supporting consumer participation is strong. Alexander and Hicks, who presented a model for involving consumers, community members and health service staff in strategic planning for resource allocation, concluded that ‘developing an understanding of people’s values provides important information to support more equitable and effective decision-making for health services planning’ (Alexander & Hicks, 1998).

In 2001, the Australian Government funded the Consumer Focus Collaboration Project which concluded that:

- Effective consumer participation in quality improvement and service development activities is achieved through the adoption of a range of methods.
- Effective consumer participation uses methods that facilitate participation by those traditionally marginalized by mainstream health services.
- Active involvement of consumers at all levels of the development, implementation and evaluation of health strategies and programs is integral to their success.

The current *National Drug Strategy: Australia’s Integrated Framework 2004–2009* states the following commitment to consumer participation:

- improved access to quality treatment – through the involvement of consumers and drug user organisations; and
- a coordinated, integrated approach – through a commitment to partnership.

Other than broadly identifying the issue of consumer participation as shown above, the current NDS does not outline a framework or approach to guide and support the implementation of consumer participation in relation to drug related services and programs. In addition, outside of the general requirements under the National Health Care Agreements relating to patients of public hospitals, there remain no specific policies or guidelines at the national level to support consumer participation in drug related and drug treatment services. Despite specifically identifying drug user organisations as key strategic players in relation to consumer involvement, the NDS has never dedicated any funding resources to this area of activity and AIVL continues to be called upon to represent the views and issues of people who use illicit drug and people in drug treatment without any ongoing funding support through the NDS or Drug Strategy Branch.

In contrast, while the NDS does not currently outline a comprehensive policy approach to consumer participation in drug policy and services, there are a whole range of national strategies targeting other health issues that have played a role in building the existing consumer responses within drug policy and within services including drug treatment services. For example there are the national initiatives of the Australian Government Department of Health and Ageing in relation to HIV/AIDS, Hepatitis C and other related diseases which include:

- *National HIV/AIDS Strategy 2005–2008: Revitalising Australia's Response;*
- *National Hepatitis C Strategy 2005–2008;*
- *National Sexually Transmissible Infections Strategy 2005–2008;*  
and
- *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008.*

While these initiatives and strategies (that are duplicated at the state and territory level in most jurisdictions) are not exclusively focused on issues relating to drug policy and service delivery, they do demonstrate a strategic commitment on behalf of the Australian Government to the involvement of 'affected communities' or 'consumers' at the national level. These strategies have been built on the *Partnership Approach* which recognises the central importance of the affected communities in developing the policy response and in shaping the planning and delivery of services. Historically, these strategies have also supported the development of grass-roots organisations that are managed by the affected communities – including the development of the national and state/territory peer-based drug user organisations.

Given the link between blood borne viruses (BBVs) and injecting drug use, the provision of harm reduction and drug treatment services has been a key feature of Australia's national policy response to the prevention and treatment of BBVs. The lack of an equivalent policy framework within the NDS to support the active participation of drug treatment service consumers in the

planning and delivery of drug treatment services has meant that the policy response to BBVs has in many ways acted as a 'de facto' policy framework for consumer participation in drug treatment services.

Despite the lack of a clear policy framework to support consumer participation within the NDS, over the past 20 years drug user organisations have provided peer-based education, services and support, and have played a significant role in representing the perspective of people who use/have used illicit drugs community in relation to government policy development and in services planning and delivery. At the national level this role has been undertaken by AIVL and through the AIVL member organisations at the state and territory level. Under the guises of the Hepatitis C and HIV/AIDS strategies, AIVL and its members have developed capacity in relation to consumer participation and demonstrate the skills and knowledge that drug treatment service users have to offer.

Over the past 4 years, AIVL has received funding through the Drug Strategy Branch for two time-limited projects focused on consumer participation in drug treatment settings. The Treatment Service Users Project Phases 1 & 2 have demonstrated overwhelming support and need for policy frameworks to ensure consumer participation within drug treatment settings. The reports from both phases of the TSU Project have identified the need for national policy frameworks and leadership through the NDS to ensure consumer participation in the drug treatment context.

In light of the above evidence supporting the value and benefits of consumer participation in drug related services, policies and programs, AIVL recommends that principles of consumer participation and the involvement of affected communities are included as a central platform in the NDS.

**b) Health Promotion:**

The Ottawa Charter for Health Promotion recognises that 'health' is an expression of individual aspiration: health is not something that can be imposed by national strategies or health authorities – conceptions of and aspirations for health vary from individual to individual, between communities and cultures and across society. At the same time, one of the most valuable contributions of the Ottawa Charter is that it has played the role of shifting the emphasis away from individual risk behaviours to a more collective notion of public health. AIVL believes this emphasis is one that needs further attention in the NDS particularly in relation to illicit drugs and notions of individual risk and responsibility.

The Charter views an individual's ability to achieve their aspirations for their own health as being heavily affected by the context of their lives. Health promotion expert Ronald Labonte has said:

*"The Ottawa Charter and its successors, the Jakarta and Adelaide Declarations, represent the rediscovery that social and environmental conditions are more determining of personal and collective health than the narrower focus on health care and disease prevention that dominated our thinking about health for much of this century"*  
(Labonte, 1996).

The principles outlined in the Ottawa Charter are now firmly established among the guiding principles of the National HIV Strategy and the National Hepatitis C Strategy. In the context of these internationally regarded national strategies, health promotion is articulated as a process of enabling people to increase control over, and improve their health and wellbeing by:

- Building healthy public policy;
- Creating supportive environments;
- Strengthening community action;
- Developing personal skills; and
- Re-orienting health services (Ottawa Charter for Health Promotion, 1986).

Creating an enabling legislative and policy environment to support individuals and communities to increase control over and improve their health and wellbeing can and must be a central underlying principle and approach of the NDS. While reducing drug related harm must remain a priority focus of the Strategy, it is also necessary to increase or add a focus on strategies and approaches that place drug use in the larger context of people's lives. This includes assessing the impact of systems, policies and structural inequalities on the capacity of individuals and communities to improve their broader health and wellbeing.

### **c) Human Rights:**

The Ottawa Charter also emphasises that social justice and equity are fundamental prerequisites for health. In this context, in addition to recommending the need to include health promotion principles within the NDS, AIVL also see the need to ensure that the principles and practices of human rights underpin the NDS at a strategic level. Taking a human rights approach to the issues addressed within the NDS means creating a supportive social, policy and legal environment where human rights are respected and protected, and the equitable right to health is not just an ideal articulated in international conventions but an outcome that is both achieved and measured.

Three general human rights principles are seen as key to characterise the right to health, namely non-discrimination, participation and accountability (WHO, 2009). The impact of stigma and discrimination on the health and lives of people who inject or have injected drugs is significant. Although research in this area is limited, on the occasions they have been asked, people who inject drugs and those on opioid pharmacotherapy treatments routinely identify stigma, discrimination and fear of poor treatment as the main reasons they do not access primary health, harm reduction and other health and social services.

In the *Barriers and Incentives to Drug Treatment for Illicit Drug Users National Research Project* more than half the participants reported that they had been discriminated against by family (63%), staff at pharmacies (63%), friends (62%), and doctors/nurses (54%) and a significant number mentioned discrimination by partners (37%), other health workers (36%), landlords (36%) and workmates (34%) (Treloar et al, 2004). So widespread is the problem of drug use-related stigma and discrimination, that AIVL and its member organisations are aware of many individual drug users living with extremely

painful, debilitating and even life-threatening conditions rather than seeking out treatment from health services.

Indigenous drug users, drug users from CALD backgrounds and drugs users with mental health issues are among the groups that live with multiple layers of stigma, discrimination and human rights violations. Poor attitudes among service providers, the media and the general community towards these groups results in increased vulnerabilities and levels of social exclusion including significantly higher rates of homelessness, incarceration, unemployment, poverty, social isolation and chronic health problems including hepatitis C, hepatitis B and HIV infection (DoHA, 2005).

The Australian Government has recently developed its Social Inclusion Agenda. This agenda recognises the importance of allowing all Australians:

- the opportunity to work;
- to access the services they need;
- to connect with their family and friends;
- to become involved in their local community;
- have the skills to deal with crises when they might arise; and
- to have the chance to make their voices heard - recognising there are barriers that prevent participation (Department of Social Inclusion, 2009).

The current National Hepatitis C Strategy 2005-2008 also identifies “Stigma and Discrimination” as one of the strategy’s priority action areas. It recognises that injecting drug use is a highly stigmatised behaviour and in this regard is often the underlying cause of stigma and discrimination in relation to hepatitis C. The Strategy also acknowledges the additional levels of social isolation and marginalisation experienced by groups such as Indigenous Australians, people from CALD backgrounds, prisoners/ex-prisoners and people with mental health issues who have a history of injecting drug use. In this regard the Strategy notes:

*“Eliminating discrimination against people with hepatitis C, or who are assumed to have hepatitis C, is important both as a human rights issue in itself and because such discrimination affects the mental and physical health of individuals” (DoHA, 2005).*

It is in the above context that AIVL seeks to have a human rights approach embedded into the NDS as a underlying principle. We believe there is an urgent need to address the systemic problems identified across many research and policy reports over the past 20 years. AIVL believes that until we address some of the fundamental issues that underpin IDU related stigma and discrimination we will continue to see people who inject drugs disproportionately affected by preventable diseases, experiencing unnecessary levels of drug related harm and routinely dealing with unacceptable barriers to treatment and basic health and social services.

Embedding a human rights based approach within the NDS would include ensuring privacy protections and confidentiality in service provision, facilitating access to high quality health services, eliminating punitive drug treatment approaches, reviewing current laws and policies for human rights

violations and protecting the health and rights of people in law enforcement and correctional settings. A human rights approach would also ensure that people who use or have used drugs have unimpeded access to human rights agencies that can provide redress where violations occur, as well as educational and research measures to assist in recognising and reinforcing rights and responsibilities, measuring compliance, and changing discriminatory and negative attitudes. A human rights approach enables the full participation of vulnerable people in the responses to issues that affect them and in society in general, empowering a community response which is fundamental to a true partnership.

As identified in the Consultation Paper, currently the NDS also includes a number of 'sub-strategies' under the umbrella of the NDS which seek to provide a more in-depth response to key issues and target populations. Although AIVL recognises that it is impossible to address these issues in the level of detail required within a high level document such as the NDS, we are also concerned about the number and ad hoc nature of these 'sub-strategy' documents. In this regard AIVL recommends that the current sub-strategies are reviewed with a view to replacing these documents with a series of action plans or implementation documents. This would allow specific action on key priority issues such as tobacco, alcohol, illicit drugs, etc without the creation of 'mini-strategy' documents. These plans should be brief, action or outcome oriented statements concerned with implementing key actions and priorities identified through NDS or in response to emerging issues. A process linked to the implementation of the NDS should be conducted to review the current sub-strategies and develop consensus on future action plans.

### **A balanced approach**

AIVL acknowledges the political realities associated with the balance of investment and approach within the NDS and that these imperatives will call for investment across the three pillars of supply reduction, demand reduction and harm reduction. Despite this 'reality' however, we do not believe the current balance of investment reflects available evidence on either the relative effectiveness or cost-effectiveness of the different approaches. While figures are not easily available on the exact percentage of investment across the three pillars for both licit and illicit drugs combined, it is undisputed that the vast majority of financial investment is in the area of law enforcement or supply reduction.

This is further supported by the figures that are available in relation to the investment in illicit drugs policy alone which confirm of a total expenditure of approximately \$1.3 billion, 55 percent was spent on law enforcement, 23 percent on prevention, 17 percent on treatment and only 3 percent on harm reduction initiatives (Moore, 2008). This expenditure breakdown is the opposite of what is believed to be the case with the 2007 National Drug Strategy Household Survey showing the perception of a much greater investment in demand and harm reduction strategies among the general public (AIHW, 2008).

As already noted elsewhere in this response, the evidence supporting the effectiveness (in terms of reduced harms) and cost-effectiveness (in terms of the relative value for money) is nothing short of outstanding in relation to harm reduction approaches. Indeed you would be hard pressed to find another health promotion approach that delivers anything close to the return of investment provided by harm reduction initiatives such as NSP. By way of example, a report produced by NSW

Health into the impact of HIV prevention programs found that the direct cost to direct benefit ratio of harm reduction approaches such as NSP are 1:13 – that is for every \$1 invested by government the community saves \$13 in averted health and associated costs through prevented infections. This compares to a direct cost/direct benefit ratio of \$1:\$2 for tobacco and \$1:\$0.70 for heart disease (NSW Health, 2007). AIVL is not aware of similar cost-effectiveness and return on investment evidence in relation to the significant expenditure on law enforcement/supply reduction and illicit drugs.

In addition to financial investment and cost-effectiveness, in relation to illicit drugs there is also the issue of the cost to the individual and the community of the continued criminalisation of people who use illicit drugs. Approximately 10 years ago, the member states of the United Nations including Australia convened for a special UN assembly where it was agreed to work towards achieving a “drug-free world” within the decade. Member states agreed to undertake appropriate measures to eliminate or reduce the supply of and demand for illicit drugs and psychotropic substances. In the years since this UN special assembly, countries across the world including Australia have continued to invest large amounts of resources in reducing the supply of illicit drugs and as part of this approach continued to strengthen drug control policies and laws (OSI, 2009).

The combined effect of all of this activity however has not been the creation of a “drug-free world” or even steps towards it. Instead, the head of the UNODC and many other highly credible bodies have begun to admit that drug control measures have had significant unintended consequences particularly for those who have borne the brunt of this “war on drugs” – that is people who use or have used illicit drugs. Indeed too often the “war on drugs” has really been a “war on people” and has resulted in high rates of preventable disease, increasing levels of imprisonment and untold human rights violations. As the Open Society Institute states:

*“... the question is not just whether a drug-free world is possible, but how many violations of human dignity and ethical conduct are seen as acceptable in the effort to achieve it. How can drug control conventions aimed at “reducing human suffering” be permitted to excuse so much hardship and humiliation? Today, and in the next decade, the goal should be to achieve total elimination or significant reduction in these unconscionable abuses committed in the name of drug control” (OSI, 2009).*

Given the levels of suffering and abuse that routinely occur in many developing economies, it can be easy to dismiss the effect of the continued criminalisation of people who use illicit drugs as an ‘overseas’ issue. The rhetoric that Australia takes a ‘balanced harm minimisation approach’ hides the fact that there are significant negative impacts of the current approach to drug laws and policies in Australia. For example, the NT has one of the highest per capita rates of imprisonment in the world and the vast majority of people in Australian prisons are there for non-violent drug related offences. Rates of Indigenous imprisonment are many times higher than the non-Indigenous population and similarly are driven by convictions for drug related offences. Research has also shown higher rates of HIV and hepatitis C infection and increased risk of transmission associated with Asian ethnicity, recent incarceration, public injecting and duration of injecting (Maher, 2004). In Australia having been in prison is an independent risk factor for hepatitis C infection (Maher, 2004).

Poor attitudes and discrimination against people who use illicit drugs and pharmacotherapy consumers creates very real barriers to access in relation to critical health and social services. Eighty percent of over 300 drug users interviewed for a submission to the NSW Anti-Discrimination Board on illicit drug use and discrimination stated that they had experienced poor treatment and discrimination at the hands of police. The C-Change Report into hepatitis C related discrimination in 2001 also highlighted the systemic and entrenched nature of discrimination against illicit drug users across all levels of society but in particular in healthcare settings, employment, the criminal justice system and the general community including the media (NSWADB, 2001).

Drug users continue to report having unused needles and syringes taken from them by police and/or used as the basis for threats and harassment. Punitive and unfair treatment at the hands of opioid pharmacotherapy services is commonplace and people on methadone being denied access to basic services has been the subject of Supreme and High Court cases in Australia. It was this general environment of acceptance when it comes to discrimination and human rights violations against people who use illicit drugs that allowed the previous federal government to recommend amendments to the Federal Disability Discrimination Act to make it legal to discriminate against people who use illicit drugs. While this particular attempt to enshrine rather than eliminate stigma and discrimination against illicit drug users was unsuccessful, it remains an unresolved issue in the Australian community. The media drives poor attitudes and discrimination against people who use illicit drugs in the community and elections are littered with law and order auctions focused on who can be seen to be the hardest and least compassionate when it comes to illicit drugs and the people who use them.

In this context AIVL believes there is an urgent need to review our current drug laws and the unacceptable negative impacts they are having on drug users, their families and the community as a whole. One solution to the problems created by the illicit nature of certain substances is to decriminalise those substances. This will not result in these substances being legal but it will remove criminal sanctions and arguably some of the health and social problems outlined in this document. Rather than decriminalisation however, AIVL advocates the urgent need for consideration of a new system of regulation or controlled distribution for currently illicit substances.

Reports from countries such as Portugal who decriminalised possession of small amounts of drugs in 2001 found that this resulted in reductions in drug-related public health problems (Hughes and Stevens). Other countries such as Mexico are in the process of reforming their approach to illicit drugs in the face of widespread drug-related violence, police corruption and public health problems (based on report from Dr. Norm Stamper from LEAP during Parliamentary address in Australia during October 2009). In addition, studies from the Swiss, Canadian and UK trials of injectable heroin prescription have all found positive results in relation to improved social functioning, psychological health and reduced criminality (Lintzeris et al, 2009).

Despite a general reluctance within government to discuss alternatives to the current approaches to illicit drugs, AIVL believes there is evidence of community support for a more progressive and compassionate approach to these issues (Matthew-Simmons et al, 2008) The need for reform is already firmly on the international agenda with Transform Drug Policy Foundation in the UK recently publishing a monograph outlining practical strategies for reforming the current approach to illicit drugs titled: '*After the War on Drugs: Blueprint for Regulation*'. This monograph

follows increasing public discussions in many countries in Europe, Asia and in the U.S. on the need to end the war on drugs in favour of a more humane approach.

Ultimately however, regardless of ideology and personal views on the availability and use of illicit substances, there are ethical, social and health imperatives driving the need to review our current approach. AIVL believes it is time to ask: “What constitutes a genuinely balanced approach within the NDS and how is this best achieved?” Further, these questions need to be considered in the context of the best interests of all Australians including people who use illicit drugs and pharmacotherapy consumers. As it currently stands the interests and needs of both of these groups are not being served by the current so-called ‘balanced approach’. It is in the interests of the entire community to achieve some balance before further harms are inflicted. This process must include a review of the impact of current drug laws and policies with a view to replacing the current approach with a regulatory system of controlled supply for all currently illicit substances. Given the evidence supporting the positive benefits associated with treatment options such as heroin prescription, this review should also include increasing the range of treatment options available in Australia to bring our treatment sector into line with world’s best practice. This would include the provision of heroin prescription programs and pharmacotherapy treatment options for people with ATS dependencies.

### **International contribution and cooperation**

While AIVL supports the current commitment to international partnership and cooperation we are concerned that under the current NDS this area is almost solely focused on law enforcement and curbing the supply of drugs without a sufficient assessment of the unintended negative consequences of continued criminalisation of people who use illicit drugs. AIVL believes this is a particularly important issue in our region given the very high and increasing levels of HIV among injecting drug users and the extremely high levels of incarceration in many Asian countries.

Rather than an exclusive focus on supply reduction activities at the international level, AIVL believes Australia should be taking a greater leadership role in supporting the implementation of evidence based harm reduction programs in partner countries including NSP and opioid pharmacotherapy programs. This is particularly important given the lack of access to evidence-based drug treatment programs in many countries in the Asian and Pacific regions.

In 2009, the WHO published an assessment of human rights violations within compulsory treatment centres in Cambodia, China, Malaysia and Viet Nam. This paper found that these services were frequently staffed by mainly administrative and law enforcement personnel rather than health and medical professionals, often lacked basic facilities such as drinkable water and sanitation, used emotional and physical abuse including beatings and lacked prevention and care services for HIV despite the high levels of infection among those accessing the services (WHO, 2009). Further, a report produced by the Canadian HIV/AIDS Legal Network in January 2009 on compulsory drug treatment in Thailand states that the current structure of Thailand’s compulsory drug treatment system means that most people who are drug dependent must undergo detoxification in prison as opposed to a health care setting (Canadian HIV/AIDS Legal Network, 2009).

Based on the evidence produced in this and other reports, AIVL strongly believes the Australian Government needs to play a leadership and advocacy role in relation to

the closure of these compulsory and detention camp-style treatment centres where human rights abuses are common place and rates of HIV and other infections are high. This leadership role needs to be included in the NDS as a legitimate expression of Australia's human rights obligations and commitment to evidence-based drug treatment.

AIVL also believes the Australian Government through its role in international contribution and cooperation under the NDS needs to show leadership on issues such as abolishing the death penalty for illicit drug related offences. As a country Australia opposes the use of the death penalty for any reason and this policy and humanitarian stance needs to be strongly reflected in the international partnership section of the NDS. On 26 June each year in the name of the UN International Day Against Drug Abuse and Drug Trafficking, China routinely executes people in prison for drug related offences. AIVL strongly voices our opposition to capital punishment and believes the use of the death penalty is an inhumane and cruel punishment that violates human rights.

Recently the Director of the United Nations Office of Drugs & Crime (UNODC) Antonio Costa publicly declared that “we should never kill in the name of drugs.” In this context, AIVL believes the Australian Government needs to articulate in the NDS its intention to work through the United Nations and world governments to condemn the use of the death penalty and develop humane and just legislative responses to all issues associated with the use of illicit drugs in society. We also call on the Australian Government to take further action under the NDS to secure the release of Australians currently facing the death penalty for illicit drug related offences in other countries.

### **Emphasis on prevention**

AIVL does not support the definition of prevention that is used in the current NDS or the positioning of prevention as a major and necessary focus of the next NDS. First, AIVL believes the focus of the NDS should be on the reduction of problematic drug use and drug-related harms not on the prevention of drug use per se. Drug use both licit and illicit is a social reality. As discussed elsewhere in this document, a ‘drug-free world’ is not a meaningful concept and indeed has been shown to be a very harmful one under certain circumstances.

In this regard, while AIVL in no way objects to developing resilience and protective factors among children and young people, we do not view such programs as having a focus on drug use. Such programs should be about ensuring people have the skills and capacity to make decisions in the best interests of their health and wellbeing. There are many complex factors and life circumstances that affect such decision making and the uptake of drug use does not have to result in poor health outcomes for individuals. If it is accepted that drug use is simply part of society, then AIVL believes the main focus of the NDS should be to ensure that harms and problems associated with drug use are minimised rather than wasting resources on poorly targeted, often ideology-driven and sometimes harmful drug prevention approaches.

Definitions and use of language within the AOD sector is also of paramount importance as it provides clarity and understanding for all stakeholders. In this context, AIVL challenges the definition that is used within the current NDS with prevention defined as “measures that prevent or delay the onset of drug use as well as measures that protect against risk and prevent harm associated with drug supply and use”. The term prevention is not broadly understood to be congruous with the

aim of reducing harm associated with drug use. Harm reduction is the principle and philosophy that undertakes this role. Prevention is focused on the prevention of the uptake of drug use. Harm reduction is focused on the reduction of drug related harms among people who are engaged in active drug use.

It is vital that there remains clarity of language and definitions for the philosophies and models that are implemented in the sector not only to ensure that individuals correctly understand what they are actually doing, but also for clarity around resource allocation. AIVL does not support a definition of prevention that claims to encompass harm reduction as harm reduction is a model that exists within its own right and is evidenced as a best practice.

## **Emerging issues and new developments**

### **1. Cross Sectoral Approaches**

Consultation Paper talks about the need to coordinate complementary areas of work and coordinate efforts across government and sectors however the law enforcement and drug policy approach is often counter-productive for harm reduction approaches. In this regard, AIVL believes there is an urgent need to ensure that drugs policy is harmonised with the aims and outcomes of harm reduction approaches. Too often the policies and initiatives of other government departments and sectors such as law enforcement/attorneys general, corrections, family and community services, social security, etc create barriers to accessing harm reduction and primary health services due to fear of arrest, imprisonment, removal of children, loss of benefits, etc. These competing and inconsistent agendas must be harmonised with the goal of reducing drug related harm and improving health and wellbeing as the number one policy and legislative goal across government.

In this context, AIVL believes there is a need to review the current governance and coordination arrangements for the NDS (currently through the MCDS and IGCD) to allow the inclusion of additional external expert advice including the non-government sector and consumers/affected communities and to support genuine partnership and involvement.

### **2. Indigenous Australians**

Indigenous Australians who use illicit drugs are disproportionately affected by all of the key health and social issues discussed throughout this submission. In this regard AIVL recommends a greater linking between the NDS and other key national strategies and approaches in relation to Aboriginal and Torres Strait Islander people particularly the soon to be released Aboriginal and Torres Strait Islander BBV & STIs Strategy. AIVL also advocates the greater involvement of young Indigenous Australians who use and inject illicit drugs to allow them to speak for themselves and develop responses that are appropriate for their communities. In this regard AIVL advocates support for peer-based models such as The Connection – Young Indigenous IDU Project based in the ACT.

### **3. Capacity Building**

Capacity building and workforce development are vital for the implementation of the NDS. In this context, AIVL believes it is important to ensure the definition of 'workforce' is an inclusive one that does not only include those

people who are working within the area of drug treatment but includes those workers employed or volunteering within other AOD services and related sectors such as NSP, community health, social services as well as peer-based drug user organisations.

There is also a need to greatly increase training and capacity building within the workforce in line with the comments about 'workforce definitions' above. This recommendation is linked to comments in the section on 'improved access to quality treatment' below about the need to develop continuous improvement service delivery models, accreditation and national minimum standards for all AOD and related services.

In line with the findings of the AIVL Treatment Service Users (TSU) Project Phases 1 & 2 there is also a need to build capacity among drug treatment services to undertake consumer participation. Drug treatment consumers also need support and capacity building to have greater involvement in treatment programs. Despite identifying strong support for the principle of consumer participation among both staff and consumers, neither group felt confident in implementing consumer participation in practice. The TSU Projects also identified the need for culture change within treatment services to build the communication and trust necessary for genuine consumer involvement and engagement. Research has shown that improving opportunities for consumer engagement in drug treatment settings leads to improvement in service quality, better retention in treatment and therefore better treatment outcomes (Consumer Collaboration 2001).

#### **4. New Technologies and On-Line Services**

While AIVL is aware of initiatives at the federal level to develop e-health and other online health record systems, we have consistently raised issues in relation to these developments from the perspective of confidentiality and privacy concerns. Given the widespread discrimination and poor treatment routinely experienced by people who inject drugs, AIVL is concerned that the imposition of online e-health systems could force people further away from critical health services due to fear of confidentiality breaches and disclosure. For this reason, AIVL strongly recommends further consultation with drug user organisations, people who use illicit drugs and those on drug treatment programs before the introduction of e-health and on-line records systems in this area.

Research conducted by AIVL in 2004 found that people who inject and use illicit drugs and people on pharmacotherapies have much greater access to the internet and on-line resources than assumed by many within the AOD sector. Providing further support for this conclusion is the fact that the AIVL website has a very high level of traffic which has been sustained and consistently grown over the past 5 years. In this context, AIVL supports the greater use of on-line resources as a strategy to provide better access to information and services particularly for those in regional and rural areas. On-line resources can also help to address confidentiality concerns which can act as a barrier to service access for many people who use illicit drugs.

The use of social networking sites can provide a very good way to ensure people have access to timely information and services that can be updated regularly and include interactive functions for greater engagement. Online resources are also very good for addressing issues such as poor literacy as unlike printed materials, they allow for audio and visual files. It should be noted however that there are people who do not have easy or any access to internet and online resources and for this reason a balanced approach should be continued which includes the availability of printed materials and telephone and face to face service delivery.

## 5. Increased vulnerability

While AIVL can provide further detail on each of these issues for the purposes of this submission we would like to identify the following groups and issues as requiring attention as emerging issues:

1. **Older Injecting Drug Users** - in particular concerns about multiple health and social problems, poor access to adequate pain management, long term grief and loss and the impact of anxiety and depression caused by routine discrimination and the long term negative impact of criminalisation on their lives and health. AIVL is soon to release a new national discussion paper on the issues and needs of this group and would be interested in discussing this issue further in the context of the NDS and in particular in relation to new research, policy and programmatic priorities.
2. **Hepatitis C & Other BBVs** – although there are dedicated national strategies for viral hepatitis and HIV, AIVL believes the growing impact of the hepatitis C epidemic on the Australian health system will be such over the coming 5-10 years that the NDS will need to ensure the AOD sector is more adequately equipped to understand and response to this issue. In particular as NSP (the frontline of HCV and HIV prevention among IDU) is part of the AOD rather than BBV sector in some states and territories and the fact that there is an increasing role for pharmacotherapy services in HCV treatment both indicate the need for greater links and partnership between the NDS and the BBV related strategies.

## 6. Performance Measures

AIVL believes performance monitoring should be one of the priorities for the NDS. This approach should include timely and meaningful performance measures with clear outcome indicators for each of the key priorities within the strategy. Each priority under the NDS should specify an intended outcome such as supply reduction, demand reduction or harm reduction and then be measured and evaluated against whether set outcomes have been achieved. AIVL strongly recommends an additional assessment of any unintended negative outcomes from each priority area. These performance measures and associated reporting on intended and unintended outcomes should be publicly available.

### Other Issues:

#### Improved Access to Quality Treatment

AIVL believes that improved access to quality treatment needs to remain as a major priority for the next NDS. In this context, the following specific priority activities should be included within the strategy:

- There needs to be a commitment to the evaluation of current drug treatment provision and this should be linked to the development of national quality based minimum standards and a rigorous accreditation system for all treatment services;
- There needs to be a review of currently available treatment options with the view to expanding the range of options available for treatment related to illicit drugs to ensure treatment is more appropriately matched to individual need and is client-focussed. The growing evidence base demonstrating the effectiveness of heroin prescription should be a major consideration within this process with AIVL's recommendation that heroin prescription be introduced into the mix of drug treatment services available in Australia;
- Additional resources must be identified to increase access to quality treatment, remove waiting lists and ensure individuals can access their treatment of choice without delay;
- The current unacceptably high cost of opioid pharmacotherapies needs to be addressed as a matter of urgency through the removal of dispensing fees for individuals and the review of current scheduling arrangements under the PBS;
- The ethical and safety issues associated with the ongoing TGA approval, without appropriate monitoring to a small number of clinics to provide naltrexone implants under the TGA Special Access Scheme must be addressed as a matter of urgency – AIVL does not support what amounts to ongoing medical experimentation on people with opioid dependencies through the routine use of a device that does not have the appropriate level of TGA approval required of other medications and devices for the treatment of opioid dependency;
- The role of drug user organisations in drug treatments advocacy needs to be an acknowledged and this role needs to be adequately resourced;
- The value and benefits of consumer participation should also be acknowledged with a commitment for increased consumer involvement and partnerships at the policy and service levels (see comments about consumer participation as an underpinning principle articulated above).

## Conclusion

AIVL is pleased to be able to contribute to the development of this important strategy. Partnerships are crucial to the success of the NDS and AIVL hopes that our comments will be given appropriate consideration by the MCDS.

AIVL believes that it is no longer acceptable to refer to people who use illicit drugs and those on pharmacotherapies in a tokenistic manner or as passive recipients of the initiatives and policy approaches within the NDS. We wish to be treated as equal partners with a significant contribution to make to the development and implementation of the NDS. In this regard, we look forward to further consultation on the matters we have raised in this submission.

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