New South Wales 2024 Drug Summit Position Paper of the Community Restorative Centre

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Community Restorative Centre (CRC) works with who are people leaving prison or who are at risk of involvement with the criminal legal system.[1] CRC assists people with reintegration into the community by providing intensive, holistic case management in outreach settings. CRC clients often have multiple, intersecting support needs, relating to substance use, health issues, cognitive disability, and social disadvantage.

All of CRC's programs operate from a model of harm reduction. A harm reduction approach aligns with CRC's principles of being client-centred and 'meeting people where they are at', being open and honest with clients, and offering non-coercive, non-punitive, and non-judgemental support which aims to holistically address client's needs as they rebuild their lives in the community.

Ahead of the New South Wales Drug Summit, CRC would like to make the following recommendations that could make a positive change to people who use drugs and to the communities they live in:

1. **Treatment for problematic substance use and other co-occurring health issues in prison should compare, and be linked to, treatment available in the community.** This should include reducing barriers to pharmacotherapy while in prison, provision of needle-syringe programs in prison, training in Naloxone provision before release, and providing people with Naloxone upon release. Also, continuity of care from prison needs to be ensured.
2. **Substance use should be treated as a health/ social issue, not a criminal one.** This requires coordinated approaches to achieve de-policing of communities where drug use is prevalent, decriminalisation of drug use, diversion from the criminal legal system for people who use drugs and re-directing people who use drugs into relevant treatment and support services.
3. **We need a coordinated effort to remove the "perpetual punishment" people face when accessing treatment.** People who have criminal charges are often excluded from mainstream AOD and other support services. We advocate for funding bodies to ensure that the services they commission don't discriminate against criminalised populations and that any structural barriers to access by these communities are removed.
4. **There should be greater availability of outpatient and outreach drug treatment, i.e. treatment that people access while they are in the community.** This type of treatment ensures that people experiencing the intersection of substance dependence, complex health needs, and social disadvantage, can be meaningfully engaged and that they can translate the

[1] The term 'criminal legal system' reflects how the 'justice system' in Australia has been imposed on First Nations communities without their consent through settler colonialism. The term 'criminal legal system' also highlights the way the system-including police, courts and prisons-frequently fails to deliver justice. These failures aren't isolated but are part of a broader, ongoing problem. This is evident in the fact that First Nations people in Australia have the highest imprisonment rates in the world, are racially targeted by police, and experience a lack of accountability from the 'justice system' when First Nations people die in custody. More broadly, the system criminalises people experiencing homelessness, poverty, mental illness, disability, alcohol and other drug dependency, and trauma. The criminal legal system perpetuates cycles of marginalisation and disadvantage. In this way, the system does not deliver 'just' outcomes for individuals or communities. By using 'criminal legal system', we acknowledge the harmful effects of colonial legal systems and seek to validate people's lived experiences. Changing language is one aspect of our effort to advocate for systems that are 'just' for all communities.

skills obtained in treatment into real-life settings. This may be particularly relevant to First Nations people.

5. **People with substance use histories need to have multiple social determinants and health needs addressed.** Systemic changes are required to address structural inequalities and barriers. For example, diversion programs like drug courts should enhance their case-management and counselling components. When basic social and health needs are covered, people can minimise their drug use or make it less risky.

1 Treatment of substance use and other co-occurring health issues in prison should compare, and be linked to, treatment available in the community

According to the United Nations, **people in prison have the right to access the same healthcare services in prison that they may access in the community**, irrespective of their legal and custodial status, and it is the government's responsibility to ensure that such healthcare rights are safeguarded (1).

People who use drugs are over-represented in prisons. People in prison are about four times as likely to report illicit drug use in the preceding 12 months than people in the general community (2). 73% of people entering prison reported using illicit drugs in the last 12 months and almost one-third (29%) reported injecting drugs at some point in their lives.

The overrepresentation of people who use drugs in prisons speaks to the importance of providing comparable, if not greater accessibility of AOD programs in prison. Reducing barriers to pharmacotherapy while in prison, the provision of needle-syringe programs in prison, and training in Naloxone provision before release, are all necessary steps that we detail in this section. We emphasise:

- ✔ **The types and the standard of AOD treatment in prison should be the same as in the community**, including confidential counselling, the variety of opioid treatment medications, and culturally appropriate care.
- ✔ **Continuity of treatment before and after prison needs to be ensured**. There need to be clear referral pathways for care from the community into prison and from prison into the community.
- ✔ **There should be a greater in-reach of community organisations in prison** that follow up with clients after release, which can facilitate continuity of care. An example of a community-based AOD program with in-reach into prison is provided in Box 1.

Box 1 – Community Restorative Centre's in-reach into prison – the Transitional AOD Project

CRC's Transitional AOD Project is an outreach-based AOD counselling service for people of all genders with a history of AOD use and involvement in the criminal legal system. The following groups of people are given priority access to the project:

- People who have a cognitive disability (including Acquired Brain Injury, Fetal Alcohol Spectrum Disorder, an Intellectual Disability and a Borderline Intellectual Disability)
- People who have a mental illness

- First Nations people
- Women with dependent children.

The program provides pre-release and post-release outreach AOD support to people exiting NSW Correctional Centres. It involves individual, confidential counselling appointments for up to 12 months. The Transitional AOD Project works in a respectful, culturally appropriate manner. Workers listen to what the clients want to achieve and assist them in reaching those goals. Clients can be abstinent from drugs and alcohol, or they may be actively using. The program was shown to be effective in reducing criminal legal system involvement, in reducing client's substance use, and in improving their wellbeing (3).

The Transitional AOD Project is funded by Central and Eastern Sydney PHN, Western Sydney Primary Health Network, Federal Health (through the NGOTGP) and NSW Health.

1.1 Opioid agonist treatment in prisons should be urgently expanded

To support our call, it should be noted that only 1.5% of the people in prison receive opioid agonist treatment (OAT) – while 7.5 % of them report having received OAT in the community (2,4). **Considering that people who have a history of opioid use are over-represented in prison, custodial OAT needs to be expanded.** We argue that:

- ✔ There is an urgent need to **increase the funding and the continuity of OAT treatment between prison and community** to meet the needs of people who require opioid treatment in prison.
- ✔ OAT prescription in prison shouldn't be conditioned upon receiving the said prescription in the community – **eligibility criteria need to be the same in prison as in the community**.
- ✔ One of the historical reasons for restricting access to OAT in prison has been the risk of diversion (5,6). With preparations like buprenorphine depot now being available in Australia, **OAT should no longer be restricted in prisons based on diversion risks.**

A recent study has shown that people who use drugs and have histories of incarceration found accessing OAT in prison difficult (4). We provide a case study of a CRC client experiencing such difficulty in Box 2.

Box 2 – Case study of OTP access in prison

A CRC female client with a history of opioid dependency requested AOD treatment upon entry to custody in February 2023. She has consistently sought support from custodial and Justice Health NSW staff to be assessed for a buprenorphine depot. While waiting, she was increasingly exposed to illicit Buprenorphine in prison and subsequently developed a dependency.

The client missed a scheduled AOD assessment with Justice Health in early July 2023 due to attending her employment in prison. She was not notified of what the appointment was at the time. She sought to reschedule the appointment yet has been placed back on the extensive waiting list with 10+ patients before her. There was a 100-130 day wait period for people to access an AOD assessment at the correctional centre, and a minimum of eight weeks left on sentence is required to commence Buvidal.

The client was due for release on 9 September 2023 and was therefore no longer able to be assessed for OTP before her release. The client has continued to ask prison staff for support and access to treatment.

1.2 Needle syringe programs (NSPs) should be provided in prisons

Despite efforts put into prison security, drug use may continue or even be initiated in prison. 14% of people leaving prison reported injecting drugs while in custody. The majority of those who injected drugs in prison reported sharing injecting equipment (2). There is an urgent case for implementing needle-syringe programs in Australian prisons, including New South Wales.

- ✔ Australia is now on track to eliminate hepatitis C with broad accessibility to direct-acting antiviral treatments. **Prison-based NSPs are an essential step in combatting the perpetual risk of re-infection from hepatitis C in prison** (9)**.**
- ✔ Australia and New South Wales in particular have been leaders in harm reduction programs and should **join other countries who have successfully piloted NSPs in prisons**, including Armenia, Canada, Kyrgyzstan, Macedonia, Moldova, Tajikistan, Afghanistan, Luxembourg, Spain, and Switzerland (11).
- ✔ **Evidence shows that NSPs can reduce the risk of transmitting blood-borne diseases in prisons, can facilitate entry into drug treatment programs, and may enhance workplace safety**. No increase in drug use or availability following prison NSP implementation, in addition to safety issues, has been documented (7,8).
- ✔ **There exists a high level of support for needle syringe programs in prison among peak bodies,** including the Australian Medical Association, Australasian Society for HIV Medicine and the Royal Australasian College of Physicians, as well as the World Health Organization, UNAIDS, and the United Nations Office on Drugs and Crime (10).

We advocate for a carefully designed NSP trial in NSW prison(s) that considers insights from people who have lived experience of the criminal legal system. There may be the following considerations when designing and implementing trials or programs of prison-based NSPs:

- The main concerns of implementing NSPs may include risks to the confidentiality of people using the service and a related potential lack of engagement on their end (12). NSP program design in prison needs to alleviate this issue.
- Prison staff may have concerns regarding syringes being used as weapons. However, innovative technologies such as retractable syringes are now available that can alleviate safety concerns (13).
- A prison-based NSP trial in the Australian Capital Territory was retracted in 2009 due to a lack of engagement by prisons (10). Therefore, effective partnerships and government leadership are needed to ensure this essential harm-reduction program will be implemented.

1.3 People who are at risk of opioid overdose should be trained and equipped to use naloxone before leaving prison

The risk of overdose death increases three to eight times in the two weeks following release from custody compared to other times (14). It is essential to ensure that people leaving prison are equipped with life-saving medication to reverse opioid overdose.

We call for a coordinated effort in the prison system so that **every person who is being released and who may be at risk of opioid overdose is trained and equipped to use naloxone before re-entering the community**. We believe Naloxone provision upon release from prison would be a feasible and effective initiative. Research supports such a program in the following ways:

- A recent study among men in prison in Victoria with a history of regular injecting drug use found that they were **overwhelmingly willing to participate in take-home naloxone training before their release** (17).
- Initial studies from the UK indicate that **naloxone provision upon release can reduce overdose among people leaving prison** (15,16).
- A study from New South Wales showed widespread **support for naloxone training in custody among people who are incarcerated, key stakeholders in healthcare provision, and prison administration (18).**

2 Substance use shall be treated as a health issue, not as a criminal issue.

Treating substance use as a health issue requires coordinated approaches to achieve de-policing of communities where drug use is prevalent, decriminalisation of drug use, diversion from the criminal legal system for people who use drugs, and re-directing people who use drugs into relevant treatment and support services.

2.1 De-policing of communities where substance use is present should be a priority

The COVID pandemic has shown that the use of law enforcement is a choice made by the public authorities. It is imperative that aside from reducing the punitiveness of drug policies, the following de-policing practices are explored:

- Research has shown that there is an over-representation of First Nations young men in the juvenile legal system as a result of racial profiling, surveillance, and over-policing (19). **Combatting the over-surveillance of minoritised communities should be a priority.**
- **Dehumanising police practices such as strip searches should be abandoned**. At present, the *Law Enforcement (Powers and Responsibilities) Act 2002* allows police in NSW to stop and search a person if they have a reasonable suspicion that the person has stolen property, has crime-related items, or has drugs on their person. Strip searches disproportionately target First Nations people and are elevated in particular areas of Sydney (20). Strip searches contribute to stigmatisation and trauma among young people, particularly First Nations young people (21).
- **Alternatives to police responses, when possible, should be sought in New South Wales, such as the involvement of health-based first responders.** For instance, in Denver, United States, a program replaced police presence with health first responders in situations involving mental health and substance use, which achieved a 34% reduction in less serious crime and no impact on serious crime (22).
- **Discontinuing the use of drug detection dogs.**
  In NSW it is part of policing practice to use drug detection dogs in public spaces to search people without a warrant for illicit drugs, however, the use of drug detection dogs is ineffective (23) and can be harmful to communities overrepresented in prisons. Research shows that the use of drug dogs has a low success rate in detecting the possession of illicit substances- namely, a success rate of approximately 25 percent (24). Research also shows that drug dogs can propel unnecessary strip searches (25), which can be particularly harmful for people with histories of being subjected to strip searches while incarcerated. The use of

drug dogs can increase the risk of drug-related harm to individuals, including through panic ingestion, purchasing lesser-known substances within music festival grounds, and people preloading drugs before going out (26). Concerningly, people can be deterred from accessing health services at events when drug detection dogs are close by (27).

Drug dogs are implicated in the over-policing of minoritised communities, such as First Nations communities (28-30) and LGBTQ+ communities (31), who are overrepresented in prisons (32-33). The use of drug dogs envelop such communities in unnecessary interactions with law enforcement. The removal of drug dogs from policing practice would help reduce unnecessary interactions between police and communities we support, who may experience police interactions as anxiety-inducing and re-traumatising given previous interactions with law enforcement.

2.2 "De jure" de-criminalisation is required to minimise inequalities

NSW should follow the recommendations of the Ice Inquiry, the example of the ACT and of countries like Portugal, Switzerland, and the Czech Republic, which have decriminalised personal possession of all illicit drugs.

- **Decriminalisation of drug use and possession is an essential step in reducing drug-related harm**. In the remarkable and well-documented case of Portugal, the estimated number of people using heroin fell from 100 000 in 2021 to 25 000 in 2017, heroin overdoses decreased by over 85% and new HIV cases fell by more than 90 % (34).
- Importantly, **decriminalisation reform needs to be "de jure" (by the law), rather than "de facto" (leaving discretion to the police in terms of when an offense should be prosecuted criminally)**. "De-facto" decriminalisation of cannabis possession in New South Wales has yielded uneven law enforcement outcomes. A recent study of NSW Bureau of Crime Statistics data showed that Aboriginal people, people residing in Western Sydney and the Hunter area were more likely to be criminally prosecuted for their cannabis-related crimes than non-Aboriginal people, and people residing in other jurisdictions (35).

2.3 Diversion from the criminal legal system into treatment requires expansion

There needs to be a greater emphasis on diverting people who use drugs from the criminal legal system into treatment and support for all types of crimes. People who use drugs may not only violate drug laws but may also commit other crimes due to their alcohol or drug dependence.

According to the United Nations Office for Drugs and Crime, **AOD treatment should be regarded as more effective in rehabilitating people than criminal punishment**, **and treatment in the community should be preferred to that offered in prison** (36).

- Governments need to guarantee **a wide range of treatment options available for diversion**. Abstinence shouldn't be a criterion for assessing treatment compliance (37).
- Options to **divert people who have drug dependence should be embedded in all stages of criminal proceedings**, that is: when decisions are being made to arrest, prosecute, convict, or suspend a sentence (37). In New South Wales, some diversion options are in place, including the MERIT program on pre-sentencing level (38), drug courts on the sentencing level (39), or attendance at residential rehabilitation as a bail condition, but could be expanded (see the next point).

- **While expanding the diversion options in New South Wales, a deferral of sentencing could be used by courts according to section 11 of the *Crimes (Sentencing Procedure) Act 1999*,** provided that the person convicted of a crime who is dependent on AOD completes a course of treatment. A similar mechanism of suspending proceedings after conviction for people who use drugs is common practice in other countries (for instance, Czech Republic, Estonia, Spain, France, Germany, Latvia, Luxembourg, the Netherlands, Austria and Slovakia) (40,41).[2]

A shift in opinion among judges and the broader sector may be required to achieve a wider move to divert people who use drugs from the criminal legal system. For instance, a recent study from the UK showed a limited uptake of treatment measures among law enforcement officials was underpinned by the perceived lack of benefits of treatment over incarceration, a lack of clarity in what defines treatment success, and a lack of awareness about what diversion options were available. Other barriers included a lack of funding, bureaucratic procedures, and varying levels of partnership between health, social care, and justice systems (42). Similar barriers may exist in New South Wales.

2.4 Making free drug checking services publicly available

Given the higher rates of AOD-related harms experienced by people who've been incarcerated (43,44), it is important for people exiting prison to have the opportunity to test drugs they could be consuming for safety purposes. CRC's harm reduction, non-abstinence-based approach to working with people who use drugs aims to reduce potential harms associated with drug use, which drug checking supports. Notably, there is sparse access to public, free drug-checking facilities in Australia, which inhibits the capacity of people who consume drugs to make safer and more informed decisions about what they are consuming. Drug checking is needed because, as evaluators of a fixed site drug checking pilot in the ACT called CanTEST noted:

> Illicit drug markets are unregulated, meaning that the type and quality of substances available can vary widely (Cole et al., 2011, Peck et al., 2019, Giné et al., 2014). Variability in illicit drug composition (e.g., dose, presence of adulterants) can elevate risk of harm, including overdose (Cole et al., 2011). Without objective information on drug contents, people have limited capacity to understand potential risks of use and to modify behaviour accordingly (45).

Given people exiting prison are at a heightened risk of overdose in the weeks immediately following release (44), variability in drug composition, and its linked risk of overdose, can be particularly impactful for people leaving prison, making access to free drug checking important.

Free drug checking services, such as CanTEST, and mobile services should ultimately be available to people across Australia. This will ensure people using drugs can test the content and safety of the substances before use, which can empower people with the knowledge they need to make more informed, safer decisions about substance consumption.

Research notably supports the need for drug-checking services. For instance, evaluators of the CanTEST pilot, conducted by research institutions like Australian National University (ANU), recommended the CanTEST pilot become an ongoing part of ACT Health's services (45). The evaluation showed the service: 'is well received by service users, has wide professional and community support, and is producing new information about the Australian drug market' (45). 70% of people who used the service had never spoken to a healthcare worker for AOD advice, and two-

[2] Indeed, a court may suspend proceedings before passing judgment and recommend drug treatment in several European countries (Belgium, Czech Republic, Denmark, France, Luxembourg, Austria), or the person who's been convicted may opt for treatment (Hungary, Poland) (40).

thirds accepted an AOD or general health intervention after using the service. This demonstrates the capacity of drug-checking services to connect people with AOD support in addition to checking people's substances. Given the benefits of publicly accessible drug-checking services, it is recommended that more free facilities be rolled out and supported through government funding plus resources.

3 We need a coordinated effort that can remove the "perpetual punishment" against people with criminal histories when it comes to treatment

People who have criminal charges may be excluded from mainstream Alcohol and Other Drugs (AOD) rehabilitation and other treatments. **Funding bodies should ensure that the services they commission don't discriminate against criminalised communities** and that any structural barriers to accessing AOD treatment by these communities are removed.

As an example, people leaving prison experience difficulties enrolling in AOD residential rehabilitation programs- see Box 3. We recommend that the NSW government takes the following steps:

- ✔ Enhance standardisation and transparency of AOD residential rehab admission criteria.
- ✔ Ensure that criminalised communities have access to adequate AOD treatment programs.
- ✔ Explore approaches from other jurisdictions that offer centralised brokerage to AOD treatment for criminalised communities (46) and provide specialised AOD treatment for criminalised populations.

Box 3 – CRC's Advocacy Registry: difficulties accessing AOD rehabilitation for people leaving prison

To understand the systemic barriers clients of Community Restorative Centre (CRC) face, CRC draws on its Advocacy Registry. The Advocacy Registry is an online submission system, launched in July 2023, that enables CRC case workers to share systemic barriers to client rehabilitation. Multiple entries to the Advocacy Registry highlighted difficulties faced by CRC clients when trying to access AOD residential rehabilitation. The following issues were noted:

- There are no direct referral pathways from prison to AOD rehabilitation.
- People in prison, and on remand, could not comply with general admission requirements for AOD rehabs such as documentation and regular phone contact.
- Each AOD rehabilitation program has different rules, and it is difficult to acquire information about them. Thus, standardisation and transparency are required for these admission criteria.
- People leaving prison may be excluded from AOD rehabilitation due to their complex criminal histories, behavioural concerns, or due to difficulties adjusting to the rehab culture.
- Barriers in enrolment and long waitlists mean people may lose their chance for bail due to not being able to secure a bed in an AOD rehabilitation facility as a part of their bail.
- When criminalised people miss out on AOD treatment, they are missing out on an intervention that is likely to keep them out of prison. By being rejected, people can feel shame, guilt, and become more vulnerable to re-offending.

4 There should be greater availability of outpatient and outreach drug treatment that people can access while they are in the community.

People leaving prison may have multiple, intersecting needs compounded by trauma, victimisation, and substance use. Their complex histories may complicate AOD treatment engagement when they experience mistrust and exclusion (47)**.**

Specific program features may influence how such populations access and benefit from AOD treatment, and more research is needed to understand what is most effective (48). **Outreach programs are important for criminalised communities to access AOD treatment**- see Box 4.

In New South Wales, CRC's outreach model of intensive case management and AOD counselling is effective in reducing client's criminal legal system involvement and substance use, and in improving their wellbeing (3). **We argue for sustained and expanded provision of flexible, person-centred, outreach-based AOD care for these populations.**

- ✓ **Outreach program delivery models can ensure continued engagement** of people experiencing the intersection of substance use, multiple health needs, and social disadvantage.
- ✓ **Outreach treatment delivery can ensure that people learn to translate the skills obtained in treatment into real-life settings.** This may be particularly relevant to First Nations people.

Box 4: Research evidence regarding outreach programs

The following research has demonstrated the effectiveness of outreach programs in various domains.

- Outreach treatment components have been linked to higher engagement rates among people who use drugs who are hard to reach (49,50)
- Outreach-based programs have been shown to decrease risk behaviours (51)
- A Dutch randomised study demonstrated that an outreach AOD treatment program was associated with high compliance, general improvement, and treatment satisfaction (52).

An increased understanding of the effectiveness of these programs could mitigate over-reliance on certain types of residential treatment programs for community-based sentencing, in addition to achieving better outcomes for people who use drugs and the community overall.

5 People with substance use histories need to have multiple social determinants and health needs addressed

Substance use and related harm are largely linked to, and partially an outcome of, social inequalities (53). It is often the case that substance use is adopted as a coping mechanism for people who experience trauma, violence, or discrimination (54,55). Moreover, inequity in health, welfare, and human rights is understood as a risk environment that shapes the potentially adverse consequences of substance use (56).

Research shows that access to supported housing improves outcomes for people involved in the criminal legal system, particularly when provided alongside supports that address life skills, vocational training, AOD use, and mental health (57). **Systemic changes are required to address structural inequalities and barriers**. Examples of how social determinants of substance use can be addressed include, but are not limited to:

- ✔ **Diversion programs like drug courts should further enhance their case-management**, in addition to their counselling components, and include access to housing.
- ✔ **Housing policies shouldn't exclude people who use drugs,** or people who have drug-related criminal histories, from accessing social housing. Housing policies should not be punitive (58)
- ✔ Drug use and related criminal involvement **shouldn't be a barrier to accessing community mental health services** (59)

When basic social and health needs are covered, people have more capacity to minimise AOD use and make it less risky (60,61).

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