Submission No: 61
Supp to Sub:
AUTHORISED: KS
9/5/07

Parliamentary submission into the impact of illicit drugs on families

From the National Centre in HIV Social Research, University of New South Wales, Sydney NSW 2052
Professor Susan Kippax (Director), Dr Carla Treloar (Deputy Directors, Head Hepatitis C Program), Dr kylie valentine, Dr Joanne Bryant, Dr Martin Holt, Mr Max Hopwood, Dr Suzanne Fraser.

March 21, 2007.

The National Centre in HIV Social Research (NCHSR) conducts social research in relation to HIV and hepatitis C. Of particular relevance to this submission is our work in the areas of injecting drug use and drug treatment.

The background literature in the field offers the following insights in relation to drug policy, treatment and families:

- The harms associated with drugs have multiple causes, including lack of access to support and treatment services. Interventions to reduce the harms associated with drugs should be targeted at poverty and social marginalisation. The harms associated with drug use are suffered more by the poor than the privileged, and poverty places drug users and their families in danger of harm [1-6].
- 'Macro-level' policies to address poverty should be included in any strategy to reduce the harms done by drugs. 'Micro-level' policies should also be included. Of these, harm reduction[1] strategies, including access to clean needles, are effective in improving the lives of people who use drugs and their families [7, 8].
- For those people whose drug use is problematic, the most effective treatments are based on substitution pharmarcotherapies: methadone, buprenorphine, buprenorphine/naloxone, and therapies for amphetamine use (which are currently unavailable in Australia). Substitution treatments are more effective and have saved more lives than any other treatment for illicit drug dependence [9-12].
- Many pharmacotherapy clients raise their children in safe and loving households, and provide material (and other) support to other family members [13].
- Caring and family responsibilities have an impact on the ability of clients to participate in treatment and treatment is more effective when treatment programs take caring responsibilities into account [14].

NCHSR research provides the following considerations in relation to drug use, treatment and families:

---

[1]The principle of harm minimisation forms the basis of Australia's National Drug Strategy. It comprises the three components of supply reduction, demand reduction and harm reduction.

- Drug users can have highly ambivalent relationships with members of their families: sometimes a person's drug use is initiated within the family unit [15] or may be precipitated by events including abuse within the family [16]
- Many pharmacotherapy clients feel that family members do not understand their experiences, and report feeling largely isolated from each other, staff and their families [17].
- Harm can be done to pharmacotherapy clients when they experience any of the following: punitive and prejudiced treatment by health professionals; the prejudice of family, friends and the wider community; and poorly resourced, difficult to access or inappropriate treatment. These experiences are commonly reported by pharmacotherapy clients. The following selections from interviews and analysis conducted for research projects at the National Centre in HIV Social Research are used in support of this point. All names are aliases. Interviews were conducted in regional NSW and Victoria and in Sydney and Melbourne.

Discrimination

Many methadone clients report discriminatory treatment from service providers, including at the pharmacies where they collect their dose. Clients Pauline, Debbie, Graham and Renee describe examples:

> There was only one methadone pharmacotherapy consumer allowed in the pharmacy at a time, and you had a sort of spot you had to stand on. And if you saw someone standing in that spot you weren't allowed to come in the door. And he had hours that you were allowed to come in, that were much shorter than the hours that any other customer was allowed to come in. And if you were standing out front because someone was in the spot, and it went past time, he would sometimes refuse to dose. (Pauline)
>
> They asked me to sign this contract. And it's all things like don't shoplift. And I was just so offended, I thought well, you know, the law is that you don't shoplift, so I don't have to sign a contract saying that. And, you know, things like, you need, you have to come in on your own. (Debbie)
>
> I have to sign a behavioural contract when the chemist takes me on, I mean I wish I had it still, to remember all the crap that it said on there. But it's stuff like "don't have anyone with you when you come in". You know, that's one that I remember. I used to tell my wife to wait outside while I'm going to get my [methadone]. (Graham)
>
> You are a methadone client so you're treated differently [...] you're only allowed to have two methadone clients in the shop at one time so and you're not allowed to wait outside the store either, so you've got to go to somewhere else, which I think like, where do you go when you've got kids and things? I've got to stand out the front, like most people

> actually stand out the front and down two stores, and there's a group of them. And nobody will leave because their place will be lost...and it's obvious who they are, and I was standing there one day and three of the mothers from the school walked past, looked and then did a double take...now I stand up the other end. (Renee)

Renee also describes the treatment she experienced by doctors and nurses at the hospital where she gave birth to one of her daughters. A drug test was done on her newborn baby without her knowledge and the doctors who analysed the results made an error, reading the drugs for which she was *tested* as evidence of drugs that were *present*:

> the doctors come into neonatal unit and at the top of his voice sort of said 'this, these are the drugs that your poor child has got in its system' and threw down this paperwork with, it had a list, it was about two foolscap pages of all these drugs [...] Now over the whole weekend they treated us so appallingly we were like pariahs and you know. It turned out on the Monday [that] all that was saying was they were the drugs they had tested for [...] and there had been no drugs found at all.

Renee did not receive an apology for her treatment and when she was asked that nurses and other hospital staff be notified of the doctor's error a note was made on her chart instead that 'mother throwing a temper tantrum'.

Resourcing

In some Australian towns and suburbs waiting times for programs can be as long as twelve months. Jeff describes the impact of a lack of places and resources for treatment, including increased violence and dangerous injecting practices:

> I noticed it a lot actually when, in 2000 when there was a heroin drought here in Victoria, and programs were all full, people couldn't get on programs. So there was a lot of selling of methadone or stand, you know, stand over tactics [...] Well, a lot of those same people started injecting Normison [temazepam] and they found out pretty soon after (laughs), after the first of tastes that their veins were fucked. (Jeff)

Sam reports a long wait for a place:

> I think it [...] might have been about three or four weeks. Which is the last thing you want to hear when you finally go in and put your hands up and say "okay, please help me", and they go "oh, we'll ring you up when you've got a place". And then you have to ring there every day saying "is my name any further on the list?" And of course, well obviously the time you go in and say "give me help", it should be right then and there, they're willing to put you in a detox or whatever it takes. Because often a week later, things have changed, you know, you've got money, you can handle, whatever, you feel better. But, yeah,

you should never have to wait for a treatment program in a country like Australia, never. It's too important. (Sam)

Our work in this area has raised other issues which should be considered in relation to pharmacotherapy clients and their families. In summary:

- All pharmacotherapy clients have families, and do not just rely on their families *for* support – many clients continue to *provide* support to their families emotionally and materially. Caring for children and other family members can be an important motivator for those seeking to reduce, quit or control their use of illicit drugs, and can encourage people to seek and/or maintain treatment [16].
- Pharmacotherapy clients can have highly ambivalent relationships with their families. It is important not to assume that families always and appropriately represent the needs of clients. Clients themselves must be included when considering what is best for them and their families [17].

References

1. Moore, D. and Dietze, P. Enabling environments and the reduction of drug-related harm: re-framing Australia's policy and practice. Drug and Alcohol Review, 2005. 24: p. 275-84.
2. Vimpani, G. and Spooner, C. Minimising substance misuse by strategies to strengthen families. Drug and Alcohol Review, 2003. 22(3): p. 251-254.
3. Spooner, C. and Hetherington, K. Social Determinants of Drug Use. 2004, National Drug and Alcohol Research Centre: Sydney.
4. Bessant, J., et al. Heroin users, housing and social participation: attacking social exclusion through better housing. 2003, Australian Housing and Research Institute: Melbourne.
5. Scott, D. Building Communities that Strengthen Families. Family Matters, 2001. 58: p. 76-79.
6. Marsh, J.C. and Cao, D. Parents in Substance Abuse Treatment: implications for child welfare practice. Children and Youth Services Review, 2005. 27(12): p. 1259-1278.
7. Health Outcomes International, the National Centre for HIV Epidemiology and Clinical Research and Centre of Health Economics York University. Return on investment in needle and syringe programs in Australia. 2002, Australian Government Department of Health and Ageing: Canberra.
8. Wodak, A. and Cooney, D. Do needle syringe programs reduce HIV infection among injecting drug users: A comprehensive review of the international evidence. Substance Use & Misuse, 2006. 41: p. 777-813.
9. Wodak, A. Methadone and heroin prescription: Babies and bath water. Substance Use & Misuse, 2002. 37(4): p. 523-531.
10. Gibson, D.R., Flynn, N.M. and McCarthy, J.J. Effectiveness of methadone treatment in reducing HIV risk behaviour and seroconversion among injecting drug users. AIDS, 1999. 13: p. 1807-1818.

11. World Health Organization and United Nations Office on Drugs and Crime. Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention : position paper. 2004, World Health Organisation: Geneva.
12. Shearer, J., Sherman, J., Wodak, A. and van Beek, I. Substitution therapy for amphetamine users. Drug and Alcohol Review, 21(2): 179-185.
13. Taylor, A. Needlework: The lifestyle of female drug injectors. Journal of Drug Issues, 1998; 28(1): 77-90.
14. Ashley, O.S., Marsden M.E. and Brady, T.M. Effectiveness of substance abuse treatment programming for women: A review. American Journal of Drug & Alcohol Abuse, 2003. 29(1): p. 19.
15. Treloar, C., Abelson, J., Crawford, J., Kippax, S., Howard, J., van Beek, I., Copeland, J., Weatherall, A.M. and Madden, A. (2003) Risk for Hepatitis C: Transition and initiation to injecting drug use among youth in a range of injecting drug user networks. Monograph 8/2003. National Centre in HIV Social Research.
16. Holt, M., Treloar, C., McMillan, K., Schultz, L., Schultz, M. and Bath, N. (forthcoming). *Barriers and Incentives to Treatment for Illicit Drug Users with Mental Health Comorbidities and Complex Vulnerabilities.*
17. Bryant, J., Saxton, M., Madden, A., Bath, N. and Robinson, S. Consumers' and providers' perspectives about consumer participation in drug treatment services: Is there support to do more? What are the obstacles? Drug and Alcohol Review [manuscript submitted 19/02/07]