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Law Reform, Road and Community Safety
Committee

Inquiry into drug law reform

Parliament of Victoria
Law Reform, Road and Community Safety Committee

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Committee functions

The Victorian Law Reform, Road and Community Safety Committee (the Committee) is established under the *Parliamentary Committees Act 2003* (the Act).

The Committee comprises seven members of Parliament: five from the Legislative Assembly and two from the Legislative Council.

Section 13 of the Act sets out the functions of the Committee:

1. The functions of the Law Reform, Road and Community Safety Committee are, if so required or permitted under this Act, to inquire into, consider and report to the Parliament on any proposal, matter or thing concerned with –
 - a. legal, constitutional or parliamentary reform;
 - b. the administration of justice;
 - c. law reform;
 - d. the use of drugs, including the manufacture, supply or distribution of drugs;
 - e. the level or causes of crime or violent behaviour
 - f. road trauma;
 - g. safety on roads and related matters
2. It is not a function of the Committee to inquire into, consider or report to the Parliament on any proposal, matter or thing concerned with:
 - a. the joint standing orders of the Parliament
 - b. the standing orders or rules of practice of the Council or the Assembly

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This report and a Summary Booklet version are available on the Committee’s website.

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Terms of reference

Inquiry into drug law reform

That under section 33 of the *Parliamentary Committees Act 2003*, the Law Reform, Road and Community Safety Committee is required to inquire into, consider and report, no later than 3 March 2017, on the effectiveness of laws and procedures relating to illicit and synthetic drugs and prescription medication. This was received from the Legislative Council of the 58th Parliament, 11 November 2015.

The Law Reform, Road and Community Safety Committee refined the terms of reference, amended the inquiry title to the *Inquiry into Drug Law Reform*, and sought an extension to the reporting date to 9 March 2018.*

The Committee will inquire into, consider and report, on:

1. The effectiveness of laws, procedures and regulations relating to illicit and synthetic drugs and the misuse of prescription medication in minimising drug-related health, social and economic harm; and
2. The practice of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law.

* The reporting date was later extended to 29 March 2018.

Chair's foreword

Drug law reform is an incredibly complex area of public policy. This is due to the interweaving nature of the relevant issues and the challenges arising from drug use and its consequences. This complexity is also due to conflicting views about how best to address the use of drugs in the community.

Historically, the approach to drugs both internationally and in Australia was based on prohibition of recreational drug use, although there is growing recognition that a dominant focus on law enforcement strategies has not eradicated the supply or demand for such substances, but has contributed to increased harms such as overdoses and black market crime. Now more than ever, there is also greater availability of new and often more harmful substances on the illicit market. Related to this, is the rising misuse of approved pharmaceutical drugs within the broader community.

It is in the context of these issues that the Law Reform, Road and Community Safety Committee received the Terms of Reference for this inquiry. A key focus was to consider how effective current drugs laws are and whether they are successful in reducing health and social harms associated with their use. The Committee was also asked to examine best practice in this area from other jurisdictions and their suitability for implementation in Victoria. These terms of reference provided the Committee with the unique opportunity to examine drug use as a whole, rather than focus on individual substances as has been done in previous inquiries.

While the title of the inquiry relates specifically to law reform, the Committee's investigations were largely informed by the evidence received in submissions and public hearings, which called for a broader examination of drug-related laws, policies, procedures, programs and initiatives. The result is a report that comprehensively explored the key areas of prevention, law enforcement, treatment and harm reduction, and acknowledges the need for a more effective drug response framework, one that prioritises health and community safety.

A common theme throughout the inquiry was the need for honest and open discussions to understand why people may use drugs and to work towards more compassionate and balanced responses. The Committee was committed to providing a platform for this dialogue throughout the inquiry. The report and recommendations reflect the outcomes of these discussions, including that while people continue to use substances, whether illicit or pharmaceutical, more should be done to keep people safe.

A reorientation to a health-based framework does not suggest going soft on crime but rather emphasises that responses to illicit drug use should focus on trafficking and punishment of criminal behaviour arising from use, while people apprehended solely for use and personal possession be directed to a range of treatment and support options, where necessary. As part of this, the Committee acknowledged that substantial funding is necessary to ensure the availability of these treatment and support services to address substance use issues and reduce reoffending. The Committee believes that investment in these services will also enhance the effectiveness of early intervention efforts, and in particular prevent young and/or recreational users from using in more harmful ways.

The Committee recognises the current commitment of the Victorian Government to address substance use issues in the community, including through the trial of the medically supervised injecting centre in North Richmond, the introduction of a real-time prescription monitoring system, investment in alcohol and other drug treatment services, and the ongoing efforts of our law enforcement agencies in targeting the illicit drug market. These efforts will be complemented by the various recommendations proposed throughout the report. Strengthening Victoria's approach to drugs requires acting on the best evidence available from around the world and taking new directions where appropriate.

The Committee is grateful to the various individuals and agencies who shared their personal experiences, expertise and ideas during the inquiry through written submissions, at public hearings and during site visits both in Australia and overseas. The Committee greatly appreciated the many contributors for being so generous with their time and the honesty that they brought to the discussions.

I would like to thank my fellow Committee Members, the Honourable Martin Dixon MP, Fiona Patten MLC, Natalie Suleyman MP, Murray Thompson MP, Khalil Eideh MLC, Bill Tilley MP and Mark Gepp MLC for their commitment and contributions to this inquiry.

As is the case with Committee work, Committee members are reliant on the work of their executive support staff and I want to commend the secretariat, Yuki Simmonds, Raylene D'Cruz, Christianne Andonovski and Peter Johnston for their hard work in the development of this report. The depth of research material incorporated within this report is the result of their extensive endeavour and commitment.

I hope this report will be of value in enhancing debate on the issues of drug use and will result in actions which effectively reduce the personal and community harms associated with inappropriate drug use.



Mr Geoff Howard MP
Chair
March 2018

Executive summary

PART A: Contextualising drug law reform in Victoria

Chapter 1: Introduction

The Law Reform, Road and Community Safety Committee received the Terms of Reference (ToR) for the *Inquiry into drug law reform* in November 2015, although it did not commence work on it until February 2017. The key objective of the inquiry was to investigate the effectiveness of drug control laws and procedures in minimising drug-related harms, as well as drug law reform in other Australian and overseas jurisdictions.

Throughout the inquiry, the Committee received 231 submissions from a diverse range of experts and stakeholders working in various areas of drug policy and law reform, in addition to individual members of the community. The Committee held nine days of public hearings and two site visits in Melbourne and Sydney from June to November 2017. In addition, the Committee travelled to Geneva, Lisbon, London, Vancouver, Denver and Sacramento in July 2017, in addition to Wellington in October 2017, to explore how different jurisdictions manage the problems of substance use and impacts on broader communities, and to meet with agencies involved in international drug policy and control.

Based on the evidence received, the use of illicit substances and the misuse of pharmaceutical medication is a strong source of community concern. The Committee understands that most people who use substances do so infrequently, and only a small proportion use them in highly harmful ways. However, the adverse consequences arising from such use are far-reaching and affect individuals, families and the community. Further, a common theme throughout the inquiry was the need to acknowledge the different types of substance use and understand why people engage in certain behaviours. This dialogue has been missing from Australia's current approach to drugs despite these being important considerations when thinking about the types of strategies to prevent use and minimise harms.

There is also growing recognition among governments and the community that greater balance between traditional law enforcement and health-based responses will have a broader positive effect on the health and safety of communities. This was a driving factor of the Committee's investigations and its suite of coordinated and innovative reform recommendations. These recommendations acknowledge that while people continue to use substances, whether illicit or pharmaceutical, more needs to be done to minimise the associated harms.

Chapter 2: Background information on licit and illicit substances

Chapter 2 provides an overview of pertinent background information on the most commonly used substances, including mode of administration, their effects and harms. These are examined according to their general drug classification, including stimulant drugs, party drugs, depressant drugs, pharmaceutical drugs, new psychoactive substances, and other drug groups. It is noted, however, that these

classifications are arbitrary and give rise to much overlap. This is a common issue in drug policy discourse, creating some confusion and misunderstanding. Chapter 2 specifically defines the key terms of ‘prohibition’, ‘legalisation’, ‘decriminalisation’ and ‘depenalisation’, in addition to discussing other key terminology, such as ‘addiction’, ‘dependence’, and ‘substance use disorders’.

The chapter also outlines key drug trends and prevalence data drawing on the *National Drug Strategy Household Survey 2016*, the *National Wastewater Drug Monitoring Program*, and the *Ecstasy and Related Drugs Reporting System* and the *Illicit Drug Reporting System*.

The Committee notes that poly-drug use is a growing concern, particularly with data from the Coroners Court of Victoria indicating that between 2009 and 2016, the combined toxic effects of multiple drugs rather than a single drug contributed to around 70 per cent of Victorian overdose deaths. Aside from harms to individuals, poly-drug use has important implications for practitioners and policy makers, including health professionals treating clients who use multiple substances.

Chapter 3: Overview of international and domestic drug control frameworks

Chapter 3 provides an overview of the historical genesis of international drug control, in addition to the relevant conventions to which Australia and the majority of the world’s nations are signatories, including:

- *1961 Single Convention on Narcotics Drugs*
- *1971 Convention on Psychotropic Substances*
- *1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*.

These conventions represent the legal basis of drug prohibition, with the objectives of penalising illicit use, diversion, and trafficking of psychoactive substances. They also provide an international governance system for the legitimate scientific and medical use of drugs and access to them. In Australia, the *Commonwealth Narcotic Drugs Act 1967* incorporates the conventions’ provisions, in addition to the *Customs Act 1956*. Australia, like all member states, is responsible for ensuring that the states and territories adhere to the conventions.

The Committee notes that despite the apparent prohibition stance of the conventions, international drug policy and law reform is in a state of transition. In Europe, Latin America and some jurisdictions in North America, a shift away from prohibition has been observed, mostly regarding cannabis laws. There has also been a relaxation among the international control bodies, such as the International Narcotics Control Board (INCB), in their strict opposition to alternative initiatives. For example, the INCB softened its position on medically supervised injecting rooms and indicated support for Portugal’s model towards illicit substances, which included the decriminalisation of possession of such substances for personal use in 2001.

Chapter 3 also provides an overview of the Australian context of drug policy, including the development of the first National Drug Strategy and the three pillars approach of harm minimisation, which comprises demand reduction, supply reduction and harm reduction. Despite strong support for harm minimisation, a commonly heard criticism throughout the inquiry was that Australia’s drug policy has ‘gone backwards’

in the past two decades after being a leader in needle and syringe programs in the 1980s. Australia is no longer considered a world leader in advocating for innovative harm reduction initiatives.

At the state level, the most recent drug strategy is the Victorian *Ice Action Plan*, which comprises initiatives and findings from the Premier's Ice Action Taskforce to address the growing harms associated with methamphetamine use in the community. The Victorian Government also released the Victorian *Drug Rehabilitation Plan* in October 2017 in response to an escalation in illicit drug-related deaths and which invests substantially in treatment initiatives throughout the State.

Chapter 4: Framework for effective drug law reform

The key focus of chapter 4 is establishing a framework for which positive and effective drug law reform can be based upon in Victoria. The framework draws on evidence from the research literature, best practice from Australia and overseas jurisdictions, and evidence provided to the Committee in submissions and public hearings. It is based upon a broad acknowledgement of the importance of conceptualising illicit substance use as a health and social issue rather than a strictly law enforcement issue in recognition that the criminalisation of drugs is not achieving its intended objectives.

A key component to the new framework is a shift from a three pillars approach to drugs in the community to a four pillars approach that views treatment and prevention as separate and individual pillars, along with law enforcement (supply reduction) and harm reduction. This is important given their different purposes and strategies to prevent use, minimise harms and reduce demand for substances. The Committee received evidence that while treatment and prevention currently receive more attention and funding than harm reduction, they remain chronically underfunded. The Committee noted a shift to a four pillars approach will only achieve its intended objectives if accompanied by increased levels of funding.

The effectiveness of the four pillars approach will also be heavily influenced by the level of collaboration and coordination across the Victorian Government. As many stakeholders advised the Committee, drug-related issues are typically wrapped up together, making it difficult to focus on only one solution. Rather, it requires a combination of strategies and effective coordination of those strategies. The Committee proposed the establishment of a new governance structure to provide leadership on drug policy reform in Victoria and address drug-related issues as they arise. The governance structure will facilitate a broad range of stakeholders working together from high levels down to the grassroots, ensuring strong engagement from across government and non-government groups and individuals, including those who actively work with and support people with substance use issues, in addition to people recovering from addiction.

A key element of the governance structure is the establishment of an Advisory Council on Drugs Policy. Throughout the report, the Committee referred a number of recommendations to this Council for action (see Appendix seven). If the Victorian Government does not support the establishment of the new governance structure, the Committee trusts that these other recommendations will be redirected to appropriate agencies for implementation.

A commonly expressed concern to the Committee was that allocation of expenditure to drugs policy is disproportionate and heavily weighted to law enforcement measures rather than harm reduction, treatment and prevention initiatives. To enhance

the evidence base to inform best practice and allocation of funds, the Committee proposed an independent review into drug-related expenditure and outcomes in Victoria, which includes a cost-benefit analysis of all key initiatives.

Lastly, chapter 4 discusses the value of reliable, effective and timely data sharing across relevant agencies to further support effective drug law reform. Efficient data collection and sharing is essential to measure the effectiveness of key policy change, assist respond to drug issues as they arise, and forecast and prevent issues from occurring in the first place.

To enhance data collection and information sharing among all relevant Victorian agencies, the Committee also recommended the establishment of an early warning system (EWS), accompanied by a drug registry to understand the illicit drug market, and a rapid response clinical toxicology service for hospitals and poison centres. The purpose of the EWS is to enhance current surveillance mechanisms regarding new psychoactive substances (NPS) and adulterants in illicit substances, and to share such information in a timely way, such as through real-time public health warnings, to avoid overdoses or even death.

RECOMMENDATION 1: The Victorian Government's approach to drug policy be based on effective and humane responses that prioritise health and safety outcomes, be in accordance with the United Nations' drug control conventions, and informed by the following principles:

- promotion of safe communities – reduce drug-related crime and increase public safety
- evidence-based – empirical and scientific evidence to underpin change
- supportive and objective approach to people who use drugs and of drug addiction
- cost-effective – ensure money spent on drug policy is working to reduce harms
- responsive – flexible and open to change, new ideas and innovation.

RECOMMENDATION 2: In recognition of the imbalanced investment in drug-related expenditure under the three pillars of demand reduction, supply reduction and harm reduction, the Victorian Government develop a new drug strategy based on the four pillars of:

- Prevention
- Law enforcement
- Treatment
- Harm reduction

RECOMMENDATION 3: The Victorian Government establish a new Victorian governance structure to oversee and monitor the four pillars drug strategy. It should include:

- Ministerial Council on Drugs Policy – comprising relevant Victorian Ministers responsible for the portfolios of health, mental health, police, education, early childhood education, road safety, corrections, multicultural affairs, and families and children
- Advisory Council on Drugs Policy – comprising experts to advise the Victorian Government on drug-related issues and research in Victoria, in addition to individuals (current users, recovering users, affected families) who actively work with and support people affected by substance use.

RECOMMENDATION 4: The Victorian Government commission an independent economic review into drug-related expenditure and outcomes in Victoria. This should include a cost-benefit analysis of all key initiatives and be made publicly available.

RECOMMENDATION 5: The Victorian Government advocate to the Commonwealth Government to conduct a similar review at the national level.

RECOMMENDATION 6: Through the Victorian Centre for Data Insights, the Victorian Government encourage and facilitate a system of strong drug-related data collection and information sharing across all government departments and agencies. The purpose of this data collection and sharing is to:

- build a sound knowledge base to inform drug research and policy efforts
- support the development of timely interventions following specific drug-related events or ongoing incidents
- measure the effectiveness of Victoria's four pillars drug strategy, with regular progress reports to be made publicly available
- enhance capabilities and intelligence efforts of Victoria's law enforcement agencies.

RECOMMENDATION 7: The Victorian Government establish an early warning system (EWS) to enable analysis, monitoring and public communications about new psychoactive substances (NPS) and other illicit substances of concern. This will require greater information sharing and collaboration between Victoria Police, the Victorian Institute of Forensic Medicine, the Department of Health and Human Services, coroners, hospitals, alcohol and other drug sector organisations (particularly harm reduction and peer based services) and other interested stakeholders. Essential components of the EWS should include:

- real time public health information and warnings where required
- developing a drug registry to understand the NPS market
- a rapid response clinical toxicology service for hospitals and poison centres.

Chapter 5: Community attitudes and drugs

A commonly identified theme throughout the inquiry was the negative attitudes towards and negative labelling of people who use illicit substances, particularly those with substance use disorders, which often results in them experiencing discrimination and marginalisation. The Committee heard that negative labelling is commonly directed towards people who inject drugs, in addition to people who use methamphetamines. It is clear, however, that there is limited understanding in the broader community about the contributing factors that can lead to addiction. Further, many of these people are often already highly marginalised and live with multiple layers of stereotyping, in addition to that arising from their drug use.

There was a strong consensus in the evidence received by the Committee that negativity and fear of disapproval are significant barriers for people who use substances to access health care and treatment services. Negative community attitudes not only influence an individual's willingness to seek help but also the willingness of others, such as some health professionals, to help them. This is a considerable barrier to identification and management of people with substance use disorders, in addition to an individual completing treatment, achieving full recovery and successfully reintegrating back into the community.

The Committee notes that addressing these negative narratives in the community will positively influence people with substance use disorders to seek help for their substance use issues. It will also increase the effectiveness of broader prevention and early intervention strategies, and harm reduction and treatment efforts. Addressing these narratives is required on numerous levels, including exploring how existing laws and policies exacerbate negative attitudes, in addition to the misrepresentation of the extent of substance use and associated harms in the media.

RECOMMENDATION 8: The Victorian Government develop specific guidelines on the use of appropriate, objective and non-judgemental language regarding substance use disorders, addictions and those who use drugs for public policy-makers, law enforcement agencies and health care professionals. The Government should consult with the appropriate agencies to ensure the guidelines are implemented throughout the working practices of these identified groups. In addition, the guidelines be conveyed to the media and non-government agencies.

PART B: The four pillars approach to drug policy: Prevention

Chapter 6: Prevention and early intervention

Prevention strategies are essential to addressing illicit substance use in the community, which when done well can importantly reduce the demand for such substances.

Universal prevention strategies aimed at broader population groups, for example mass media campaigns, can provide a variety of health-related messages through platforms such as television, radio and social media. A particular universal prevention measure identified by the Committee is a campaign to improve community understanding of the facts regarding substance use disorders and the people who use illicit substances to counter many of the false assumptions that negative community attitudes are based upon. This campaign would also aim to enhance health prevention and early intervention messages around drug use.

Another prevention strategy discussed in chapter 6 are those that target children and young people, particularly school-based programs which focus on building their resilience and enabling them to make healthy decisions. The Committee noted ways to enhance current prevention efforts, such as school education programs relevant to young people's real life experiences and perspectives; programs and resources for parents; and exploring the role of families, communities and recreational opportunities in drug prevention.

Other groups that may benefit from targeted prevention efforts include Aboriginal and Torres Strait Islander (ATSI) people, people living in rural and regional areas, culturally and linguistically diverse (CALD) communities, and people experiencing mental health issues. The Committee particularly found a need to enhance data collection on substance use prevalence among CALD communities, as there is currently limited understanding of these issues.

As well as prevention strategies, early intervention measures can identify people engaging in substance use early and assist them to refrain from progressing into harmful use. Primary care professionals, largely general practitioners (GPs) and others, were identified as providing the appropriate setting to deliver brief interventions with patients presenting with substance use issues. Evidence of the

effectiveness of this strategy is mixed, and the Committee heard a range of views on the extent to which this strategy is possible, given current barriers such as time constraints, negative staff attitudes and training issues. However, the Committee found that GPs and other primary care workers should be supported to undertake this role, with the first step a mapping exercise to gain a better understanding of current barriers and mechanisms to assist them respond more effectively.

RECOMMENDATION 9: The Victorian Government develop a public awareness campaign on substance use and disorders in order to reduce negative labelling of people who use substances, both illicit and prescription medications, and to reduce the harms associated with substance misuse.

RECOMMENDATION 10: The Victorian Government enhance its existing prevention measures that target children and young people including:

- School education programs and resources for young people around resilience and life training skills, in addition to appropriate, age-specific and evidence-based drug education programs that focus on preventing drug use, as well as being relevant to young people's real life experiences and perspectives. This should also include ensuring that school policies align with prevention goals.
- Specific programs within schools that aim to build protective factors, particularly for young people identified as at-risk or requiring enhanced support.
- Programs and resources for parents to build resilience and life skills, and enhance protective factors.
- Explore the effectiveness of the Iceland model further, particularly the role of communities and families in prevention, in addition to encouraging participation of young people in meaningful recreational opportunities.

RECOMMENDATION 11: The Victorian Government, in consultation with the Victorian Multicultural Commission, conduct research into substance use prevalence among culturally and linguistically diverse communities to inform the development of appropriate prevention measures.

RECOMMENDATION 12: With the intention to develop a primary health care early intervention strategy, the Victorian Government commission an appropriate peak medical body to review the network of general practitioners (GPs) and public hospitals across Victoria and their role in screening and intervening early in people presenting with substance use issues and guide them accordingly. This review should map the current network including identifying GPs knowledge of and attitudes towards substance use and disorders, and barriers to effectively respond to these issues. The strategy should comprise practical responses to overcome identified barriers.

Law enforcement

Chapter 7: Personal use and possession offences

This chapter considers the ways that illicit substance use and personal possession offences are dealt with and enforced, and options for reform in this area. The Committee heard that criminalisation for the use and possession of illicit drugs

for personal use can result in a range of negative outcomes for individuals, such as having a criminal record which can impact future employment opportunities, and experiences of discrimination.

A common program employed across Australia to deal with people apprehended for these offences is police drug diversion programs. In Victoria, these are the Cannabis Cautioning Program and the Illicit Drug Diversion Program (for other illicit drugs). Under these programs, drug use and personal possession remain criminal offences, however, police can divert people away from the criminal justice system and into treatment, rather than lay charges (a form of de facto decriminalisation). While the Committee received evidence in support of Victorian police drug diversion programs, some highlighted current gaps in their operation, particularly regarding eligibility requirements and inconsistent access across Victoria due to its discretionary nature.

The chapter analyses other types of reform in this area, particularly the removal of criminal penalties for these offences and replacement with non-criminal penalties (a form of de jure decriminalisation). In Australia, such reform has occurred in relation to cannabis in South Australia, the Australian Capital Territory and the Northern Territory. Internationally, Portugal is the most well-known example of a jurisdiction that removed criminal penalties for all illicit drugs, as part of a social integrated policy that also focused on enhancing prevention, treatment and harm reduction areas of drug policy. The Committee visited Portugal as part of its overseas study tour, and considered issues such as the impact of this reform on illicit drug use and harms, health issues, the criminal justice system and cost effectiveness. In discussions with Portuguese health and police authorities, the Committee found that the reforms had bipartisan support and were accompanied by substantial investments in health and treatment, leading to improved outcomes across a range of social and health measures.

The Committee found there is a need to treat the offences of drug use and possession of illicit drugs for personal use as a health issue rather than a criminal justice issue, to ensure the timely referral of people apprehended for these offences to treatment and/or other social services as required by their personal circumstances. This would retain all offences in criminal law, and would punish other criminal behaviours where appropriate while treating the drug use. There are a variety of mechanisms to achieve this, including exploring alternative models for the treatment of these offences, such as the Portuguese model, codifying current drug diversion processes to reduce discretion regarding its use by Victoria Police, and conducting education and awareness programs to communicate with the public about the need to treat drug use as a health issue.

As part of considering these offences, the Committee also identified that current legislative thresholds for quantities of drugs that determine possession as personal or for trafficking require review, to ensure there is accurate information about patterns of illicit drug use to distinguish drug traffickers from people who use drugs.

RECOMMENDATION 13: The Victorian Government, while maintaining all current drug offences in law, treat the offences of personal use and possession for all illicit substances as a health issue rather than a criminal justice issue. This approach will ensure appropriate pathways are in place for the referral of people to health and treatment services in a timely manner where required. Mechanisms to achieve this should include:

- exploring alternative models for the treatment of these offences, such as the Portuguese model of reform
- removing the discretion involved with current Victoria Police drug diversion processes by codifying them

- reviewing all threshold amounts for drug quantities in order to appropriately distinguish between drug traffickers and people who possess illicit substances for personal use only
- conducting education and awareness programs to communicate with the public about the need to treat drug use as a health issue.

Chapter 8: Drug-related offending

Chapter 8 outlines a range of programs used by the courts to address substance use issues or disorders where they are an underlying cause of people committing crimes and coming before the courts. These include the Court Integrated Services Program and the CREDIT/Bail Support program, which are used to refer alleged offenders to various social and treatment services to address their substance use issues. Consistent with findings of previous similar inquiries, the Committee found there is a need to expand such programs, as well as support services to provide additional assistance to participants.

Chapter 8 also outlines the Drug Court of Victoria, which provides for the sentencing and supervision of offenders with a drug and/or alcohol dependency, who commit an offence under the influence of drugs or alcohol or to support their dependence. In analysing the Drug Court, which is currently operational in two locations, the Committee similarly found that expanding its reach across Victoria is required, as well as ensuring appropriate support services are in place for the Court's operation.

The Committee was also informed of a potential program similar to the Hawaii Opportunity Probation with Enforcement (HOPE) program to provide swift, certain and fair responses for breaches of conditions, particularly drug use breaches. The Committee heard from the Drug Court of Victoria that such a program may provide an avenue to deal with such breaches, while accompanied by appropriate treatment and support mechanisms.

The chapter also considers ways to address drug use among people within the parole system. According to the Adult Parole Board of Victoria, drug use was the most common reason for cancellation of parole (which returns the person to custody). The Board advised the Committee that a power to suspend parole in certain circumstances for longer-term parolees in the case of drug use could be an additional step before cancellation, with the person returned to custody to receive treatment, before being assessed for cancellation. Such a step would impact very few cases, but would provide those who have completed a substantial portion of parole an opportunity to continue where appropriate.

RECOMMENDATION 14: The Victorian Government expand access to the Magistrates' Court of Victoria Court Integrated Services Program (CISP) and CREDIT/Bail Support Programs, to ensure consistency in access and equity throughout Victoria. This should be accompanied by enhanced funding to ensure that appropriate support services and alcohol and other drug treatment is available to people diverted from the court system into these programs. The expansion should also include exploring options for the CISP to be available in the County Court of Victoria.

RECOMMENDATION 15: The Victorian Government expand the number of Drug Courts in Victoria, accompanied by funding to ensure appropriate support services and alcohol and other drug treatment is available for program participants.

RECOMMENDATION 16: The Victorian Government explore other court programs for potential implementation in Victoria, including the Hawaii Opportunity Probation with Enforcement (HOPE program).

RECOMMENDATION 17: As proposed by the Adult Parole Board of Victoria, the Victorian Government provide the Adult Parole Board with the power to suspend parole for longer-term parolees who have been found to use illicit substances but whom have not reoffended. Suspension could be up to three months, and parolees offered treatment during that time. Following the period of suspension, the Board would assess whether they can continue on parole.

Chapter 9: Cannabis regulation

Globally, cannabis is the most widely used and trafficked illicit substance. A number of harms can arise from cannabis use, particularly regular and sustained use, however, it is also one of the less harmful substances when compared to others such as alcohol or heroin. Given these issues, countries around the world are considering the regulation and supply of cannabis.

In Victoria as well as nationally, there are arrangements in place for the use of pharmaceutical-grade cannabis products for medical purposes, recognising that they have a role in the therapeutic treatment of some conditions. This is a rapidly evolving area, involving multiple levels of regulation at state and federal levels. The Committee found that close collaboration between the Victorian and Commonwealth Governments is required to improve access to medicinal cannabis by streamlining currently complex approval processes. In terms of enhancing understanding in the medical profession and community about the use of this treatment in various circumstances, the Committee recommended that:

- the proposed Advisory Council on Drugs Policy investigate the role of and ways to support general practitioners to provide access to medicinal cannabis
- the work of the Victorian Independent Medical Advisory Committee, which has an important role in guiding the Victorian regime, be made publicly available to assist health professionals and patients access medicinal cannabis.

Further, continued investment in research and trials is also necessary to improve understanding of the potential health benefits of medicinal cannabis, and improve access. The Committee noted in particular the need to research the potential role of medicinal cannabis in addressing chronic non-cancer pain, to help address the overuse of prescription opioids to treat such conditions.

In terms of the non-medical use of cannabis (also termed ‘adult use’), the Committee considered various regulatory models developed in Uruguay and some jurisdictions in the United States (US), including Colorado and California which the Committee visited during its overseas study tour. The chapter analyses these and other regulatory models, including public health requirements to minimise harms from cannabis use and over-commercialisation of cannabis products, pricing and taxation issues, the supply chain, and conflicts between federal and state laws in the US. The Committee found this is an area of drug law reform worthy of further investigation.

RECOMMENDATION 18: The Victorian Government work closely with the Commonwealth Government to improve patient access to medicinal cannabis products, particularly in relation to streamlining requirements at federal and state levels to ensure patients who will benefit from medicinal cannabis treatment in appropriate circumstances have proper access to it.

RECOMMENDATION 19: The Victorian Government continue to work with the Commonwealth Government to explore ways to improve understanding among the medical profession and the public of the current evidence base and situations where medicinal cannabis products may be considered as an appropriate treatment option.

RECOMMENDATION 20: The proposed Advisory Council on Drugs Policy should investigate the role of general practitioners in providing access to medicinal cannabis, and consider how they can be best supported in this area.

RECOMMENDATION 21: To assist health professionals and patients to access this form of treatment, the work of the Independent Medical Advisory Committee be made publicly available.

RECOMMENDATION 22: The Victorian Government facilitate continued investment for research and clinical trials into the use of medicinal cannabis and its effects, including its role in working alongside prescription opioids for pain management and reducing reliance and dosage levels of medication prescribed for pain relief.

RECOMMENDATION 23: The proposed Advisory Council on Drugs Policy investigate international developments in the regulated supply of cannabis for adult use, and advise the Victorian Government on policy outcomes in areas such as prevalence rates, public safety, and reducing the scale and scope of the illicit drug market.

Chapter 10: Drug driving and road safety

Chapter 10 explores Victoria's current drug driving laws and their effectiveness in minimising the role of illicit substances in road crashes to achieve overall safety on the roads. Enforcement of Victoria's drug driving laws is conducted through random roadside drug testing and impairment testing. The only three illicit substances that Victoria Police can test at the roadside are cannabis, methylenedioxymethamphetamine (MDMA) and methamphetamine.

Drug driving laws differ from drink driving laws, with the former based on a detection threshold where any presence of a prescribed substance in a driver is deemed an offence. Drink driving laws, on the other hand, are based on an impairment threshold with a prescribed blood alcohol content (BAC) limit of 0.05. This is based on a historical science-based model that is accepted and implemented worldwide. The Committee noted that the drug driving approach does not consider the effect of individual substances on driving impairment, which some stakeholders suggested undermines the objective of the road safety legislation. There were calls throughout the inquiry for drug driving laws to be based on a similar approach to drink driving, one that establishes the impact of substances on driving performance which is then reflected in established impairment thresholds.

The chapter also considers international evidence and experience in this area, as well as the impact of the legalisation of medicinal and/or recreational cannabis use on drug driving laws in some United States jurisdictions, and the relevance of these issues to the Victorian context where the use of medicinal cannabis is likely to increase.

RECOMMENDATION 24: The proposed Advisory Council on Drugs Policy investigate the current drug driving laws and procedures to determine their effect on road crashes and as a deterrent strategy. The Council should also explore:

- alternative drug driving regimes that use impairment limits/thresholds, and their potential applicability in Victoria
- options for expanding the types of drugs captured under the regime
- likely changes to drug driving laws resulting from medicinal cannabis use in Victoria.

Chapter 11: Legislative responses to new psychoactive substances

Both locally and internationally, the emergence and prevalence of new psychoactive substances (NPS) has become a significant concern. Designed to mimic the effects of traditional illicit substances such as cannabis or cocaine, these substances have been difficult to prohibit as by the time laws are developed to control one NPS, an alternative is available on the market. Chapter 11 analyses key challenges in this area, particularly the lack of knowledge on NPS' long and short term health effects, the high prevalence of unintentional use of NPS, and the resilience of the NPS market in adapting to legal changes.

Various regulatory models have been used internationally, nationally and in Victoria to control and reduce the availability of NPS. Most approaches aim to prohibit them, although the approach in New Zealand attempted instead to regulate some low-risk substances. While there have been implementation challenges with this, some inquiry stakeholders advised the Committee of the value of this approach as a framework that is not based solely on prohibition.

The most recent legislative attempt to prohibit NPS in Victoria is the *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Act 2017*. The Act provides for a general prohibition on all psychoactive substances (with some exclusions), and a range of offences to prohibit their production, sale, commercial supply and advertisement. As well as concerns from inquiry stakeholders on the broad nature of this legislation, the Committee also heard that, in terms of implementation, there is some uncertainty regarding the definition of 'psychoactive effect' which should be monitored. The Committee proposed that the legislation be reviewed more generally, including on issues relating to enforcement, NPS-related harms, NPS availability, and any unintended consequences.

RECOMMENDATION 25: The Victorian Government review the implementation and enforcement of the recently enacted *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Act 2017* in mid-2019 to evaluate its effectiveness in eliminating the emergence of new psychoactive substances (NPS), and identify any unintended consequences. Other areas for review should include enforcement, NPS-related harms, NPS availability and prevalence. It should also review the implementation and workability of the definition of 'psychoactive effect'.

Treatment

Chapter 12: Victorian alcohol and other drug treatment sector

The Victorian alcohol and other drug (AOD) treatment sector plays an important role in responding to illicit substance use in the Victorian community. While it is typically characterised as of a high standard, there was broad acknowledgement among inquiry stakeholders that it is underfunded. Although, the Victorian Government recently announced a number of funding commitments, which allocates over \$100 million to additional residential rehabilitation beds and other treatment options.

Chapter 12 provides an overview of the Victorian AOD treatment sector, including treatment options and an overview of utilisation of treatment in Australia and Victoria (where data is available). Various challenges facing the sector were also discussed in detail, including reports of:

- lengthy wait periods before a patient can access treatment, particularly residential rehabilitation
- limited access to treatment services in rural and regional areas
- inflexible service delivery with limited capacity to respond effectively to new drug trends, in addition to gaps in the provision of services relating to aftercare, recovery and coordination
- lack of specialised addiction medicine capabilities
- limited understanding among general practitioners about how to navigate the AOD treatment sector.

In response to these issues, the Committee recommended that the existing AOD Sector Reference Group review current gaps and shortfalls in service provision and enhance the capacity of the broader medical community to effectively respond to people presenting with substance use disorders.

Chapter 12 also explores concerns arising from the proliferation of private unregistered AOD treatment providers, which are not subject to the same ethical, quality and safety provisions as regulated services but which charge substantial fees for their services. A commonly shared view, and one that the Committee agrees with, is that addressing such regulatory gaps will ensure that a consistent and evidence-based approach applies across all treatment services, both in Victoria and nationally.

RECOMMENDATION 26: The Victorian Government, in conjunction with Turning Point and other relevant agencies, develop a practice-friendly treatment pathway tool/resource for general practitioners (GPs) to enhance their awareness and understanding of referral to the alcohol and other drug treatment sector. To accompany this, the Victorian Government also review how Turning Point's Drug and Alcohol Clinical Advisory Service (DACAS) could be better utilised among GPs, including through increased funding.

RECOMMENDATION 27: The Victorian Government via the Alcohol and Other Drug Sector Reference Group provide expert advice to the Government, the alcohol and other drug (AOD) treatment sector, and the broader medical community on ways to enhance their capacity to effectively respond to people presenting with substance use issues. Specific areas for action might include:

- identify further funding options through mapping the current capacity and gaps within AOD service delivery against existing and future demand for services. Particular attention to be provided to all treatment options to ensure flexibility in service delivery, acknowledging diversity and differing needs among potential clients. Specific opportunities should be identified for different cohort groups such as clients with co-existing mental health issues and substance use disorders, culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander communities, and those from rural and regional areas
- explore effective and workable measures to expand Victoria's specialist addiction medicine capacity, in addition to ensuring the AOD treatment sector is adequately supported by its existing workforce
- explore options for a public multidisciplinary health clinic model that comprises access to opioid substitution therapy prescribing doctors, addiction specialists, mental health services, support and other allied health services
- develop a model of care for public hospitals when treating patients presenting with substance use issues, which could include medical staff undertaking drug screening and developing clear treatment pathways and reintegration with specialist AOD treatment services.

RECOMMENDATION 28: The Victorian Government note ongoing considerable concerns within the community about private unregistered providers of alcohol and other drug (AOD) treatment and continue to advocate for the development of a national regulatory framework and standards for private AOD treatment.

Chapter 13: Drug treatment for specific drug user groups

Continuing from the previous chapter, chapter 13 discusses some of the treatment needs of specific groups of people who use substances, on the basis that a 'one size fits all' approach to treatment is both ineffective and inappropriate. The specific groups discussed include:

- people with co-morbid mental health conditions
- Aboriginal and Torres Strait Islander people
- people from culturally and linguistically diverse communities
- young people
- families of people who use drugs
- prisoners.

Lastly, the chapter highlights debates on the issue of compulsory, or involuntary drug treatment, for people identified as having substance use disorders and at risk of harming themselves and/or others.

RECOMMENDATION 29: The Victorian Government provide increased support and funding to family support programs to minimise the adverse impact of substance misuse on family and friends, and to contribute to the effective reintegration of people with substance use disorders back into the community.

RECOMMENDATION 30: The Victorian Government evaluate prison alcohol and other drug programs based on their effectiveness in reducing recidivism, particularly where offending is directly related to substance use issues.

Chapter 14: Medication assisted treatment for opioid dependence

Opioid dependence refers to a person's condition of physical and mental reliance on opioids such as heroin and pharmaceutical opioids, and can cause a range of health, financial and social harms for the individual and communities. As a chronic relapsing condition, it is recognised that abstinence is not easily achieved, but medication assisted treatment aims to reduce the harms of substance use in a person's life.

The main form of treatment for opioid dependence in Australia is opioid substitution therapy (OST), where the drug of dependence is substituted with controlled opioid medication, mainly methadone and buprenorphine. Along with the medication, OST involves the provision of psychosocial support to address issues such as mental health, homelessness and unemployment. The Committee heard that OST is associated with a range of positive outcomes, such as reduced illicit drug use, reduced criminal activity, reduced mortality, and improved health and wellbeing.

In Victoria, the OST program is primarily administered through a community-based model, involving the prescription and management of OST by general practitioners (GPs) within primary health care settings, with the medication dispensed through community pharmacies.

The Committee found that, while the program is effective, it could be improved with measures such as better governance of the program through more oversight and management of permits for GPs and patients, clinical issues, enhanced data collection, and opportunities for greater OST access. Regarding costs of OST, inquiry stakeholders advised that dispensing fees for the medication is a barrier to people entering and remaining on the program. Finally, the chapter considers strategies to enhance health professionals' engagement to improve overall accessibility across Victoria, particularly in light of concerns of inquiry stakeholders on maintaining and increasing the number of GPs and pharmacists involved in providing these services.

The Committee also heard of expansions to the types of OST options available for a small group of opioid dependent people who have not benefited from other types of treatment. Heroin-assisted treatment (HAT) is particularly used in overseas jurisdictions, including Switzerland, the UK and Canada, which the Committee visited during its overseas study tour. It involves the prescription and strict clinically-supervised consumption of pharmaceutical-grade heroin (diacetylmorphine or diamorphine). The Committee found there was a strong evidence base for such treatments, with key benefits including improved health and wellbeing, reduced crime rates, and cost effectiveness. The Committee considered that exploring such options, particularly through a trial of other controlled and pharmaceutical grade opioids (such as hydromorphone) for a small group of people should be conducted, accompanied by robust evaluation.

RECOMMENDATION 31: The Victorian Government establish a dedicated arm of government to actively manage opioid substitution therapy (OST) policy in Victoria. The dedicated unit should explore options for enhanced data collection on OST, including current take-up, compliance rates, people who have ceased treatment and why. It should also explore an OST registry for general practitioners and pharmacies where they can seek information on current prescribers/dispensers in specified areas.

RECOMMENDATION 32: The Victorian Government fund opioid substitution therapy (OST) dispensing fees to enhance access and remove barriers to a person entering and remaining on OST.

RECOMMENDATION 33: The Victorian Government expand access to opioid substitution therapy (OST) through a range of measures including:

- the provision of financial incentives to general practitioners and pharmacists to prescribe OST, particularly as the current cohort of prescribing doctors is ageing and a shortage is expected
- enhancing the role of nurse practitioners to prescribe OST
- exploring models for hospitals to provide OST to suitable patients as part of emergency department treatment.

RECOMMENDATION 34: The Victorian Government trial the expansion of the opioid substitution therapy program to include other controlled and pharmaceutical grade opioids (such as hydromorphone), for a small group of people for whom other treatment types have not been successful. This should be accompanied with robust evaluation.

Chapter 15: Pharmaceutical drugs

While playing an important role in society, some types of pharmaceutical drugs are subject to misuse, resulting in harms such as mortality, hospitalisations and an illicit trade in these substances. This is particularly the case for prescription drugs such as opioid analgesics and benzodiazepines, which are increasingly being prescribed and used in the broader community. The contribution of pharmaceuticals to overdose deaths is a particular cause for concern, with the Victorian State Coroner advising the Committee that pharmaceuticals contributed to approximately 80 per cent of all overdose deaths between 2009 and 2016.

The Committee found there is a need to reduce reliance on prescription drugs, particularly opioids. This could be achieved through various strategies, such as changing practices among the medical profession in treating issues such as chronic pain with opioids, which could be done through issuing guidelines for general practitioners (GPs) and improved training on these matters. The chapter also explores the development of a stewardship framework for public hospitals to provide guidance and best practices for addressing pharmaceutical misuse. Public education is also required to promote safe use of such medication within the community, including consideration of non-pharmacological options where appropriate. There are also possibilities to adapt the fee structures involved with dispensing medications to encourage fewer amounts to be dispensed where appropriate.

A key strategy to minimise the misuse of pharmaceutical medication is a real-time prescription monitoring (RTPM) system, which aims to ensure that all health professionals involved in a person's care are aware of the drugs being prescribed to them. These systems can improve the coordination of care among professionals and clinical decision-making. There are plans for the creation of a national RTPM system, as well as recent Victorian legislation for a state-based model under the *Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Act 2017*. In exploring overseas models, as well as the potential interaction between the Victorian and Commonwealth systems, the Committee identified key issues for the Victorian RTPM system to ensure it is just one component of a broader response to the misuse and overprescribing of pharmaceutical drugs. These include:

- appropriate training and clinical support for the medical profession to effectively use the RTPM system, as well as respond to pharmaceutical drug misuse more generally. There is a significant focus on training and workforce development as part of the Victorian Government's implementation plans for the RTPM system

- enhanced capacity of the alcohol and other drug treatment sector to treat people identified through the RTPM system as having substance use issues that require further support. This is to ensure that such people do not ‘fall through the gaps’ and progress to more harmful substance use
- arrangements for the review and evaluation of the Victorian RTPM system, which the Victorian Government has recently outlined.

RECOMMENDATION 35: In the short term, the Victorian Government, in conjunction with the Australian Medical Association and other relevant medical bodies, develop prescription opioid medication guidelines for general practitioners and training on appropriate prescribing practices. This should include guidance on monitoring patients, lowering dosages when appropriate, education on the risks of dependence, and effective pain relief alternatives to such medication.

RECOMMENDATION 36: The Victorian Government develop and promote a sector-wide stewardship trial program for the medical profession (hospitals, specialist services and general practitioners) based on the Alfred Health model to promote and audit best practice regarding the prescribing and use of medications with potential for misuse (such as analgesics and benzodiazepines). This should be accompanied with promotion and education of best practice in this area and of appropriate attitudes towards pain relief among health professionals. The program should also be accompanied with an evaluation.

RECOMMENDATION 37: The Victorian Government develop resources and support or conduct awareness raising campaigns targeting the broader community about the safe and appropriate use of prescription medications for pain relief and promoting the role of non-pharmacological treatments for certain conditions (e.g. stress, anxiety and chronic pain). This could start with a targeted campaign that aims to reach patients in health settings and expand to a broader audience if required.

RECOMMENDATION 38: The Victorian Government work with the Commonwealth Government to review the fee structure for dispensing medication with potential for misuse, so that the volumes prescribed and dispensed be based on individuals’ needs. Fee structure changes could include: incentivising pharmacies to dispense fewer tablets and subsidising patients who receive smaller amounts of medications. As part of this, the Victorian Government should work with the Pharmacy Guild of Australia and other relevant bodies regarding the role of pharmacies in improving dispensing practices.

RECOMMENDATION 39: The Victorian Government adopt measures to ensure the effectiveness of the real-time prescription monitoring (RTPM) system and prevent the diversion of patients with prescription misuse issues to the illicit drug market, including:

- adequately resourcing the alcohol and other drug public treatment sector to accommodate the likely influx of demand resulting from patients identified in the RTPM system with opioid dependency
- as part of Department of Health and Human Service’s workforce development and training, ensure that health professionals are equipped to appropriately deal with patients identified in the RTPM system with substance use issues, for example through providing immediate and seamless access to harm reduction and/or treatment services, such as opioid substitution therapies.

Harm reduction

Chapter 16: Minimising the spread of blood borne viruses

One of the most important and effective harm reduction initiatives in Australia is the needle and syringe program (NSP), an integral component to Australia's harm minimisation approach to illicit drug use since its inception in 1986. The NSP is a prime example of a health-based response that is compassionate, evidence-based and has resulted in few, if any, unintended consequences.

Despite its success, however, some stakeholders advised of concerns, mainly regarding access, that could lead to serious consequences from continued sharing of injecting equipment. Evidence indicates there is inadequate coverage of the program across Victoria, either due to the limited times at which NSPs operate or the limited availability of services in certain areas. The Committee also heard that unsafe injecting practices are particularly prevalent in vulnerable communities where people might be disengaged from the community and disconnected from health and social services.

In response, the Committee proposed the Victorian Government review ways to enhance syringe coverage across the State, in addition to improving the quantity and quality of NSP services. Related to this is the broader issue of the illegality of the distribution of non-injecting drug paraphernalia.

The chapter also explores the potential role of NSPs in prisons, on the basis that prisoners typically have histories of high levels of substance use prior to entering prison, including injecting drug use and high rates of blood borne viruses. The Committee also received evidence of harmful drug taking practices in prisons. The chapter draws on international evidence and the broader literature to identify the benefits and risks of NSPs in prisons.

RECOMMENDATION 40: The Victorian Government review Victoria's needle and syringe program (NSP) in order to strengthen the aims, coverage, service models, harm reduction information and equipment distributed to people who use illicit substances. This should include:

- exploring avenues to increase NSP availability in areas where there is an identified shortfall particularly after-hours, such as in public hospitals, vending machines/dispensing units, and community pharmacies
- ensuring that staff of NSPs are culturally aware and sensitive to the needs of people who identify as Aboriginal and Torres Strait Islander and others from culturally and linguistically diverse communities
- enhancing the capacity of the NSP workforce to engage with people with hepatitis C to educate them about potential treatment options and refer them accordingly.

RECOMMENDATION 41: The Victorian Government remove the prohibition of peer distribution of sterile needles and syringes in the *Drugs, Poisons and Controlled Substances Act 1981*.

RECOMMENDATION 42: The proposed Advisory Council on Drugs Policy review harms arising from current laws that prohibit or discourage non-injecting routes of drug administration, such as increased injecting use of methamphetamines and other drugs, and make recommendations to the Government accordingly.

RECOMMENDATION 43: The Victorian Government review its screening policies for blood borne viruses in prisons to:

- offer screening to prisoners upon release, in the same way they are offered screening upon entering prison or transferring between prisons
- explore the feasibility of introducing compulsory blood screening of prisoners upon entering and exiting prisons to determine transmission of blood borne viruses within prisons. This review should consider all human rights implications associated with mandatory screening.

RECOMMENDATION 44: The Victorian Government monitor data from screening processes, as recommended above, and monitor international needle and syringe prison programs to consider their potential value to minimise transmission of blood borne viruses. The Victorian Government share information with prison staff and relevant bodies to increase awareness and open dialogue about the benefits and risks of needle and syringe programs in prisons.

Chapter 17: Overdose prevention strategies

During the last decade, there has been a steady increase in the number of overdose deaths in Victoria. Data from the Coroners Court of Victoria indicated a rise in deaths from 379 in 2009 to 492 in 2016, with many involving multiple drugs (72.2 per cent in 2016). Chapter 17 provides an overview of these deaths, drawing further on coronial data and evidence from various stakeholders about the impact of these deaths on stakeholders, their families and local communities.

A contributing factor to the rising rate of overdoses and overdose deaths in Victoria is the increasing appearance of heroin, due to its greater availability on the illicit drug market and increase in purity. North America is also experiencing rising opioid use and overdose deaths, although to a much greater extent. In 2016, approximately 64,000 people died from a drug overdose in the United States, mostly from opioid-based illicit substances. Similarly, when the Committee visited Vancouver as part of its overseas study tour, British Columbia had officially declared a public health emergency due to an escalation in opioid overdose deaths, increasing from 269 overdoses in 2012 to 931 in 2016. Of grave concern to public health officials in North America is the presence of fentanyl and carfentanil in these overdose deaths.

Chapter 17 discusses a range of overdose prevention strategies, some of which are existing Victorian Government policy, such as the distribution of naloxone, in addition to the Medically Supervised Injecting Centre (MSIC) scheduled for operation in North Richmond from June 2018.

The chapter also discusses the need for an overdose prevention strategy in the event that, similar to North America, fentanyl and carefentanil become more available on the Australian illicit drug market and/or if heroin purity increases. A number of interventions could form the prevention strategy, including drug checking at the MSIC to allow people to test their illicit substances for purity and other contaminants, enhance availability of opioid substitution therapy by lowering thresholds for access, expand opioid-based treatment for people with a chronic heroin addiction, and wider distribution of naloxone to people who inject drugs. The goal of the strategy is to keep people alive as a first priority, with the intention and hope that people will soon commence their journey to recovery with the appropriate support.

RECOMMENDATION 45: The Victorian Government explore avenues to distribute naloxone more effectively. Such avenues might include:

- needle and syringe programs and other community health services where staff are trained to educate others in administering naloxone
- making naloxone available in appropriate settings where people who use opioids may frequent, such as treatment services (detox and residential rehabilitation services), crisis and emergency accommodation, which staff can administer when necessary
- making naloxone available to first responders to overdose calls in areas with high concentrations of injecting heroin use, accompanied with appropriate training
- other ways to make naloxone available, including through enhanced peer distribution.

RECOMMENDATION 46: The Victorian Government make naloxone available to prisoners with a history of opioid use upon their release from prison to minimise the high risk of overdose deaths among this cohort of people, and provide them with appropriate information and support services available in the broader community to minimise the likelihood of overdose.

RECOMMENDATION 47: The Victorian Government develop an emergency action plan to respond to a potential increase in deaths or overdoses as a result of high strength and purity of illicit substances, for example the presence of fentanyl and carfentanil in the drug market. This could include:

- targeted strategies for specific cohorts of people that use substances, such as those based in regional and rural areas, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, and people experiencing mental health issues
- wider distribution of naloxone to people who inject drugs (recommendations 45 and 46)
- explore avenues to enhance availability of opioid substitution therapies, such as lowering thresholds for access and reducing costs (recommendations 32 and 33), and expanding opioid-based treatment for people with a chronic heroin addiction (recommendation 34)
- possible establishment of temporary medically supervised injecting facilities in areas with high concentrations of injecting drug use and overdoses
- drug checking at the Medically Supervised Injecting Centre to test for heroin purity and other contaminants.

Chapter 18: Safe events

Chapter 18 relates specifically to the use of illicit substances on a recreational basis, particularly in party environments such as music festivals. Noting the presence of illicit substances at these events has been accompanied by increased risks of harms such as overdose and hospitalisations, the chapter outlines the role of event organisers in ensuring the availability of harm reduction and public safety initiatives.

The chapter also explores a range of models and evidence received regarding drug checking services, which enable individuals to have their substances tested using a range of equipment, and receive information about the results, as well as harm

reduction advice or counselling where relevant. Drug checking services can also enhance monitoring of the illicit drug market, particularly for new psychoactive substances. Such services, which are common across Europe, can be located onsite at music festivals or offsite at fixed sites. The Committee heard there can be a range of benefits with such approaches, such as reduced harms from illicit substance use and improved monitoring of the illicit drug market. It also heard of potential issues of concern, such as perceptions of ‘safe’ illicit substance use and technological limitations with drug checking equipment.

The Committee also discussed the option of ‘back of house’ or ‘halfway house’ testing at appropriate venues or festivals where police, health authorities and harm reduction organisations work together to identify substances of concern through testing, and notify patrons and the broader community through alerts where appropriate.

Some inquiry stakeholders also raised the issue of drug detection dogs, which are employed by Victoria Police at events where illicit drug use is likely. Given there is a lack of information on whether drug detection dogs may have a potential role in increasing drug-related harms, and their effectiveness in reducing the supply and use of illicit drugs, the Committee found this requires an independent evaluation.

RECOMMENDATION 48: The Victorian Government work with the Department of Health and Human Services, Victoria Police, Ambulance Victoria and DanceWize to facilitate the availability of an onsite drug testing unit for health and law enforcement authorities at an appropriate music festival to be used in the event of a suspected overdose or other serious adverse effects due to an illicit substance. The unit would not be public facing and its purpose is to test substances to determine their composition to assist health authorities treat the patient and, where appropriate, release a public alert to prevent further incidents. The unit will operate as part of the early warning system as recommended in chapter four.

RECOMMENDATION 49: The Victorian Government refer to the proposed Advisory Council on Drugs Policy the issue of drug checking services, and request that it monitor overseas and domestic models to obtain relevant evidence to inform consideration of a trial in Victoria. If appropriate, the Council should develop guidelines for such a trial (and include appropriate messaging e.g. not condoning drug use nor indicating that drug use is safe, appropriate technology, data collection and clear liability safeguards). The Council should also consider an evaluation framework to measure the future trial’s effectiveness in minimising drug-related harms.

RECOMMENDATION 50: Victoria Police commission an independent evaluation of the use of drug detection dogs at music festivals and other public spaces to determine their effectiveness in deterring the use and trafficking of illicit substances, and any unintended consequences or risk of harms resulting from this strategy.

Acronyms

AACMC	Australian Advisory Council on the Medicinal Use of Cannabis
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
ACEM	Australasian College for Emergency Medicine
ACIC	Australian Criminal Intelligence Commission
ACMD	Advisory Council on the Misuse of Drugs
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
ADF	Alcohol and Drug Foundation
ADHD	Attention deficit hyperactivity disorder
ADLRF	Australian Drug Law Reform Foundation
AFP	Australian Federal Police
AIC	Australian Institute of Criminology
AIDS	Acquired immune deficiency syndrome
AIHW	Australian Institute of Health and Welfare
AIVL	Australian Illicit and Injecting Drug Users League
AMA	Australian Medical Association
AMC	Alexander Maconochie Centre
ANCD	Australian National Council on Drugs
AOD	Alcohol and other drugs
AODstats	Alcohol and Other Drug Data, Research Planning
AP	Authorised Prescriber
APPG	All Party Parliamentary Group for Drug Policy Reform
ARTG	Australian Register of Therapeutic Goods
ASI	Antimicrobial Stewardship Initiative
ASSAD	Australian Secondary Students Alcohol and Drug Survey
ATJC	Abolitionist and Transformative Justice Centre
ATS	Amphetamine type substances
ATSI	Aboriginal and Torres Strait Islander
BAC	Blood and alcohol content
BC	British Columbia
BCCDC	British Columbia Centre for Disease Control
BCCSU	British Columbia Centre for Substance Use
BCMHSUS	British Columbia Mental Health and Substance Use Services
CAHMA	Canberra Alliance for Harm Minimisation and Advocacy
CALD	Culturally and linguistically diverse
CCO	Community Correction Order
CCOV	Coroners Court of Victoria
CDDC	Compulsory Drug Detention Centre

CDPH	California Department of Public Health
CDT	Commission for the Dissuasion of Drug Addiction
CDTCC	Compulsory Drug Treatment Correctional Centre
CEN	Cannabis Expiation Notice
CISP	Court Integrated Services Program
CJDP	Criminal Justice Diversion Program
CND	Commission on Narcotic Drugs
COAG	Council of Australian Government
COPE	Community Overdose Prevention Education
CPSU	Community and Public Sector Union
CRCR	Council on Responsible Cannabis Regulation
CREIDU	Centre for Research Excellence into Injecting Drug Use
CSA	<i>Controlled Substances Act 1970</i>
DACAS	Drug and Alcohol Clinical Advisory Service
DAMEC	Drug and Alcohol Multicultural Education Centre
DCHAP	Drug Court Homelessness Assistance Program
DCPC	Drugs and Crime Prevention Committee
DET	Department of Education and Training
DFA	Drug Free Australia
DHHS	Department of Health and Human Services
DIMS	Drugs Information and Monitoring System
DIZ	Drug Information Centre
DJR	Department of Justice and Regulation
DMS	Drug Monitoring System
DNet	Drugs and Emerging Technologies Project
DOJ	Department of Justice
DOPE	Drug Overdose Peer Education
DORA	Drugs and Poisons Information System Online Remote Access
DPA	Drug Policy Australia
DPCSA	<i>Drugs, Poisons and Controlled Substances Act 1981</i>
DPHE	Department of Public Health and Environment
DPMP	Drug Policy Modelling Program
DRUID	Driving Under the Influence of Drugs, Alcohol and Medicines
DTO	Drug treatment orders
DUMA	Drug Use Monitoring Australia Survey
ECDD	Expert Committee on Drug Dependence
ED	Emergency Department
EDRS	Ecstasy and Related Drugs Reporting System
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERRCD	Electronic Recording and Reporting of Controlled Drugs
EWS	Early warning system
FFDLR	Families and Friends for Drug Law Reform
FLS	Fitzroy Legal Service
FT-IR	Fourier transform infra-red spectrometer
GCDP	Global Commission on Drug Policy

GC-MS	Gas chromatography-mass spectrometry
GDP	Gross Domestic Product
GHB	Gamma Hydroxybutyrate
GP	General Practitioner
HAT	Heroin-assisted treatment
HCV	Hepatitis C virus
HDM	Hydromorphone
HIV	Human immunodeficiency virus infection
HRI	Harm Reduction International
HRV	Harm Reduction Victoria
HOPE	Hawaii Opportunity Probation with Enforcement
HPLC	High-performance liquid chromatography mass spectrometry
IDAT	Involuntary Drug and Alcohol Treatment
IDDI	Illicit Drug Diversion Initiative
IDPC	International Drug Policy Consortium
IDRS	Illicit Drug Reporting System
IDU	Identified drug user
IGCD	Intergovernmental Committee on Drugs
IMAC	Independent Medical Advisory Committee
INCB	International Narcotics Control Board
IRCCA	Institute for Regulation and Control of Cannabis
JACS	Justice and Community Safety Directorate (ACT)
LC-MS	HPLC-Mass Spectrometry
LS	Lysergic acid diethylamide
MAST	Multi Agency Safety Testing
MATOD	Medication-Assisted Treatment of Opioid Dependence
MCDS	Ministerial Council on Drug Strategy
MDA	Methylenedioxyamphetamine
MDMA	Methylenedioxymethamphetamine
MIG	Marijuana Industry Group
MJA	Medical Journal of Australia
MoU	Memorandum of Understanding
MQS	Minimum qualification strategy
MS	Multiple Sclerosis
MSIC	Medically Supervised Injecting Centre
MSIR	Medically Supervised Injecting Room
NAOMI	North American Opiate Medication Initiative
NCADA	National Campaign Against Drug Abuse
NCETA	National Centre for Education and Training on Addiction
NCIA	National Cannabis Industry Association
NDARC	National Drug and Alcohol Research Centre
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NEWIP	Nightlife Empowerment and Well-being Implementation Project

NGO	Non-governmental organisation
NHTSA	National Highway Traffic Safety Administration
NICE	National Institute for Health and Care Excellence
NIDIP	National Illicit Drug Indicator Project
NIMBY	Not in my backyard
NOPSAD	National opioid pharmacotherapy statistics
NPS	New psychoactive substance
NRCH	North Richmond Community Health
NSFAD	National Strategy for the Fight Against Drugs
NSP	Needle and Syringe Program
NSW	New South Wales
NWDMP	National Wastewater Drug Monitoring Program
NZ	New Zealand
ODC	The Office of Drug Control
OFT	Oral Fluid Test
OHV	Odyssey House Victoria
OST	Opioid substitution therapy
OSTP	Opioid Substitution Therapy Program
PABN	Pharmacotherapy area-based network
PAMS	Pharmacotherapy, Advocacy, Mediation and Support
PBS	Pharmaceutical Benefits Scheme
PHAA	Public Health Association of Australia
PHN	Public health network
PIEDS	Performance or image enhancing drugs
PMA	Paramethoxyamphetamine
PNP	Peer Network Program
POFT	Preliminary Oral Fluid Test
PRHR	Prison related harm reduction
PSP	Public Security Police
PWID	People who inject drugs
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RIS	Regulatory Impact Statement
RRHR	Pre-release related harm reduction session
RSPH	Royal Society for Public Health
RSVDS	Residents for Victoria Street Drug Solutions
RTPM	Real-time prescription monitoring
SAC	Sentencing Advisory Council
SALOME	Study to Assess Longer-term Opioid Medication Effectiveness
SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	Special access program
SAS	Special Access Scheme
SBIRT	Screening, Brief Intervention and Referral to Treatment
SCF	Swift, certain and fair
SCON	Simple Cannabis Offence Notice

SICAD	General Directorate for Intervention on Addictive Behaviours and Dependencies
SMLS	Springvale Monash Legal Service
SSDP	Students for Sensible Drug Policy
TEDI	Trans European Drug Information
TGA	Therapeutic Goods Administration
THC	Delta-9 tetrahydrocannabinol
THN	Take home naloxone
TLC	Thin layer chromatography
ToR	Terms of Reference
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
US	United States
VAADA	Victorian Alcohol and Drug Association
VAGO	Victorian Auditor-General's Office
VAHS	Victorian Aboriginal Health Service
VCH	Vancouver Coastal Health
VCSA	Victorian Crime Statistics Agency
VDDI	Victorian Dual Diagnosis Initiative
VGBO	Victorian Government Business Office
VIFM	Victorian Institute of Forensic Medicine
VLA	Victoria Legal Aid
VLRC	Victorian Law Reform Commission
VMC	Victorian Multicultural Commission
VOCAT	Victims of Crime Assistance Tribunal
VPD	Vancouver Police Department
VPIC	Victorian Poisons Information Centre
WHO	World Health Organization
YDHF	Yarra Drug and Health Forum
YoDAA	Youth Drug and Alcohol Advice Service
YSAS	Youth Support and Advocacy Service
YTO	Youth Therapeutic Order

Recommendations

4 Framework for effective drug law reform

RECOMMENDATION 1: The Victorian Government’s approach to drug policy be based on effective and humane responses that prioritise health and safety outcomes, be in accordance with the United Nations’ drug control conventions, and informed by the following principles:

- promotion of safe communities – reduce drug-related crime and increase public safety
- evidence-based – empirical and scientific evidence to underpin change
- supportive and objective approach to people who use drugs and of drug addiction
- cost-effective – ensure money spent on drug policy is working to reduce harms
- responsive – flexible and open to change, new ideas and innovation. 69

RECOMMENDATION 2: In recognition of the imbalanced investment in drug-related expenditure under the three pillars of demand reduction, supply reduction and harm reduction, the Victorian Government develop a new drug strategy based on the four pillars of:

- Prevention
- Law enforcement
- Treatment
- Harm reduction. 74

RECOMMENDATION 3: The Victorian Government establish a new Victorian governance structure to oversee and monitor the four pillars drug strategy. It should include:

- Ministerial Council on Drugs Policy – comprising relevant Victorian Ministers responsible for the portfolios of health, mental health police, education, early childhood education, road safety, corrections, multicultural affairs, and families and children
- Advisory Council on Drugs Policy – comprising experts to advise the Victorian Government on drug-related issues and research in Victoria, in addition to individuals (current users, recovering users, affected families) who actively work with and support people affected by substance use. 78

RECOMMENDATION 4: The Victorian Government commission an independent economic review into drug-related expenditure and outcomes in Victoria. This should include a cost-benefit analysis of all key initiatives and be made publicly available. 83

RECOMMENDATION 5: The Victorian Government advocate to the Commonwealth Government to conduct a similar review at the national level. 83

RECOMMENDATION 6: Through the Victorian Centre for Data Insights, the Victorian Government encourage and facilitate a system of strong drug-related data collection and information sharing across all government departments and agencies. The purpose of this data collection and sharing is to:

- build a sound knowledge base to inform drug research and policy efforts
- support the development of timely interventions following specific drug-related events or ongoing incidents
- measure the effectiveness of Victoria’s four pillars drug strategy, with regular progress reports to be made publicly available
- enhance capabilities and intelligence efforts of Victoria’s law enforcement agencies. 87

RECOMMENDATION 7: The Victorian Government establish an early warning system (EWS) to enable analysis, monitoring and public communications about new psychoactive substances (NPS) and other illicit substances of concern. This will require greater information sharing and collaboration between Victoria Police, the Victorian Institute of Forensic Medicine, the Department of Health and Human Services, coroners, hospitals, alcohol and other drug sector organisations (particularly harm reduction and peer based services) and other interested stakeholders. Essential components of the EWS should include:

- real time public health information and warnings where required
- developing a drug registry to understand the NPS market
- a rapid response clinical toxicology service for hospitals and poison centres. . . . 96

5 Community attitudes and drugs

RECOMMENDATION 8: The Victorian Government develop specific guidelines on the use of appropriate, objective and non-judgemental language regarding substance use disorders, addictions and those who use drugs for public policy-makers, law enforcement agencies, and health care professionals. The Government should consult with the appropriate agencies to ensure the guidelines are implemented throughout the working practices of these identified groups. In addition, the guidelines be conveyed to the media and non-government agencies. . . . 113

6 Prevention and early intervention

RECOMMENDATION 9: The Victorian Government develop a public awareness campaign on substance use and disorders in order to reduce negative labelling of people who use substances, both illicit and prescription medications, and to reduce the harms associated with substance misuse. 127

RECOMMENDATION 10: The Victorian Government enhance its existing prevention measures that target children and young people including:

- School education programs and resources for young people around resilience and life training skills, in addition to appropriate, age-specific and evidence-based drug education programs that focus on preventing drug use, as well as being relevant to young people’s real life experiences and perspectives. This should also include ensuring that school policies align with prevention goals.

- Specific programs within schools that aim to build protective factors, particularly for young people identified as at-risk or requiring enhanced support.
- Programs and resources for parents to build resilience and life skills, and enhance protective factors.
- Explore the effectiveness of the Iceland model further, particularly the role of communities and families in prevention, in addition to encouraging participation of young people in meaningful recreational opportunities. **137**

RECOMMENDATION 11: The Victorian Government, in consultation with the Victorian Multicultural Commission, conduct research into substance use prevalence among culturally and linguistically diverse communities to inform the development of appropriate prevention measures. **141**

RECOMMENDATION 12: With the intention to develop a primary health care early intervention strategy, the Victorian Government commission an appropriate peak medical body to review the network of general practitioners (GPs) and public hospitals across Victoria and their role in screening and intervening early in people presenting with substance use issues and guide them accordingly. This review should map the current network including identifying GPs knowledge of and attitudes towards substance use and disorders, and barriers to effectively respond to these issues. The strategy should comprise practical responses to overcome identified barriers. **150**

7 Personal use and possession offences

RECOMMENDATION 13: The Victorian Government, while maintaining all current drug offences in law, treat the offences of personal use and possession for all illicit substances as a health issue rather than a criminal justice issue. This approach will ensure appropriate pathways are in place for the referral of people to health and treatment services in a timely manner where required. Mechanisms to achieve this should include:

- exploring alternative models for the treatment of these offences, such as the Portuguese model of reform
- removing the discretion involved with current Victoria Police drug diversion processes by codifying them
- reviewing all threshold amounts for drug quantities in order to appropriately distinguish between drug traffickers and people who possess illicit substances for personal use only
- conducting education and awareness programs to communicate with the public about the need to treat drug use as a health issue. **193**

8 Drug-related offending

RECOMMENDATION 14: The Victorian Government expand access to the Magistrates’ Court of Victoria Court Integrated Services Program (CISP) and CREDIT/Bail Support Programs, to ensure consistency in access and equity throughout Victoria. This should be accompanied by enhanced funding to ensure that appropriate support services and alcohol and other drug treatment is available to people diverted from the court system into these programs. The expansion should also include exploring options for the CISP to be available in the County Court of Victoria. 201

RECOMMENDATION 15: The Victorian Government expand the number of Drug Courts in Victoria, accompanied by funding to ensure appropriate support services and alcohol and other drug treatment is available for program participants. 209

RECOMMENDATION 16: The Victorian Government explore other court programs for potential implementation in Victoria, including the Hawaii Opportunity Probation with Enforcement (HOPE program). 211

RECOMMENDATION 17: As proposed by the Adult Parole Board of Victoria, the Victorian Government provide the Adult Parole Board with the power to suspend parole for longer-term parolees who have been found to use illicit substances but whom have not reoffended. Suspension could be up to three months, and parolees offered treatment during that time. Following the period of suspension, the Board would assess whether they can continue on parole. 216

9 Cannabis regulation

RECOMMENDATION 18: The Victorian Government work closely with the Commonwealth Government to improve patient access to medicinal cannabis products, particularly in relation to streamlining requirements at federal and state levels to ensure patients who will benefit from medicinal cannabis treatment in appropriate circumstances have proper access to it. 229

RECOMMENDATION 19: The Victorian Government continue to work with the Commonwealth Government to explore ways to improve understanding among the medical profession and the public of the current evidence base and situations where medicinal cannabis products may be considered as an appropriate treatment option. 233

RECOMMENDATION 20: The proposed Advisory Council on Drugs Policy should investigate the role of general practitioners in providing access to medicinal cannabis, and consider how they can be best supported in this area. 233

RECOMMENDATION 21: To assist health professionals and patients to access this form of treatment, the work of the Independent Medical Advisory Committee be made publicly available. 233

RECOMMENDATION 22: The Victorian Government facilitate continued investment for research and clinical trials into the use of medicinal cannabis and its effects, including its role in working alongside prescription opioids for pain management and reducing reliance and dosage levels of medication prescribed for pain relief. . . . 236

RECOMMENDATION 23: The proposed Advisory Council on Drugs Policy investigate international developments in the regulated supply of cannabis for adult use, and advise the Victorian Government on policy outcomes in areas such as prevalence rates, public safety, and reducing the scale and scope of the illicit drug market. 248

10 Drug driving and road safety

RECOMMENDATION 24: The proposed Advisory Council on Drugs Policy investigate the current drug driving laws and procedures to determine their effect on road crashes and as a deterrent strategy. The Council should also explore:

- alternative drug driving regimes that use impairment limits/thresholds, and their potential applicability in Victoria
- options for expanding the types of drugs captured under the regime
- likely changes to drug driving laws resulting from medicinal cannabis use in Victoria. 258

11 Legislative responses to new psychoactive substances

RECOMMENDATION 25: The Victorian Government review the implementation and enforcement of the recently enacted *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Act 2017* in mid-2019 to evaluate its effectiveness in eliminating the emergence of new psychoactive substances (NPS), and identify any unintended consequences. Other areas for review should include enforcement, NPS-related harms, NPS availability and prevalence. It should also review the implementation and workability of the definition of ‘psychoactive effect’.. . . . 280

12 Victorian alcohol and other drug treatment sector

RECOMMENDATION 26: The Victorian Government, in conjunction with Turning Point and other relevant agencies, develop a practice-friendly treatment pathway tool/resource for general practitioners (GPs) to enhance their awareness and understanding of referral to the alcohol and other drug treatment sector. To accompany this, the Victorian Government also review how Turning Point’s Drug and Alcohol Clinical Advisory Service (DACAS) could be better utilised among GPs, including through increased funding.. . . . 301

RECOMMENDATION 27: The Victorian Government via the Alcohol and Other Drug Sector Reference Group provide expert advice to the Government, the alcohol and other drug (AOD) treatment sector, and the broader medical community on ways to enhance their capacity to effectively respond to people presenting with substance use issues. Specific areas for action might include:

- identify further funding options through mapping the current capacity and gaps within AOD service delivery against existing and future demand for services. Particular attention to be provided to all treatment options to ensure flexibility in service delivery, acknowledging diversity and differing needs among potential clients. Specific opportunities should be identified for different cohort groups, such as clients with co-existing mental health issues and substance use disorders, culturally and linguistically diverse communities, Aboriginal Torres Strait Islander communities, and those from rural and regional areas
- explore effective and workable measures to expand Victoria’s specialist addiction medicine capacity, in addition to ensuring the AOD treatment sector is adequately supported by its existing workforce
- explore options for a public multidisciplinary health clinic model that comprises access to opioid substitution therapy prescribing doctors, addiction specialists, mental health services, support and other allied health services
- develop a model of care for public hospitals when treating patients presenting with substance use issues, which could include medical staff undertaking drug screening and developing clear treatment pathways and reintegration with specialist AOD treatment services. 305

RECOMMENDATION 28: The Victorian Government note ongoing considerable concerns within the community about private unregistered providers of alcohol and other drug (AOD) treatment and continue to advocate for the development of a national regulatory framework and standards for private AOD treatment.. . . . 313

13 Treatment for specific drug user groups

RECOMMENDATION 29: The Victorian Government provide increased support and funding to family support programs to minimise the adverse impact of substance misuse on family and friends, and to contribute to the effective reintegration of people with substance use disorders back into the community. 331

RECOMMENDATION 30: The Victorian Government evaluate prison alcohol and other drug programs based on their effectiveness in reducing recidivism, particularly where offending is directly related to substance use issues. 339

14 Medication assisted treatment for opioid dependence

RECOMMENDATION 31: The Victorian Government establish a dedicated arm of government to actively manage opioid substitution therapy (OST) policy in Victoria. The dedicated unit should explore options for enhanced data collection on OST, including current take-up, compliance rates, people who have ceased treatment and why. It should also explore an OST registry for general practitioners and pharmacies where they can seek information on current prescribers/ dispensers in specified areas. 364

RECOMMENDATION 32: The Victorian Government fund opioid substitution therapy (OST) dispensing fees to enhance access and remove barriers to a person entering and remaining on OST. 367

RECOMMENDATION 33: The Victorian Government expand access to opioid substitution therapy (OST) through a range of measures including:

- the provision of financial incentives to medical practitioners and pharmacists to prescribe OST, particularly as the current cohort of prescribing doctors is ageing and a shortage is expected
- enhancing the role of nurse practitioners to prescribe OST
- exploring models for hospitals to provide OST to suitable patients as part of emergency department treatment. 372

RECOMMENDATION 34: The Victorian Government trial the expansion of the opioid substitution therapy program to include other controlled and pharmaceutical grade opioids (such as hydromorphone), for a small group of people for whom other treatment types have not been successful. This should be accompanied with robust evaluation. 383

15 Pharmaceutical drugs

RECOMMENDATION 35: In the short term, the Victorian Government, in conjunction with the Australian Medical Association and other relevant medical bodies, develop prescription opioid medication guidelines for general practitioners and training on appropriate prescribing practices. This should include guidance on monitoring patients, lowering dosages when appropriate, education on the risks of dependence, and effective pain relief alternatives to such medication.. . . . 401

RECOMMENDATION 36: The Victorian Government develop and promote a sector-wide stewardship trial program for the medical profession (hospitals, specialist services and GPs) based on the Alfred Health model to promote and audit best practice regarding the prescribing and use of medications with potential for misuse (such as analgesics and benzodiazepines). This should be accompanied with promotion and education of best practice in this area and of appropriate attitudes towards pain relief among health professionals. The program should also be accompanied with an evaluation. 405

RECOMMENDATION 37: The Victorian Government develop resources and support or conduct awareness raising campaigns targeting the broader community about the safe and appropriate use of prescription medications for pain relief and promoting the role of non-pharmacological treatments for certain conditions (e.g. stress, anxiety and chronic pain). This could start with a targeted campaign that aims to reach patients in health settings and expand to a broader audience if required. 407

RECOMMENDATION 38: The Victorian Government work with the Commonwealth Government to review the fee structure for dispensing medication with potential for misuse, so that the volumes prescribed and dispensed be based on individuals' needs. Fee structure changes could include: incentivising pharmacies to dispense fewer tablets and subsidising patients who receive smaller amounts of medications. As part of this, the Victorian Government should work with the Pharmacy Guild of Australia and other relevant bodies regarding the role of pharmacies in improving dispensing practices. 410

- RECOMMENDATION 39:** The Victorian Government adopt measures to ensure the effectiveness of the real-time prescription monitoring (RTPM) system and prevent the diversion of patients with prescription misuse issues to the illicit drug market, including:
- adequately resourcing the alcohol and other drug public treatment sector to accommodate the likely influx of demand resulting from patients identified in the RTPM system with opioid dependency
 - as part of Department of Health and Human Service’s workforce development and training, ensure that health professionals are equipped to appropriately deal with patients identified in the RTPM system with substance use issues, for example through providing immediate and seamless access to harm reduction and/or treatment services, such as opioid substitution therapies.. 426

16 Minimising the spread of blood borne viruses

- RECOMMENDATION 40:** The Victorian Government review Victoria’s needle and syringe program (NSP) in order to strengthen the aims, coverage, service models, harm reduction information and equipment distributed to people who use illicit substances. This should include:
- exploring avenues to increase NSP availability in areas where there is an identified shortfall particularly after-hours, such as in public hospitals, vending machines/dispensing units, and community pharmacies
 - ensuring that staff of NSPs are culturally aware and sensitive to the needs of people who identify as Aboriginal and Torres Strait Islander and others from culturally and linguistically diverse communities
 - enhancing the capacity of the NSP workforce to engage with people with hepatitis C to educate them about potential treatment options and refer them accordingly.. 440

RECOMMENDATION 41: The Victorian Government remove the prohibition of peer distribution of sterile needles and syringes in the *Drugs, Poisons and Controlled Substances Act 1981*.. 443

RECOMMENDATION 42: The proposed Advisory Council on Drugs Policy review harms arising from current laws that prohibit or discourage non-injecting routes of drug administration, such as increased injecting use of methamphetamines and other drugs, and make recommendations to the Government accordingly. 444

- RECOMMENDATION 43:** The Victorian Government review its screening policies for blood borne viruses in prisons to:
- offer screening to prisoners upon release, in the same way they are offered screening upon entering prison or transferring between prisons
 - explore the feasibility of introducing compulsory blood screening of prisoners upon entering and exiting prisons to determine transmission of blood borne viruses within prisons. This review should consider all human rights implications associated with mandatory screening.. 456

RECOMMENDATION 44: The Victorian Government monitor data from screening processes, as recommended above, and monitor international needle and syringe prison programs to consider their potential value to minimise transmission of blood borne viruses. The Victorian Government share information with prison staff and relevant bodies to increase awareness and open dialogue about the benefits and risks of needle and syringe programs in prisons. 456

17 Overdose prevention strategies

RECOMMENDATION 45: The Victorian Government explore avenues to distribute naloxone more effectively. Such avenues might include:

- needle and syringe programs and other community health services where staff are trained to educate others in administering naloxone
- making naloxone available in appropriate settings where people who use opioids may frequent, such as treatment services (detox and residential rehabilitation services), crisis and emergency accommodation, which staff can administer when necessary
- making naloxone available to first responders to overdose calls in areas with high concentrations of injecting heroin use, accompanied with appropriate training
- other ways to make naloxone available, including through enhanced peer distribution. 472

RECOMMENDATION 46: The Victorian Government make naloxone available to prisoners with a history of opioid use upon their release from prison to minimise the high risk of overdose deaths among this cohort of people, and provide them with appropriate information and support services available in the broader community to minimise the likelihood of overdose. 476

RECOMMENDATION 47: The Victorian Government develop an emergency action plan to respond to a potential increase in deaths or overdoses as a result of high strength and purity of illicit substances, for example the presence of fentanyl and carfentanil in the drug market. This could include:

- targeted strategies for specific cohorts of people that use substances, such as those based in regional and rural areas, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, and people experiencing mental health issues
- wider distribution of naloxone to people who inject drugs (recommendations 45 and 46)
- explore avenues to enhance availability of opioid substitution therapies, such as lowering thresholds for access and reducing costs (recommendations 32 and 33), and expanding opioid-based treatment for people with a chronic heroin addiction (recommendation 34)
- possible establishment of temporary medically supervised injecting facilities in areas with high concentrations of injecting drug use and overdoses
- drug checking at the Medically Supervised Injecting Centre to test for heroin purity and other contaminants. 488

18 Safe events

RECOMMENDATION 48: The Victorian Government work with the Department of Health and Human Services, Victoria Police, Ambulance Victoria and DanceWize to facilitate the availability of an onsite drug testing unit for health and law enforcement authorities at an appropriate music festival to be used in the event of a suspected overdose or other serious adverse effects due to an illicit substance. The unit would not be public facing and its purpose is to test substances to determine their composition to assist health authorities treat the patient and, where appropriate, release a public alert to prevent further incidents. The unit will operate as part of the early warning system as recommended in chapter four. 526

RECOMMENDATION 49: The Victorian Government refer to the proposed Advisory Council on Drugs Policy the issue of drug checking services, and request that it monitor overseas and domestic models to obtain relevant evidence to inform consideration of a trial in Victoria. If appropriate, the Council should develop guidelines for such a trial (and include appropriate messaging e.g. not condoning drug use nor indicating that drug use is safe, appropriate technology, data collection and clear liability safeguards). The Council should also consider an evaluation framework to measure the future trial’s effectiveness in minimising drug-related harms. 527

RECOMMENDATION 50: Victoria Police commission an independent evaluation of the use of drug detection dogs at music festivals and other public spaces to determine their effectiveness in deterring the use and trafficking of illicit substances, and any unintended consequences or risk of harms resulting from this strategy. 533

PART A

Contextualising drug law reform in Victoria

1 Introduction

Upon receiving the Terms of Reference (ToR) for this inquiry from the Legislative Council, the Law Reform, Road and Community Safety Committee (the Committee) was committed to providing a platform for genuine debate about drug law reform. The Committee received views from a broad range of stakeholders across the community and comprehensively reviewed the available research and evidence in this area. Importantly, this inquiry provided an opportunity to develop a drug law and policy reform roadmap to achieve a safer, healthier and fairer community, based on the best evidence and analysis. It was also an opportunity to encourage more open and honest conversations about drug use and the associated issues in the broader community.

There is significant community concern about the use of illicit substances. Most people who use illicit substances do so infrequently, although a small proportion of people use them often and in highly harmful ways. The adverse consequences arising from this type of drug use are far-reaching and can lead to significant and lasting harms to individual users, families and communities. The motivation for this inquiry was to explore why these harms occur – is it because these substances are inherently dangerous, is it because of their illegality, and what is the role of drug laws and procedures in minimising these harms. Further, and equally important, is the extent to which these laws and procedures have reduced the availability and demand for illicit substances.

The emerging issues associated with the misuse of pharmaceutical drugs are also of concern, particularly given their increasing presence in overdose deaths in Victoria and the opioid crises observed in North America. In Victoria, pharmaceutical drugs were present in approximately 77 per cent of all overdose deaths in 2016.¹ Similar to illicit substances, the Committee explored the harms rising from these legal substances and whether current medical models too readily enable their availability in the community and contribute to their misuse and overuse.

In Victoria, parliamentary committees and government reviews have addressed the harms arising from illicit drug use and the misuse of prescription medication on numerous occasions. The Committee acknowledges and commends the comprehensive investigatory work of the former Victorian Law Reform, Drugs and Crime Prevention Committee and the Drugs and Crime Prevention Committee. Over

1 Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, p.2.

the years, these committees have examined and made recommendations to the Victorian Government on a broad range of issues relating to methamphetamines, party drugs, the misuse of pharmaceutical drugs and the impact of drug-related offending on female prison numbers. These issues are once again addressed in the current report, although as noted in the Penington Institute's submission, this inquiry is different to previous reviews as 'it is not trying to solve specific problems (such as ice), but rather take a wide-ranging look at Victoria's drug laws and the people who interact with them'.² The State Coroner of Victoria, Judge Sara Hinchey made a similar point in her submission to the inquiry:

To date in Australia there has been a widespread tendency when examining drug-related harm, to focus only on a particular drug or group of drugs that are perceived to be 'the issue' at a given point in time. However, as the attached data summary indicates, a broad and ever-shifting range of drugs are implicated in drug-related harm, and the evidence supports a conclusion that drug misuse needs to be approached in a wholistic manner, rather than one drug at a time.³

1.1 Balancing health and law enforcement approaches

While Australia's official approach to drugs is based on harm minimisation, the predominant focus is law enforcement to reduce the supply of illicit drugs in the community. There is overwhelming evidence, however, that the focus on law enforcement is not having the intended impact. Despite the continued position of prohibition over the last 50 years, in reality drug consumption is endemic and the drug market is more volatile than ever. This is reflected in the emergence of new and more potent drugs, the resurfacing of old drugs, and an increasing number of overdose deaths. This is not a criticism of law enforcement agencies, whom the Committee strongly believes operate as effectively as possible, but rather it reflects the constantly evolving nature of drug use and production.

There is also growing recognition among governments that greater balance between traditional law and order and health-based responses will have a broader positive impact on safeguarding the health and safety of communities. The need for this policy shift has been raised in various government and parliamentary reports over the years and was most recently reflected in Commonwealth funding for the *National Ice Action Strategy*. The Commonwealth Government allocated \$298.2 million over four years to reduce the impacts of drug misuse through strengthening education, prevention, treatment, support and community engagement initiatives.⁴ John Rogerson, the Chief Executive Officer (CEO) of the Alcohol and Drug Foundation (ADF) advised the Committee that the *National Ice Taskforce* report, chaired by Ken Lay APM, is one of the most important reports on drugs released in the last 10 years in Australia because:

[i]t did three things. It led to significant additional funding for the country around treatment, some funding for prevention, and it provided no extra dollars for law enforcement. I think that was a very interesting statement that the government and the task force talked about.⁵

² Penington Institute, *Submission*, no. 209, 24 March 2017, p. 2.

³ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017.

⁴ Department of Health, 'National Ice Action Strategy', viewed 15 November 2017, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/MC15-009596-national-ice-taskforce>>.

⁵ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 195.

Reaching this point of understanding has taken time, however, with the Committee noting a similar conclusion from a 1988 federal parliamentary committee *Inquiry into the National Crime Authority*, which stated:

...not only that our law enforcement agencies have not succeeded in preventing the supply of illicit drugs to Australian markets, but that it is unreasonable to expect them to do so. If the present policy of prohibition is not working then it is time to give serious consideration to the alternatives, however radical they may seem.⁶

Similar conclusions were also expressed in the Victorian report *Turning the Tide* in 1996, developed by the Premier's Drug Advisory Council. Emeritus Professor David Penington AC led the Advisory Council under the direction of the former Premier of Victoria Jeff Kennett. Driven by the heroin crisis in the 1990s, Premier Kennett requested Professor Penington to explore new approaches to deal with drugs. The report proposed various recommendations, although no action was taken due to the political difficulties associated with drug policy at the time.⁷

In 2000, Professor Penington once again chaired a Victorian Government drug advisory committee, but this time under the direction of former Premier Steve Bracks. With 359 overdose deaths in 1999, the Drug Expert Advisory Committee proposed the establishment of medically supervised injecting centres (MSICs) in five hot spots in Victoria. The proposal was defeated in the Legislative Council⁸ and the issue had not returned to the legislative agenda until 2016, when overdose deaths hit crisis point in the City of Yarra.

The need for an MSIC trial in North Richmond was a constant discussion point throughout this inquiry. It was also the subject of another parliamentary inquiry by the Legal and Social Issues Committee, *Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017*.⁹ The Committee notes strong media and community support for the trial, and the Victorian Government's commitment to conduct such a trial from June 2018.

The MSIC is one of many reform initiatives that the Committee explored throughout this report. It offers a useful example of an approach that prioritises health and community safety. These have been the driving factors of the Committee's investigations, which reflect on past successes and failings and builds on these with a suite of coordinated and innovative reform recommendations. These recommendations endorse the essential role of the three pillared approach of supply reduction, demand reduction and harm reduction, but acknowledge that while people continue to use substances, whether illicit or pharmaceutical, more needs to be done to minimise the associated harms. Most importantly, this can occur as part of a coordinated strategy that equally emphasises the role of law enforcement.

6 Victoria, *Parliamentary Debates*, Legislative Assembly, Friday, 31 May 1996, p. 472 (Professor Penington).

7 Green, S, 'New pillars of wisdom', *The Sydney Morning Herald*, 23 May 2012, viewed 6 November 2017, <<https://www.smh.com.au/politics/federal/new-pillars-of-wisdom-20120522-1z30f.html>>.

8 Green, S, 'New pillars of wisdom', *The Sydney Morning Herald*, 23 May 2012, viewed 6 November 2017, <<https://www.smh.com.au/politics/federal/new-pillars-of-wisdom-20120522-1z30f.html>>.

9 Legal and Social Issues Committee, *Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017*, Parliament of Victoria, Melbourne, 2017.

1.2 Starting the conversation: types of drug use and driving factors for use

A common theme in the evidence was the need for open and frank conversations about drugs in order to help the community understand why people use them and to work towards more compassionate and balanced responses to drug issues. Peter Wearne, Chair of the Yarra Drug and Health Forum was one of many stakeholders who raised this with the Committee:

... a society that should look at a health, human rights and harm reduction approach towards drugs, we need to have a conversation about those people's lives the same as we do about the lives, for example, of people who die from asthma.

I know that one is a legal situation and one is an illegal situation...If we had those types of conversations about people's lives in terms of illicit drugs, then I think that would make a significant change in terms of the way in which the community saw illicit drugs. We would take a more humane approach towards the issue.¹⁰

Acknowledging the different types of drug use and understanding why people engage in certain behaviours are important considerations when thinking about the types of strategies required to prevent use and minimise harms. This dialogue is dramatically missing from Australia's current approach to illicit substances.¹¹

According to Dr Kenneth Tupper, Director of Implementation and Partnerships at the British Columbia (BC) Centre on Substance Use (BCCSU) in Canada, there is a spectrum of psychoactive substance use which recognises the various relationships that people can have with alcohol or other drugs. This includes:

- some people choose abstinence and use no substances at all
- some people who use substances do so in beneficial or non-problematic ways, e.g. drinking alcohol moderately in social situations, or drinking coffee to be alert at work
- some people engage in non-problematic substance use that involves recreational, casual or other use that has negligible health or social effects
- some people engage in problematic substance use which increases the risk of harm that can and should be prevented, e.g. using at an early age, using while pregnant or driving while impaired
- some people develop chronic dependent substance use, or addiction, which may require treatment or other drug-related health and community support.¹²

Similarly, in his evidence to the Committee, Mick Palmer AO APM, Vice President of Australia²¹ and former commissioner of the Australian Federal Police (AFP), advised that illicit substance use falls into two categories:

One is recreational drug users, most of whom are young people holding down decent jobs who go about productive careers or otherwise live fully productive lives but as young people always do take risks and explore – stretch the boundaries...

¹⁰ Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 48.

¹¹ Mick Palmer AO APM, Vice President, Australia²¹, *Transcript of evidence*, 23 May 2017, p. 83.

¹² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 54-55.

They represent many of our children, friends and so on. At the other end, you've got problematic drug use. Not many recreational drug users finish up suffering problematic drug use...¹³

For the majority of people who use illicit substances, it is not because they are dependent but because they wish to enhance their mood or experience. Various stakeholders told the Committee that young people who use these substances recreationally typically 'age' or 'mature' out of the behaviour and continue as contributing and productive members of society.¹⁴ Gino Vumbaca, President of Harm Reduction Australia advised:

...if you look at the amount of people who use cannabis in their earlier age or use ecstasy in particular at a young age, most of them just stop...They get married, they have kids, they have a mortgage or whatever it may be – a job – and life overtakes that sort of partying attitude that maybe when you're young and free and don't have commitments you actually engage in that sort of behaviour a lot more.¹⁵

The Committee understands that these are incredibly challenging ideas, particularly the notion that people may try or use illicit substances to enhance their experiences despite their illegality. However, on a societal level, seeking to be intoxicated is common, although this is predominantly through alcohol. Similarly, the inclination to alleviate pain through pharmaceutical drugs and 'popping a pill' is also common. It is difficult to ignore the likely influence of these culturally acceptable practices on some people's willingness to try other substances. John Rogerson of the ADF indicated to the Committee that this is a conversation that should be had in the community:

We have got used to hearing in our community, 'I'll have a pill with this'. We will have a pill with anything if it is going to help us change our mood or deal with pain, and that is just the way our community responds. So is it therefore surprising that young people want to go to a music festival and enhance their experience with a pill?¹⁶

At the other end of the spectrum are people who become addicted to illicit substances. According to the *2015 World Drug Report*, this represents around 10 per cent of people who use illicit substances overall. However, it is that 10 per cent who use the most drugs and in the most harmful way, both to themselves and to the broader community.¹⁷ Geoff Munro, the National Policy Manager of the ADF indicated that the 80-20 rule loosely applies in understanding this issue, in that '20 per cent of drug users are using 80 per cent of the drugs by and large, and they are the people at risk of drug dependency'.¹⁸

The Committee acknowledges that treating addiction as a health condition and taking the time to understand how and why people reach this point is essential to developing appropriate and compassionate responses. The reasons for addiction are incredibly complex and correlate strongly with a range of health and social issues, including

13 Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017, p. 82.

14 Debbie Warner, Volunteer Manager, Family Drug Support, *Transcript of evidence*, 23 May 2017; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017; Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017; Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017.

15 Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 110.

16 John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 196.

17 United Nations Office on Drugs and Crime, *World Drug Report 2015*, United Nations, Vienna, 2015.

18 Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 204.

high rates of mental illness, significant levels of trauma, particularly in childhood, poverty, social marginalisation and disadvantage. There may also be instances when casual experimentation with substances may lead to addiction.

In these circumstances, people may use drugs to make their lives tolerable and to 'emotionally regulate and be normal'.¹⁹ As explained by Dr Alex Wodak AM, President of the Australian Drug Law Reform Foundation and Director of Australia21, people who use for these reasons do so to experience 'an enjoyable, chemical vacation in a life of total wretchedness and misery'.²⁰ Associate Professor Nadine Ezard identified similar driving factors, among others, as to why people misuse prescription medication:

The causes are multiple. One of the important factors is the prescriber: someone has to be actually prescribing the drug of dependence. The other factors are individual factors, so related to somebody's predisposition to developing dependence on anything. There might be social factors and one of the things that we see in our treatment population – particularly strong – is a history of trauma, multiple trauma, particularly in early childhood. So if you have any of these predisposing factors, plus something else, plus doctors prescribing the medicines, plus the doctors encouraged to prescribe the medicine, plus remuneration framework that encourages shorter consultation at that first point of call, plus our medication funding support, system...²¹

Regardless of how or why people use illicit substances, a disconnect exists between the legal framework and the way people behave as a community. Illicit substance use continues regardless of the drug laws that seek to prohibit it. A continued emphasis on law and order alone ensures that only the symptoms of drug use are dealt with, such as the offending behaviour or overdoses. Very little is done to address the causes of drug use, which will ultimately reduce demand and minimise risks.

The Committee strongly believes that without understanding patterns of use, the social groups and sub-populations of people who use substances, and the environments that they use in, there will be limited success in reducing demand for such substances. These are important conversations for governments, members of parliaments, the media and the community. Dr Stefan Gruenert, CEO of Odyssey House Victoria reaffirmed to the Committee, the value of having honest and public conversations about drugs:

I think we really need to get honest and have those conversations. For example, I have been on the public record saying, 'I don't want to eradicate drugs from society because I want my children to benefit from them in a range of things as medications'. We need to be honest about our own use of drugs, whether that be caffeine or alcohol. It is not the drug use itself but where a combination of underlying social factors takes that drug use from a medicinal use, a social use, to a very harmful use, a dependent use. These are the things we need to change — so a community conversation, some courage from leaders of all types. We see too many police commissioners have those conversations once they leave office. It is that fear — the fear to talk about our own drug use and policies that change. But I honestly think we are at the crossroads now, where even at the United Nations some significant shifts have occurred from some

¹⁹ Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 46.

²⁰ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 80.

²¹ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 123.

very conservative countries that really understand that the evidence is behind a different approach. And I think families sharing their stories and telling their stories is very powerful.²²

The Committee also believes that these conversations need to involve people who use illicit drugs in recognition of the contribution of their lived experiences to developing balanced, compassionate and effective responses.

1.3 Inquiry scope and processes

On 11 November 2015, the Legislative Council instructed the Committee to inquire into the effectiveness of laws and procedures relating to illicit and synthetic drugs and prescription medication. As the ToR were broad-ranging (see Appendix 1), the Committee agreed to refine them to ensure it had capacity to conduct the appropriate level of investigative work required for this momentous public policy matter. The refined ToR asked the Committee to investigate the effectiveness of drug control laws and procedures in minimising drug-related harms, as well as drug law reform in other Australian and overseas jurisdictions and how these could be implemented in Victoria. The Committee commenced work on this inquiry in February 2017.

Despite attempts to condense the scope of the Committee's investigations, it became apparent throughout the inquiry process that it was impossible to disregard many of the areas identified in the original ToR. This reflects the interweaving and complex nature of the issues relevant to drug policy reform, and the challenges associated with responding to drug use and its consequences. While many of the original ToR are worthy of separate inquiries, such as the effectiveness of drug treatment programs and roadside drug testing, they are addressed, albeit briefly, in this report.

Similarly, while the report's predominant focus is illicit substances, including new psychoactive substances (NPS), the emerging issues associated with the misuse of pharmaceutical drugs are also discussed briefly in the report.

As alcohol and tobacco were not within the inquiry's ToR, they are not within the scope of the Committee's investigations. The Committee acknowledges, however, that alcohol misuse creates more health, social and economic harms in the broader community than any illicit drug and is second only to tobacco as a leading cause of drug-related death and morbidity among Australians. Various stakeholders advised throughout the inquiry that these drugs are widely accepted in the community because of their legal nature and are not politicised as a drug problem, whereas many of the harms associated with illicit substances stem from their illegality. On this basis, the Committee agreed to focus on the latter and keep these issues separate. Further, given the breadth of harms arising from all drugs, both licit and illicit, an inquiry of this nature would require an entire parliamentary term to complete rather than 12 months.

22 Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 163.

1.3.1 Evidence gathering

The Committee commenced its formal call for submissions at the beginning of February 2017. This included a direct stakeholder mail-out and advertising the ToR in *The Age* and extensive promotion of the inquiry through the Parliament of Victoria's Facebook page, Twitter and You Tube Channel, in addition to news alerts via its news service.

The Committee received 231 submissions from a diverse range of experts and stakeholders working in various areas of drug policy and law reform, including advocacy groups, not-for-profit organisations, the alcohol and other drug treatment sector and other service providers, government departments, health and legal professionals, medical and health peak bodies, community legal centres, research institutes and academics. The Committee also received a significant number of submissions from individual members of the community. A list of submitters is provided in Appendix 2.

The Committee held nine days of public hearings in Melbourne and Sydney, commencing in June 2017 and concluding in November 2017. A list of public hearing participants is provided in Appendix 3. The Committee also travelled to Wellington, New Zealand in October 2017 to meet with various health and law enforcement officials. A list of meeting participants is provided in Appendix 4.

The Committee wishes to acknowledge the many people who shared their experiences of using drugs in their submissions. Some requested confidentiality, while in other circumstances when it was not requested but the submission contained sensitive information, the Committee agreed to publish it but withhold individuals' names and other identifying information. While wanting to encourage open and frank discussions about drug use, the Committee prioritised protecting people's anonymity at this time. The Committee was also very interested to meet and hear directly from people who use drugs, whether it be recreationally or of a dependent nature, or people who are in recovery. Few people were willing to give evidence, possibly due to the stigma associated with drug use. Those who spoke to the Committee gave their evidence confidentially. While this evidence has not been included in the report, it was insightful and valued by the Committee.

1.3.2 Overseas study tour

As the use of illicit substances is a global phenomenon, the Committee was interested to explore how different jurisdictions manage the problems of drug use and impacts on broader communities, and to meet with agencies involved in international drug policy and control. The Committee unanimously agreed that the experiences of service providers, policy makers and researchers from international jurisdictions would be instrumental in developing a report that comprehensively addresses the key legal, social and health issues associated with drug law reform. This was also consistent with the inquiry's ToR, which required the Committee to examine the practices of overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law.

On this basis, the Committee conducted an international study tour from 17 July to 3 August 2017, visiting Geneva, Switzerland; Lisbon, Portugal; London, United Kingdom; Vancouver, Canada; Denver and Sacramento, United States of America. These cities were chosen as they are widely recognised as being at the forefront of drug policy and law reform, or because they offered an alternative approach also worthy of exploration. A list of agencies that the Committee met with is provided in Appendix 4.

The Committee was represented on the study tour by the Chair of the Committee, Geoff Howard MP, Member for Buninyong; Hon. Martin Dixon MP, Member for Nepean; Khalil Eideh MLC, Member for Western Metropolitan; Fiona Patten MLC, Member for Northern Metropolitan; and Natalie Suleyman MP, Member for St Albans, in addition to Yuki Simmonds, the executive officer of the Committee. The Committee was also accompanied by Rick Nugent, Assistant Commissioner of Victoria Police – Eastern Region. This was a first for the Parliament of Victoria and the Committee found it highly valuable to have someone with Assistant Commissioner Rick Nugent’s law enforcement expertise accompany them. According to Assistant Commissioner RickNugent, the tour and key learnings were equally beneficial to him and Victoria Police:

What has been particularly helpful and has broadened our thinking was the opportunity to attend overseas with the delegation, to be honest. Some really good initiatives, some good policies being trialled in various areas, and all of that has been brought back to VicPol as well to help inform our thinking, to challenge our thinking and to really look at a contemporary way in which we can target the harms from drugs in the community.²³

In North America, the Committee was supported by the Victorian Government Business Office (VGBO) headed by Commissioner to the Americas, Michael Kapel. Jessica Lascelles, the VGBO Research and Visitor Project Officer, accompanied the Committee on this component of the study tour.

The Committee is incredibly grateful to the various individuals and agencies that it met with as part of the study tour, and was humbled by their generosity and the invaluable discussions held about developing effective, evidence-based and humane drug policy, both locally and on a broader scale. The evidence it received throughout the three weeks was instrumental to many of the Committee’s recommendations and developing a report that comprehensively explores the key legal, social and health issues associated with drug law reform.

1.4 Report structure

The report is divided into two parts:

PART A: Contextualising drug law reform in victoria

- Chapter one introduces the key themes and scope of the inquiry and outlines the inquiry process.
- Chapter two outlines pertinent information on the most common substances, an overview of drug trends, in addition to the growing problem of poly-drug use.
- Chapter three provides a historical overview of drug policy, including the international drug control framework and its continued relevance, in addition to an overview of domestic drug policies.
- Chapter four outlines the framework for effective drug law reform in Victoria, including the reorientation of drug policy to a health-based framework, and the proposal of a new governance structure and strong data collection to support the reorientation of drug policy.

23 Assistant Commissioner Rick Nugent, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 454.

- Chapter five focuses on the negative labelling and discrimination experienced by people who use illicit substances or have a substance use disorder, as well as the long-term impacts of this negative labelling and strategies to overcome it in the broader community.

PART B: Four pillars approach to drug policy

Prevention

- Chapter six focuses on various types of prevention strategies to reduce or delay the uptake of illicit drug use. It particularly discusses a universal prevention strategy to enhance public awareness and understanding of illicit drug use, and targeted prevention approaches for children and young people and other specific population groups. It also analyses an early intervention strategy in primary care health settings.

Law enforcement

- Chapter seven provides an overview of the ways that use of illicit substances and personal possession offences are dealt with and enforced in Victoria, including a focus on the impacts of criminalisation on individuals and the role of alternative policing through diversion programs. Various options for reform in this area are discussed, including the Portuguese socially integrated approach which comprises the key policy of decriminalisation of possession of illicit substances for personal use offences.
- Chapter eight outlines how offending behaviour is dealt with in Victoria where substance use is an underlying cause for other criminal activities. In particular, the chapter explores current approaches employed to reduce rates of imprisonment among this cohort of people, including court diversion programs and the parole system.
- Chapter nine discusses cannabis regulation in the context of the Victorian and Commonwealth systems for medicinal cannabis, in addition to exploring various regulatory models for the adult use of cannabis that have been implemented in some international jurisdictions.
- Chapter ten reviews the basis of Victoria's current drug driving laws, specifically the effectiveness of the detection threshold system, as opposed to an impairment threshold system used for drink driving, in addressing road safety.
- Chapter eleven discusses the various international and local legislative responses to reduce the emergence of NPS in the context of challenges posed by NPS, including their unknown health effects, distinguishing between intentional and unintentional use, and the evolving nature of the market.

Treatment

- Chapter twelve provides an overview of the Victorian alcohol and other drug (AOD) treatment sector, including current limitations with the availability, flexibility and delivery of treatment services. The chapter also discusses options for reform, including enhancing funding arrangements, strengthening the role of primary health, and addressing regulation of unregistered AOD service providers.
- Chapter thirteen outlines treatment considerations for specific groups of people, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, young people, people experiencing

both substance and mental health issues, people living in rural and regional areas, and prisoners. The chapter also briefly discusses the role of mandatory treatment.

- Chapter fourteen explores the main form of treatment for opioid dependency in Australia, opioid substitution therapy (OST), including the current barriers which obstruct improved utilisation of this treatment and strategies to enhance effectiveness of the Victorian program. The chapter also explores an option to expand opioid-based treatments for a very specific and limited group of people with a chronic heroin addiction for whom other forms of treatment have not been effective.
- Chapter fifteen focuses on the increasing misuse of pharmaceutical substances, particularly opioids, and the harms arising from this misuse, including their growing contribution to overdose deaths and hospitalisations in Victoria. The chapter discusses various options for reducing the reliance on pharmaceutical substances, particularly the Victorian real-time prescription monitoring system and key considerations for implementation.

Harm reduction

- Chapter sixteen examines measures to enhance the current Victorian needle and syringe program and explores other measures to complement it, including enhanced coverage of the program and removing barriers to peer or secondary distribution of injecting equipment.
- Chapter seventeen provides an overview of overdose deaths in Victoria. Drawing on the experiences of North America regarding the opioid crisis and local reports of increased purity and strength of illicit substances, this chapter also explores strategies to prevent a continued rapid rise in overdoses in Victoria.
- Chapter eighteen outlines strategies to minimise the harms arising from illicit substance use among people who typically use on a recreational basis and in party environments, such as music festivals, rave events and nightclubs. It particularly discusses the benefits and risks associated with drug checking services and the use of drug detection dogs as a law enforcement strategy.

1.5 A note about language

From the beginning of this inquiry, it was clear that the topic of drugs and drugs policy is vexed with a minefield of expressions and concepts that have different definitions. This includes terms that are highly stigmatising of people who use drugs and which are loaded with negative or blaming connotations. Often these terms are misleading and/or value laden.

This report attempts to use only appropriate, objective and non-judgemental language. This includes using people-first language, in addition to language that reflects the medical nature of addiction and substance use disorders, and obviously, which avoids slang and idioms. This is important as it shifts the focus of addiction away from a moral or criminal issue to one that deserves treatment and broader social responses.

Language influences cognitive biases, particularly regarding drug use. The Committee believes that using non-judgemental and neutral language is an important starting point to positively guide public discourse in this complex policy area, and start to influence the way the community perceives people who use illicit substances.

2 Background information on licit and illicit substances

The purpose of this chapter is to outline pertinent background information on the most commonly used substances, including how they are administered and their effects. Not all drug types are discussed in great or equal detail, for example hallucinogens are dealt with briefly, not because they are not harmful or potentially so, but because they are not as prevalent in Australia, certainly not compared to other substances, such as cannabis.

The chapter also provides an overview of drug trends, in addition to examining the increasingly common problem of poly-drug use.

2.1 Issues pertaining to terminology and nomenclature

Drug policy discourse is sometimes a minefield with regard to terms and concepts, and without universally accepted definitions, even at the United Nations (UN) level, it can create much confusion and misunderstanding.²⁴ For example, there are somewhat arcane debates as to what constitutes a ‘drug’ in the context of both medicine and substance use. In the latter context, the definition used in the National Drug Strategy (NDS) of a ‘substance that causes a psychoactive effect’ seems the most straightforward.²⁵ Under this definition, drugs can be licit (alcohol, caffeine, nicotine), and illicit. The terms ‘drug’ and ‘substance’ are often used interchangeably in the literature, as reflected throughout this report.

Some terms that are used rather loosely may also have applicability to particular types of drug. For example, ‘narcotic’ usually refers to a drug that has the ability to cause narcosis – a state of stupor or sleepiness. While strictly speaking it refers to opiates such as heroin, in some categorisations, for example its use under the UN drug control conventions, applies more generally to a wide range of proscribed psychoactive substances.²⁶ ‘Psychotropic drug’ is also a term used rather loosely. In specific contexts, it can refer to a substance that produces mind altering or hallucinogenic effects, but as with narcotics it can also be used more broadly (and erroneously) to cover a wide range of psychoactive substances.

24 McDonald, D, *A background paper for an Australia 21 Roundtable, Sydney 2012 Addressing the question ‘What are the likely costs and benefits of a change in Australia’s current policy on illicit drugs?’*, Australia21, Canberra, 2011, p. 5.

25 Intergovernmental Committee on Drugs, *National Drug Strategy 2016-2025: Draft for public consultation*, 2015, p. 5.

26 Macintosh, A, *Drug Law Reform: Beyond Prohibition: Discussion Paper Number 83*, The Australia Institute, Canberra, 2006.

Apart from definitional issues regarding the drug or substance itself, confusion also arises with regard to other terms used in drug policy and drug control regimes, for example 'prohibition', 'legalisation', 'decriminalisation' and 'depenalisation'.

For the sake of clarity, following international guidelines and academic work, the following terms are used:²⁷

- Prohibition – under a prohibition regime, most behaviours relating to illicit drugs, including use, possession, cultivation, manufacture and supply are criminal offences. Offences will usually attract custodial penalties and in some countries the death penalty where they relate to trafficking offences. In Australia, prohibition regimes apply to all illicit drugs.
- Decriminalisation – specified proscribed behaviour, commonly drug use and personal possession, remain as offences but attract civil rather than criminal penalties. Decriminalisation can be further divided into de jure and de facto schemes.²⁸ Offenders may still be charged with a criminal offence if they do not pay a civil sanction or attend a required diversion program (see below).
- Depenalisation – drug offences remain illegal under criminal law, but the offender may have the penalty reduced or not enforced or may avoid a conviction being recorded. In some circumstances, as with de facto decriminalisation, the offender may enter a drug diversion program in order for the offence to be erased. Depenalisation almost never applies to supply offences other than in some countries with regard to small scale trading or where the user is trading in order to support their own use or dependence.
- Legalisation – former drug offences are no longer considered offences and no longer dealt with by the legal system.
- Regulation – a (controlled) legal market is established for illicit drugs, akin to pharmaceutical products, tobacco and alcohol. The level of controls vary depending on the regime in question.
- Free availability/free markets – in such an option, all restrictions are removed on the use, possession and in some cases supply of a drug or substance. Such regimes are almost non-existent with regard to illicit drugs, and even tobacco and alcohol in most countries are subject to regulation. Caffeine/coffee would be the substance most relevant to a free market regime. The UK drug reform group, Transform argues that opponents of drug law reform often and misleadingly

27 The above definitions are a synthesis from a number of publications including: Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010; Transform Drug Policy Foundation, *After the War on Drugs: Blueprint for Regulation*, Bristol, 2009; Lenton, S, 'Pot, politics and the press - reflections on cannabis law reform in Western Australia', *Drug and Alcohol Review*, vol. 23, no. 2, 2004; Australia21, *Alternatives to Prohibition: Illicit Drugs: How we can stop killing criminalising young Australians, Report of the second Australia 21 Roundtable on illicit drugs*, Canberra, 2012; Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012; Global Commission on Drug Policy, *Taking Control: Pathways to Drug Policies That Work*, Geneva, 2014; Hughes, C, et al., *Decriminalisation of drug use and possession in Australia – A briefing note*, National Drug and Alcohol Research Centre, Sydney, 2016; Macintosh, A, *Drug Law Reform: Beyond Prohibition: Discussion Paper Number 83*, The Australia Institute, Canberra, 2006; McDonald, D, *A background paper for an Australia 21 Roundtable, Sydney 2012 Addressing the question 'What are the likely costs and benefits of a change in Australia's current policy on illicit drugs?'*, Australia21, Canberra, 2011.

28 From a definitional perspective, decriminalisation can be either de jure or de facto. With de jure decriminalisation, penalties are generally removed from the criminal law, in some cases to be replaced with civil fines, administrative sanctions or as in some states expiation notices in the case of cannabis possession. Even under de jure criminalisation regimes, any drugs seized are still not 'legal'. De facto decriminalisation at least in Australia sees the laws remain but they are not administered in practice, for example by establishing police guidelines not to investigate, prosecute or enforce the law. Alternatively the offender may be diverted into an education or treatment program.

equate a free market model with legalisation. According to Transform, other than a fringe of hard core libertarians, most drug law reform advocates would not wish to see a free market regime established:

Arguably such an approach is from a public health perspective at least an even worse scenario than unregulated criminal control of drug markets. Legal commercial actors – whose primary concern is profit maximisation – would be free to aggressively promote consumption through marketing and advertising.²⁹

The Committee is also aware of differing understandings in the broader literature and among inquiry stakeholders of the concepts of ‘addiction’ and ‘dependence’. These terms are also often used interchangeably. According to the Global Commission on Drug Policy (GCDP), dependence refers to a reliance on a substance to function and to avoid suffering from withdrawal symptoms on abrupt cessation. Whereas addiction is characterised by compulsive drug seeking and use, despite the likely harmful consequences. The GCDP notes that the World Health Organization’s International Classification of Diseases still refers to dependence as compulsive use of a substance despite negative consequences.³⁰ In his book, *Chasing the Scream*, Johann Hari provides an interesting distinction between dependence and addiction that extends on the GCDP’s explanations:

...I talked to many scientists, and they explained a distinction that really helped me – between physical dependence, and addiction. Physical dependence occurs when your body has become hooked on a chemical, and you will experience some withdrawal symptoms if you stop...But addiction is different. Addiction is the psychological state of feeling you need the drug to give you the sensation of feeling calmer, or manic, or numbed, or whatever it does for you.³¹

The Committee is also aware of the increasing use of the term ‘substance use disorders’ to refer to an individual’s addiction or dependence on a substance. This was particularly evident among many of the stakeholders that the Committee met with in Vancouver, many of whom prefer to use neutral and medical language.

2.2 Drug classifications and basic drugs information³²

The following section examines various substances according to their general drug classification, including stimulant drugs, ‘party’ drugs, depressant drugs, prescription medications, synthetic or new psychoactive substances (NPS), and other drug groups.

It should be noted that these classifications are arbitrary and give rise to much overlap. For example, many party drugs can be classified as stimulants. Stimulants most often refer to the physiological effects on the body after ingesting the drug whereas party drugs refer to the context in which they are used. Similarly, there is overlap between certain drugs that, while sharing the same physical properties, can

29 Transform Drug Policy Foundation, *After the War on Drugs: Blueprint for Regulation*, Bristol, 2009, p. 19.

30 Global Commission on Drug Policy, *The opioid crisis in North America*, GCDP, Geneva, 2017, p. 6.

31 Hari, J., *Chasing the Scream: The First and Last Days of the War on Drugs*, Bloomsbury USA, New York, 2015, pp. 183-184.

32 The information presented in this section is sourced and synthesised from various sources: Alcohol and Drug Foundation, ‘Drug Facts’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/>>; Department of Health, ‘Drug Help: Types of Drugs’, viewed 18 January 2018, <<https://campaigns.health.gov.au/drughelp/types-drugs/>>; National Drug and Alcohol Research Centre, ‘Fact Sheets’, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/resource-type/fact-sheets/>>; NIH U.S. National Library of Medicine, ‘Fact Sheets’, viewed 18 January 2018, <<https://www.nlm.nih.gov/pubs/factsheets/factsheets.html>>; United State Drug Enforcement Administration, ‘Drug Fact Sheets’, viewed 18 January 2018, <<https://www.dea.gov/druginfo/factsheets.shtml>>.

be used in completely different contexts. For example, both heroin and oxycodone are strong depressant drugs, yet heroin is used almost exclusively illicitly for the purposes of intoxication while, when used legitimately as a prescription drug, oxycodone has important therapeutic value.

This section has been designed to complement and be read alongside the table in Appendix 5.³³

2.2.1 Stimulant drugs

Amphetamines

Amphetamines stimulate or speed up the messages travelling between the brain and the body. Doctors can legally prescribe some types of amphetamines to treat conditions, such as attention deficit hyperactivity disorder (ADHD), weight loss and narcolepsy. Other types, such as speed, are produced and sold illegally. The most potent form, crystal methamphetamine (ice), is covered separately below.

The effect of amphetamines is typically influenced by the purpose for which it is used. Amphetamines may be used for purely recreational reasons or for instrumental reasons as referred to above. Recreationally, amphetamines (and other stimulants) are used to enhance a rave or dance party experience and increase stamina and energy.³⁴

Methamphetamine

Methamphetamine is a particularly potent member of the amphetamine group. It can include a powdered version (speed) and paste or resinous versions (base). The crystallised version of methamphetamine is commonly referred to as ice and is stronger and more potent than other stimulant drugs, with more harmful side effects than the powdered form of methamphetamine. Crystal methamphetamine is arguably far more addictive than other forms of amphetamines due to its greater purity levels and therefore potency.³⁵

2.2.2 Party and other stimulant drugs

While the term party drug is not without its critics, it is generally accepted as referring to a group of drugs often used in group or 'sharing' situations, particularly at dance parties or raves.

³³ These tables include information on each drug according to the headings of appearance, street names, mode of administration, effects, overdose, other serious consequences, coming down, long-term effects, withdrawal, and poly-drug use.

³⁴ Alcohol and Drug Foundation, 'Amphetamines', viewed 18 January 2018, <<https://adf.org.au/drug-facts/amphetamines>>.

³⁵ National Drug and Alcohol Research Centre, 'Methamphetamine', *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Methamphetamine.pdf>>; Alcohol and Drug Foundation, 'Ice', viewed 18 January 2018, <<https://adf.org.au/drug-facts/ice>>.

Methylenedioxymethamphetamine (MDMA)³⁶

MDMA is a stimulant drug that is often colloquially referred to as ecstasy, although ecstasy nowadays has been generalised to cover a broad range of other substances. MDMA can come in tablet form or in a powdered form, which is typically snorted.

While MDMA is a banned substance, it has been shown to have therapeutic value, and is increasingly being used in trials as a tool, in conjunction with psychotherapy, to assist people experiencing post-traumatic stress disorders.

Cocaine³⁷

Cocaine is also a form of stimulant drug, extracted from the leaves of the coca bush (*Erythroxylum coca*), which is native to South America. The leaf extract is processed to produce three different forms of cocaine:

- Cocaine hydrochloride: a white, crystalline powder with a bitter, numbing taste. It is often mixed, or 'cut', with other substances such as lactose and glucose, to dilute it before being sold.
- Freebase: a white powder that is more pure with less impurity than cocaine hydrochloride.
- Crack: crystals ranging in colour from white or cream to transparent with a pink or yellow hue, and may contain impurities. Crack is arguably the most addictive form of the drug, due to its purity and potency.

Indigenous people of South America have traditionally chewed the leaves of the coca bush, or brewed them as a tea, for use as a stimulant or appetite suppressant. This has led to political and legal questions about whether the UN drug conventions should proscribe certain forms of drug use that are an inherent part of Indigenous and folk cultures.³⁸

Gamma Hydroxybutyrate (GHB)³⁹

Unlike most other party drugs, GHB is chemically a depressant, not a stimulant. Like ecstasy, however, it is often used in the context of nightclubbing, dancing and raves.

GHB usually comes as a colourless, odourless, bitter or salty liquid, which is typically sold in small bottles or vials. Given its appearance, it is not easily detected. It can also come as a bright blue liquid known as 'blue nitro', and less commonly as a crystal powder.

³⁶ National Drug and Alcohol Research Centre, 'Ecstasy', *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Ecstasy.pdf>>; Alcohol and Drug Foundation, 'Ecstasy', viewed 18 January 2018, <<https://adf.org.au/drug-facts/ecstasy>>.

³⁷ National Drug and Alcohol Research Centre, 'Cocaine', *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Cocaine.pdf>>; Alcohol and Drug Foundation, 'Cocaine', viewed 18 January 2018, <<https://adf.org.au/drug-facts/cocaine>>.

³⁸ Bolivia for example has withdrawn from some parts of the UN drug treaties to enable Bolivian Indigenous groups to continue their practice of chewing coca leaves.

³⁹ National Drug and Alcohol Research Centre, 'GHB', *Fact Sheet*, 2016, viewed 18 January 2018, <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20GHB_0.pdf>; Alcohol and Drug Foundation, 'GHB', viewed 18 January 2018, <<https://adf.org.au/drug-facts/ghb>>.

Ketamine⁴⁰

Ketamine is a veterinary anaesthetic drug that is illegally diverted for recreational use, often in the party drug context to get ‘high’. Ketamine can produce hallucinogenic effects, including auditory, olfactory and visual hallucinations.

2.2.3 Depressant drugs

Depressant drugs are those that slow down the central nervous system, and includes opioids (drugs derived either naturally or synthetically from opium), alcohol and cannabis. These drugs slow down the messages that travel between the brain and the body.

Cannabis⁴¹

Cannabis (*cannabis sativa*) is the most popular of the recreational illicit drugs. In large doses, it may also produce hallucinogenic effects. The main psychoactive compound of cannabis is THC (delta-9 tetrahydrocannabinol). Cannabis sativa is the principal type of cannabis plant used for recreational (and medicinal) use. To a lesser extent the by-products of the cannabis indica plant are also used for recreational purposes. Sometimes hybrids of both sativa and indica plants are used.

Medicinal cannabis is increasingly being prescribed to relieve the symptoms of medical conditions, such as cancer or epilepsy. Many jurisdictions around the world have in place regimes for controlling and administering medicinal cannabis, including in Australia and Victoria.

Opioid drugs – heroin⁴²

Heroin is the most well-known of the opioids and is mostly used for illicit purposes. It is deemed a crude preparation of and ‘is a semisynthetic product obtained by acetylation of morphine, which occurs as a natural product in opium’.⁴³ Illicit heroin may be smoked or solubilised with water and injected.

Heroin withdrawal (and dependence) can be assisted through heroin replacement treatments including the prescribing of methadone or buprenorphine or in some countries, pharmaceutical grade heroin or diamorphine in a tapering off exercise.

40 National Drug and Alcohol Research Centre, ‘Ketamine’, *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Ketamine.pdf>>; Alcohol and Drug Foundation, ‘Ketamine’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/ketamine>>.

41 National Drug and Alcohol Research Centre, ‘Cannabis’, *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NCPIC%20Cannabis%20fact%20sheet.pdf>>; United States Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide*, U.S. Department of Justice, Washington, 2017, p. 74; Alcohol and Drug Foundation, ‘Cannabis’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/cannabis>>.

42 United States Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide*, U.S. Department of Justice, Washington, 2017, p. 42; Alcohol and Drug Foundation, ‘Heroin’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/heroin>>.

43 European Monitoring Centre for Drugs and Drug Addiction, ‘Heroin Drug Profile’, viewed 3 January 2018, <<http://www.emcdda.europa.eu/publications/drug-profiles/heroin>>.

Opioid prescription drugs - fentanyl and carfentanil⁴⁴

Fentanyl is prescribed for the control of chronic, severe pain as a result of cancer, nerve damage, back injury, major trauma or other causes. In Australia, fentanyl is a Schedule 8 drug, in that it has been placed in one of the most restrictive categories for access and prescription. It is about 80 to 100 times stronger than morphine.

Carfentanil is an analogue of fentanyl. It is 10,000 times more potent than morphine, making it among the most potent of the opioids. Carfentanil was first synthesized in 1974 and marketed as a veterinary drug, particularly a general anaesthetic agent for large animals, such as elephants.

Fentanyl and carfentanil are typically taken with heroin, with many people unaware that they are taking it. These can be added to or sold as heroin because they are less expensive and easier to traffic, particularly over the internet. This issue has recently increased in North America, and while it is still relatively uncommon in Australia there are growing concerns of their presence on the illicit drug market.

Opioid prescription drug - Oxycodone⁴⁵

Oxycodone hydrochloride is a form of opioid analgesic. Like fentanyl, oxycodone is a Schedule 8 drug. Doctors must follow state and territory laws when prescribing oxycodone and must notify, or receive approval from, the appropriate health authority to prescribe or administer it.

Oxycodone is most commonly prescribed by doctors to relieve moderate to severe pain, although it is increasingly being diverted for illicit use or misused among those in receipt of legitimate prescription. It is not uncommon for such people to develop a dependency to it.⁴⁶

Misuse of oxycodone has become a significant problem in certain parts of the United States, where the use of 'hillbilly heroin' as it has been colloquially named in some regions, has surpassed heroin and methamphetamine as drugs of misuse and dependence.

Opioid prescription drug - Codeine⁴⁷

Codeine is also part of the opioid group of drugs. It is used to provide relief from a number of conditions, including:

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- 44 National Drug and Alcohol Research Centre, 'Pharmaceutical opioids', *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Pharmaceutical%20Opioids.pdf>>; United States Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide*, U.S. Department of Justice, Washington, 2017, p. 40; Alcohol and Drug Foundation, 'Fentanyl', viewed 18 January 2018, <<https://adf.org.au/drug-facts/fentanyl>>.
- 45 National Drug and Alcohol Research Centre, 'Pharmaceutical opioids', *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Pharmaceutical%20Opioids.pdf>>; National Drug and Alcohol Research Centre, 'Oxycodone', *fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Oxycodone.pdf>>; Alcohol and Drug Foundation, 'Oxycodone', viewed 18 January 2018, <<https://adf.org.au/drug-facts/oxycodone>>.
- 46 National Drug and Alcohol Research Centre, 'Oxycodone', *fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Oxycodone.pdf>>.
- 47 National Drug and Alcohol Research Centre, 'Codeine', *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Codeine%20update.pdf>>; Alcohol and Drug Foundation, 'Codeine', viewed 18 January 2018, <<https://adf.org.au/drug-facts/codeine>>.

- mild to moderate pain
- severe pain when combined with aspirin or paracetamol
- coughs
- cold and flu (when combined with antihistamines and decongestants).

Some people misuse codeine by intentionally taking more than the recommended dosage. Also ‘backyard chemists’ may seek to extract codeine from common cold and flu preparations and divert it as an illicit drug. Consequently, from February 2018 painkillers and other medications containing codeine became no longer available over the counter across Australia and were placed in the more strictly regulated Schedule 3 classification (prescription required), rather than Schedule 2 (over the counter pharmaceuticals). This was introduced by the federal Therapeutic Goods Administration in order to reduce codeine dependence.

Other prescription drugs - benzodiazepines⁴⁸

Benzodiazepines, also known as minor tranquillisers, are depressant drugs, usually prescribed by doctors to relieve stress and anxiety or address insomnia and other sleep problems. There is, however, increasing concern among medical professionals about the risks of using these drugs, particularly over long periods of time. There has also been a marked rise in the number of people misusing benzodiazepines to become intoxicated or to help with the ‘come down’ effects of stimulants, such as amphetamines or cocaine. Alternatively, as with opioid use for pain relief, a person may misuse these drugs as a result of a dependence that has occurred subsequent to the legitimate use of the drug.

2.2.4 Synthetics or new psychoactive substances⁴⁹

New psychoactive substances or synthetic drugs refers to a range of substances that have been designed to mimic established illicit drugs, such as cannabis, cocaine, MDMA and lysergic acid diethylamide (LSD). Manufacturers of these drugs constantly formulate new chemical structures to replace any that are banned, thus staying ahead of any efforts to proscribe them by law.

As discussed in chapter 11, NPS are being developed at an unprecedented rate and have become a disturbing phenomenon. As of December 2015, 643 NPS were registered in the UN Office of Drugs and Crime (UNODC) Early Warning Advisory on NPS. Given how rapidly these drugs are emerging, it has been difficult to determine their common effects and levels of harmfulness.

48 National Drug and Alcohol Research Centre, ‘Benzodiazepines’, *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDA073%20Fact%20Sheet%20Benzodiazepines.pdf>>; Alcohol and Drug Foundation, ‘Benzodiazepines’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/benzodiazepine>>.

49 National Drug and Alcohol Research Centre, ‘Emerging psychoactive substances (EPS)’, *Fact Sheet*, 2016, viewed 18 January 2018, <<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDARC%20Fact%20Sheet%20-%20EPS.pdf>>; Alcohol and Drug Foundation, ‘New psychoactive substances’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/new-psychoactive-substances>>.

2.2.5 Other substance groups⁵⁰

A number of other drug groups are identified for the sake of completeness but for reasons of length are not dealt with in detail in this report. From a prevalence perspective, these substances are of less concern than the drugs discussed above.

Performance or image enhancing drugs (PIEDS)⁵¹

These include anabolic steroids, hormones and peptides. They are typically used by people with the intention of improving their physical appearance, particularly bodybuilding, and/or enhancing their sporting performance.

Hallucinogens⁵²

Hallucinogens (also referred to as ‘psychedelics’) distort a person’s perceptions of sight, hearing, smell or taste, and as the name suggests cause hallucinations. Hallucinogens can be made either from organic matter or plants such as magic mushrooms (psilocybin) or mescaline (peyote cactus extract). Alternatively, it can be manufactured in laboratories such as LSD.

Inhalants⁵³

These substances, sometimes referred to as volatile substances, are not drugs per se but everyday substances that can be misused by inhalation to achieve a psychoactive effect. In Aboriginal and Torres Strait Islander (ATSI) communities, the inhalation of petrol is the most common form of this substance misuse, while in non-ATSI communities, aerosol paint inhalation, referred to as chroming, is more prevalent. Apart from petrol and paint, household items such as cleaners and solvents can be misused in this way.

2.3 Drug trends and prevalence data

Drug markets are essentially volatile depending on supply and demand factors and changes in demographics and drug taking practices. John Ryan, Chief Executive Officer (CEO) of the Pennington Institute told the Committee that the ‘drug market typically moves more quickly than government and policy responses’.⁵⁴ Similarly, Sam Biondo, Executive Officer of the Victorian Alcohol and Drug Association advised the Committee of the ‘adaptability’ of drug markets and drug consumers, noting that illicit drugs remain accessible despite a raft of laws and policies that try to minimise

50 United States Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide*, U.S. Department of Justice, Washington, 2017, p. 86.

51 United States Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide*, U.S. Department of Justice, Washington, 2017, p. 78; Alcohol and Drug Foundation, ‘Performance and image enhancing drugs’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/pieds>>.

52 United States Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide*, U.S. Department of Justice, Washington, 2017, p. 64; Alcohol and Drug Foundation, ‘Hallucinogens’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/hallucinogens>>.

53 United States Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide*, U.S. Department of Justice, Washington, 2017, p. 80; Alcohol and Drug Foundation, ‘Inhalants’, viewed 18 January 2018, <<https://adf.org.au/drug-facts/inhalants>>.

54 John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, p. 2.

supply and availability, with ‘displacement’ from one drug to another occurring.⁵⁵ For example, a ‘heroin crisis’ in the 1990s was followed by an increase in amphetamine use, particularly methamphetamine use, partly in response to an insufficient supply of heroin during the heroin drought.

The Committee understands that in Victoria drug use has remained fairly stable over the past decade. A number of datasets, both national and state, contribute to understanding drug trends and prevalence rates. The Australian Institute of Health and Welfare’s (AIHW) *National Drug Strategy Household Survey* (NDSHS) is Australia’s most comprehensive collection of statistical data pertaining to licit and illicit drug use nationally and in all states and territories. It collects information on alcohol and tobacco consumption, and illicit drug use among the general population in Australia. It also surveys people’s attitudes and perceptions relating to tobacco, alcohol and other drug use. Survey findings relate mainly to people aged 14 years or older.⁵⁶

The fieldwork for the most recent NDSHS was conducted from June to November 2016 and results were published in August 2017. Prior to this, the last NDSHS was conducted in 2013 with results published in 2014.⁵⁷

As discussed further in chapter four, the Committee notes that caution is required when presenting and reviewing self-reported data on drug use. Time lags exist between when survey responses and other data are gathered and collated and then when published. Sometimes this time lag can be as much as two or three years. Consequently, any presentation of data should only be viewed as a snapshot of when the survey was conducted. Another limitation of the NDSHS is that because the sample is based on households, people who are homeless are not included in the sample. This is of concern given the high rates of alcohol and illicit substance use among this group. Further, the Committee was advised by various stakeholders that due to the criminalisation of illicit drug use, people might be reluctant to acknowledge that they consume such drugs. Moira Hewitt, Head of the Tobacco, Alcohol and Other Drugs Unit at the AIHW advised the Committee that ‘because [the survey] is reporting often illegal behaviour, it is likely to be underreported. As certain behaviours become less socially acceptable, underreporting may happen over time as well’.⁵⁸ Despite these concerns, the Committee understands that the synthesis of data from the NDSHS offers valuable insights into illicit drug use in Australia and Victoria.

2.3.1 National Drug Strategy Household Survey 2016

Overall, key findings for both licit and illicit drug use demonstrated that across Australia:

- fewer Australians than ever are taking up smoking, however, the decline in the daily smoking rate slowed in 2016
- fewer people exceeded the lifetime risk guidelines for alcohol use
- illicit drug use remained stable but use of some drugs declined

⁵⁵ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 31.

⁵⁶ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017.

⁵⁷ Material in this section, particularly with regard to Victoria, is reproduced in part from a synthesis of NDSHS data supplied to the Committee by Ms Moira Hewitt Head Tobacco Alcohol and Other Drugs Unit, Australian Institute of Health and Welfare.

⁵⁸ Moira Hewitt, Head, Tobacco, Alcohol and Other Drugs Unit, Australian Institute of Health and Welfare, *Transcript of evidence*, 13 November 2017, p. 432.

- Australians perceived methamphetamines to be the drug of most concern to the community and was the drug most likely to be associated with a ‘drug problem’.⁵⁹

Illicit drug use

The NDSHS defines illicit use of drugs as including use of illegal drugs, non-medical use of pharmaceutical drugs and inappropriate use of other substances (such as inhalants). ‘Lifetime use’ is defined as using at least once in a person’s lifetime whereas ‘recent use’ refers to using at least once in the previous 12 months.

Nationally, the key findings were:

- In 2016, about 8.5 million (or 43 per cent) of people in Australia aged 14 or older had used an illicit drug in their lifetime (including misuse of pharmaceuticals). Around 3.1 million (or 15.6 per cent) had illicitly used in the last 12 months and 2.5 million (12.6 per cent) had used an illegal drug not including pharmaceuticals.⁶⁰
- Although the proportion using any illicit drug did not significantly increase from 2013 to 2016, there has been a gradual increase in use since 2007 (from 13.4 per cent to 15.6 per cent) and the number of people using illicit drugs increased from about 2.3 million to 3.1 million.⁶¹
- Significant declines were observed in the recent use of meth/amphetamines (from 2.1 per cent to 1.4 per cent), hallucinogens (1.3 per cent to 1 per cent), and synthetic cannabinoids (1.2 per cent to 0.3 per cent) from 2013 to 2016. Use of other drugs surveyed remained relatively stable between 2013 and 2016. Recent cocaine use increased since 2004. Although the increase between 2013 and 2016 was not significant (from 2.1 per cent to 2.5 per cent), it was significantly higher than the proportion reported in 2004 (1 per cent). Cocaine is now the second most commonly used illegal drug in the last 12 months after cannabis.⁶²

Key national overview data regarding use of illicit drugs is presented in figure 2.1.

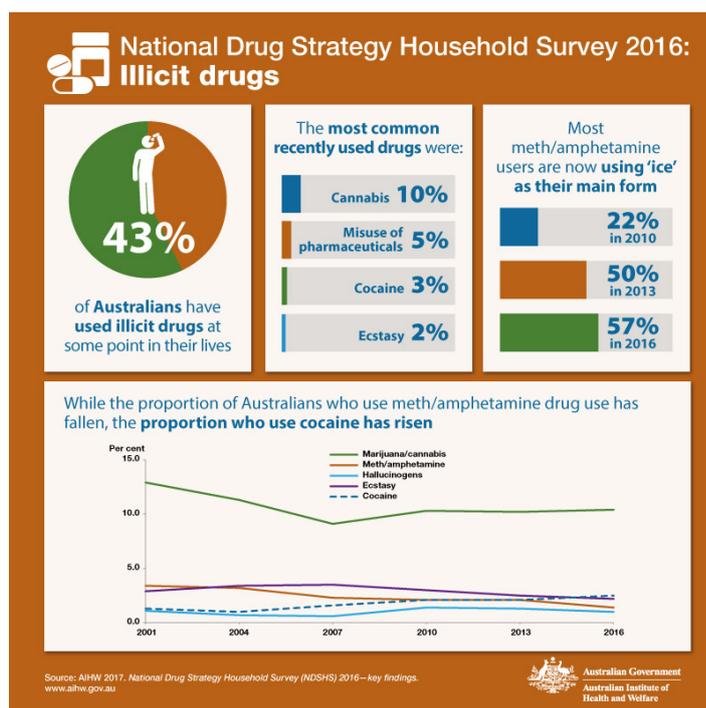
⁵⁹ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 9.

⁶⁰ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 56.

⁶¹ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 9.

⁶² Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, pp. 9,56.

Figure 2.1 National overview of NDSHS 2016 data



Source: Australian Institute of Health and Welfare, 'National Drug Strategy Household Survey 2016: Illicit drugs', viewed 13 March 2018, <<https://www.aihw.gov.au/getmedia/8da7136b-b57b-4be1-b080-a42dd02394d1/National-Drug-Strategy-Household-Survey-2016-Illicit-Drugs-30May17.jpg.aspx>>.

Victorian data

Similar to the national trends, 15 per cent of Victorians aged 14 or older had used an illicit drug in the previous 12 months, and was slightly below the Australian average of 15.6 per cent (see Table 2.1). While the proportion using any illicit drug did not significantly increase from 2013 to 2016, there was a gradual increase in use since 2007, with the number of Victorians illicitly using drugs increasing from about 540,000 in 2007 to 750,000 in 2016.

Table 2.1 Recent illicit use of any drug, people aged 14 years and older, by state/territory, 2001 to 2016 (per cent)

State/territory	2001	2004	2007	2010	2013	2016
NSW	15.6	14.6	12.1	13.8	14.2	14.7
VIC	15.9	14.3	12.8	13.7	14.3	15.0
Qld	16.3	15.9	13.7	15.1	15.5	16.8
WA	21.7	17.3	16.2	18.6	17.0	16.8
SA	17.6	15.4	14.7	14.9	15.7	15.7
Tas	14.4	15.4	14.8	12.0	15.1	17.4
ACT	17.8	17.6	13.8	13.9	15.3	12.9
NT	28.7	26.0	20.4	21.3	22.0	21.6
Australia	16.7	15.3	13.4	14.7	15.0	15.6

Source: Australian Institute of Health and Welfare, 'National Drug Strategy Household Survey 2016: detailed findings: Data tables: Chapter 5 Illicit use of drugs', viewed 3 January 2018, <<https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data>>.

The most commonly used drugs in the previous 12 months among Victorians aged 14 or older were:

- cannabis (9.9 per cent)
- misuse of pain-killers/opioids (3.4 per cent)
- cocaine (2.5 per cent)
- ecstasy (2.4 per cent)
- tranquilisers/sleeping pills (1.7 per cent)
- meth/amphetamines (1.5 per cent).⁶³

The survey also noted that some drugs are used more frequently than others. Very few people who used cocaine and ecstasy in Victoria did so as often as weekly (less than 2 per cent in 2016), however, 15 per cent of people who used meth/amphetamine used it weekly or more often, thereby making it more commonly used than ecstasy and cocaine. In Victoria, only the use of synthetic cannabis significantly declined between 2013 and 2016, from 1 per cent to 0.4 per cent.⁶⁴ Other notable findings included:

- Victorians in their 20s continued to be the most likely age group to use illicit drugs with three in ten doing so in 2016 (refer Table 2.2).
- Recent illicit drug use among Australians in their 40s significantly increased between 2013 and 2016 (from 13.6 per cent to 16.2 per cent) and there was a similar increase among Victorians in their 40s (from 11.8 per cent to 15.1 per cent). (refer Table 2.2).
- Recent cannabis use significantly increased among Victorians in their 40s (from 7.2 per cent in 2013 to 10.3 per cent in 2016) and among those aged 60 or older (from 0.7 per cent to 1.7 per cent). In addition, Victorians in their 20s were about twice as likely to use cannabis as people in their 40s (22 per cent compared with 10.3 per cent).
- Overall, use of methamphetamines declined among people in Australia and in Victoria. The decrease among Victorians was not significant between 2013 and 2016, although it was lower than the rate in 2010 (from 2.3 per cent in 2010 to 1.5 per cent in 2016).
- There was a switch in the form of meth/amphetamine mainly used between 2010 and 2016 with the use of speed/powder declining from 72 per cent to 36 per cent among recent methamphetamine users, while the use of crystal methamphetamine increased from 10.1 per cent in 2010 to 42 per cent in 2016.⁶⁵

⁶³ Moira Hewitt, Head, Tobacco, Alcohol and Other Drugs Unit, Australian Institute of Health and Welfare, Presentation to Committee: 'Summary of results from the National Drug Strategy Household Survey', 13 November 2017.

⁶⁴ Moira Hewitt, Head, Tobacco, Alcohol and Other Drugs Unit, Australian Institute of Health and Welfare, Presentation to Committee: 'Summary of results from the National Drug Strategy Household Survey', 13 November 2017.

⁶⁵ Moira Hewitt, Head, Tobacco, Alcohol and Other Drugs Unit, Australian Institute of Health and Welfare, Presentation to Committee: 'Summary of results from the National Drug Strategy Household Survey', 13 November 2017.

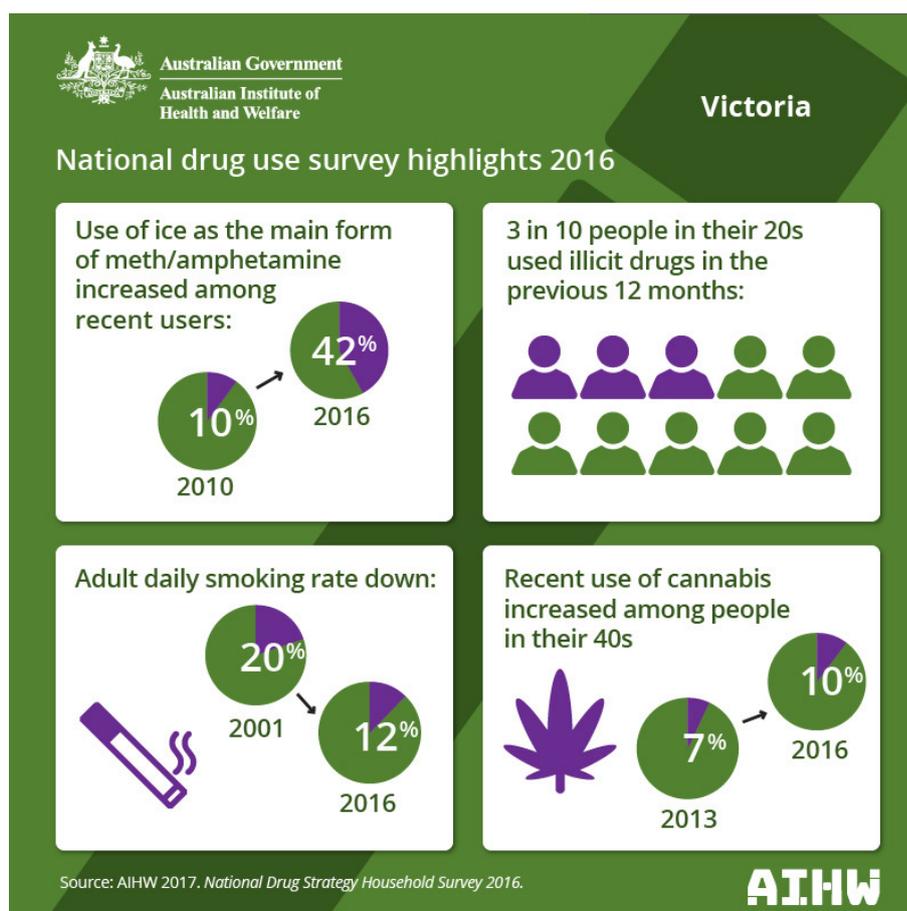
Table 2.2 Recent illicit use of any drug, people aged 14 years or older, by age and state/territory, 2010 to 2016 (per cent)

Age group (years)	Victoria			Australia		
	2010	2013	2016	2010	2013	2016
14-19	17.8	16.0	14.0	18.2	17.6	15.9
20-29	26.0	27.4	29.8	27.5	27.3	28.2
30-39	17.9	16.5	16.2	18.8	17.6	18.1
40-49	11.4	11.8	15.1	12.8	13.6	16.2#
50-59	8.1	10.3	10.0	8.8	11.1	11.7
60+	4.2	6.3	6.5	5.2	6.4	6.9
14+	13.7	14.3	15.0	14.7	15.0	15.6
18+	13.7	14.5	15.3	14.7	15.1	15.9

Source: Australian Institute of Health and Welfare, 'National Drug Strategy Household Survey 2016: detailed findings: Data tables: Chapter 5 Illicit use of drugs', viewed 3 January 2018, <<https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data>>.

Key data regarding Victorian’s use of substances is highlighted in the below figure.

Figure 2.2 Victorian overview of NDSHS 2016 data



Source: Australian Institute of Health and Welfare, 'National drug use survey highlights 2016: Victoria', viewed 13 March 2018, <<https://www.aihw.gov.au/getmedia/5f957132-876e-4244-b0f3-d4239f85d885/AIHW-State-Territory-Twittergraphics-VIC.jpg.aspx>>.

The Committee notes that despite the assertion that illicit drug use has become ‘normalised’ among young people in western countries including Australia,⁶⁶ of particular interest is the survey finding that illicit drug use among Australians in their 40s significantly increased between 2013 and 2016. This reflects a possible ageing cohort of illicit drug users which has implications for policy development and service delivery. As John Rogerson, CEO of the Alcohol and Drug Foundation (ADF) told the Committee:

Drug use in our community is moving away from young people into being a significant issue for those people over 30. We keep making drug use in our community a young person’s problem. It is actually now becoming a problem for older people, and a very significant problem...the latest results from the national household drug survey...identifies that we have got to be much more nuanced now around who we are targeting with these programs.⁶⁷

2.3.2 Other drug sets

Aside from the NDSHS, numerous other data collections contribute to the overall picture of drug use and demand at both state and national levels. One in particular is the National Wastewater Drug Monitoring Program (NWDMP) conducted by the Australian Criminal Intelligence Commission (ACIC), in conjunction with the University of Queensland and University of South Australia. According to the ACIC, wastewater analysis has become the standard for measuring population-scale use of a range of different compounds. It involves analysis of measured concentration of drug metabolites, which are excreted into the sewer system after consumption in wastewater samples. The analysis measures demand for illicit drugs in Australia through data about drug use and distribution across a large number of sites in capital cities and regional areas. According to Shane Neilson, Head of the High Risk and Emerging Drugs Determinations of the Drug Intelligence Hub at the ACIC, the wastewater analysis data substantially captures all those who consume in the population, compared to the NDSHS which captures people’s perception of what is happening.⁶⁸

The latest NWDMP Report, published in November 2017, includes data from 54 sites with monitoring of 14 substances. According to the ACIC, the report covers roughly 61 per cent of the population, around 14.2 million Australians. The 2017 report found that alcohol and nicotine remain the most commonly used substances, and methamphetamine the most consumed tested illicit drug across all regions, although nationally there was a slight reduction.⁶⁹ It is important to acknowledge, however, that the program does not test for cannabis. Shane Neilson advised the Committee of the rationale for this:

There are two reasons for that. The first is there is still a very high level of uncertainty around testing for cannabis, to a level where we just do not think for our dollar it is worth doing. The other thing too is I think it is now well established that cannabis has for decades now been the highest used illicit drug in Australia, and it really has

⁶⁶ Fitzgerald, R, et al., ‘Drug normalisation and Australian youth: group differences in the social accommodation of drug use’, *Journal of Youth Studies*, vol. 16, no. 7, 2013, pp. 901-915.

⁶⁷ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 203.

⁶⁸ Shane Neilson, Head of the High Risk and Emerging Drugs Determination, Drug Intelligence Hub, Australian Criminal Intelligence Commission, *Transcript of evidence*, 13 November 2017, p. 469.

⁶⁹ Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program - Report 3*, Australian Criminal Intelligence Commission / The University of Queensland / University of South Australia, Canberra, 2017, pp. 4-5.

not changed much. So we thought why would we pour money into confirming what we all know. What we did was, for the dollar, we thought it was a lot better to try to understand about the level of use of fentanyl and oxycodone....⁷⁰

The report also noted that oxycodone and fentanyl consumption (both licit and illicit) across all jurisdictions continues ‘at concerning levels,’ while the consumption levels of tested NPS was low. Regarding Victoria, the report noted that cocaine consumption increased from August 2016 to February 2017, but methamphetamine and MDMA consumption were generally below the national average. Victoria, along with the Australian Capital Territory, reported the highest heroin consumption nationally, although this was considerably less than methamphetamine.⁷¹

Shane Neilson also advised the Committee of emerging drug trends:

The drug markets that are causing the most concern to the ACIC right now are the methylamphetamine, cocaine and pharmaceutical opioid markets. But what is interesting about that is that the reasons are slightly different, particularly in pharmaceutical opioids. We remain concerned about the high and apparently resilient level of demand for methylamphetamine across Australia, the disproportionate harm that this drug, particularly in its high purity form, causes to families and communities, its hold on many regional and rural communities, the combination of bulk imports of finished product and precursors, and what we believe to be an increase in sophisticated manufacture of the drug from imported precursor chemicals or chemicals that have been diverted locally...

The opioids that we are particularly concerned about are obviously fentanyl and related substances. You mentioned carfentanil, which of course is a veterinary substance and there is really only a very small niche market legitimately for that substance, and oxycodone and fentanyl, which obviously have far greater legitimate uses. We see the threat more in terms of potential rather than current risk for oxycodone and fentanyl, and we are aware, having said that, that people are dying in Australia from overdoses of these drugs and others are suffering phenomenally from overdoses. So the current threat is real enough and we need to be concerned, but thankfully the level of threat in Australia has not yet reached the levels being experienced in some countries in Europe and North America.⁷²

Other data sets that provide useful information about emerging drugs trends are the Ecstasy and Related Drugs Reporting System (EDRS) and the Illicit Drug Reporting System (IDRS), both of which are conducted by the National Drug and Alcohol Research Centre (NDARC).⁷³ Both systems work with the National Illicit Drug Indicator Project (NIDIP), which contains data about drug-related harms, such as hospital data. Further, the Drugs and Emerging Technologies Project (DNet) provides information about internet drug markets and NPS.⁷⁴

70 Shane Neilson, Head of the High Risk and Emerging Drugs Determination, Drug Intelligence Hub, Australian Criminal Intelligence Commission, *Transcript of evidence*, 13 November 2017, p. 470.

71 Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program - Report 3*, Australian Criminal Intelligence Commission / The University of Queensland / University of South Australia, Canberra, 2017.

72 Shane Neilson, Head of the High Risk and Emerging Drugs Determination, Drug Intelligence Hub, Australian Criminal Intelligence Commission, *Transcript of evidence*, 13 November 2017, pp. 466-467.

73 National Drug and Alcohol Research Centre, *Australian Drug Trends 2017: Preliminary Findings from the Illicit Drugs Reporting System (IDRS)*, University of NSW, Sydney, 2017; National Drug and Alcohol Research Centre, *Australian Drug Trends 2017: Findings from the Ecstasy and Related Drugs Reporting System (EDRS)*, University of NSW, Sydney, 2017.

74 Burns, L, et al., ‘Monitoring drug markets in the Internet age and the evolution of drug monitoring systems in Australia’, *Drug Testing and Analysis*, vol. 6, no. 7-8, 2014, p. 1.

The IDRS and EDRS are 'intended to identify emerging trends of local and national concern' across illicit, ecstasy and related drug markets.⁷⁵ They each compile three data sources – interviews with the sentinel populations in capital cities across Australia (about 100 people from each city); surveys of key experts that come into contact with the sentinel populations; and secondary data indicators such as population data, law enforcement and health information. The National Drug and Alcohol Research Centre collects and reports on data annually. The data captures many significant issues related to drug trends over time, including preferred and types of drugs on the market, drug use patterns and perceptions of the drug market.⁷⁶

In 2017, 786 regular psychostimulant users were interviewed for the EDRS. Key findings on patterns of use included:

- Ecstasy was the drug of choice by over a third of the sample (36 per cent), followed by cannabis (28 per cent).
- Two-fifths (42 per cent) of the sample reported weekly or more frequent use of any psychostimulant in the past month, with 36 per cent reporting fortnightly use, and 18 per cent reporting monthly use.
- Most participants (99 per cent) reported recent ecstasy use, with use occurring fortnightly.
- Recent use of methamphetamine declined in 2017 from 38 per cent in 2016 to 31 per cent.
- Recent use of ketamine increased in 2017, from 26 per cent in 2016 to 37 per cent, with highest use in Victoria (80 per cent).
- About half (48 per cent) of the sample reported recent use of cocaine.
- Recent use of cannabis remained high (89 per cent) and stable.⁷⁷

For the 2017 IDRS, 888 people were interviewed, and produced the following findings:

- Cannabis was the drug most commonly used on a 'weekly or more' (54 per cent) and daily basis' (32 per cent), followed by heroin (43 per cent using 'weekly or more' and 17 per cent using 'daily').
- Heroin was the most commonly reported drug of choice for participants (46 per cent), and one third (32 per cent) reported methamphetamine (any form) as their drug of choice.
- Recent use of crystal decreased in 2017 from 73 per cent in 2016 to 68 per cent.
- Methamphetamine was the most commonly injected drug in the preceding six months, and injecting was the main route of administration for all forms of methamphetamine.⁷⁸

⁷⁵ Stafford, J, et al., *Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System (IDRS)*, NDARC Annual Research Symposium, National Drug and Alcohol Research Centre, University of NSW, Sydney, 2016, p. 2; Stafford, J, et al., *Australian Drug Trends 2016: Findings from the Ecstasy and Related Drugs Reporting System (EDRS)*, NDARC Annual Research Symposium, National Drug and Alcohol Research Centre, University of NSW, Sydney, 2016, p. 28.

⁷⁶ National Drug and Alcohol Research Centre, *The Ecstasy and related Drugs Reporting System (EDRS) 2017 preliminary findings*, University of NSW, Sydney, 2017.

⁷⁷ Uporova, J, et al., *Australian Trends in Ecstasy and Related Drug Markets 2017: Findings from the Ecstasy and Related Drugs Reporting System (EDRS)* National Drug and Alcohol Research Centre, Sydney, 2018, pp.x-xii.

⁷⁸ Karlsson, A and Burns, L, *Australian Drug Trends 2017: Findings from the Illicit Drug Reporting System (IDRS)* National Drug and Alcohol Research Centre, Sydney, 2018, pp. x-xi.

2.4 Selective focus on drugs and their attendant harms

While an inquiry into the issues and problems associated with the use of illicit drugs and misuse of pharmaceutical drugs is undoubtedly important, these issues also need to be examined in the context of harms resulting from the misuse of legally available products and substances. Yet for a range of reasons a comparison between the harms caused by licit and illicit drugs is often overlooked. Clearly, there is not the same level of community disapproval towards tobacco, and to a lesser extent alcohol, as there is towards illicit drugs, particularly those at the ‘harder’ edge of the spectrum. However, alcohol misuse causes more problems than all other drugs and is one of the leading contributors to violent crimes, including fatal assaults, homicides, road trauma and domestic violence. In 2004-05, the cost of alcohol, tobacco and other drug misuse in Australia was estimated at \$56.1 billion, including costs to the health and hospitals system, lost workplace productivity, road accidents and crime. Of this, tobacco accounted for \$31.5 billion (56.2 per cent) and alcohol accounted for \$15.3 billion (27.3 per cent). By comparison, illegal drugs accounted for \$8.2 billion (14.6 per cent).⁷⁹

Nonetheless, there are well-documented medical, social and economic harms arising from use of illicit drugs to individual users, affected families and friends, and the broader community. As noted by the Pennington Institute in its submission:

Drug use exists on a spectrum, with some drug use particularly problematic. Most people never experience significant, serious or lasting harm from drug use, but rather manage their use to ensure their educational, employment and social commitments are not unduly affected. Most people eventually ‘age out of’ drug use, although the pathways may not be linear.

Harmful or ‘problematic’ drug use does not have an objective or settled meaning, but would usually be defined by the presence of adverse consequences. It may include a wide range of any drug use leading to physical or psychological dependence, as well as to adverse consequences to personal or public safety, public order, relationships and/or personal commitments. The accumulation and interaction of multiple harms generates greater severity.⁸⁰

Some of the main harms arising from illicit drug use include:

- dependency and addiction
- overdose
- serious medical problems including blood borne virus transmission, particularly HIV/AIDS and hepatitis B and C
- disability and death
- acquisitive and violent crime
- involvement with law enforcement including arrest, imprisonment and/or a criminal record
- domestic violence
- family breakdown and family discord
- child welfare and neglect issues
- mental health problems

⁷⁹ Ministerial Council on Drug Strategy, *National Drug Strategy 2010-2015*, Commonwealth of Australia, Perth, 2011, p. 2.

⁸⁰ Pennington Institute, *Submission*, no. 209, 24 March 2017, p. 17.

- unemployment or loss of employment
- homelessness and poverty
- stigma and discrimination.

Harms may vary in frequency and intensity depending on the particular drug or its mode of administration. As Macintosh states in his paper *Drug Law Reform: Beyond Prohibition*:

Placing opiates in the same category as some other illicit drugs such as cannabis provides a distorted picture of the relative safety of licit and illicit drugs. Yet even cannabis can have adverse effects. Similarly, both alcohol and tobacco may be less dangerous than heroin, but they currently have a far greater impact on society.⁸¹

Harms associated with crime and violence for example are increasingly associated with crystal methamphetamine use. Clearly, blood borne virus transmission is associated with injecting drug use. Harms may differentially affect different drug using populations. For example, drug use may have particularly deleterious effects on ATSI individuals and communities and addressing or treating these problems requires close consideration of cultural factors.

Similarly, a drug may be more or less harmful depending on the context in which it is provided and used. As Dr Alex Wodak AM, President of the Australian Drug Law Reform Foundation (ADLRF) and Director of Australia21 told the Committee:

To an extent the amount of harm that a drug causes is also a product of the environment that they are in and if we choose the same drug and distribute it through a black market, it's much more damaging to an individual and the community than if the same drug is managed by a prescription-controlled - in other words, by doctors and nurses and pharmacists - damage is much, much less. So to an extent it's always an interaction between the intrinsic pharmacological properties of the drug and also the regulatory environment that it enters into.

...it is very clear that alcohol and tobacco are fearsomely dangerous to individuals and communities and amongst the illicit drugs heroin and cocaine are amongst the more dangerous. Cannabis is close to the bottom but there are drugs that are considered in this paper to be less damaging to individuals and communities, like ecstasy and LSD.⁸²

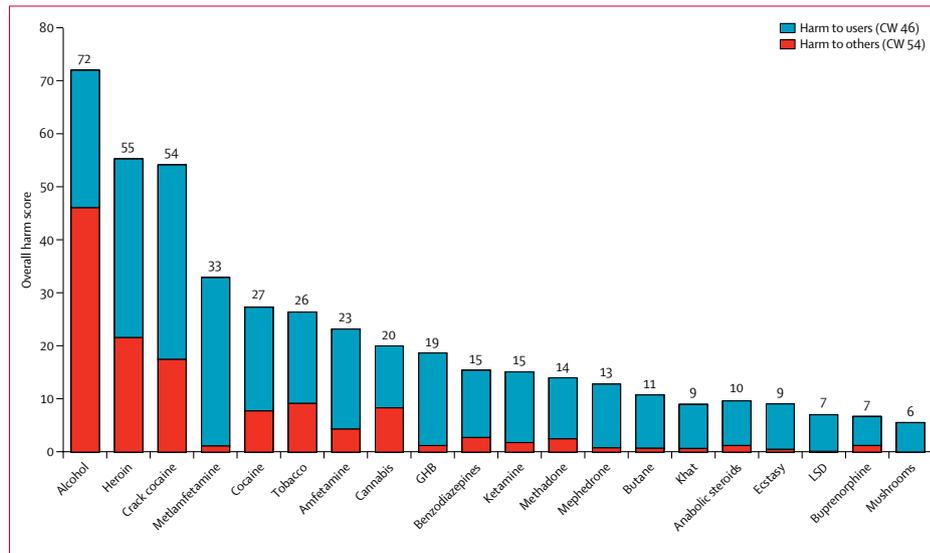
In his evidence, Dr Wodak AM also referred to an academic paper, *Drug harms in the UK: a multicriteria decision analysis* published in *The Lancet* that reviewed various licit and illicit substances to classify them according to harmfulness.⁸³ Well-known United Kingdom (UK) scientist, Professor David Nutt and other members of the Independent Scientific Committee on Drugs conducted the study, which assessed the harms of 20 substances according to 16 separate criteria relating to harms to the individual user and harms to the community. As shown in figure 2.3, alcohol was the most harmful drug (overall harm score of 72), followed by heroin (overall harm score of 55) and crack cocaine (overall harm score of 54). Interestingly, the study concluded that its findings correlated poorly with the UK drug classification system, which has limited relevance to the evidence of harm.

⁸¹ Macintosh, A, *Drug Law Reform: Beyond Prohibition: Discussion Paper Number 83*, The Australia Institute, Canberra, 2006, p. 93.

⁸² Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 98.

⁸³ Nutt, D, et al., 'Drug harms in the UK: a multicriteria decision analysis', *The Lancet*, vol. 376, no. 9752, 2010, viewed 1 November 2010, <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61462-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/abstract)>, p. 1561.

Figure 2.3 Drugs ordered by their overall harm scores



Source: Nutt, D, et al., 'Drug harms in the UK: a multicriteria decision analysis', *The Lancet*, vol. 376, no. 9752, 2010, viewed 1 November 2010, <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61462-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/abstract)>, p. 1561.

2.5 Poly-drug use

Contemporary research into drug use patterns indicates that many people who use drugs commonly use a variety of licit and illicit drugs. Poly-drug use may mean a person uses multiple types of drugs contemporaneously or alternatively the person may use different drugs as substitutes for a preferred drug when the original drug is unavailable. Early research in 2001 by Williams and Parker on amphetamine and 'club drug' use in recreational settings found a strong correlation between drinking, smoking and illicit recreational drug use. Despite its commonality, poly-drug use is rarely sufficiently factored into research studies and policy analysis, which typically focus on specific drug types:

Due to the traditional separation of tobacco, alcohol and illegal drug use in terms of markets, policy and research foci there is little enquiry about combination or consecutive substance taking episodes. So official household surveys and even the national drug treatment data base do not allow poly-drug repertoires to be adequately recorded. Yet when we do enquire about poly drug use, we find high rates and when we profile drug users in treatment its presence is endemic...Given the warnings from the literature on drugs transitions across the adolescent–adult life course and the inter-relationship between tobacco, alcohol and illicit drug use this is a worrying omission with public health implications.⁸⁴

More recent research, while acknowledging the importance of research into particular drugs and drug types, has reiterated the findings that many people use a suite of drugs, both recreationally or to support an addiction, depending on need and availability. A 2005 study of Sydney methamphetamine users found very high levels of poly-drug use among their respondents, with people having a median of ten drug classes consumed in their lifetime and seven drug classes within the past year prior

⁸⁴ Williams, L and Parker, H, 'Alcohol, cannabis, ecstasy and cocaine: drugs of reasoned choice amongst young adult recreational drug users in England', *International Journal of Drug Policy*, vol. 12, no. 5, 2001, p. 399.

to the survey. Cannabis was the other primary drug of choice, with 76 per cent of methamphetamine users having smoked cannabis in the past month and 42 per cent smoking it daily. Alcohol and tobacco use were also very common among this group.⁸⁵

Other studies have also demonstrated that people who use stimulant drugs tend to be extensive poly-drug users, including of substances that produce sedative effects, such as opioids and benzodiazepines, which are often used to self-medicate against adverse effects of amphetamines.⁸⁶

2.5.1 Prevalence of poly-drug use

Several major national datasets and research projects have sought to quantify the prevalence of poly-drug use among people who use drugs. These include the *Australian Secondary Students Alcohol and Drug Survey* (ASSAD), the EDRS, the IDRS, the *Drug Use Monitoring Australia Survey* (DUMA) and NDSHS.

In the NDSHS report, poly-drug use is defined as the use of more than one illicit or licit drug in the previous 12 month period. The 2016 survey found that recent users of illicit drugs were overwhelmingly poly-drug users, with at least two illicit drug types being used. In 2016, just under 4 in 10 (39 per cent) of Australians either smoked daily, drank alcohol in ways that placed them at risk of harm or used an illicit drug in the previous 12 months, with 2.8 per cent engaging in all three of these behaviours.⁸⁷

Among recent illicit drug users, cannabis was the drug most often used in addition to other illicit drugs, with use particularly high among users of hallucinogens (88 per cent), ecstasy (79 per cent), synthetic cannabinoids (78 per cent) and meth/amphetamines (74 per cent). However, cannabis users and people who misused pharmaceutical drugs were most likely to only use those substances, while users of other psychoactive substances used at least one other illicit drug.⁸⁸

Apart from quantitative data, reports from stakeholders in the field including clinicians, treatment providers, mental health workers, social workers, police and criminal justice personnel and alcohol and other drug services staff have repeatedly indicated that multiple or poly-drug use among their clients is the norm.

2.5.2 Reasons for poly-drug use

Poly-drug use can be influenced by a number of contextual factors such as access to certain drugs and environments that promote the use of multiple drugs. Poly-drug use habits can also be influenced by the type of user (recreational or dependent), the experience they are seeking, individual preferences, knowledge of different substances and their effects, and which substances are available to the user at any given time.⁸⁹

⁸⁵ McKetin, R, et al., *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences: Monograph Series No. 13*, National Drug Law Enforcement Research Fund (NDLERF), Canberra, 2005, p. 86.

⁸⁶ Herbeck, D, et al., 'Poly-drug and marijuana use among adults who primarily used methamphetamine', *J Psychoactive Drugs*, vol. 45, no. 2, 2013, pp. 136-137.

⁸⁷ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 9.

⁸⁸ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 10.

⁸⁹ Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria - Volume 1*, Parliament of Victoria, East Melbourne, 2014, p. 226.

As discussed in the final report for the *Inquiry into the Supply and Use of Methamphetamine in Victoria*, people who use illicit drugs recreationally may prefer to use more than one substance in order to balance the effects of stimulants and depressants and minimise negative reactions. For example, it is possible that people who use stimulant drugs may choose to consume alcohol and cannabis, which are both depressants, to counter the strong stimulant effect of the original drug. Opioid and benzodiazepine or other tranquilliser prescription drug use might be a common strategy to assist during the methamphetamine ‘comedown’ phase, particularly to mitigate depression and enhance sleep.⁹⁰ Some research has indicated that young people in particular who use recreational stimulant or party drugs can find the combination of alcohol and stimulants useful in allowing them to drink more without feeling sleepy. Some experts have described this as creating ‘wide awake drunks’ — ‘people who have all the disinhibition of alcohol but who are not sleeping it off’, thus increasing the potential for violent and disorderly conduct.⁹¹

On the other hand, some people with substance use disorders may choose to use more than one drug with similar properties to experience a greater effect as they attempt to counterbalance an increasing tolerance to their drug of choice. For other users, poly-drug use may simply be a product of what is on offer.⁹² In other words, as noted earlier drug choice is influenced by variations in drug availability, price and purity. For example, during the ‘heroin drought’ the lack of access to heroin resulted in users seeking alternative drugs, particularly methamphetamines.

2.5.3 Poly-drug use and coronial data

A submission to the inquiry from the Victorian State Coroner, Judge Sara Hinchey, reaffirmed the prevalence and serious consequences of poly-drug use in Victoria. Drawing from overdose deaths data between 2009 and 2016, it was clear that the combined toxic effects of multiple drugs rather than a single drug caused 70 per cent of Victorian overdose deaths. In particular, the use of pharmaceutical drugs, such as benzodiazepines, in combination with illicit drugs was more likely to result in an overdose death than a single drug alone. Alcohol, in combination with either pharmaceutical drugs or illicit drugs (or in some cases both), was also often a contributing factor to overdose deaths.

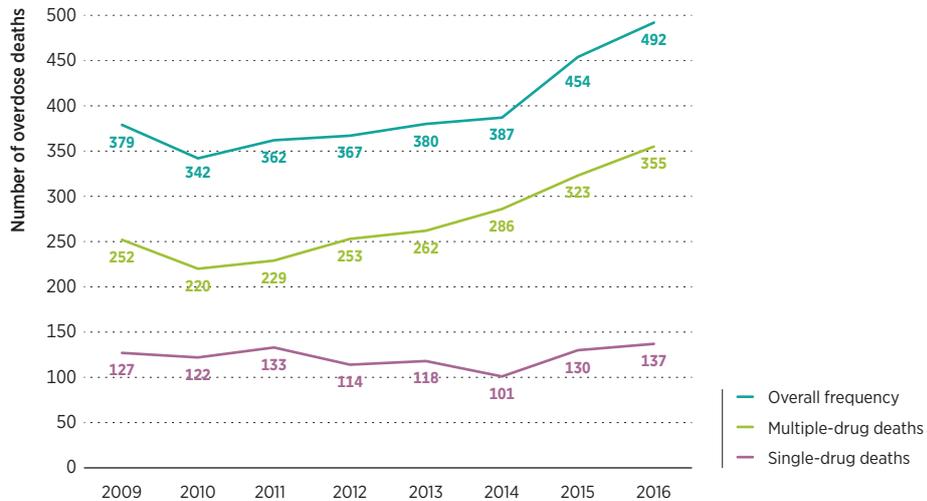
Of particular concern to Judge Sara Hinchey were the complicating factors of both poly-drug use and mental health co-morbidity and their contributions to overdose deaths. Figure 2.4 shows the overall annual frequency of overdose deaths in Victoria for the period 2009-2016, and the frequency and proportion of overdose deaths which were due to the toxic effects of a single drug versus multiple drugs.

⁹⁰ Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria - Volume 1*, Parliament of Victoria, East Melbourne, 2014, p. xi.

⁹¹ Dr Matthew Frei, Head of Clinical Services, Turning Point *Transcript of evidence*, Inquiry into the Supply and Use of Methamphetamine Use in Victoria, Law Reform, Drugs and Crime Prevention Committee, Parliament of Victoria, 30 September 2013, p. 277.

⁹² Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria - Volume 1*, Parliament of Victoria, East Melbourne, 2014, p. 226.

Figure 2.4 Annual frequency and proportion of single-drug and multiple-drug overdose deaths, Victoria 2009-2016

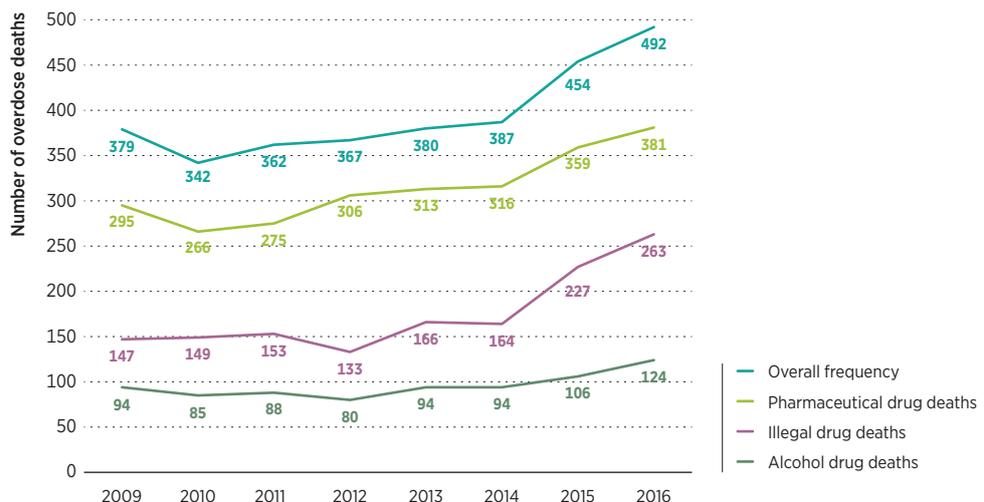


Source: Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, p. 2.

The annual frequency of Victorian overdose deaths declined between 2009 and 2010, but then climbed steadily over the following years to reach 492 deaths in 2016. The proportion of Victorian overdose deaths involving multiple drugs increased slightly across this period, from 66.5 per cent of deaths (252 of 379) in 2009 to 72.3 per cent of deaths (355 of 492) in 2016.

Further, when assessing Victorian drug overdose deaths, the Coroners Court classifies them according to pharmaceutical drugs, illegal drugs, and alcohol. Figure 2.5 shows the annual frequency of Victorian overdose deaths involving each of these three drug types.

Figure 2.5 Annual frequency and proportion of overdose deaths by contributing drug types, Victoria 2009-2016



Source: Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, p. 2.

Finally, to explore further how the interaction of pharmaceutical drugs, illegal drugs and alcohol contributed to overdose deaths, the Coroners Court classified each death according to the combination of drug types that contributed to the fatal overdose.

Table 2.3 shows the annual frequency and proportion of Victorian overdose deaths for each of these combinations.

Table 2.3 Annual frequency and proportion of overdose deaths by combinations of contributing drug types, Victoria 2009-2016

Combination of drug types	2009	2010	2011	2012	2013	2014	2015	2016
Overall frequency	379	342	362	367	380	387	454	492
Pharma only	163	140	146	169	146	160	153	153
Pharma + illegal	72	68	67	78	86	91	126	144
Illegal only	50	49	61	40	54	42	69	71
Pharma + alc	45	32	44	46	56	45	52	47
Pharma + ill + alc	15	26	18	13	25	20	28	37
Alcohol only	24	21	19	19	12	18	22	29
Illegal + alcohol	10	6	7	2	1	11	4	11
Overall proportion	100.0							
Pharma only	43.0	40.9	40.3	46.1	38.4	41.3	33.7	31.1
Pharma + illegal	19.0	19.9	18.5	21.3	22.6	23.5	27.8	29.3
Illegal only	13.2	14.3	16.9	10.9	14.2	10.9	15.2	14.4
Pharma + alc	11.9	9.4	12.2	12.5	14.7	11.6	11.5	9.6
Pharma + ill + alc	4.0	7.6	5.0	3.5	6.6	5.2	6.2	7.5
Alcohol only	6.3	6.1	5.2	5.2	3.2	4.7	4.8	5.9
Illegal + alcohol	2.6	1.8	1.9	0.5	0.3	2.8	0.9	2.2

Source: Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, p. 3-4.

Pharmaceutical drug only overdose deaths were consistently the most frequent type of Victorian overdose death between 2009 and 2016. However, as reported by the Coroners Court, it is concerning that in 2015 and 2016, ‘there was a decline in the frequency and proportion of pharmaceutical drug only overdose deaths, and a shift towards overdose deaths involving pharmaceutical drugs in combination with illegal drugs’.⁹³

In his evidence to the Committee, Demos Krouskos, CEO of North Richmond Community Health (NRCH) raised another concern regarding the issue of poly-drug use and overdose deaths. He told the Committee that the increase of poly-drug use, particularly the combination of pharmaceutical drugs with heroin, was not only worrying in itself but the combination of drugs renders the drug naloxone⁹⁴ less effective in reversing the effects of heroin overdose.⁹⁵

⁹³ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 32.

⁹⁴ Naloxone, known by the trade name Narcan, is a medication used to block the effects of opioids, especially in overdose. See Chapter 17 for further discussion.

⁹⁵ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 154.

2.5.4 Other consequences of poly-drug use

As identified above, the consequences of poly-drug use for both individuals and the community can be serious. In regard to physical and mental health, the use of a 'cocktail' of drugs exponentially increases the risk to the user. In particular, the combination of one or more illicit drugs with alcohol is especially dangerous.⁹⁶ The combination of methamphetamine and alcohol can be particularly harmful given the capacity of stimulants to mask the effects of alcohol, which may be especially dangerous when driving a motor vehicle.⁹⁷ Similarly, the use of prescription drugs, particularly tranquillisers or opioids, could have serious impacts on a person's health when used in association with stimulants. Problems could also eventuate when doctors prescribe these drugs without being aware of other substances that patients may have been taking concurrently.

Irrespective of why poly-drug use occurs, it has a number of important consequences for practitioners and policy makers. From a medical perspective, poly-drug use brings with it a number of potentially serious health consequences which can have both long and short-term effects on individuals. From a law enforcement perspective, managing intoxicated offenders both on the street and in custody can be complicated if the mix of substances used by a particular individual is unknown. Finally, identifying appropriate diversion and referral-to-treatment options, not to mention the likely success of such treatment, can be complicated if and when more than one licit or illicit drug is being used.

96 Degenhardt, L and Hall, W, 'Extent of illicit drug use and dependence, and their contribution to the global burden of disease', *The Lancet*, vol. 379, no. 9810, 2012.

97 Topp, L, 'Amphetamine-type stimulant use and risk-taking behaviours', in *Perspectives on amphetamine-type stimulants*, S Allsop and N Lee (eds), IP Communications, East Hawthorn, 2012, p. 82.

3 Overview of international and domestic drug control frameworks

An understanding of current approaches to drug policy requires at least a rudimentary awareness of the historical genesis of international drug control. In particular, an understanding of historical processes can explain why the use of some substances, despite their inherent or potential harmfulness escapes sanction and yet others are severely penalised. Further, different political, social, cultural and economic conditions contribute to differences in substance use, both between countries and within communities in a single country. Understanding national context is important as it affects not only the well-being of the community and drug use, but also the choice of policy solutions:

Drug policies differ among nations in both appearance and substance. Some nations treat drugs primarily as a problem for law enforcement and give great prominence to efforts to suppress trafficking; others focus their efforts primarily on prevention and education, on helping dependent drug users [treatment], and on reducing the adverse consequences of drug use [harm reduction]. The variety of drug policy approaches across nations reflects differences in attitudes towards drug use itself, toward individual rights and toward the role of government as well as the nature and history of drug problems, the broader political structure of the country and the different ways in which drugs affect a nation.⁹⁸

In addition to providing a brief history of international drug policy, this chapter examines the international framework for drug control and drug policy, including the three United Nations (UN) drug control conventions to which Australia and the overwhelming majority of the world's nations are signatories. It also considers whether the conventions are an impediment to positive drug law reform in today's world.

The second half of the chapter explores the domestic drug policy context and the influence of the international framework on drug policy in Australia. This includes an overview of the *National Drug Strategy* (NDS), in addition to other national and state drug policies and frameworks.

98 Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 221.

3.1 Early drug regulation

The first serious efforts to regulate drug control at an international level commenced in the late 19th century in response to the opium trade. Opium had largely been used in China as a medicine until the mid-nineteenth century when, in part as a result of the opium trade wars between China and Britain, it was increasingly being smoked for pleasure.⁹⁹ The United States (US), an emerging power on the international stage, began to take an active role against the opium trade and convened a conference to combat its trade and use in Shanghai in 1909. This led to the *Hague Convention of 1912*, ‘the foundation document of the present system of international controls’.¹⁰⁰

Subsequently, laws were introduced in many national and sub-national jurisdictions, including the Australian colonies, to prohibit opium smoking.¹⁰¹ The newly formed Australian Commonwealth was also quick to ban the importation of opium suitable for smoking. In addition to international pressure, the laws were also a result of the growing temperance movement and racist attitudes towards Chinese people in Australia, who were commonly viewed as degenerate opium smokers.¹⁰² The ban’s efficacy, however, in preventing use was questioned even at the time it was introduced:

It did not take long for the failures of the policy to become apparent. The Commonwealth Comptroller-General of Customs, HNP Wollaston, stated in his report to the Commonwealth Parliament in 1908: ‘it is very doubtful if such prohibition has lessened to an extent the amount [of opium] which is brought into Australia’. He added: ‘owing to total prohibition, the price of opium has risen enormously...the Commonwealth gladly gave up about £60,000 revenue with a view to a suppression of the evil, but the result has not been what has been hoped for. What now appears to be the effect of total prohibition is that, while we have lost the duty, the opium is still imported pretty freely.’¹⁰³

In 1925, a new international Opium Convention extended the range of drugs controlled by the Hague treaty to include cocaine and morphine and it established a Control Board, the forerunner of today’s International Narcotics Control Board (INCB). Nonetheless, in Australia at least, many of the most prominent current illicit drugs including cocaine, heroin and cannabis were legally available until the mid-twentieth century. Most often they were used for medicinal purposes, particularly to address drug dependence. The Commonwealth Government did not prohibit the production and importation of medicinal heroin until 1953, although this was to the disappointment of many doctors who were using it for clinical purposes.¹⁰⁴ According to Dr Alex Wodak AM, the President of the Australian Drug Law Reform Foundation (ADLRF) and Director of Australia21, when such laws were introduced the demand for recreational use of heroin was virtually non-existent. Many commentators argue that drug availability, use and associated harms were not prominent in Australia until the 1960s when recreational drug use became more

99 Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 203.

100 Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 204.

101 But not its use in patent medicines such as laudanum

102 Macintosh, A, *Drug Law Reform: Beyond Prohibition: Discussion Paper Number 83*, The Australia Institute, Canberra, 2006; Manderson, D, *From Mr Sin to Mr Big: A History of Australian Drug Laws*, Oxford University Press, Melbourne, 1993.

103 Manderson, D, *From Mr Sin to Mr Big: A History of Australian Drug Laws*, Oxford University Press, Melbourne, 1993., quoted in {Students for Sensible Drug Policy Australia, 2017 #622}

104 Wodak, A and Moore, T, *Modernising Australia’s Drug Policy*, University of New South Wales Press, Sydney, 2002.

common. This was partly due to social and generational change, as well as the use of such drugs by US servicemen on 'R and R' in Australia while serving in the Vietnam War.¹⁰⁵

Globally, until the 1960s drugs were generally 'a peripheral political issue'.¹⁰⁶ In 1971, however, President Richard Nixon declared a 'War on Drugs', which was argued to be a political response focused on declaring war on the supply from abroad (largely Mexico and South America), 'rather than analysing and addressing the causes of the burgeoning demand at home'.¹⁰⁷ Whether this is a fair comment, it is certainly true that after the end of the Cold War, huge amounts of military assets were reassigned to military counternarcotic operations.¹⁰⁸ Further, the international system of drug control was prompted and largely influenced by the US, as were the workings and operations of the INCB, 'a country determined to impose a hard line on the rest of the world'.¹⁰⁹

Nowadays, the 'War on Drugs' is rarely embraced as an effective way to address the 'drug problem', with a growing consensus among both conservative and reformist groups that the war on drugs 'is not a war we will ever finally win'.¹¹⁰

3.2 The contemporary international drug control network

After the Second World War, the UN moved towards establishing a new regime for international control. This included the establishment of three international conventions pertaining to drug control that are still in operation today. The three treaties, in conjunction with the operations of the INCB, govern international, national and sub-national drug policy and laws for countries who are signatories. These include:

- 1961 Single Convention on Narcotic Drugs
- 1971 Convention on Psychotropic Substances
- 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

The conventions individually and jointly represent the legal basis of drug prohibition, with the dual objective of penalising illicit use, diversion and trafficking of psychoactive substances. Simultaneously, the conventions provide an international governance system for the legitimate scientific and medical use of drugs and access to them.

The conventions classify controlled substances in four Schedules according to their therapeutic value and potential for risk or misuse. Schedule 1 contains the drugs with the greatest likelihood of misuse and dependence (heroin, cocaine, cannabis etc), and Schedule 4 contains the least 'dangerous drugs'. The conventions also comprise provisions for classifying and safeguarding precursor chemicals that may be used in

¹⁰⁵ McDonald, D, *A background paper for an Australia 21 Roundtable, Sydney 2012 Addressing the question 'What are the likely costs and benefits of a change in Australia's current policy on illicit drugs?'*, Australia21, Canberra, 2011, p. 2.

¹⁰⁶ Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 218.

¹⁰⁷ Armenta, A and Jelsma, M, *The UN Drug Control Conventions*, Transnational Institute, Amsterdam, 2015, p. 7.

¹⁰⁸ Armenta, A and Jelsma, M, *The UN Drug Control Conventions*, Transnational Institute, Amsterdam, 2015, p. 7.

¹⁰⁹ Armenta, A and Jelsma, M, *The UN Drug Control Conventions*, Transnational Institute, Amsterdam, 2015, p. 3.

¹¹⁰ Wodak, A, 'The failure of drug prohibition and the future of drug law reform in Australia', *Australian Prescriber*, vol. 38, no. 5, 2015, p. 148.

the manufacture of illicit drugs. Finally, the 1988 Convention significantly reinforces the obligations of member states to establish criminal offences to combat illicit drug manufacturing, production and trafficking. The extent to which these obligations cover drug possession is discussed below.

Three specialist international bodies govern the implementation and administration of the treaties, including:

- the Commission on Narcotic Drugs (CND), a political body with states elected as members. It formulates drug policy at the international level
- the United Nations Office on Drugs and Crime (UNODC), the body responsible for administering UN drug and crime programmes
- the INCB, the body responsible for monitoring and reporting on member states observation (or not) of the three treaties.¹¹¹

The conventions have been signed by the great majority of the world's nations, guaranteeing almost universal coverage.¹¹²

3.2.1 The 1961 *United Nations Single Convention on Narcotic Drugs*

The 1961 *UN Single Convention on Narcotic Drugs* was signed in New York in March 1961 and enacted in December 1964. It created a universal zero tolerance control system for the production, distribution, possession and arguably use of opium, coca and cannabis drugs and their derivatives or analogues, other than for medical and scientific purposes. Its key objective is to protect the 'health and welfare of mankind'. It unambiguously condemns 'drug addiction', stating that 'addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind'.¹¹³ It also aimed to eliminate opium over a 15-year period, and coca and cannabis within 25 years. In addition to creating the initial four schedules of controlled substances, the Convention created a process for adding new substances to the schedules without amending the treaty.

Notwithstanding its original lofty aims, many commentators noted that the 1961 Convention was drafted and negotiated in a very different political and social environment than today. Drug misuse was significantly less prevalent and illicit drug markets were typically confined geographically and less diverse. International organised crime was yet to become a global phenomenon and the prevalent use of cocaine, synthetic drugs and other stimulants were not yet significant concerns.¹¹⁴

Criminal provisions

Article 36 of the Convention requires member states to adopt measures against:

...cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention...

¹¹¹ Armenta, A and Jelsma, M, *The UN Drug Control Conventions*, Transnational Institute, Amsterdam, 2015, pp. 13-14.

¹¹² Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 205.

¹¹³ United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, *Single Convention on Narcotic Drugs, 1961: As amended by the 1972 Protocol amending the Single Convention on the Narcotic Drugs, 1961*, United Nations, Geneva, 1972, p. 1.

¹¹⁴ Room, R and Mackay, S, *Roadmaps to reforming the UN Drug Conventions*, Beckley Foundation, Oxford, 2012, p. 2, 30-31.

As well as:

[i]ntentional participation in, conspiracy to commit and attempts to commit, any of such offences, and preparatory acts and financial operations in connexion with the offences referred to in this article.¹¹⁵

The Article also provides for the extradition of drug offenders, although member states have a right to refuse to extradite a suspect if ‘competent authorities consider that the offense is not sufficiently serious’.¹¹⁶ Further, a 1971 amendment to the Article granted member states the discretion to substitute ‘treatment, education, after-care, rehabilitation and social reintegration’ for criminal penalties if the offender is a ‘drug abuser’.¹¹⁷ As the Beckley Foundation, a UK-based think tank and NGO, states, a loophole in the Convention is that it requires member states to implement anti-drug laws, but does not clearly mandate their enforcement, except in the case of drug cultivation. Consequently, drug enforcement varies widely between countries, with many European countries, including the United Kingdom, Switzerland, and the Netherlands, rarely prosecuting minor drug offences.¹¹⁸

The 1961 Convention’s penal provisions frequently begin with clauses such as ‘[s]ubject to its constitutional limitations, each Party shall . . .’ On this basis, if a country’s constitution or legal framework prohibits instituting the criminal penalties called for by the Convention, those provisions would arguably not be binding on that country.

As the 1961 Convention’s language is ambiguous, it is unclear whether it requires members states to criminalise drug possession for personal use. As the Beckley Foundation states, a ruling by the International Court of Justice would probably be required to settle the matter decisively.¹¹⁹ Many international drug scholars and various review commissions have examined the question and concluded that states are allowed to legalise possession for personal use. This is discussed further below in section 3.3.

3.2.2

The 1971 United Nations Convention on Psychotropic Substances

While the 1961 *UN Single Convention on Narcotic Drugs* was solely concerned with plant based drugs and their derivatives such as opium, coca and cannabis, the focus of the 1971 Convention turned to psychotropic drugs and medications such as amphetamines, other stimulants, benzodiazepines, barbiturates and psychedelics, such as lysergic acid diethylamide (LSD).¹²⁰ At the time of the 1961 Convention, many of these psychotropic drugs had either not been developed or were not

115 United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, *Single Convention on Narcotic Drugs, 1961: As amended by the 1972 Protocol amending the Single Convention on the Narcotic Drugs, 1961*, United Nations, Geneva, 1972, p. 18.

116 United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, *Single Convention on Narcotic Drugs, 1961: As amended by the 1972 Protocol amending the Single Convention on the Narcotic Drugs, 1961*, United Nations, Geneva, 1972, p. 19.

117 United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, *Single Convention on Narcotic Drugs, 1961: As amended by the 1972 Protocol amending the Single Convention on the Narcotic Drugs, 1961*, United Nations, Geneva, 1972, p. 18.

118 Australia21, *Alternatives to Prohibition: Illicit Drugs: How we can stop killing criminalising young Australians, Report of the second Australia 21 Roundtable on illicit drugs*, Canberra, 2012, p. 20; Blickman, T, ‘Cannabis policy reform in Europe: Bottom up rather than top down’, *Series on Legislative Reform of Drug Policies* no. 28, Transnational Institute, 2014, viewed 2 June 2017, <<https://www.tni.org/files/download/dlr28.pdf>>, pp. 10-12.

119 Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012.

120 United Nations Office on Drugs and Crime, *The International Drug Control Conventions*, New York, 2013.

causing widespread problems. Nonetheless by 1968, reports forwarded to the UN on the health problems associated with LSD and other hallucinogens led the UN's Economic and Social Council to pass a resolution calling for such substances to be placed under international control. As the 1961 Convention was not deemed readily adaptable to these newly emerging drugs, a new convention was drafted and agreed to at an international level. Similar to the 1961 Convention, the 1971 Convention aims to restrict the use of psychotropic substances to legitimate medical, scientific and therapeutic purposes.

The Convention was signed in Vienna, Austria in February 1971 and enacted in August 1976.

Scheduling psychotropic drugs

Similar to the 1961 Convention, the 1971 Convention comprises a graduated system for classifying psychotropic drugs into schedules based on different levels of restriction and access. These range from Schedule I (most restrictive) to Schedule IV (least restrictive). According to the UNODC, Schedule I is a completely different regime from the other three, as it mostly contains drugs produced by illicit laboratories, while the other three Schedules typically contain legally produced pharmaceuticals.¹²¹

The Schedules are:

- **Schedule I** includes drugs claimed to create a serious risk to public health, whose therapeutic value is not currently acknowledged by the CND. It includes synthetic psychedelics such as LSD in addition to natural psychedelics. Amphetamine type substances (ATS) such as cathinone, methylenedioxyamphetamine (MDA), and methylenedioxymethamphetamine (MDMA) also fall under this category.
- **Schedule II** includes certain ATS with therapeutic uses, such as amphetamine and methylphenidate (Ritalin) as well as some analgesics such as morphine.
- **Schedule III** includes barbiturate products with fast or average effects, flunitrazepam and some analgesics like buprenorphine. Dronabinol, a cannabis derivative, is also included.
- **Schedule IV** includes some weaker barbiturates like phenobarbital and other hypnotics, anxiolytic benzodiazepines (except flunitrazepam), and some weaker stimulants.¹²²

In scheduling a substance under the Convention, the World Health Organization (WHO), in conjunction with other international and national health bodies, must take into account the following matters:

- the extent or likelihood of abuse
- the degree of gravity in the public health and social problem
- the degree of utility of the substance in legitimate medical therapy
- whether international control measures as provided in the treaty would be appropriate and useful.¹²³

121 United Nations Office on Drugs and Crime, *The International Drug Control Conventions*, New York, 2013.

122 United Nations Office on Drugs and Crime, *The International Drug Control Conventions*, New York, 2013, p. 80.

123 Specifically, under Article 2, Paragraph 4 of the Treaty

Criminal provisions

Under the 1971 Convention, the system for criminalising the non-medical use of psychotropic substances functions similarly to the plant based drugs under the 1961 Convention. Specifically, Article 22 of the 1971 Convention states:

1 (a) Subject to its constitutional limitations, each Party shall treat as a punishable offence, when committed intentionally, any action contrary to a law or regulation adopted in pursuance of its obligations under this Convention, and shall ensure that serious offences shall be liable to adequate punishment, particularly by imprisonment or other penalty of deprivation of liberty.

(b) Notwithstanding the preceding sub-paragraph, when abusers of psychotropic substances have committed such offences, the Parties may provide, either as an alternative to conviction or punishment or in addition to punishment, that such abusers undergo measures of treatment, education, after-care, rehabilitation and social reintegration.¹²⁴

Therefore, while offences pertaining to supply, distribution, cultivation and preparation are strictly criminalised, the Convention provides members states with the flexibility to offer treatment, rehabilitation and therapeutic options to offenders.

3.2.3 The 1988 *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*

The genesis of the 1988 *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* was based on concerns at an international level that the previous conventions had limited effectiveness in curtailing the worldwide illicit trade in and illegal cultivation/production of drugs and substances. The 1988 Convention's central purpose is therefore to harmonise criminal legislation and law enforcement efforts worldwide to curb production, possession and trafficking of illicit drugs to 'eliminate the root causes of the problem of abuse of narcotic drugs and psychotropic substances, including the illicit demand for such drugs and substances and the enormous profits derived from illicit traffic'.¹²⁵ The Convention is largely concerned with fighting organised crime by mandating cooperation in international drug law enforcement, as well as with the INCB.

Criminal provisions

A controversial aspect of the Convention is whether it enables the criminalisation of drug possession for personal use. Certainly, there is a consensus among lawyers and scholars in this area that the previous two conventions do not require member states to criminalise mere use of an illicit substance. However, Article 3 of the 1988 Convention reads:

Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession,

¹²⁴ United Nations Office on Drugs and Crime, *The International Drug Control Conventions*, New York, 2013, pp. 99-100.

¹²⁵ UN Economic and Social Council (ECOSOC), *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, Vienna and New York, 19 December 1988, p. 1.

purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.

Drug policy academics Bewley-Taylor and Jelsma argue in their text, *The UN Drug Control Conventions: The Limits of Latitude*, that this provision does not mandate prohibition of drug possession for personal use, due to the caveat that such possession need only be prohibited if it is 'contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention'.¹²⁶ He argues that the 1961 Convention does not in fact apply to personal use possession but only that relating to trafficking and this has been the view of many national drugs commissions and domestic courts and legal tribunals. This is discussed further in section 3.3.

3.2.4 The Conventions as part of domestic law

The UN Conventions individually and together regulate the production, possession, sale and use of controlled psychoactive substances. They control both international trade of drugs and substances and domestic drug law. However, they are not self-executing, that is member states must pass laws to ratify and implement their provisions. In Australia, the Commonwealth *Narcotic Drugs Act 1967* incorporates the conventions' provisions. The *Customs Act 1956* also governs some of the provisions, particularly the 1988 treaty pertaining to international drug trafficking and importation. Australia, like all member states, must also ensure that the states and territories adhere to the conventions:

If a State, irrespective of its constitutional framework and legal system, enters into an international agreement by acceding to the international drug control treaties, that State must ensure that all state and/or provincial policies and measures do not undermine its efforts to combat drug abuse and trafficking in narcotic drugs, psychotropic substances and precursor chemicals.¹²⁷

Further, most national laws include analogous schemes pertaining to drug scheduling, which detail procedures for adding, removing and transferring drugs between the schedules subject to international directives under the conventions. Currently 124 narcotic drugs and 130 psychotropic substances are controlled under the three conventions.¹²⁸ In Australia, drug scheduling is the responsibility of the Commonwealth Department of Health and the Therapeutic Goods Administration.

3.3 Does the international drug control system impede drug law reform?

Many international legal scholars have examined the contradictions inherent in the conventions, in addition to whether reform for more liberal policies among member states is achievable, despite the conventions ostensibly supporting a prohibitionist framework. As Bewley-Taylor and Jelsma note there is:

¹²⁶ Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012, p. 6.

¹²⁷ International Narcotics Control Board, *Report of the International Narcotics Control Board for 2013*, United Nations, Vienna, 2014, p. 42.

¹²⁸ International Narcotics Control Board, 'Narcotic Drugs', viewed 19 March 2018, <<https://www.incb.org/incb/en/narcotic-drugs/index.html>>; International Narcotics Control Board, 'Psychotropic Substances', viewed 19 March 2018, <<https://www.incb.org/incb/en/psychotropics/index.html>>.

...a vast grey area lying between [the treaties] latitude and limitations, including the legal ambiguities that are subject to judicial interpretation and political contestation.¹²⁹

This is an extremely complex area of law and policy and a report of this type can only briefly deal with these complexities. The key issue is how much latitude the international framework provides national and sub-national policymakers in the area of drug law reform.

An area of ongoing debate is what the conventions require of member states in the context of personal use and possession of illicit substances. As noted earlier, according to various scholars, none of the UN conventions actually criminalise the use of illicit substances per se. Member states' provisions that cover use and possession and 'social supply' (sharing of substances) are typically understood to have some flexibility. While it is questionable as to whether the 1988 Convention criminalises drug possession for personal use, the Committee notes the INCB's recent support for Portugal's liberal drug policy framework that is based on decriminalisation. In particular, at the April 2016 UN General Assembly Special Session (UNGASS) on drugs, the former INCB President, Werner Sipp, identified the model as one of best practice and that is 'fully committed to the principles of the Drug Control Conventions'.¹³⁰

The Committee is aware that provisions for the legalisation of illicit drugs or downgrading offences for the commercial supply, such as trafficking, remain in breach of the treaties. This does not affect, however, the depenalisation of criminal provisions, nor the removal of custodial penalties as long as the specific conduct or activity outlawed by the treaties remains an offence.¹³¹ On the other hand, a 'legal' or regulated market for recreational or non-medical use of cannabis infringes the treaties framework.¹³² On this basis, Uruguay's state sanctioned regulatory framework for all types of cannabis consumption is arguably in breach of its obligations under the conventions, as are those US states that have implemented similar cannabis regulatory models.

In terms of the concept of 'medicalisation' under the conventions, this has generally been left to member states' discretion and thus arguably covers most scenarios where controlled substances are used in a medical or therapeutic context. The framers of the treaties realised that it was unwise to be over prescriptive in this area on the basis that the meaning of what was 'therapeutic' would differ between countries and cultures and would no doubt change over time. As Bewley-Taylor and Jelsma state, the lack of a clear definition of 'medical and scientific purposes' under the conventions provides 'considerable interpretive autonomy'.¹³³ Certainly, the use of harm reduction programs to reduce or combat the spread of HIV/AIDS would be legitimate under the medical/therapeutic provisions. Further, medicinal cannabis programs are arguably allowed on the basis of the conventions' coverage of legitimate use of drugs for pain relief.

129 Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012, p. 1.

130 Sipp, W, 'The Portuguese Approach and the International Drug Control Conventions', Paper presented at the UNGASS 2016, International Narcotics Control Board, New York, 2016.

131 Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012, p. 4.

132 Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012, p. 17.

133 Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012, p. 9.

At an international level, drug policy is also influenced by other bodies and instruments outside the conventions, and in some cases contradict the conventions. The scheduling of drugs at the international level, for example, often creates tension between conservative and reformist bodies such as the INCB and the WHO, who are often at loggerheads over the appropriate direction of drug policy. While the WHO Expert Committee on Drug Dependence (ECDD) is responsible for drug scheduling under the conventions, on several occasions the INCB has stymied the WHO's efforts to reform the scheduling system or place a particular drug in a less regulated category.¹³⁴

Drug reformers also question the rationale for certain illicit substances, particularly cannabis, to be so rigidly governed by the conventions, arguing that its inclusion in the most restrictive schedule was based on 'somewhat arbitrary decisions taken many decades ago'.¹³⁵ Further, there have been criticisms regarding the anomalous situation whereby some substances viewed if not with approval, at least not negatively at the time the treaties were enacted, are no longer seen as so benign. As Babor et al state:

The classification of substances within the international conventions reflects historical circumstances and cultural factors as [much as] scientific evidence. For these reasons international treaties and national laws may not always be consistent with expert opinion and the scientific evidence regarding the danger or harm associated with a particular substance. For example, many experts consider tobacco products to present greater risk than cannabis, yet the former substance is legal in most countries while the latter is not.¹³⁶

At its meeting with the WHO on its overseas study tour, the Committee was advised that the scheduling of cannabis is complicated. There are varying views on how to deal with this substance, although considerable progress was believed to be made at a recent congress of the World Health Assembly where member states agreed to focus on the health impacts rather than previous policy positions.¹³⁷

Tension also exists between the objects and impacts of the drug conventions and other aspects of international law, particularly international human rights and the UN conventions that govern and promote human rights. For example, many national legal frameworks impose disproportionately long custodial sentences for relatively minor drug offences, in some cases even the death penalty, which runs counter to the premise of the UN human rights framework. Consequently, the WHO has unambiguously called upon countries around the world to stop criminalising people who use drugs, proposing in a 2014 report that member states '[s]hould work toward developing policies and laws that decriminalise injection and other use of drugs, and thereby reduce incarceration'.¹³⁸

¹³⁴ Armenta, A and Jelsma, M, *The UN Drug Control Conventions*, Transnational Institute, Amsterdam, 2015, pp. 6, 10-16; Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012, pp. 1, 13; Transform Drug Policy Foundation, *After the War on Drugs: Blueprint for Regulation*, Bristol, 2009, p. 173.

¹³⁵ Australia21, *Alternatives to Prohibition: Illicit Drugs: How we can stop killing criminalising young Australians*, Report of the second Australia 21 Roundtable on illicit drugs, Canberra, 2012, p. 40.

¹³⁶ Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 15.

¹³⁷ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 5.

¹³⁸ World Health Organization, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*, Geneva, 2014, p. 87.

3.3.1 A note on United Nations General Assembly Special Sessions

The United Nations General Assembly Special Sessions is a meeting of member states to debate global issues, including poverty, health, gender, or as in 1998 and April 2016, the international drug control issues and priorities. The UNGASS meeting in 1998 resulted in a resolution to eliminate or significantly reduce the illicit cultivation of opium and coca in order to make the world ‘drug free’ within ten years.

Leading up to the April 2016 UNGASS meeting, there were hopes that the ‘fractured consensus’ between reformist and conservative member states would be in large part mended through the UNGASS deliberations. In particular, the reformist nations were aiming to achieve greater liberalisation towards the rescheduling of cannabis to a less restrictive schedule, and a greater acceptance of harm reduction programs at domestic and international levels. This was viewed as especially important given the advances made in the medicinal use of cannabis in the 18 years since the 1998 UNGASS.

The 2016 UNGASS convened round-tables on demand and supply reduction, human rights and alternative development, and new threats and challenges, however, there was minimal, if any, discussion on harm reduction. Significant progress was made in discussing ways to enhance the accessibility of therapeutic drugs to third world countries, how to assist developing nations to enhance their economies in lieu of cultivating illicit drugs, and the need for penalties and punishments for drug offences to be proportionate to the type of crime engaged in and the type of drug used.¹³⁹

It was largely the Latin American countries, those most affected by the War on Drugs, from the reformist group that pushed for the Special Session and whom were bitterly disappointed with the outcomes. For drug law reformers, UNGASS was a missed opportunity to promote a paradigm reformist shift in drug policy. Countries supporting the status quo included China and the ASEAN countries, and to some extent the US. The ASEAN bloc stymied any meaningful reform, particularly in regard to decriminalisation, depenalisation and abolition of the death penalty for drug crimes. However, UNGASS arguably at least brought these differences into the open and at best represented a ‘small evolution in thinking’,¹⁴⁰ which was even acknowledged by those who support the status quo. According to Klein, ‘the consensus holds, but only under protest’.¹⁴¹

In its meeting overseas, the International Drug Policy Consortium (IDPC) told the Committee that little progress was achieved at UNGASS, although there was a clear shift in the language used around human rights, indigenous rights, women and access to controlled substances. Currently, the IDPC is lobbying the INCB to acknowledge harm reduction as a key objective of drug policy.¹⁴²

In her evidence to the Committee, Australian drug policy expert, Professor Margaret Hamilton, indicated that she was not overly pessimistic about the UNGASS outcomes despite the strong prohibitionist rhetoric:

¹³⁹ United Nations General Assembly Special Session on Drugs, ‘Our joint commitment to effectively addressing and country the world drug problem’, *Thirtieth special session*, 2016, viewed 18 January 2018, <<https://undocs.org/A/S-30/L.1>>, pp. 2-24.

¹⁴⁰ Besant, D, ‘Region’s harsh drug policies slammed by experts’, *Southeast Asia Globe*, 5 May 2016, viewed 10 November 2016, <<http://sea-globe.com/regions-harsh-drug-policies-slammed>>.

¹⁴¹ Klein, A, ‘UNGASS 2016 - The consensus holds, but only under protest’, viewed 20 April 2017, <<http://idpc.net/alerts/2016/05/ungass-2016-the-consensus-holds-but-only-under-protest>>.

¹⁴² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 25.

I do not think it was a failure. Yes, there were some disappointments. If people went there expecting a revolution, they were very distressed. I have been around long enough not to expect revolutions and I think even those people, if they read through the outcome document now, they would say, 'Okay, it did actually talk about harm reduction. It did talk about it being unacceptable to have capital punishment for drug-related crimes. It did say it is important to make opiates available in the countries where they are not currently available and that people die in pain because they are too scared of what they hear about drug abuse'. So there are a lot of elements in that outcome document that I think are important.

Overall I think the general thrust was to, as I suggested, bring a higher profile for human rights, respecting human rights, respecting health and the importance of health driving these agendas as we become more and more knowing.¹⁴³

3.3.2 Future prospects for drug policy and law reform

It is clear that international drug policy and law reform is in a state of transition. While the conventions are to some degree theoretically inflexible, developments in drug policy in a number of countries suggest otherwise. In particular, a shift away from a rigidly prohibitionist approach has been observed in a number of countries, particularly in Europe and Latin America.¹⁴⁴ As Babor et al advised, the counter trend applied primarily to cannabis, but in parts of Europe it is extended to other illicit substances. Other European developments as part of this 'counter trend' have included the European parliament and most of its constituent members encouraging the decriminalisation of the possession of drugs for personal use.¹⁴⁵

It is also worth noting that Australia has had a 30 year history of drug law reform that has to some extent 'bucked' the international and American influenced prohibitionist model.¹⁴⁶ As a result of the HIV crisis in the mid-1980s, harm minimisation policies such as needle and syringe programs, de facto criminalisation of cannabis schemes and diversion programs including the 1999 Commonwealth Illicit Drug Diversion program largely received bipartisan support. Further, in the US at a sub-national (state) level, the possession of cannabis for personal use has been depenalised since the 1980s. The US has also experienced other shifts in drugs policy over the last ten years, some of which contradicts the basis of the UN conventions.

On its overseas study tour, the Committee was advised by various international stakeholders of examples of significant law reform in countries despite the UN conventions, with California and Colorado key examples of such reform. The Committee was advised by the WHO that there is no appetite to review the conventions and consequently, some member states are ignoring them, including Canada, Jamaica and as noted above Uruguay. Some member states are implementing health-focused interventions, despite having on the surface a strong prohibition focus towards illicit substances. One example is Iran, which now offers opioid substitution therapies as a treatment option.¹⁴⁷ This was also reaffirmed in the Committee's meeting with the Global Commission on Drug Policy (GCDP) and the IDPC who advised of various countries achieving progress in drug law reform, including:

¹⁴³ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 61.

¹⁴⁴ See Bewley-Taylor, D and Jelsma, M, *The UN Drug Control Conventions: The Limits of Latitude*, Transnational Institute/International Drug Policy Consortium, Amsterdam/London, 2012.

¹⁴⁵ Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010.

¹⁴⁶ Ritter, A, et al., *An Assessment of Illicit Drug Policy in Australia (1985 to 2010): Themes and Trends*, National Drug and Alcohol Research Centre UNSW, Sydney, 2011, p. 66ff.

¹⁴⁷ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 6.

- Thailand – key changes introduced at the beginning of 2017 resulted in reduction of penalties for possession, import/export and production for sale of illicit drugs. The amendments also replaced the previous *Narcotics Act*'s automatic assumption that anyone in possession of drugs was 'regarded' as intending them for sale, whereas now anyone in possession of drugs is now 'presumed' to have them for sale, with greater opportunity for officers to investigate the circumstances and real intent of the accused.
- Ireland – approval of the *Misuse of Drugs (Supervised Injecting Facilities) Bill 2017* by the Parliament of Ireland, and consideration of decriminalisation of small quantities of drugs by the Irish Government.
- Norway – two of the country's largest political parties agreed to support decriminalisation of personal use and possession of illicit drugs.¹⁴⁸

According to the GCDP, the strength of the UN conventions is based on the consensus of support from member states, although as discussed above 'this consensus is now fractured'. A positive reading of the conventions and views of most legal experts in this field is that most harm reduction provisions employed by member states are permissible both within the actual letter of the conventions and when read alongside other international treaties and conventions pertaining to health and human rights, in addition to the policies and practices of the WHO.

It is also worth noting that international control bodies, such as the INCB, have shown a relaxation in their strict opposition to harm reduction approaches. Up until recently, it was absolutely committed to a prohibitionist model of drug control. However, under new directorship, the INCB has somewhat softened its position on some aspects of harm reduction, for example medically supervised injecting rooms. In his speech to the 60th meeting of the CND, the former INCB President Werner Sipp indicated that the INCB's hard line position on drug consumption rooms had neutralised, although he advised that they must adhere to the following conditions to comply with the conventions:

The ultimate objective of such facilities,' said Mr Sipp, 'must be to reduce the adverse consequences of drug abuse *without* condoning or increasing drug abuse or encouraging drug trafficking.'¹⁴⁹

Based on the international evidence it received, the Committee does not believe that the UN conventions will be amended to any significant degree in the near future. In his evidence to the Committee, Dr Alex Wodak AM of the ADLRF indicated that member states wishing to take a more liberal path may simply acknowledge that they are breaching the conventions and continue to act unilaterally.¹⁵⁰ The Committee also notes that in the context of Canada's proposed cannabis legislation, the report commissioned by the Federal Government, *The framework for the legalization and regulation of cannabis in Canada*, while acknowledging the tension with the conventions, also highlights its shared objectives:

...Canada's proposal to legalize cannabis shares the objectives agreed to by member states in multilateral declarations, namely: to protect vulnerable citizens, particularly youth; to implement evidence-based policy; and to put public health, safety and welfare at the heart of a balanced approach to treaty implementation.¹⁵¹

¹⁴⁸ The Norwegian Parliament approved decriminalisation of all illicit substances in December 2017.

¹⁴⁹ International Drug Policy Consortium, 'The Board at the 60th CND', viewed 28 December 2017, <<http://idpc.net/incb-watch/updates/2017/03/the-board-at-the-60th-cnd>>.

¹⁵⁰ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 95.

¹⁵¹ Health Canada, *A Framework for the Legalization and Regulation of Cannabis in Canada: The Final Report of the Task Force on Cannabis Legalization and Regulation*, Government of Canada, Ottawa, 2016, p. 10.

In the meantime, more liberal UN bodies such as the WHO and UNAIDS continue to advocate an approach to international drug policy based on human rights and the dignity of people who use drugs.

3.4 The domestic context of drug policy

The key strategy guiding Australian drug policy is the National Drug Strategy (NDS), which operates in the context of Australia's acceptance of its international obligations in drug law and policy through the UN drug conventions.

Since 1985, the NDS has been the guiding framework on drug policy at both national and state levels, although the states and territories have considerable latitude to develop policies, laws and programs that accommodate local circumstances and preferences.¹⁵² It also acts as a key document to inform expenditure decisions in drug policy.

The overarching aim of the NDS is to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic consequences among individuals, families and communities.¹⁵³ One of its key focuses is to set priority areas addressing topical and contemporary drug issues of concern.

The NDS is reformulated every five years after a thorough process of research and consultation. The seventh and current iteration of the NDS was finalised in mid-2017 and is the first one to cover a ten year period (2017-2026). The concept of 'harm minimisation' with its emphasis on supply, demand and harm reduction remains the primary direction of the NDS with a continued emphasis on the partnership between health and law enforcement sectors. As discussed below, the partnership approach between health, law enforcement and other key stakeholders has generally been viewed as a major success of the NDS.

3.4.1 Background to the National Drug Strategy

In the 1970s and 1980s, there was growing community concern about the effects of apparently increasing drug use among young people, especially around Australia's hotspots, such as Kings Cross in Sydney and St Kilda in Melbourne. Academic, Ian Webster, wrote at the time:

...there is a feeling abroad that the drug problem is undermining our society: threatening the future of young people, escalating drug and organised crime and corrupting our social institutions of law and order and politics. How sensible that perception is, and whether and how we should respond are crucial questions which need to be answered.¹⁵⁴

In the lead up to the development of the policy, the Hawke Government held a Drug Summit on 2 April 1985, and just prior to that the Minister for Health, Dr Neal Blewett and the Australian Drug Foundation hosted a national action workshop. The

152 McDonald, D, *A background paper for an Australia 21 Roundtable, Sydney 2012 Addressing the question 'What are the likely costs and benefits of a change in Australia's current policy on illicit drugs?' , Australia21, Canberra, 2011, p. 9.*

153 Ministerial Council on Drug Strategy, *National Drug Strategy 2010-2015*, Commonwealth of Australia, Perth, 2011.

154 Webster, I, 'NCADA and NDS - Looking Forward While Looking Back', in *The National Drug Strategy: The First 10 Years and Beyond: Proceedings from the Eighth National Drug and Alcohol Research Centre Annual Symposium, November 1995*, P Dillon (ed.). Sydney, 1995, p. 1.

workshop recommended the development of a comprehensive national drug policy based on the objectives of improving health outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.¹⁵⁵

The Prime Minister Bob Hawke then announced the introduction of the National Campaign Against Drug Abuse (NCADA), which led to the development of Australia's first coordinated drug policy, the NDS. At the time, two important developments added weight to the policy: the Prime Minister announced publicly that his daughter was a heroin user; and the rapid spread of a new disease, HIV/AIDS, with injecting drug users identified as a key group affected through the sharing of injecting equipment.¹⁵⁶ Consequently, both NCADA and the NDS were created with bipartisan political support and involved a cooperative venture between Australian and state/territory governments, and the non-government sector.

The policy was one of the first in the world to specifically articulate an explicit harm minimisation approach, one that continues today. Harm minimisation acknowledges that there will always be some people in society who use alcohol and other drugs and, therefore, it incorporates policies that aim to prevent or reduce drug-related harms, rather than solely focusing on reducing drug use itself. Harm minimisation does not so much espouse a reduction in drug consumption per se, although that remains a desirable outcome.¹⁵⁷

At various times, there have been sub-strategies to the NDS, including the National Illicit Drug Strategy, National Alcohol Strategy and the National Tobacco Strategy. There have been illicit drug-specific strategies including the National Cannabis Strategy (2006–2009) and the National Amphetamine-Type Stimulants Strategy (2008–2011). There has also been a population specific strategy for Aboriginal and Torres Strait Islander people (2006–2009) and the National Pharmaceutical Drug Misuse Framework for Action (2012–2015). The most recent strategies are the updated National Tobacco Strategy (2012–2018), National Ice Action Strategy, National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019 and the National Alcohol and other Drug Workforce Development Strategy (2015–2018). It is also expected that a National Alcohol strategy will be completed in 2017–2018.

3.4.2 The National Drug Strategy: the three pillars of harm minimisation

Australia's drug policy achieves the minimisation of harm through three 'pillars': demand reduction, supply reduction and harm reduction (refer Figure 3.1). On this basis, harm minimisation is a broader term that encompasses all three pillars. It is not synonymous with harm reduction, although some commentators mistakenly use these terms interchangeably. The three pillars of demand, supply and harm reduction are outlined below.

¹⁵⁵ Standing Committee on Family and Community Affairs, *Inquiry into Substance Abuse in Australian Communities*, House of Representatives, Canberra, 2001.

¹⁵⁶ Aubusson, K, 'Hooked for 30 years: the changing faces of Australia's drug misuse', *Sydney Morning Herald*, 28 January 2018, viewed 18 March 2018.

¹⁵⁷ Dr Alex Wodak, *Submission*, no. 153, Undated, *Inquiry into Substance Abuse in Australian Communities*, Standing Committee on Family and Community Affairs, Parliament of Australia, p. 6.

Figure 3.1 Main components of Australia’s National Drug Strategy



Source: Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 7.

Demand reduction

Demand reduction strategies focus on preventing the uptake of drug use, delaying the first use of drugs, and reducing the misuse of alcohol, and the use of tobacco and other drugs across society. Demand reduction acknowledges that people use drugs for a range of reasons and are influenced by social norms, the need to experiment, as well as to cope with past and present stressors. A key component of demand reduction is the availability of accessible, evidence-based and tailored treatment options to people with substance use issues, such as withdrawal services, counselling, residential rehabilitation and opioid substitution therapies.

Supply reduction

Supply reduction strategies entail enforcing the prohibition of illegal drugs and regulating and enforcing access to legal drugs, including alcohol, tobacco, pharmaceuticals and other drugs. Supply reduction activities, including both border

and domestic policing, extend to controlling the availability of precursor chemicals and equipment used for manufacturing drugs. It also extends to compliance with Australia's obligations under international drug control treaties.

Harm reduction

Harm reduction is in some respects the most contentious of the current three pillars of the NDS. Marlatt describes in his text, *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviours*, it as 'more of an attitude than a fixed set of rules or regulations'.¹⁵⁸ The response, then, is one that is respectful of the drug user, takes into account a person's freedom of choice, even for activities that others may find disagreeable, and recognises that it may be impossible to eliminate drugs from the community. Such a perspective results in a set of compassionate and pragmatic strategies that aim to reduce harm to the person and the community in which he or she lives rather than concentrating on the cessation of drug use.

Drug-related harm reduction strategies include:

- needle and syringe programs to reduce the spread of blood borne viruses
- programs to divert offenders from the criminal justice system to improve chances of recovery
- overdose prevention activities, such as safe injecting rooms
- 'chill-out' spaces, supply of water and availability of peer support and medical facilities at festivals and dance parties.

As noted in the NDS, a harm reduction approach is neither oppositional nor contradicts an abstinence-based focus to drug rehabilitation.¹⁵⁹

3.4.3 Current criticisms of the National Drug Strategy

As researchers Ritter et al remark in *An Assessment of Illicit Drug Policy in Australia (1985 to 2010): Themes and Trends*, Australian drug policy is striking in the degree of consistency and coherence (and to a certain extent bipartisanship) in the overall approach since the advent of the harm minimisation framework in 1985.¹⁶⁰ This consistency was also confirmed in formal reviews of the NDS, with a 2009 evaluation noting:

The NDS policy framework has successfully informed development and implementation of drug policies and strategies at many levels and across government and the public, private and non-government domains. The NDS is broad and flexible enough to enable State and Territory and local drug strategies to be tailored to local needs and priorities. This is an effect of a consistent approach to harm minimisation, partnerships and the use of evidence over a long period.¹⁶¹

Despite this, not all commentators on drug policy have been so commendatory of the NDS. Many stakeholders expressed to the Committee that Australia's drug policy has 'gone backwards' in the past two decades, and that Australia is no longer a world

¹⁵⁸ Marlatt, G, *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviours*, Guilford Press, New York, 2011, p. 6.

¹⁵⁹ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 6.

¹⁶⁰ Ritter, A, et al., *An Assessment of Illicit Drug Policy in Australia (1985 to 2010): Themes and Trends*, National Drug and Alcohol Research Centre UNSW, Sydney, 2011, p. 1.

¹⁶¹ Miller, S, *Evaluation and monitoring of the National Drug Strategy 2004-2009*, National Drug Strategy, Canberra, 2009, p. viii.

leader in advocating innovative harm reduction policies and programs. Peter Wearne, Chair of the Yarra Drug and Health Forum (YDHF), advised the Committee that 'Australia used to lead this debate, and now we are followers in this debate. We no longer lead evidence-based practice in this area in the world. Other people have taken over that mantle'.¹⁶² In its submission, the YDHF also stated:

Australia, which was once a country that set the standard for effective drug policy implementation, has more recently turned its back on the success gained in the 1980's and 1990's and failed to capitalize on the progress made during that era. Once seen internationally as the leading light in progressive, evidence-informed health based responses aimed at reducing harms from illicit drugs, Australia is now viewed as somewhat of a backwater in progressing drug policy reforms. Illicit drug policy is now driven by the 'political capital' which is almost entirely driven by continually investing funding in police, courts and prison based responses to illicit drugs, despite their fruitless efforts to 'fix' the drug problem.¹⁶³

Professor Margaret Hamilton also told the Committee that Australia has become 'complacent' in this area:

We thought we were so good that we could rest on our laurels. Things change in this environment. The drugs change, the people who use them change, the way they are used change, the context of use changes — and we did not change with them. So I think it was like we were so proud and cocky and we thought, 'Well, we've got this sorted'.¹⁶⁴

Macintosh argues in his paper, *Drug Law Reform: Beyond Prohibition*, that the general bipartisan approach to the NDS was compromised from 1997 to 2007 during the *National Illicit Drug Strategy: 'Tough on Drugs'* campaign with an arguably renewed emphasis on prohibitionist models and drug law enforcement.¹⁶⁵ The Howard Government generally supported the harm minimisation approach of the NDS, and the 'Tough on Drugs' campaign promoted initiatives such as the Illicit Drug Diversion Strategy and research into pharmacotherapies and new treatment modalities. It did, however, block the proposal for a heroin prescription trial and the development of medically supervised injecting facilities, which critics viewed as a shift to a more conservative Australian drug policy.¹⁶⁶

Similarly, Dr Alex Wodak AM of the ADLRF, in a submission to a separate inquiry, saw the adoption of this rhetoric at the time centred on US notions of 'zero tolerance' as promoting an 'unfamiliar' and 'intolerant' approach to the previous bipartisan model. In practical terms this resulted in:

The allocation of substantial resources to illicit drug law enforcement and minimal resources to treatment, prevention, research and harm reduction indicat[ing] that the solid core of the national drug policy is supply reduction, while demand reduction and harm reduction are but a thin veneer.¹⁶⁷

¹⁶² Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 45.

¹⁶³ Yarra Drug and Health Forum, *Submission*, no. 107, 14 March 2017, p. 2.

¹⁶⁴ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, pp. 60-61.

¹⁶⁵ Macintosh, A, *Drug Law Reform: Beyond Prohibition: Discussion Paper Number 83*, The Australia Institute, Canberra, 2006, p. vii.

¹⁶⁶ Ritter, A, et al., *An Assessment of Illicit Drug Policy in Australia (1985 to 2010): Themes and Trends*, National Drug and Alcohol Research Centre UNSW, Sydney, 2011.

¹⁶⁷ Dr Alex Wodak, *Submission*, no. 153, Undated, Inquiry into Substance Abuse in Australian Communities, Standing Committee on Family and Community Affairs, Parliament of Australia, p. 10.

Professor Paul Dietze, Director of Behaviours and Health Risks Program at the Burnet Institute told the Committee that in addition to this sense of complacency, Australia has largely lost its bipartisan approach to drug policy that was so evident in the 1980s. Since that time debate about the relative weightings given to the pillars of the NDS have been politically polarised.¹⁶⁸

The current NDS states that the framework for national drug policy promotes a balanced ‘adoption of effective demand, supply and harm reduction strategies’.¹⁶⁹ It remains to be seen, however, whether the latest iteration of the NDS and related expenditure allocation may change or redress what its critics view as an imbalance in favour of supply reduction expenditure. This is discussed further in chapter four.

At the other end of the spectrum, some commentators are critical of the NDS for arguably encouraging drug use. Drug Free Australia, for example, opposes some of the stances of the NDS, especially the concept of harm reduction:

Opponents of drug legalisation express concern that ‘harm reduction’ interventions are often used by drug legalisation advocates as a pathway to normalizing drug use in a society, and via a pathway of incrementalism, overwhelming a society’s conscious concerns with a political, but not popular, acceptance of drug use. At the same time, critics of harm reduction, where it is used to alleviate the harms of illegal practices or behaviours, cite concerns about its strategies sending a message of sanctioned acceptance of the very behaviours which the community, through its legislators or governance, do not accept.¹⁷⁰

3.4.4 The National Ice Taskforce

As noted above, in conjunction with the NDS, a series of separate national strategies concentrating on a particular drug or a discrete area of drug use have been developed. One of the most important of these in the contemporary context is the *National Ice Taskforce Strategy 2015*. The National Ice Taskforce was established on 8 April 2015 to advise the Commonwealth Government on the impacts of crystal methamphetamine (‘ice’) in Australia and drive the development of a National Ice Action Strategy. The Taskforce presented its interim findings to the Council of Australian Governments on 23 July 2015, and delivered its Final Report to the Prime Minister of Australia on 9 October 2015.¹⁷¹

The Taskforce engaged extensively with people around Australia to develop the report. It spoke to over 100 experts in the areas of research, education, prevention, treatment, law enforcement and support services for users, families and Aboriginal and Torres Strait Islander people. The Taskforce also visited nine treatment and support services, and received around 100 submissions from organisations, clinics, research bodies and academics. The *Final Report of the National Ice Taskforce* found that ice use in Australia ‘is a complex problem that requires a multi-faceted response.

¹⁶⁸ Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 35.

¹⁶⁹ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 1.

¹⁷⁰ Drug Free Australia, ‘Drug Free Australia’s Arguments Against Drug Legislation’, viewed 26 October 2016, <<https://www.drugfree.org.au/index.php/8-general/140-drug-free-australia-s-arguments-against-drug-legalisation.html>>.

¹⁷¹ Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Commonwealth of Australia, Canberra, 2015.

Proportionally, Australia uses more methamphetamine than almost any other country, and the number of users continues to grow. Today, evidence suggests there are well over 200,000 users'.¹⁷²

The Taskforce made 38 recommendations across five areas of priority:

- supporting families, workers and communities to better respond to people affected by ice
- efforts to reduce demand for ice through prevention activities must be strengthened
- people who use ice need treatment and support services that cater to their needs
- efforts to disrupt supply must be more coordinated and targeted
- better data, more research and regular reporting is needed to strengthen Australia's response and keep it on track.¹⁷³

While many of the recommendations centered on supply reduction strategies, there was a substantial emphasis on demand reduction initiatives including more funding for and better access to treatment, research programs, the training of professionals and family support. The Committee notes, however, the limited focus on harm reduction interventions in the report.

3.5 Victorian drug strategies

Subsequent to and complementing the NDS, Victoria has at various times developed localised drug strategies to address drug-related issues specific to this state.

The most recent general framework was *Reducing the alcohol and drug toll. Victoria's plan 2013 – 2017*, a whole of government strategy to reduce the negative impact of alcohol and drug use, including pharmaceutical drugs, on the Victorian community.

This strategy largely lapsed with the change of government in November 2014 and has been replaced with other specialist policies and programmes concerning individual drugs such as the *Victorian Ice Action Plan*, *Community Based Alcohol and other Drug Service Provision Review*, the *Alcohol and Drug Workforce Framework*, and the *Alcohol and Other Drug Data, Research Planning (AODstats)*, and the *Health and Well-being Plan 2015 -2019*.

3.5.1 The Victorian Ice Action Plan

The *Victorian Ice Action Plan* substantially builds on the Victorian Parliament's landmark 2014 *Inquiry into the supply and use of Methamphetamine in Victoria*, which identified a significant increase in the number of people using crystal methamphetamine in this state. It also incorporated findings from the Premier's Ice Action Taskforce established at state level to develop the plan.¹⁷⁴

172 Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Commonwealth of Australia, Canberra, 2015, p. 16.

173 Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Commonwealth of Australia, Canberra, 2015, pp. iv-v.

174 State Government of Victoria, *Ice Action Plan*, Melbourne, 2015.

Under the Plan, the Victorian Government committed \$4.7 million to assist families identify and manage people who use crystal methamphetamine and \$1 million to support frontline workers at risk of assault in the workforce such as health professionals. The Government also promised significant investment to expand drug treatment and rehabilitation, including the introduction of therapeutic day rehabilitation treatment services in Melbourne and regional Victoria. It also established a dedicated Ice Help Line that directs families and health professionals to the support they need. Further, supply reduction measures to reduce ice use included a \$4.5 million plan to crack down on clandestine drug labs, in addition to \$15 million for new drug and 'booze' buses and \$500,000 to help community groups tackle ice use in their local area.¹⁷⁵

3.5.2 The Victorian Health and Well-being Plan 2015-2019

The *Victorian Health and Well-being Plan 2015-2019* was developed subject to the provisions of the *Public Health and Wellbeing Act 2008* and is currently in its second iteration. It does not specifically, or solely, concern itself with drug policy or addressing drug-related harms, although that is one aspect of its overarching brief. Rather, the plan establishes a long-term agenda for improving health and social outcomes in Victoria with the aim to reduce inequalities in health and wellbeing. The plan seeks to complement the range of other existing, or currently in development, health plans, strategies and policies including those relating to licit and illicit drug use.¹⁷⁶

For alcohol and illicit drug use specifically, the Plan's strategic directions are to:

- Develop strategies across government to reduce the risk of short-term harms due to the misuse of alcohol, and minimise the chronic health problems associated with long term unhealthy drinking patterns.
- Continue to address the impacts of illicit drug use, for example, through the *Victorian Ice Action Plan*.
- Develop a Victorian pharmaceutical misuse strategy and education program to reduce problematic use of prescription medications.
- Improve alcohol and drug education in schools and access to early intervention services for people with alcohol and drug use issues.¹⁷⁷

A range of appropriate targets were developed to measure the Plan's progress against the key priorities, which are also supported by a comprehensive public health and wellbeing outcomes framework.¹⁷⁸

3.5.3 The Victorian Drug Rehabilitation Plan

In October 2017, the Victorian Government committed to a substantial increase in treatment initiatives throughout the state through the *Victorian Drug Rehabilitation Plan*.¹⁷⁹ This was driven by the escalation in the number of illicit drug-related deaths,

¹⁷⁵ State Government of Victoria, *Ice Action Plan*, Melbourne, 2015.

¹⁷⁶ Department of Health and Human Services, *Victorian public health and wellbeing plan 2015-2019*, State Government of Victoria, Melbourne, 2015.

¹⁷⁷ Department of Health and Human Services, *Victorian public health and wellbeing plan 2015-2019*, State Government of Victoria, Melbourne, 2015, p. 22.

¹⁷⁸ See Department of Health and Human Services, *Victorian public health and wellbeing outcomes framework*, State Government of Victoria, Melbourne, 2016.

¹⁷⁹ Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017.

particularly through heroin use, occurring in Melbourne and regional Victoria. The Plan aims to expand treatment, boost alcohol and other drug training, and invest in 100 more rehabilitation beds which will double the number of current rehabilitation beds available in Victoria since 2014. In addition, as noted in chapter one, the Government will also trial a medically supervised injecting centre in North Richmond from June 2018. Further discussion of the *Drug Rehabilitation Plan* in the context of both treatment and harm reduction is found in chapters 12 and 17 respectively.

4 Framework for effective drug law reform

I believe that drugs have destroyed many lives, but wrong government policies have destroyed many more. We all want to protect our families from the potential harm of drugs. But if our children do develop a drug problem, surely we will want them cared for as patients in need of treatment and not branded as criminals. The widespread criminalisation and people who use drugs, the overcrowded prisons, means that the war on drugs is to a significant degree war on drug users – a war on people.¹⁸⁰

Overwhelmingly, the evidence received by the Committee reaffirmed the need to take a different approach to drugs policy. As discussed below, despite the best of intentions, a dominant focus on law enforcement strategies has not eradicated the supply and availability of illicit substances but has contributed to increased harms associated with these substances, in addition to the availability of new and often more harmful drugs on the illicit drug market. Some commentators have argued equally that the ‘drug problem’ is in fact not about the drug per se but the attendant problems associated with illicit drug markets and drug distribution systems, something not applicable to the regulated markets for alcohol and tobacco. There is increasing recognition at both domestic and international levels that individuals and communities will benefit greatly from a health and social response to drugs. This will not only serve people who use illicit substances but also the growing number of Victorians misusing pharmaceutical drugs.

This chapter sets the tone for the remainder of the report and the recommendations of the Committee. This chapter establishes the framework for which positive and effective drug law and policy reform can be based upon in Victoria. It draws on the evidence from the research literature, best practice from within Australia and overseas jurisdictions and evidence provided to the Committee in submissions and public hearings. The Committee acknowledges the strong appetite within the community for reform in this area.

4.1 Effectiveness of a largely law enforcement approach

Australia has arguably never had a strong prohibitionist stance on drug policy, at least in comparison to the United States (US). Nonetheless, there was a clear consensus in the evidence received by the Committee and in the broader literature regarding the limited effectiveness of prohibition-based policies in Australia. The Yarra Drug and Health Forum (YDHF) stated in its submission:

¹⁸⁰ Kofi Annan, Chairman and founder of the Kofi Annan Foundation quoted in International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 3.

There has been...a movement growing and slowly building over the past decade questioning the cost-effectiveness of policies that commit billions of dollars toward enforcement of illicit drug prohibition yet have little or no impact in drug availability, cost and purity. Further questions are also being asked about a system that continues to pit police against drug consumers with arrest rates in many parts of the world, including Australia, significantly increasing and yet the number of people who use illicit drugs continues to rise.

Questions about a 'war on drugs' approach to justify the investment in drug prohibition, if not in words definitely in deeds, are being asked by many people, not only about the amount of public money being spent enforcing prohibition, but also on the many unanticipated consequences.¹⁸¹

Policy think tank, Australia 21, hosted a roundtable in September 2015 on the effectiveness of law enforcement in responding to illicit drugs. Participants comprised senior police officers including current and former commissioners, judges and magistrates, coronial staff, barristers and solicitors, criminologists and legal academics. The consensus of the forum was that police 'will always be chasing their tails or playing catch up' when addressing drug issues, particularly with regard to the lower ends of the 'criminal spectrum' (i.e. users and low level user-dealers). By using the provisions of the criminal law, it was argued that police 'unavoidably contribute to the further victimisation of the users rather than assisting in their well-being and rehabilitation'.¹⁸²

According to the National Drug and Alcohol Research Centre (NDARC), Australia's drug laws conflict with the National Drug Strategy's (NDS) policy of harm minimisation.¹⁸³ Similarly, Mick Palmer AO APM, former commissioner of the Australian Federal Police and Northern Territory Police and now Vice President of Australia21, believes Australia has 'failed miserably in its attempt to achieve the aim [of harm minimisation] and indeed many aspects of current policy actually aggravate harms rather than reduce them'.¹⁸⁴

In its submission to this inquiry, NDARC drew from various academic and other sources to demonstrate that the criminalisation of drugs has had 'a high level of perverse or unintended impacts':

[Prohibition] has in many cases increased health, social and economic harms associated with drugs (Babor et al., 2010; LSE Expert Group on the Economics of Drug Policy, 2014). For example, as summed up by Room and Reuter (2012, p. 84):

"The system's emphasis on criminalisation of drug use has contributed to the spread of HIV, increased imprisonment for minor offences, encouraged nation states to adopt punitive policies (including executions, extra-judicial killings, imprisonment as a form of treatment, and widespread violations of UN-recognised human rights of drug users), and impaired the collection of data on the extent of use and harm of illicit drugs, all of which have caused harm to drug users and their families".

More recently the *Lancet Commission on Drug Policy and Health* concluded that:

"Policies meant to prohibit or greatly suppress drugs present a paradox. They are portrayed and defended vigorously by many policy makers as necessary to preserve public health and safety, and yet the evidence suggests that they have contributed

181 Yarra Drug and Health Forum, *Submission*, no. 107, 14 March 2017.

182 Australia21, *Can Australia Respond to Drugs More Effectively and Safely?*, Sydney, 2015, p. 2.

183 National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 4.

184 Palmer, M, 'Australia's Illicit Drugs Policy - There Really is a better Way A REPOST', *John Menadue - Pearls and Irritations*, 28 December 2017, viewed 2 January 2018, <<https://johnmenadue.com/mick-palmer-australias-illicit-drugs-policy-there-really-is-a-better-way>>.

directly and indirectly to lethal violence, communicable-disease transmission, discrimination, forced displacement, unnecessary physical pain, and the undermining of people's right to health" (Csete et al., 2016, p. 1429).¹⁸⁵

Again, drawing from the academic evidence, NDARC raised a number of other specific harms arising from prohibition:

- very high demand placed on the criminal justice system due to the emphasis on policing and imprisoning people who use drugs, rather than on health or social responses to drugs
- over-emphasis on targeting people who use drugs, rather than drug traffickers
- encourages high risk drug use practices, such as rapid or unsafe injecting
- increases barriers to the provision and use of harm reduction and other HIV prevention services
- jeopardises employment and educational prospects for people who use drugs who receive a criminal conviction
- damages police-community relations, particularly with young people; gay, lesbian, bisexual, transgender and intersex (GLBTI) communities; and ethnic minorities.¹⁸⁶

The idea of unintended consequences was a reoccurring theme throughout the inquiry, from both drug reformers in the context of prohibition, and conservatives about the possible consequences from scaling back on the criminalisation of drugs. A key concern of the latter group was that retreating from a strict law enforcement approach would send the wrong message and increase the use of such substances within the community. In its submission, UnitingCare ReGen refuted this argument and indicated that drug law reform would promote greater discussion of prevention strategies:

The notion that removing criminal penalties will 'send the wrong message' or provide implicit endorsement of drug use is misleading. There is little evidence to suggest that the current penalties provide an effective deterrent to illicit drug use but there is abundant evidence of the impacts of the criminalisation of drug use on stigmatisation and marginalisation of vulnerable Victorians and creating obstacles to help seeking by those directly affected.¹⁸⁷

In response to a question from the Committee about possible increased levels of harm from wide-ranging reforms, Australian drug policy expert, Professor Margaret Hamilton, advised that it is important to balance the risks with the benefits and acknowledge that in drug policy there is no simple solution. Professor Margaret Hamilton also stated that there will be some adverse outcomes from reform but many more exist from the current approach:

There are a lot of perverse consequences of some of what we do now. I have mentioned some of them: people trading in more potent products because they can be handled in smaller quantities; people going to prison who are not already infected with bloodborne viruses as a result of drug use, and then they go in there, they cannot get access to safe injecting equipment and they become infected. There are a lot of things that we contribute to through our current policies. So yes...I think it is an important reflection to always bear in mind.¹⁸⁸

¹⁸⁵ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 4.

¹⁸⁶ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 4.

¹⁸⁷ UnitingCare ReGen, *Submission*, no. 168, 17 March 2017, p. 6.

¹⁸⁸ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 61.

Additionally, in response to a similar question from the Committee, Dr Alex Wodak AM, the President of the Australian Drug Law Reform Foundation (ADLRF) and the Director of Australia21, indicated that there is limited relationship between drug policy and the extent of drug use. Various countries have reformed their drug laws and drug use has not increased or increased minimally, and for some countries, drug use decreased. He also advised that ‘the more restrictive we make drug policy, the more we harm people’.¹⁸⁹ This was reflected in the evidence provided to the Committee regarding the impact of law enforcement efforts on people who inject drugs, specifically around North Richmond. For example, North Richmond Community Health stated in its submission:

A large police presence in North Richmond and on the housing estate (where NRCH is located) was reported by professional key experts as contributing to riskier injecting practices among PWID [people who inject drugs], including inappropriate needle and syringe disposal after injection...

[there are also] higher risk behaviours when police activity is strong in the area including injecting in unsafe locations, mixing up and injecting quickly, injecting larger amounts rather than keeping some for later, discarding used injecting equipment, and buying drugs from people they don’t know.¹⁹⁰

The question of unintended consequences was also raised in the context of drug checking services. However, responses from experts in the field highlighted again the likely harms arising from the current strict law enforcement approach for individuals at music festivals that involves strategies such as drug detection dogs and searching individuals, in addition to a general police presence. This was in contrast to the experience of drug checking services in various European countries where there have been few reports, if any, of harms arising from this harm reduction initiative.

4.1.1 Reducing the supply of illicit drugs

Moreover, in addition to a prohibition approach possibly causing harms to people who use drugs as indicated above, various stakeholders argue that it has done very little to reduce the flow of these substances into Australia. The Penington Institute stated in its submission:

Australia’s efforts to reduce the supply of illicit drugs have not made any substantive or lasting progress against this goal – a fact now broadly acknowledged by experts, decision makers and law enforcement itself. The statement that Australia cannot arrest its way out of drug problems has become fairly embedded in the policy debate (even if subsequent government decisions do not always reflect that accepted wisdom).

Most recently, the National Ice Taskforce and all Australian governments acknowledged that the low price, high purity and wide availability of crystal methamphetamine in this country appears to have been unmoved by Australia’s large investment in supply reduction measures. These findings hold true across all major drug types.

¹⁸⁹ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 81.

¹⁹⁰ North Richmond Community Health, *Submission*, no. 162, 17 March 2017.

The failure of supply reduction is not for want of trying. Supply reduction attracts significant investment - primarily directed through border protection and police forces and enforced all the way through the broader criminal justice system. The exact quantity of government funding expended for this purpose in Victoria is unknown, but would likely amount to several billion dollars over the past decade.¹⁹¹

Detective Superintendent Matt Warren, Coordinator of Joint Counterterrorism at the Australian Federal Police (AFP), while noting the incredible efforts of AFP personnel to prevent or reduce the supply of illicit drugs coming into Australia, told the Committee that substantial amounts continue to make it into the local illicit drug market:

If you really have a massive impact on supply, then the price will go up. But what we have certainly seen consistently over the last few years is that despite the very high seizure rate, we are still seeing consistent demand and a drop in price, which tends to lead to the conclusion that there is a significant supply still reaching our shores...I think it would be safe to say that the problem is serious and continuing.¹⁹²

Similarly, at the state level, Wendy Steendam, Deputy Commissioner of Capability at Victoria Police commented to the Committee how the illicit drug market continues to evolve and diversify, with incredibly strong organised crime groups operating in this area:

Consistent through this has been the resilience of serious and organised crime in illicit drug markets. These groups are generating significant profits for the sale of illicit drugs, with the cost of illicit drugs in Australia being one of the highest in the world.¹⁹³

The limited capacity of a law enforcement approach to reduce the supply of illicit drugs was also emphasised by Mick Palmer AO APM in his evidence to the Committee. He indicated that despite police being more effective in their law enforcement operations than ever, it is not impacting the illicit drug market due to the significant profits to be made:

The reality is police are more effective now than they've ever been in their history: they have more collaboration, more intelligence sharing, better use of telephone interception listening devices and other technology than has ever happened before.

There are very significant seizures of drugs, arrests of very significant players but at the end of the day we don't make any damn difference. You know, the price doesn't go up, the supply doesn't come down and in an untested and totally unregulated market there are too many people making too much money. In my experience it is not a penalty to a crime that is the deterrent but the chance of getting caught. No-one cares what the penalty is, including it being the death penalty, if they don't think they're going to get caught...

But when you've got a situation like we have here, where the profits are huge and the chances of getting caught are low, we're never going to control the market. Untested markets are what create the problems that we are now dealing with. I mean, to me at the heart of this is the fact that the problems we're now really worried about and are facing are being caused by a current policy.¹⁹⁴

¹⁹¹ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 11.

¹⁹² Detective Superintendent Matt Warren, Coordinator, Joint Counterterrorism, Australian Federal Police, *Transcript of evidence*, 13 November 2017, p. 441.

¹⁹³ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 449.

¹⁹⁴ Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017, p. 85.

Reviewing the evidence, and in particular that received from current and veteran law enforcement representatives, the Committee acknowledges that a strict law enforcement approach is counterproductive. Despite the increased investment in law enforcement measures and the seizure of illicit drugs, drug availability and consumption are not decreasing. This is an incredibly complex area of policy, although it is difficult to support the current state of play with the understanding that the Committee now has on its impact on creating significantly more harms than intended, with little impact on reducing the illicit drug market.

4.2 Reorientation to a more effective drug response framework

An overwhelming majority of evidence provided to the Committee affirmed the importance of conceptualising illicit drug use as a health and social issue rather than a strictly law enforcement issue.¹⁹⁵ As noted above, a constant theme throughout the inquiry, and almost universally agreed upon is that the current system is not achieving its intended objectives. Moreover, the Committee notes there is now considerable expert and community support for such a view.

The Committee notes that a reorientation or reframing the ‘drug problem’ as a health issue does not suggest ‘going soft’ on drugs. Rather it requires a smarter approach. The Committee strongly supports continuing efforts to ensure drug traffickers are subject to the full force of the law. Similarly, those who commit crimes, particularly crimes of violence, while under the influence of drugs should not be immune from prosecution. However, according to a large number of stakeholders, including those who work in law enforcement, arresting and prosecuting people for personal possession and use or for dealing to pay for their own habit, is largely counterproductive. The Committee was advised on numerous occasions that the use of an illicit substance is one of the few actions where the act of use rather than the consequences arising from that use is criminalised.

Judge Sara Hinchey, the State Coroner of Victoria, told the Committee that from a coronial perspective, drug addiction must be addressed as a public health issue:

¹⁹⁵ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017; Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017; Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017; Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017; Demos Krousos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017; Greg Chipp, CEO and Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017; Jon O’Brien, Head of Social Justice Forum, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017; Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017; Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017; Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017; Paul Bodisco, Secretary, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017; Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017; Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017; Australian Injecting & Illicit Drug Users League, *Submission*, no. 169, 17 March 2017; cohealth, *Submission*, no. 140, 16 March 2017; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017; Humanist Society of Victoria, *Submission*, no. 184, 17 March 2017; Justice Action, *Submission*, no. 207, 21 March 2017; Penington Institute, *Submission*, no. 209, 24 March 2017; Public Health Association Australia, *Submission*, no. 152, 17 March 2017; Unharm, *Submission*, no. 182, 17 March 2017; UnitingCare ReGen, *Submission*, no. 168, 17 March 2017; Victorian AIDS Council, *Submission*, no. 206, 21 March 2017; Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017.

Drug addiction is a public health issue. People who use drugs involved in the large number of overdose deaths which the Coroners Court sees every year face a daily battle against their compulsion to use those drugs and are at continued risk of death from their use. They include people from all walks of life, many of whom suffer from other issues, such as physical or mental ill health, unemployment and homelessness. Some come into contact with the criminal justice system as a result of their addiction. It is only when we as a society accept that addiction is a health issue that we are able to see more clearly what can and must be done to support drug users to reduce their risk of harm, and in the worst cases, their risk of death.¹⁹⁶

Throughout the inquiry, there was also a push for a ‘human rights compliant’ drug law framework’.¹⁹⁷ This is not a new phenomenon, although it has developed great momentum in recent years with increased international recognition of the need to realign drugs policy with the original and ultimate goal of drug control, that being to save lives. As noted by Kofi Annan, the former Secretary-General of the United Nations:

Sadly, drug policy has never been an area where evidence and effectiveness have driven decisions. All too often it appears to be ideological arguments which prevail. However, the original intent of drug policy, according to the UN Convention on Narcotic Drugs, was to ‘protect the health and welfare of mankind’. We need to refocus policy on this objective.¹⁹⁸

Similarly, Professor Margaret Hamilton advised the Committee that this ultimate goal has been lost and now is the time to reconnect with human rights, health, justice and people.¹⁹⁹

This was a view shared by various stakeholders, with many indicating that this inquiry provides an opportunity to consider relevant legislation and policies from a human rights framework.²⁰⁰ In particular, Dr Kate Seear, Senior Lecturer of Law at Monash University stated in her evidence that human rights considerations are principally relevant to Victoria, as it is one of only two jurisdictions in Australia that has a human rights charter.²⁰¹

The *Charter of Human Rights and Responsibilities Act 2006* (the Charter) establishes the basic rights, freedoms and responsibilities of all people in Victoria through 20 human rights principles. It requires all public authorities and people delivering services on behalf of government to act consistently with the Charter and to consider human rights principles when developing policies and making laws and decisions.²⁰² Dr Kate Seear asserted that the rights protected in the Victorian charter place positive obligations on the Victorian Government regarding drug law reform:

196 Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 15.

197 Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, p. 170.

198 International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 3.

199 Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 58.

200 Australian Injecting & Illicit Drug Users League, *Submission*, no. 169, 17 March 2017; Dr Kate Seear, *Submission*, no. 126, 16 March 2017, p. 4; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 18; Springvale Monash Legal Service Inc., *Submission*, no. 160, 17 March 2017, p. 4.

201 Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, p. 169.

202 *Charter of Human Rights and Responsibilities Act 2006* (Vic), no. 43.

In this sense, the charter both enables and I think necessitates drug law reforms, including wherever it is possible to make reforms that may reduce harms, improve health and preserve life. Importantly as well the Victorian charter, as the committee well knows, requires every bill introduced into Parliament to be assessed for its compatibility with human rights.²⁰³

More broadly, the Committee received extensive evidence about other principles that drug law reform should be based upon, including public safety, health and reducing harms. For example, Peter Wearne, Chair of the Yarra Drug and Health Forum (YDHF), indicated that the key priorities should be ‘public safety, public health and wellbeing and people being accountable for their actions when they are harming the community’.²⁰⁴ Mick Palmer AO APM advised that the predominant driver of illicit drug policy should be to reduce harms:

Every time we find a practice or an arrangement that in fact aggravates the harm or doesn’t lead to a reduction in harm or a potential reduction of harm we should re-evaluate it and say, “Hang on, what the hell are we doing that for?”²⁰⁵

The Victorian AIDS Council shared a similar view, arguing in its submission that the following principles underpinning the concept of harm reduction should be written into Victorian law, such as:

- **Pragmatism:** acknowledgment that some level of drug use is expected, and that limiting use, addressing dependency, and minimising related harms is more realistic than the complete eradication of drug use.
- **Humane values:** moral judgments about the use of drugs or the people who use them must not interfere with the development of policy. Rather than approving drug use, this acknowledges that health, welfare, rights, and dignity of the individual are of greater importance than personal moral concerns.
- **Focus on harms:** the harms associated with drug use (e.g. transmission of blood-borne viruses, overdose, and death) must be the primary focus of any drug law reform. Once these are addressed, attention can then turn to a person’s use and, if necessary, developing appropriate treatment and care strategies with a trained and knowledgeable workforce.
- **Balancing costs and benefits:** responsible authorities must continually monitor and evaluate the personal, social, and economic costs of various interventions as they are deployed, and weigh them against their benefits. Ineffective practices should be discontinued, while evidence-based practices and strategies must be considered.
- **Priority of immediate goals:** government and people who use drugs should work together to determine a range of strategies to respond to drug issues, and identify which goals are of immediate concern.²⁰⁶

The Committee strongly supports a reorientation to more effective and humane responses to drugs that prioritises health and safety outcomes. This will have a greater impact on reducing overall levels of harm than the current criminal justice-focused model. However, law enforcement remains a crucial component. Collaboration between these two elements is essential at every level as it promotes safe and healthy communities, for both people who use drugs and the broader community who might

²⁰³ Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, p. 169.

²⁰⁴ Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 48.

²⁰⁵ Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017, p. 79.

²⁰⁶ Victorian AIDS Council, *Submission*, no. 206, 21 March 2017, p. 3.

be victim to drug-related crimes. In this context, the Committee believes that the ultimate goal of saving lives relates to everyone in the community. In its *Pathways to drug policies that work* document, the Global Commission on Drug Policy (GCDP) identifies putting ‘people’s health and safety first’ as a key pathway on the basis that:

....policies should prioritize the safeguarding of people’s health and safety. This means investing in community protection, prevention, harm reduction, and treatment as cornerstones of drug policy.²⁰⁷

This reorientation will also place greater emphasis on treatment interventions and assisting people to overcome harmful use of illicit substances. Further, according to Transform in its report *The Alternative World Drug Report*, policy and law reforms that reflect a reorientation to a health-based approach are consistent with the overarching international drug control framework.²⁰⁸

Based on the evidence it received throughout the inquiry and community support for reform, the Committee recommends that the Victorian Government’s approach to drug policy be based on a health and safety framework and be informed by a number of key principles as raised in this and other chapters.

RECOMMENDATION 1: The Victorian Government’s approach to drug policy be based on effective and humane responses that prioritise health and safety outcomes, be in accordance with the United Nations’ drug control conventions, and informed by the following principles:

- promotion of safe communities – reduce drug-related crime and increase public safety
- evidence-based – empirical and scientific evidence to underpin change
- supportive and objective approach to people who use drugs and of drug addiction
- cost-effective – ensure money spent on drug policy is working to reduce harms
- responsive – flexible and open to change, new ideas and innovation.

4.3 The need for ‘evidence-based’ policy versus pragmatism

A constant refrain from policymakers, researchers and clinicians in drug policy is the need for programs and policies to be ‘evidence-based’ or ‘evidence informed’. Leading drug researcher Wayne Hall argues that:

...research contributes to policy debate by: clarifying factual issues where relevant; identifying options for intervention; evaluating the effects of current policies; and changing conceptual understandings of the problems that policy is designed to address.²⁰⁹

In effect, evidence-based policy refers to the use of a scientific evidence base, removed from moral or ideological judgements, for the evaluation and implementation of drug policies and programs.

²⁰⁷ Global Commission on Drug Policy, *Taking Control: Pathways to Drug Policies That Work*, Geneva, 2014, p. 18.

²⁰⁸ Transform Drug Policy Foundation, *The Alternative World Drug Report*, Bristol, 2016, p. 141.

²⁰⁹ Hall, W, ‘The contribution of research to the development of national cannabis policy in Australia’, *Addiction*, vol. 103, no. 5, 2008, pp. 712-720.

Dr Nicole Lee, Director of drug consultancy firm 360Edge, reaffirmed to the Committee the importance of evidenced-based approaches even if they seem ‘counterintuitive:’

...drug responses can seem counterintuitive, and I think that it is really important that we use the evidence base in order to avoid unintended consequences. For example, it might seem logical that if you show young people the worst of the horrible consequences of drug use, they might want to avoid them, but actually we know that that does not happen. The people who were never going to try drugs are just more determined not to, and those who are at risk become actually more interested in trying them, and that is not what we want to see at all. So I think we need to really make sure that our drug policy and laws use the evidence base and we use what we know works and we do not do what we know does not work, and that will help us avoid those increased harms and unintended consequences.²¹⁰

Babor and his colleagues, some of the world’s leading academic drug policy experts, asserted in *Drug Policy and the Public Good* that often drug policy options proven to be effective from a scientific basis are not politically popular.²¹¹ On the other hand, policies that are politically or socially palatable are not necessarily effective or rigorously evaluated. This is why in Australia, while high quality research into drug policy is being produced and disseminated, it ‘does not inevitably lead to evidence informed policy’.²¹² As David Ruschena, General Counsel from Alfred Health told the Committee:

The translation of existing research and evidence into health policy and practices takes somewhere between 10 and 17 years, according to the current research. We think that time has to come down, and the only way in which it can come down is by the creation of an appropriate body to assist researchers to understand what is necessary and policymakers to understand what already exists.²¹³

Indeed, harm reduction, where drug use is implicitly acknowledged, is a good example of where research utilisation can be limited by policy choice and competing agendas, a point highlighted in the YDHF’s submission:

Drug law reform, once the domain of a few isolated ‘radical’ groups such as drug user organisations and political pressure groups is now becoming mainstreamed. Even within the United Nations and other key global drug policy makers the momentum is swinging toward more evidence-informed policies that place health and human rights foremost in any response to drug issues.... Furthermore, the debate about the need for evidence-informed drug policy and increased resource commitment in the harm reduction and primary prevention areas has been somewhat stifled. Consequently, there has been a significant lack of investment in these key areas, especially harm reduction, given the progress in many other parts of the world. Harm reduction programs that reflect evidence-informed practice and achieve a range of beneficial outcomes, yet don’t receive strong policy support at either Federal or State government levels...²¹⁴

In Australia, even though harm reduction is central to harm minimisation, the more controversial initiatives are yet to be accepted as ‘mainstream’ despite the strong evidence base supporting their benefits. Some programs and interventions have more

210 Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 56.

211 Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 95, 263-273.

212 Ritter, A, et al., *An Assessment of Illicit Drug Policy in Australia (1985 to 2010): Themes and Trends*, National Drug and Alcohol Research Centre UNSW, Sydney, 2011, p. 33.

213 David Ruschena, General Counsel, Alfred Health, *Transcript of evidence*, 19 June 2017, p. 240.

214 Yarra Drug and Health Forum, *Submission*, no. 107, 14 March 2017, pp. 5-6.

political (and public) salience then others. For example, needle and syringe programs (NSPs) have for the most part been accepted in Australia because of their role in preventing blood borne virus diseases, whereas NSPs in prisons have proven a step too far.

In some instances, the evidence base for supporting drug initiatives is underdeveloped or does not conform to the ‘gold standard’, not necessarily because the evidence is weak but rather because there has been limited investment in such research, one example being the use of medicinal cannabis to treat certain conditions. As Davoli, Simon and Griffiths state in their text *Current and future perspectives on harm reduction in the European Union*:

It is understandable that policymakers will be more concerned with the quality and availability of evidence for politically controversial measures than they are for actions that have broad based support.²¹⁵

The problem for policymakers and public health experts, however, is that if the evidence bar is set too high; for example, requiring a program to be subject to random controlled trials, it may never get off the ground. There are good reasons why absolute certainty of outcomes may not be possible ‘given that in the real world there are practical, methodological and ethical reasons that mean it may be extremely difficult or even impossible to generate such a high level of evidence’.²¹⁶

Some public health experts propose a more practical approach that does not require the gold standard on the basis that the ‘absence of evidence does not necessarily justify the absence of action’.²¹⁷ As Gino Vumbaca, President of Harm Reduction Australia and long standing drug policy expert told the Committee, ‘perfect’ solutions to address drug problems are not possible, ‘but you don’t let the perfect become the enemy of the good’.²¹⁸ Similarly, in its submission to the inquiry, Families and Friends for Drug Law Reform identified the need for a pragmatic approach when implementing strategies that work ‘even if not always perfectly’.²¹⁹ Further, when the Committee met with representatives of the Vancouver Police Department (VPD) during its overseas study tour, it was advised that it is essential for government and community agencies to try new strategies and measure them accordingly. Sergeant Mark Horsely of the VPD advised in particular ‘the worst thing a government can be is indecisive’.²²⁰

Yet for politicians, even those who might broadly support controversial measures, certainty of the evidence is, if not essential, certainly desirable in not only proposing a ‘courageous’ stance to constituents, the general public and the media but also in justifying the often considerable expenditure required for such an initiative. It is also important that funding for properly conducted evaluation be built into their

215 Davoli, M, et al., ‘Current and future perspectives on harm reduction in the European Union’, in *EMCDDA Monographs 10: Harm reduction: evidence, impacts and challenges*, T Rhodes and D Hedrich (eds), Office of the European Union, Luxembourg, 2010, p. 443.

216 Davoli, M, et al., ‘Current and future perspectives on harm reduction in the European Union’, in *EMCDDA Monographs 10: Harm reduction: evidence, impacts and challenges*, Rhodes and Hedrich (eds), Office of the European Union, Luxembourg, 2010, p. 443.

217 Davoli, M, et al., ‘Current and future perspectives on harm reduction in the European Union’, in *EMCDDA Monographs 10: Harm reduction: evidence, impacts and challenges*, Rhodes and Hedrich (eds), Office of the European Union, Luxembourg, 2010, p. 446.

218 Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 106.

219 Families and Friends for Drug Law Reform, *Submission*, no. 123, 16 March 2017, p. 1.

220 Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 4.

budgets.²²¹ Dr Alex Wodak AM of the ADLRF advised that the three key hallmarks of implementing possibly contentious strategies are that they are incrementally introduced, as evidenced based as possible, and evaluated.²²²

4.4 Four pillars approach to drugs

As discussed in chapter three, the National Drug Strategy (NDS) is based on the policy of harm minimisation, which comprises the three pillars of supply reduction, demand reduction and harm reduction. A common criticism of the NDS, however, is that authorities do not regard or treat the three pillars equally, which as discussed in section 4.6 is clearly reflected in the allocation of expenditure at both national and state levels. Gino Vumbaca of Harm Reduction Australia, who was involved in the development of the harm minimisation policy under the first NDS, advised that each of the three pillars was intended to receive the same level of attention, with proportionate funding models:

The three pillars - you're holding up a roof, which is how it was always portrayed visually, that each pillar has to have equal strength. You don't put up a building with one wall being stronger than the others. You have equal strength and that commitment needed to be to all three pillars. That's what it was about. The commitment to understanding that there needed to be a balanced approach and that they all had an important part to play in reducing drug use and the harms in drug use and the problems we see in society. They all had their role.²²³

Of particular concern to the Committee regarding the current approach is the fact that treatment and prevention fall under the one pillar of demand reduction despite their different purposes and strategies to prevent use, minimise harms and reduce demand. While treatment and prevention still receive more attention and funding than harm reduction, they remain chronically underfunded. According to Dr Nicole Lee of 360Edge, in the context of treatment, this has resulted in insufficient services and limited flexibility to respond to changing drug trends, such as the ice problem over the last five years.²²⁴ Regarding prevention, Peter Wearne of the YDHF advised that while prevention is complex and costly, 'it is the most important thing that we can do'.²²⁵ The Alcohol and Drug Foundation also strongly advocated for primary prevention in its submission, acknowledging that 'Victoria needs a systematic, integrated, coordinated long term approach to the prevention of drug problems that is informed by the best available evidence and professional judgement'.²²⁶

Internationally, the Committee learnt that a number of jurisdictions have adopted a four pillared approach to their drug policy. The first country in the world to develop a four pillars drug policy was Switzerland in 1994. It reflected a formal shift in the federal government's framework to a health-based approach and was also supported by Switzerland's system of 'direct democracy' that ensured public input into the framework:

221 Alfred Health, *Submission*, no. 173, 17 March 2017, p. 22.

222 Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 79.

223 Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 110.

224 Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 371.

225 Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 47.

226 Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 14.

...initiatives for ‘zero tolerance’ and legalisation were put to the popular vote in 1997 and 1998 respectively, and both were rejected (by 71% and 73% voters respectively). As argued by the drug strategy, through rejecting these “voters indirectly came out in favour of the four pillar model as a pragmatic middle way”.²²⁷

At the time of its introduction, the policy facilitated innovation across all four pillars, including trials for a range of treatment and harm reduction measures. Since then, the Swiss Federal Office of Public Health has supported 300 health-related programs, with an expenditure of over 15 million Swiss Francs annually.²²⁸ There have been three phases of the federal framework, although a new strategy was released in October 2017, the *National Strategy on Addiction and Action Plan 2017-2024*, which applies the four pillars approach to all types of addiction.²²⁹

Based on the Swiss model, the City of Vancouver developed a four pillars drug strategy in 2001. This was in response to a public health crisis in Downtown Eastside in the 1990s that was marked by high-grade heroin and cheap cocaine, which combined with poverty resulted in escalating rates of HIV infection and overdose deaths.²³⁰ During its time in Vancouver, the Committee met with Donald MacPherson, the Executive Director of the Canadian Drug Policy Coalition and the former Drug Policy Coordinator at the City of Vancouver who was responsible for the four pillars approach. He indicated that similar to Switzerland, this strategy reflected a reorientation of viewing drug use as a health matter and challenged the status quo by calling for new and innovative interventions:

A combination of efforts by the people who use drugs, the health authority, the city and the Vancouver Police Department put in place an expanded treatment system, more harm reduction services including needle exchange/distribution program, and a supervised injection site.²³¹

With a reorientation to a health-based approach to drugs, the Committee believes it is appropriate for treatment and prevention to accompany harm reduction and law enforcement as separate and individual pillars. The majority of the stakeholders who provided evidence to the Committee, regardless of their views on the need for drug policy reform, espoused the value of enhanced focus on these two areas.²³² Some stakeholders noted that given the limited success of law enforcement initiatives to

227 Hughes, C and Wodak, A, *What can Australian learn from different approaches to drugs in Europe including especially Portugal, Switzerland, the Netherlands and Sweden?*, Australia21, Sydney, 2012, p. 10.

228 Csete, J, *From the Mountaintops: What the World Can Learn from Drug Policy Change in Switzerland*, Open Society Foundations, New York, 2010, p. 23.

229 Federal Office of Public Health FOPH, *National Strategy on Addiction and Action Plan 2017-2024*, Bern, 2017.

230 Carter, C and Macpherson, D, *Getting To Tomorrow: A Report on Canadian Drug Policy*, Canadian Drug Policy Coalition, Vancouver, 2013, p. 44.

231 Carter, C and Macpherson, D, *Getting To Tomorrow: A Report on Canadian Drug Policy*, Canadian Drug Policy Coalition, Vancouver, 2013, p. 44.

232 Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017; Commander Bruce Hill, Manager, Organised Crime, Australian Federal Police, *Transcript of evidence*, 13 November 2017; Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017; Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017; Josephine Baxter, Executive Director, Drug Free Australia, *Transcript of evidence*, 21 August 2017; Keith Hamilton, Senior Minister / Group CEO, Parramatta Mission of the Uniting Church of Australia, *Transcript of evidence*, 23 May 2017; Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017; Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017; Dr Nicole Lee, Director, 360 Edge, *Transcript of evidence*, 4 September 2017; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017; Sonia Vignjevic, Acting Chairperson, Victorian Multicultural Commission, *Transcript of evidence*, 18 September 2017; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017; Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017.

reduce the availability of illicit substances, there is a need to realign efforts at the other end to reduce demand. In particular, John Ryan, the Chief Executive Officer (CEO) of the Pennington Institute advised that the drug market is driven by people with addictions and this is the area for greatest redress:

As an island nation we will never be able to afford a border control regime that actually eliminates the importation of drugs. It is just impossible because of global trade and the amount of commerce, imports, that we have coming in for other matters. But if we did actually manage to control our borders perfectly well, drug production would shift to domestic production and we would still be having the problem, which is that the drug market is actually being driven by people who are addicted. So we have got to concentrate on reducing the chance of people becoming addicted, and when they are addicted we have got to get them out of their addiction. That is the solution.²³³

Similarly, Commander Bruce Hill, Manager of Organised Crime at the AFP told the Committee of the importance of reducing demand at the community level, in addition to law enforcement efforts:

...I think the money and the effort that the government - both federal and state - put into prevention and rehabilitation is money well spent. That is where we need to put a lot of our effort, because this is most certainly not a law enforcement sole effort. We have a role to play with the organised crime part, but the more we can put at that front end to stop the community taking drugs the better it is for all of us.²³⁴

The Committee believes a shift to a four pillars approach can occur at the state level without a shift in the NDS, although the Committee would welcome a similar approach at the federal level as it will likely influence drug policy and law reform in other Australian jurisdictions. The Committee also notes that in Victoria a shift to a four pillars approach will only achieve its intended objectives if it is accompanied by proportionate levels of funding. Dr Nicole Lee noted to the Committee that it would be beneficial to think about prevention and treatment separately, although 'the real benefit would be in funding them effectively and to a level where they are able to make an impact regardless of whether they are split out or not in theory'.²³⁵ This is addressed further in section 4.6.

RECOMMENDATION 2: In recognition of the imbalanced investment in drug-related expenditure under the three pillars of demand reduction, supply reduction and harm reduction, the Victorian Government develop a new drug strategy based on the four pillars of:

- Prevention
- Law enforcement
- Treatment
- Harm reduction.

²³³ John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, p. 10.

²³⁴ Commander Bruce Hill, Manager, Organised Crime, Australian Federal Police, *Transcript of evidence*, 13 November 2017, p. 443.

²³⁵ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 376.

4.5 New governance structure

In the same way that the effectiveness of the four pillars approach to drugs will be influenced by proportionate and balanced funding, it will also be heavily influenced by the level of collaboration and coordination across the Victorian Government. As indicated by Judge Sara Hinchey, the State Coroner of Victoria, drug-related issues are often wrapped up together, making it difficult to focus on only one solution. Further, there is ‘no silver bullet’ to drug policy. It is not purely a health issue or legal issue but rather is a combination of strategies and coordination of those strategies.²³⁶ According to Keith Hamilton, Senior Minister and Group CEO of the Parramatta Mission of the Uniting Church of Australia, a whole-of-government approach is required:

It needs to encompass health, education, housing and other family community services as a totality, the approach. I believe there needs to be an integration or coordination of government services in working with people who are living with a substance addiction rather than a disjointed effort. The ability to recover can be affected by a plethora of variables.²³⁷

Since the inception of the NDS, there have been numerous whole-of-government coordination efforts to respond to drug-related issues. This has occurred within both state and commonwealth governments, and often at a ministerial level. However, their longevity and success have depended on the government at the time and its time in power.

At the federal level, the Ministerial Council on Drug Strategy (MCDS) was established as a council under the Council of Australian Government (COAG) and its core responsibility was implementation of the NDS. The MCDS comprised representatives of various state and territory health and law enforcement ministers who as explained by Gino Vumbaca of Harm Reduction Australia, would meet two to three times a year to discuss drug policy. He indicated that this ‘was quite unique, at the time, to actually have that, because what it recognises is that they each have a role to play’.²³⁸ Professor Margaret Hamilton informed the Committee that the MCDS met regularly for a while, although it lost momentum and the ministers would meet less and would eventually be replaced by less senior government officials. Consequently, the cohesion was lost, as was the high profile and ongoing attention to drugs policy. She stated:

So I think what we saw over time was that they went to once-a-year meetings and then half-a-day meetings and then senior officials and then government officers, who were very senior initially, and then I used to sometimes go to those meetings and I would see more and more junior officers and they did not know anything of the history. They had been in the job for three months, they were heading off to agriculture or trade and so they did not know what they were talking about. So you could not have a meaningful discussion. I think that lack of cohesion from high level right down to grassroots between law enforcement and health also became dissipated. Justice people and law enforcement started meeting on their own; health started meeting on their own. They stopped talking to one another...²³⁹

²³⁶ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 20.

²³⁷ Keith Hamilton, Senior Minister / Group CEO, Parramatta Mission of the Uniting Church of Australia, *Transcript of evidence*, 23 May 2017, p. 130.

²³⁸ Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 110.

²³⁹ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 62.

In February 2011, COAG agreed that the MCDS should not continue as a council under COAG and from that point, the officers-level Intergovernmental Committee on Drugs should coordinate efforts to implement the NDS.²⁴⁰ The Committee also understands that a Ministerial Drug and Alcohol Forum, comprising health and law enforcement ministers from each jurisdiction, has been in operation since 2015 and is responsible for overseeing the implementation of the various national drug and alcohol-related strategies.²⁴¹

In Victoria, at various times over the last 25 years, there have been different drug advisory type councils or groups established by the government of the day. As indicated in the introduction of this report, former Premier Jeff Kennett established the Premier's Drug Advisory Council, followed by the Drug Expert Advisory Committee established by Premier Steve Bracks. In 2001, the Premier's Drug Prevention Council was established following a joint sitting of Parliament that examined drug issues. Its purpose was to advise the Government on drug prevention, conduct research and promote prevention in the broader community.²⁴² Under the Bracks Government, a Chief Drug Strategy Officer was also established to coordinate strategies across government and to advise the Minister for Health, the responsible minister for drug policy at the time.²⁴³

Currently, the key drug-related advisory group in Victoria is the Premier's Ice Action Taskforce, which was established in 2014. It is chaired by the Victorian Premier, Daniel Andrews MP and comprises other government ministers across various portfolios including health, mental health, police and the Attorney-General, in addition to various other experts from the courts, research and legal groups, and the treatment sector (see Appendix 6 for full membership list). It is also supported by a Specialist Workforce Advisory Group that provides advice on issues affecting police, doctors, nurses, paramedics and health, in addition to community and support service workers.²⁴⁴ The Taskforce's initial purpose was to develop the Ice Action Plan by March 2015, as well as examine strategies to reduce the demand, supply and harm associated with ice use.

The Committee also notes the recent establishment by the Victorian Government of a panel of health and community representatives and chaired by Jeff Kennett to oversee the trial of the medically supervised injecting centre (MSIC) in North Richmond. An expert advisory group was also established, which includes health, community sector, consumers and community safety experts, to provide advice on the development of the regulations to govern the MSIC.²⁴⁵

The Committee commends the Victorian Government, past and present, for the establishment of these taskforces and advisory panels. To continue this good work and expand it across all drug-related issues, the Committee recommends the Government establish a new governance structure to oversee and monitor the four pillars drug strategy, to provide leadership on drug policy reform in Victoria, and

²⁴⁰ Ministerial Council on Drug Strategy, *COMMUNIQUÉ* Media release, Canberra, 25 February 2011.

²⁴¹ Department of Health, 'Ministerial Drug and Alcohol Forum', viewed 16 February 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/ministerial-drug-alcohol-forum>>.

²⁴² Department of Human Services, *Improving health, reducing harm: Victorian Drug Strategy 2006-09*, Victorian Government, Melbourne, 2006, p. 6.

²⁴³ Department of Human Services, *Improving health, reducing harm: Victorian Drug Strategy 2006-09*, Victorian Government, Melbourne, 2006, p. 6.

²⁴⁴ Minister for Health and Special Minister of State, *Ice Action Plan: Protecting our Frontline Workers*, Media release, Victorian Government, 5 March 2015.

²⁴⁵ Victorian Government, 'Medically supervised injecting room', viewed 13 March 2018, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/injecting-room>>.

address other drug-related issues as they arise. The proposed governance structure will facilitate a broad range of stakeholders working together from high levels down to the grassroots, ensuring strong engagement from across government and non-government groups.

First, the governance structure should be overseen by a Ministerial Council on Drugs Policy that comprises ministers currently on the Premier's Ice Action Taskforce and expanded to include ministers responsible for education, early childhood education, road safety, corrections, multicultural affairs, and families and children. The ministerial council will be responsible for coordination of drug policy, laws and other initiatives across the Victorian Government.

Secondly, the governance structure should comprise an independent Advisory Council on Drugs Policy that includes experts, similar to those currently on the Premier's Ice Action Taskforce and the Specialist Workforce Advisory Group, to advise the ministerial council on drug-related issues and research in Victoria. This recommendation is based on the UK model, specifically the Advisory Council on the Misuse of Drugs (ACMD), an independent expert body that exists under the *Misuse of Drugs Act 1971* and is sponsored by the Home Office to advise the UK Government on drug-related issues. The ACMD comprises 24 members with expertise across various areas, including treatment, enforcement, forensic chemistry, neuropharmacology, clinical psychology or general practice, prison management, offender management, public health, pharmacy and law. The Council's key responsibilities are to:

- make recommendations to government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the *Misuse of Drugs Act 1971* and its regulations
- consider any substances which are being or appear to be misused and of which is having or appears to be capable of having harmful effects sufficient to cause a social problem
- carry out in-depth inquiries into aspects of drug use that are causing particular concern in the UK, with the aim of producing considered reports that will be helpful to policy makers and practitioners.²⁴⁶

On the Committee's overseas study tour, it had the opportunity to meet with the chair of the ACMD, Dr Owen Bowden-Jones, who outlined how the Council operates and advises the UK Government. Dr Owen Bowden-Jones indicated that the ACMD receives an annual commission letter from the Home Office outlining key priorities for each year, although it also has the capacity to self-generate research on topical issues. Examples of this research include fentanyl and the report *Reducing opioid-related deaths in the UK*,²⁴⁷ released in December 2016. Upon release of a report by the ACMD, the Health Minister is mandated to respond within three months, either indicating its support for the recommendations or a comprehensive reason as to why recommendations are not supported. Importantly, Dr Owen-Jones advised that as the ACMD is an independent body, it focuses purely on the science and evidence, rather than on politics.²⁴⁸ The Committee believes this is a useful model to base the proposed advisory council for Victoria on.

²⁴⁶ Advisory Council on the Misuse of Drugs, 'About us', viewed 7 March 2018, <<https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs/about>>.

²⁴⁷ Advisory Council on the Misuse of Drugs, *Reducing Opioid-Related Deaths in the UK*, UK Government, London, 2016.

²⁴⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 31.

The Committee also acknowledges the important role played by frontline workers and individuals who actively work with and support people with substance use issues, in addition to the wisdom of people who are recovering from addiction and affected families. In its submission to the inquiry, the Australian Illicit & Injecting Drug Users League (AIVL) identified people who use drugs as the greatest resource in developing effective harm reduction strategies:

AIVL would like to take this opportunity to emphasise a reform in processes – one that is inclusive of people who use drugs and recognises the value of their contribution. We recommend that consultation with representatives of people who use drugs be prioritised in the establishment of policy, service sector reform and other government initiatives related to drug use in the community. We are not the problem, we are a crucial part of the solution.²⁴⁹

Key international agencies, such as the Global Commission on Drug Policy (GCDP) and the Latin American Commission on Drugs and Democracy, have made repeated calls for stakeholders from outside government and official policymaker channels including users, former users of drugs and their families to be included in policymaking.²⁵⁰

The Committee acknowledges and strongly supports the work of peer-based initiatives and advocacy, recognising the contributions they have made to drug law reform in Australia and internationally over the past 30 years. The wisdom and expertise of affected families was also reflected in the evidence provided to the Committee, and the value of these personal experiences in redefining drug policy and advancing change cannot be underestimated. The Committee believes that the Advisory Council on Drugs Policy should comprise representation from the community, acknowledging the unique voice this will bring to Victorian drug policy.

RECOMMENDATION 3: The Victorian Government establish a new Victorian governance structure to oversee and monitor the four pillars drug strategy. It should include:

- Ministerial Council on Drugs Policy – comprising relevant Victorian Ministers responsible for the portfolios of health, mental health police, education, early childhood education, road safety, corrections, multicultural affairs, and families and children
- Advisory Council on Drugs Policy – comprising experts to advise the Victorian Government on drug-related issues and research in Victoria, in addition to individuals (current users, recovering users, affected families) who actively work with and support people affected by substance use.

Throughout this report, the Committee refers a number of recommendations to the proposed Advisory Council on Drugs Policy for action. These are outlined in Appendix 7. If the Victorian Government does not support the establishment of the new governance structure, the Committee trusts that the Government will redirect these recommendations to appropriate agencies for implementation.

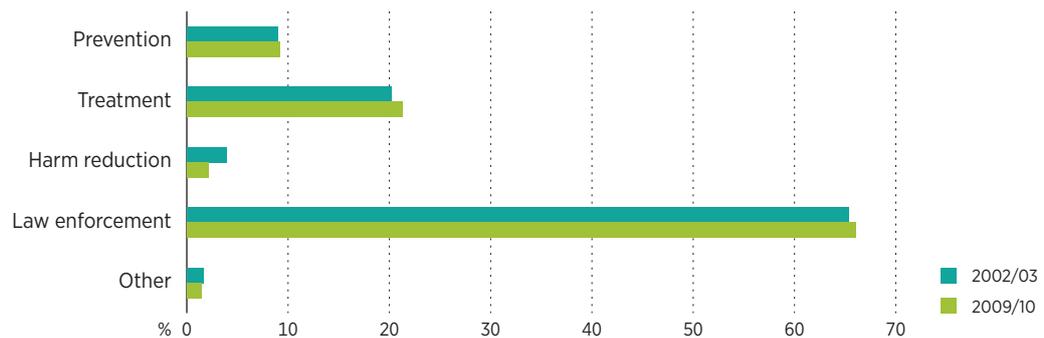
²⁴⁹ Australian Injecting & Illicit Drug Users League, *Submission*, no. 169, 17 March 2017.

²⁵⁰ Latin American Commission on Drugs and Democracy, *Drugs and Democracy: Toward a Paradigm Shift*, 2009, p. 11.

4.6 Drug-related expenditure

Throughout the inquiry, the Committee received overwhelming evidence that the allocation of expenditure to drugs policy in Australia is disproportionate and heavily weighted to law enforcement measures rather than harm reduction, treatment and prevention initiatives. According to research by drug researcher and clinician Dr Alison Ritter and colleagues, Australian governments spent approximately \$1.7 billion on illicit drugs in 2009-10, which equated to .13 per cent of gross domestic product (GDP) and .8 per cent of all government spending.²⁵¹ Ritter et al demonstrated that 66 per cent of government funding was allocated to law enforcement, followed by 21 per cent to treatment, 9 per cent to prevention and 2 per cent to harm reduction. As shown in figure 4.1, they compared this spending with similar research conducted in 2002-03, and found the relative allocations to be 'exceptionally similar'.²⁵² They highlighted, however, one notable exception which was a decrease in spending in harm reduction initiatives from 2002-03 to 2009-10 from 3.9 per cent to 2.1 per cent. The researchers commented that this was concerning given the 'solid evidence-base for the effectiveness of harm reduction initiatives',²⁵³ a view that the Committee agrees with.

Figure 4.1 Comparison of government drug policy expenditure in Australia between 2002/3 and 2009/10



Source: Ritter, A, et al., *Government drug policy expenditure in Australia - 2009/10*, Sydney, 2013, p. 2.

At the state level, Kym Peake, Secretary of the Department of Health and Human Services (DHHS) told the Committee that the Victorian Government is the main funder of drug treatment and harm reduction programs, as well as having substantial investments in supply reduction efforts. She indicated that the Government provides \$20 million each year for the following harm reduction services:

...focusing on education, around how to reduce and prevent the transmission of bloodborne viruses through the needle and syringe program. It is targeted at health workers — GPs, nurses, counsellors — to provide good information to people about general health care, HIV and hepatitis testing and treatment in non-stigmatising environments. There are peer and outreach services into the community to connect with drug users in their homes or other public places to try and reduce risky behaviours and support them to access services, as well as education for family and friends on how to respond to opioid overdoses.²⁵⁴

²⁵¹ Ritter, A, et al., *Government drug policy expenditure in Australia - 2009/10*, Sydney, 2013, p. 1.

²⁵² Ritter, A, et al., *Government drug policy expenditure in Australia - 2009/10*, Sydney, 2013, p. 3.

²⁵³ Ritter, A, et al., *An Assessment of Illicit Drug Policy in Australia (1985 to 2010): Themes and Trends*, National Drug and Alcohol Research Centre UNSW, Sydney, 2011, p. 3.

²⁵⁴ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 320.

Kym Peake also referred to other harm reduction services provided by the Victorian Government, including trialling new peer-led networks for outreach services to target people disconnected from mainstream services, a new initiative to expand access to naloxone, and a new post-overdose outreach service.²⁵⁵

While the Committee commends the Victorian Government for these initiatives, it is clear that based on overall expenditure allocations, the aim of the NDS of ‘a balanced approach across the three pillars of harm minimisation’²⁵⁶ is far from being achieved. According to Dr Nicole Lee of 360Edge, spending under the NDS largely supports a prohibitionist approach to illicit substances and is a reflection of the prevailing ‘war on drugs’ approach:

This imbalance that we see in the implementation of the *National Drug Strategy* is really a reflection on the prevailing law on drugs approach and the prohibitionist approach to drug policy. It continues to focus on eliminating drug use rather than reducing harms, and this has an impact on a range of areas, including treatment...It means that our treatment services are chronically underfunded because of the policy approach that we have taken. ... across Australia less than half the need is being met by the current funding levels in treatment. This has meant that our services are not flexible enough to respond to changing drug trends.²⁵⁷

Dr Nicole Lee also identified to the Committee how unreasonable it is for two per cent of funding to be allocated to harm reduction initiatives given the scale of the problem and the number of people adversely affected by drug-related harms. She advised that the bulk of at least intervention funding should go to harm reduction, which would have a significant public health benefit.²⁵⁸

In its overseas meeting with Dr Rick Lines, Executive Director of Harm Reduction International (HRI), the Committee was informed of HRI’s *10 by 20 Campaign*, which was created in the lead up to the United Nations General Assembly Special Sessions on drugs in April 2016. The campaign called for governments to redirect 10 per cent of resources currently spent on punitive responses to drugs and invest in harm reduction by 2020. According to HRI, a ten per cent redirection of funding from drug control to harm reduction would:

- end AIDS among people who inject drugs by 2030
- cover annual hepatitis C prevention needs for people who inject drugs across the globe and twice over
- pay for enough naloxone to save thousands of lives every year from opiate overdose
- ensure effective advice, healthcare and emergency responses in the face of newly emerging challenges
- strengthen networks of people who use drugs to provide peer services and campaign for their rights.²⁵⁹

²⁵⁵ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 320.

²⁵⁶ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 1.

²⁵⁷ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 373.

²⁵⁸ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 373.

²⁵⁹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 32.

Stakeholders presenting evidence to the Committee frequently proposed allocating more funding to health-based initiatives.²⁶⁰ Although, some specifically identified that this funding should not be redirected from policing as ‘there is never going to be enough money to go around in terms of being effective as a police officer or being effective as a police service’.²⁶¹ It was also identified that current funding to policing could be more productively spent, focusing on the higher end of criminal activity.²⁶² The Committee agrees with this position, noting that it would be consistent with the Victorian Government reorientating its approach to drugs on a health framework, as proposed in recommendation one. This approach calls for more funding for health-based responses and smarter policing that focuses enforcement efforts on drug trafficking and organised crime, rather than minor participants in the market, whether they are individual users of illicit substances or user-dealers. This should redirect funding into upfront investments that aim to prevent use and demand, rather than predominantly dealing with people at the ‘pointy end’²⁶³, either when they are heavily addicted or in contact with the criminal justice system. As noted by Sam Biondo, the Executive Officer of the Victorian Alcohol and Drug Association (VAADA):

You look at policing systems and prison systems and the billions that get put into that area to deal with the consequences of these problems, and you look at the up-front investment in the prevention and the treatment side of it, it is minuscule.²⁶⁴

4.6.1 Economic modelling of drug policy initiatives and programs

The Committee was surprised to learn that very limited, if any, economic modelling has occurred of investment in drug policy initiatives across the three pillars of supply, demand and harm reduction. It did receive, however, evidence of economic returns of specific initiatives, costs of drug-related incidents and of not dealing with drug use and the related harms. This evidence in particular makes an important contribution to understanding the economic burden of illicit substances on the broader community. For example, Greg Denham, Executive Officer of the YDHF advised the Committee that there are hundreds of ambulance call outs per year in the City of

260 Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 271; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, pp. 159, 163; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, pp. 299, 303; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 44; Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 35; Paul Bodisco, Secretary, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 90; Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, pp. 374, 376; Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 115; Meghan Fitzgerald, Social Action, Policy and Reform Manager, Fitzroy Legal Service, *Transcript of evidence*, 28 June 2017, p. 267; Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, p. 129; Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, pp. 56, 58; Jon O'Brien, Head of Social Justice Forum, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, p. 128; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 3; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 195; Greg Chipp, CEO and Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 288; Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 480; Dr Christian Smyth, Special Adviser, Turning Point, *Transcript of evidence*, 8 May 2017, p. 24; Commander Bruce Hill, Manager, Organised Crime, Australian Federal Police, *Transcript of evidence*, 13 November 2017, p. 443; Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 79.

261 Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017, p. 85.

262 Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 270; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 160; Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017, p. 85; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 47.

263 Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 60.

264 Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 303.

Yarra in response to the escalation in heroin overdoses, which costs around \$1000 per ambulance. Greg Denham stated it is not usual to see more than one ambulance attend an overdose situation and spend two hours there, which when occurring on multiple occasions, is a significant cost to the Victorian Government.²⁶⁵ Michael Stephenson, the Executive Director of Operations at Ambulance Victoria, also advised the Committee of the significant burden on the system of dealing with patients with alcohol and drug issues, and especially if they have mental health concerns:

These cases tend to be resource intensive...Of course that will often require a significant number of police resources. I mean, you see six or eight police at a case and two to four paramedics for one patient. That is an extraordinary burden on the system, and it goes on for some time because the case times tend to be quite lengthy by the time you restrain a patient so that they are safe, sedate them and care for them after the sedation.

They will often have a police presence in the transport, so at least a couple of police tied up and a couple of paramedics — and often three or four paramedics. So they are very resource intensive, labour intensive and very difficult, and, as you would imagine, on any given night, particularly on busy nights in Melbourne, our case load in relation to drug and alcohol use would add 10 per cent to our total case load for the day. So where we might see normally about 8 per cent of our case load being this, it might grow by another 10 per cent. So it is not unusual to see another 150 or 160 jobs stacked onto our normal case load in relation to this sort of work over a weekend in particular. Add six or eight police at a whole lot of those jobs, and you start to deplete the state's resources pretty quickly.²⁶⁶

In the context of court-related costs for drug-related offences, the Fitzroy Legal Service prepared some rough estimates specific to Victoria that offers further insight into the significant economic burden of illicit substances:

In 2010 Victoria spent \$2.7 billion on “Criminal Justice” costs. These costs are the largest contributor to the total expenditure that was spent by the Victorian government in relation to crime in 2010, at 27.4%. Court costs consisted of \$158.5 million, making up 6% of the total costs. Drug offences typically constitute 5% of total recorded offences. This would mean that drug related court costs at a minimum would be \$8 million in 2010. However, it is shown that from 2010 to 2016, drug offenses have nearly doubled. This could possibly mean that drug related costs would have almost doubled, to \$16 million in 2016.

In addition, the majority of drug offences are ‘low level’ drug offences, typically possession and use rather than drug dealing and trafficking. Year on year, drug use and possession accounts for 80% of all drug related crimes. The most common form of drug possessed is cannabis which accounts for at least 40% of all drug related offences since 2010. A rough estimate would show that cannabis possession costs the Victoria[n] government \$5.12 million in court costs in 2016 alone.²⁶⁷

At the other end of the spectrum, the Committee received evidence of returns on investment for NSP initiatives and treatment, which from an economic perspective provide significant incentives for governments to enhance current funding levels in these areas. John Ryan of the Pennington Institute referred to the NSP as an ‘absolute triumph’, highlighting that the economic return is \$4 to \$1 and when other economic costs are included, it is \$27 to \$1.²⁶⁸ Charles Henderson, Acting Executive Officer of

265 Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 47.

266 Michael Stephenson, Executive Director, Ambulance Victoria, *Transcript of evidence*, 19 June 2017, pp. 222-223.

267 Jennifer Black, *Supplementary evidence*, Fitzroy Legal Service, 11 August 2017, pp. 7-8.

268 John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, p. 3.

Harm Reduction Victoria also referred to the success of NSP, noting that a 10-year period of government investment resulted in 32,000 HIV infections and over 96,000 hepatitis C cases being averted, hence the savings on downstream health costs.²⁶⁹ In the context of treatment, Windana Drug and Alcohol Recovery Centre advised in its submission that there is an \$8 return for each dollar spent on alcohol and other drug (AOD) treatment. Windana also indicated that treatment reduces hospital, emergency department and ambulance demand; and diverting Aboriginal and Torres Strait Islander (ATSI) people into residential treatment rather than prison saves over \$200,000 per individual through reduced mortality and improved health outcomes, as well as a reduction in prison demand.²⁷⁰

Internationally, the Committee is aware that some of the more controversial harm reduction and treatment initiatives have proven cost-effectiveness, particularly heroin-assisted treatment (HAT). Studies into the program implemented in Switzerland, Germany and the Netherlands reported costs between €12,7000 and €20,400 per patient per year. While these costs are high, the studies demonstrated that they were more than compensated by significant savings to the broader community on less money spent on criminal procedures and imprisonment.²⁷¹ Further, when the Committee met with Vancouver Police Department as part of its overseas study tour, Staff Sergeant Mark Horsely praised Vancouver's HAT program on the specific basis of cost-savings, identifying that while HAT costs \$27,000 per person, there were suggested savings of \$130,000 per person from them no longer being involved in criminal activity to support their addiction.²⁷²

While the above evidence of costs and savings are important contributions to the current debate about appropriate expenditure allocations in drugs policy, it is important to establish a strong evidence base to inform best practice and reallocation of funds. This requires economic modelling of interventions across the pillars of law enforcement, prevention, treatment and harm reduction to assess cost-efficiencies; ideal spending proportions; and matching funding to specific outcomes. In its evidence to the Committee, the Penington Institute recommended that the Victorian Government 'commission a comprehensive evaluation of Australia's policy and expenditure with regard to illicit drugs and drug use – the first in Australia's history'.²⁷³ On this basis, the Committee makes the following two recommendations in the area of drug expenditure.

RECOMMENDATION 4: The Victorian Government commission an independent economic review into drug-related expenditure and outcomes in Victoria. This should include a cost-benefit analysis of all key initiatives and be made publicly available.

RECOMMENDATION 5: The Victorian Government advocate to the Commonwealth Government to conduct a similar review at the national level.

²⁶⁹ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 65.

²⁷⁰ Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017.

²⁷¹ Rolles, S, et al., *The Alternative World Drug Report - Counting the Costs of the War on Drugs: 2nd Edition*, Transform Drug Policy Foundation, London, 2016, p. 182.

²⁷² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 50.

²⁷³ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 52.

4.7 The importance of good data, data collection and sharing

To support the framework for effective law reform, reliable data and effective and timely data sharing are essential for drug policy and practice.

4.7.1 International experiences with drug data

As part of its overseas study tour, the Committee came to understand the true value of efficient data collection processes to measure the effectiveness of key policy change, to assist respond to drug issues as they arise, and importantly, to forecast and prevent issues from occurring in the first place. The opioid overdose crisis in North America, particularly in Vancouver, Canada and Sacramento, California where the Committee visited, reinforced this value. Both jurisdictions have implemented and enhanced existing data collection and collation of key data sources, and sharing those datasets in a timely manner across health and law enforcement agencies, which has been essential to identify hot spots for accidental overdoses and to also determine where existing service gaps might be. The California Department of Public Health established the Surveillance Data Dashboard, which monitors opioid overdoses on a real-time basis and feeds information back to local communities and other relevant agencies. Data collected relates to law enforcement activity, hospital emergency room visits and hospital discharges, as well as deaths.²⁷⁴ In Vancouver, with the declaration of a public health emergency in response to overdose deaths, a public order now requires enhanced data collection and sharing between key agencies. The British Columbia Centre for Disease Control coordinates data from the following sources:

- ambulance-attended overdoses: real-time incidence and trends
- emergency department visits: context of drug use such as whether the person is in stable housing, whether they use alone, the frequency of their use, what they think they are using compared to what the substance actually is, etc.
- physician calls: early signal of an unusual presentation. Another avenue is police services when they are called to unusual situations
- coroners' data: severity, context of drug death and toxicology.²⁷⁵

The British Columbia Centre for Disease Control advised the Committee that the data includes demographic breakdown of overdoses, which are overlaid with the presence of social and health interventions, such as injecting sites, to determine where service gaps might exist in particular areas. The datasets are made available to the appropriate authorities on a weekly basis.²⁷⁶

In the context of cannabis legalisation in Colorado, the Committee heard numerous times from both government officials and legalisation advocates, the value of collecting data to measure this significant policy's impact on harms and other health outcomes, such as prevalence of use, hospital and emergency department presentations, poison-centre control hotlines, and road crashes. The Marijuana Industry Group (MIG), the oldest and largest trade association for licenced cannabis

²⁷⁴ California Department of Public Health, 'California Opioid Overdose Surveillance Dashboard', viewed 12 February 2018, <https://pdop.shinyapps.io/ODdash_v1/>.

²⁷⁵ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 58-59.

²⁷⁶ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 59.

businesses in the US, also advised of the need to collect relevant data prior to and following implementation of the legislation. This is in order to measure its effectiveness in eliminating the illicit cannabis market, and to understand how much product is in the legal marketplace and whether it is meeting demand.²⁷⁷

Similarly, in Portugal Dr João Goulão, the General Director and National Drug Coordinator for the General Directorate for Intervention on Addictive Behaviours and Dependencies, informed the Committee that the policy of decriminalisation is supported by a comprehensive reporting system. The General Directorate for Intervention on Addictive Behaviours and Dependencies is responsible for coordinating all relevant departments' data relating to substances. Every year, Dr Goulão presents a report to the Parliament on current use and trends, along with the Director of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). This data collection and dissemination has played an important role in promoting, both locally and internationally, the Portuguese model's effectiveness in minimising drug harms.²⁷⁸

4.7.2 Victoria's experiences with drug data

As outlined in chapter two, a number of key datasets exist in Victoria and Australia that contribute to a general understanding of the types of illicit substances on the market, their price and purity levels; substance use and demand in the community; harms, deaths and other health impacts; treatment availability and utilisation; and associated criminal activity. Key datasets discussed in chapter two included the Australian Institute of Health and Welfare's National Drug Strategy Household Survey, the Australian Criminal Intelligence Commission's National Wastewater Drug Monitoring Program, and the National Drug and Alcohol Research Centre's (NDARC) Illicit Drug Reporting System (IDRS) and Ecstasy and Related Drugs Reporting System (EDRS). Other data collection sets include hospital emergency department data on drug-related admissions; Coroners Court data on drug-related deaths; police and law enforcement data, including drug seizures and drug use of police detainees; treatment data collected by the DHHS; data collected by non-government agencies; and local government data on drug-related amenity in their areas.

Further, and of particular interest to the Committee is Turning Point Alcohol and Drug Centre's *Ambo Project*, which in partnership with the DHHS and Ambulance Victoria, operates a unique dataset on non-fatal drug-related events attended by ambulances in Victoria. As advised by Professor Dan Lubman, the Director of Turning Point, the Ambo Project provides extensive information on the burden of alcohol and drugs on emergency services. The project also collects data on various other factors involved in such presentations, including pharmaceutical drug issues, police co-attendance, comorbidity factors, location of incidents, violence, presence of children, refugee status and family issues. As the data is geospatially coded and time stamped, the time and location of incidents can be determined. Professor Dan Lubman advised that the dataset has informed many of its and Victorian Government policy initiatives and planning responses to issues:

Because we are able to look at point of contact we can actually look at where things are happening, trends over time, and it gives us a very timely sort of indication of what is happening. We get the data two months after it has occurred, so it gives us a really great indication of when we are seeing changes. That allows us to think more

²⁷⁷ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 62.

²⁷⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 15.

broadly about population and planning, but it also allows us to think about hotspots, it allows us to even think about predictive forecasting — to think about if we could identify issues as they arrive, starting to model where that might happen across the state.²⁷⁹

The Committee is also aware of AODstats, produced by Turning Point and funded by the DHHS. It brings together numerous data sources and provides information on the harms relating to alcohol, illicit and pharmaceutical drug use in Victoria.²⁸⁰

Despite the broad range of data sources, many stakeholders told the Committee that drug data is ‘soft, whether it is at the policing level, at the prison level or in fact at the community level’.²⁸¹ One example is self-reported survey data regarding use, which as identified in chapter two, often does not accurately represent prevalence rates because participants are reluctant to admit that they consume illicit substances. Although, John Ryan of the Pennington Institute advised the Committee that encouraging people to be more transparent about drug use would be an easy win ‘as long as we dealt with people’s fear and anxiety around the stigma that results from self-disclosure’.²⁸²

In her evidence to the Committee, Kym Peake of the DHHS, highlighted that work is currently underway in the Department to improve data collection of treatment utilisation patterns, including the demographics of clients receiving treatment, the substances they use, and treatment options. She indicated that they are refining the datasets further to understand treatment wait times and point of intake:

We do not have a centrally captured set of information about wait times particularly for residential rehabilitation services. There are measures in BP3 that really go to the combination of both residential rehabilitation but also residential withdrawals, and there is some work planned about those measures because there are problems in terms of the data collection. We know that often what is recorded is the point of screening, rather than the actual point of intake, and we do not think that measure as currently constructed is really giving us particularly useful insights into your question around what actually are the wait times. So through the work we are doing with the sector on new data collections it is something about which there is a bit of a work in progress, and we recognise we need to get a better handle on it.²⁸³

The Committee believes that current data collection and sharing will improve with the current passing of the *Victorian Data Sharing Act 2017*. This was in response to recognition that ‘for too long government data has been held in agency silos and not available across government to tackle many of the pressing community concerns’.²⁸⁴ The Act also supports the establishment of the Victorian Centre for Data Insights and a Chief Data Officer, a newly established statutory position. The Committee commends the Victorian Government for establishing this data sharing framework, to facilitate more efficient service planning and design across departments, and improve service delivery to the community. The Committee believes that the Chief Data Officer, can work alongside the newly established Ministerial and Advisory Councils to encourage a system of strong drug-related data collection and information

²⁷⁹ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 23.

²⁸⁰ Turning Point, ‘AODStats’, viewed 13 March 2018, <<http://www.aodstats.org.au>>.

²⁸¹ John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, p. 2.

²⁸² John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, p. 6.

²⁸³ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 321.

²⁸⁴ Special Minister of State, Leader of the Government in the Legislative Council, *Improving Data to Deliver Better Services for Victorians*, Media release, State Government of Victoria, Melbourne, 18 October 2017.

sharing across government departments. This is essential for the development of evidence-based policy, and to also measure how effectively the Victorian Government is responding to drug issues in Victoria through the four pillars approach as proposed in recommendation two. As demonstrated in Vancouver and California, the capacity of governments to forecast issues and develop appropriate responses in a timely manner is essential to reducing drug-related harms. Further opportunities for sharing surveillance across relevant agencies are discussed in the following section on early warning systems.

RECOMMENDATION 6: Through the Victorian Centre for Data Insights, the Victorian Government encourage and facilitate a system of strong drug-related data collection and information sharing across all government departments and agencies. The purpose of this data collection and sharing is to:

- build a sound knowledge base to inform drug research and policy efforts
- support the development of timely interventions following specific drug-related events or ongoing incidents
- measure the effectiveness of Victoria's four pillars drug strategy, with regular progress reports to be made publicly available
- enhance capabilities and intelligence efforts of Victoria's law enforcement agencies.

4.8 Early warning systems on new psychoactive substances

As part of strengthened data collection and information sharing, the Committee received evidence about enhancing current surveillance mechanisms, particularly to provide timely information on new psychoactive substances (NPS) and adulterants in illicit substances which cause concern. The past two decades has seen an unprecedented growth in the number of NPS developed and available on the illicit market, described as a global phenomenon that poses risks to public health due to the lack of knowledge of their composition, and long and short-term effects when consumed. It is common for NPS to be used unintentionally, where people are sold products such as MDMA and which are then found to be NPS (or contain NPS). This may result in health harms such as overdose and in some circumstances, has resulted in death. The lack of knowledge on NPS has led to calls for an early warning system (EWS) to enhance data collection and information sharing to avoid such harms from occurring.

Current monitoring of NPS in Australia is fairly limited, and mainly includes NDARC's EDRS and IDRS, which captures significant issues relating to drug trends over time, including preferred and types of drugs on the market, drug use patterns and perceptions of the drug market.²⁸⁵ In this context, these datasets collect critical information that underpin drug policy responses. For example, the systems have identified key shifts and trends in drug use patterns in the areas of: significant shortages in heroin availability in 2001; increased injecting of cocaine and its harms in 2001; increased use of methamphetamine in 2001; and the emergence of methamphetamine, including identifying particular harms.²⁸⁶

²⁸⁵ National Drug and Alcohol Research Centre, *The Ecstasy and related Drugs Reporting System (EDRS) 2017 preliminary findings*, University of NSW, Sydney, 2017, p. 1.

²⁸⁶ Burns, L, et al., 'Monitoring drug markets in the Internet age and the evolution of drug monitoring systems in Australia', *Drug Testing and Analysis*, vol. 6, no. 7-8, 2014, p. 841.

A key challenge of these datasets, however, is that they provide strategic early warning, rather than tactical early warning. A 2011 article on Australian surveillance systems, *Effectiveness of and challenges faced by surveillance systems*, noted '[t]actical early warning applies to situations that require immediate response, while strategic early warning is any type of warning that is issued early enough to permit decision making to formulate a response'.²⁸⁷ As the IDRS and EDRS provide information for strategic purposes, they are not necessarily well equipped to provide timely responses to detect and identify NPS or other substances posing more immediate concerns. The article identified that, as they report annually, they are less suited to monitor low prevalence substances that constantly evolve, such as NPS.²⁸⁸

In its submission, the Victorian Institute of Forensic Medicine (VIFM) reiterated these concerns, particularly in terms of timeliness and the unique nature of NPS markets:

Challenges arise as new drugs are rapidly emerging, many having a low prevalence concentrated in a highly specific population. All these factors contribute to the difficulty of capturing information on new psychoactive substances. Also noted is the potential gap between the intended drug purchase and actual composition, as often NPS are sold as traditional drugs. Finally reporting cycles of such data occurs at 12 month intervals, which given the changing nature of NPS markets is ineffective in the monitoring of drugs.²⁸⁹

It also stated that current reporting systems 'rely on user reports rather than scientific confirmations of drugs exposure – this limits the amount of quality of information regarding overdose and drug toxicity'.²⁹⁰ In 2014, the national Intergovernmental Committee on Drugs (IGCD) issued a *Framework for a National Response to New Psychoactive Substances* (the Framework). It similarly noted that self-reporting 'is flawed as users are not always aware of what they are taking'.²⁹¹

The Committee also received evidence that a current lack of information sharing represents a missed opportunity to respond flexibly to emerging NPS and particular substances of concern. For example, Turning Point manages Victoria's Drug and Alcohol Clinical Advisory Service (DACAS), which provides widely relied upon specialist addiction telephone advice services to health professionals such as general practitioners (GPs).²⁹² Professor Dan Lubman of Turning Point highlighted how such services could be used to improve knowledge and responses to the emergence of NPS, but are not currently able to do so:

I think it comes down to surveillance again. One of the opportunities is to increase both the awareness of emergency services and frontline providers but also the community in terms of what is available, what is dangerous and what people should do about it... Being on call for DACAS we constantly get calls from ED [emergency department] physicians saying, 'Somebody has come in. They've obviously taken something. They're in a terrible state. Can you let us know what the latest thing on the streets might be?'. Unfortunately we do not have access to that data, so often

287 Dunn, M, et al., 'Effectiveness of and challenges faced by surveillance systems', *Drug Testing and Analysis*, vol. 3, no. 9, 2011, p. 636.

288 Dunn, M, et al., 'Effectiveness of and challenges faced by surveillance systems', *Drug Testing and Analysis*, vol. 3, no. 9, 2011, pp. 638-639.

289 Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, pp. 16-17.

290 Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, p. 17.

291 Intergovernmental Committee on Drugs (IGCD), *Framework for a National Response to New Psychoactive Substances*, Canberra, 2014, p. 7.

292 Turning Point, *Submission*, no. 116, 15 March 2017, pp. 4-5.

those people are stuck in EDs or are taken to ICU, they are worked up and they are very expensive in terms of time and resources because people do not have the information.²⁹³

The importance of providing timely information to relevant agencies and the general public was highlighted during an incident in Prahran in January 2017, where a number of people overdosed from a suspected ‘bad batch’ of substances. The submission from VAADA stated that:

In some cases, police have indicated that they are aware of potentially highly hazardous pills within the community and have opted not to provide the public with this information. Disturbingly, reflecting on a spate of overdoses in Prahran in January 2017, PWUD [people who use drugs] opting to consume pills are relying on the social media pages of various notorious nightspots for public health information (Lillebuen 2017)... Clearly we need an effective early warning system for bad batches, as is the case for a range of health and safety concerns, such as warnings issued by the Chief Medical Officer on disease outbreaks.²⁹⁴

In response to questions about this incident, Wendy Steendam, Deputy Commissioner of Victoria Police highlighted an opportunity to improve the dissemination of public alerts and sharing that information with other key agencies:

We are not the only agency that would perhaps have the first indicator — it can be the ambulance service, it can be event organisers and other areas that may in fact have that information — so it is making sure that there is a process to actually capture that information and to, where it is going to cause great harm to the community, get that information out as early as we can, and we are committed to that.²⁹⁵

4.8.1 International early warning systems for new psychoactive substances

The United Nations Office on Drugs and Crime (UNODC) views EWS as key to monitoring, ensuring early detection and providing timely responses to the emergence of NPS.²⁹⁶ The most prominent EWS from an international perspective are the UNODC Early Warning Advisory (tracking developments in 102 countries) and the European EWS (tracking developments from the early warning systems of 28 European Union States, Turkey, Norway and other members of its network). These systems facilitate awareness on NPS risks and information sharing between all relevant agencies, particularly law enforcement, forensic health and policy agencies. The European EWS, managed by the EMCDDA has been described as:

...a multidisciplinary network of 30 national early warning mechanisms which collect, appraise and rapidly disseminate information on new drugs and products that contain them...The EWS builds on a variety of information sources such as health and care providers, law enforcement organisations, sources closer to drug users, media, the Internet, etc.²⁹⁷

²⁹³ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, pp. 29-30.

²⁹⁴ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 12.

²⁹⁵ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 454.

²⁹⁶ United Nations Office on Drugs and Crime, *Global SMART Update: Post-UNGASS 2016: NPS trends, challenges and recommendations*, Vienna, 2016, p. 7.

²⁹⁷ European Monitoring Centre for Drugs and Drug Addiction, *Early Warning System: National Profiles*, Lisbon, 2012, p. 7.

The national systems that form the basis of the European EWS all differ in relation to issues such as composition, core functions and information flows. For example, according to a 2012 report from the EMCDDA, *Early Warning System: National Profiles*, the Austrian EWS is set up to ‘exchange relevant information as quickly as possible to prevent any negative health consequences’ and works on both federal and regional networks.²⁹⁸ The federal level includes relevant government agencies, regional drug addiction coordinators, laboratories and research institutions. The regional level includes drug services (such as outreach and treatment organisations), emergency departments, forensic medicine institutions and the public health sector. Others that can be involved include police, hospitals, GPs and youth organisations. These networks gather and report information on various issues such as new substances, impurities or high concentrations.²⁹⁹

In another example, the Spanish EWS comprises a range of relevant stakeholders including agencies of federal and regional governments, including health, police, customs and toxicology agencies and civil society organisations. A 2014 report on the Spanish Ministry of Health, Social Services and Equality website notes that civil society organisations ‘play an irreplaceable role’ from a public health perspective, providing a link to young people to gather information about new substances.³⁰⁰

Key benefits of establishing EWS are outlined below.

Detection and identification of new psychoactive substances

The United Nations Office on Drugs and Crime reiterates that detecting and identifying NPS is ‘critical to supply reduction, data collection, health interventions and form the basis of effective drug policy responses’.³⁰¹ In terms of the European EWS, countries provide reports to the EMCDDA with relevant information, such as ‘the first time a new substance is identified in a country, large or unusual seizures, trafficking and the involvement of criminal groups’.³⁰² Following analysis by EMCDDA, formal notifications for new substances can be issued, and such information is shared by email in a timely manner with the European Network. This ensures that national systems are kept up to date with the most recent information about new substances.³⁰³ The continuous loop between national systems and the coordinating body ensures a central repository for information, as well as rapid feedback mechanisms to national systems so that they can effectively respond to the presence of emerging NPS.

Facilitating public health alerts

One of the main functions is to provide timely public health alerts when serious harms occur, such as deaths. The European EWS issues public health alerts based on information received from its EWS Network and other data sources. It

²⁹⁸ European Monitoring Centre for Drugs and Drug Addiction, *Early Warning System: National Profiles*, Lisbon, 2012, p. 11.

²⁹⁹ European Monitoring Centre for Drugs and Drug Addiction, *Early Warning System: National Profiles*, Lisbon, 2012, p. 11.

³⁰⁰ Gonzalez, A and Llorens, A, *New Psychoactive Substances. A Challenge to Public Health: The Spanish Early Warning System*, Asociación de Técnicos para el Desarrollo de Programas Sociales and the Spanish Government Office for the National Drug Plan (DGPNSD), Madrid, 2013, pp. 77-78.

³⁰¹ United Nations Office on Drugs and Crime, *Global SMART Update: Post-UNGASS 2016: NPS trends, challenges and recommendations*, Vienna, 2016, p. 4.

³⁰² European Monitoring Centre for Drugs and Drug Addiction, *EMCDDA - Europol 2016 Annual Report on the implementation of Council Decision 2005/387/JHA*, EMCDDA and Europol, Lisbon, 2017, p. 14.

³⁰³ European Monitoring Centre for Drugs and Drug Addiction, *EMCDDA - Europol 2016 Annual Report on the implementation of Council Decision 2005/387/JHA*, EMCDDA and Europol, Lisbon, 2017, pp. 14-15.

issued 117 public health alerts from 2005 to 2015,³⁰⁴ and reported issuing a further 15 communications in 2016, addressing issues across Europe including: deaths involving opioids such as various types of fentanils, safe handling of carfentanil, deaths and intoxications involving synthetic cannabinoids, and ocfentanil sold as heroin.³⁰⁵

Dr Monica Barratt, Research Fellow of the Drug Policy Modelling Program at NDARC also described an example from the Netherlands where the national early warning system facilitated an effective public health alert in 2014. The pills in question contained a high content of a concerning substance called PMA and was being sold as ecstasy or MDMA. The Dutch early warning system issued a public alert that was widely distributed, and no deaths were recorded in the Netherlands. Dr Barratt highlighted that in the United Kingdom, four deaths from the same substance were recorded in the following week.³⁰⁶ This example highlights the utility in having an early warning system that can rapidly pick up and disseminate information to the broader community.

Early warning systems as a tool for monitoring the new psychoactive substances drug market

The European Monitoring Centre for Drugs and Drug Addiction notes that, while detecting and identifying the presence of NPS that emerge for the first time in Europe is important, this ‘does not reflect the foothold that each substance gains in the market’.³⁰⁷ National early warning systems contribute to this evidence base by providing regular reports to the EMCDDA, which then uses this information to publish and monitor integrated information about the European drug market.

4.8.2 Establishing a Victorian early warning system

The Committee heard evidence from stakeholders in support of the establishment of an EWS.³⁰⁸ Most strikingly, the Victorian Institute of Forensic Medicine recommended the establishment of a Victorian EWS, with the intention of being:

...Australia’s first surveillance system to monitor the harms of NPS use across Victoria, providing an evidence base and key research tool to inform drug research, policy and practice. Once established, the system could be expanded nationally to provide a coordinated approach to public education and awareness of drug harm.³⁰⁹

The Victorian Institute of Forensic Medicine stated that the EWS could enable real-time public health warnings from the Coroner of Victoria, the DHHS, the Chief Medical Officer or Victoria Police depending on the circumstances involved. This

304 European Monitoring Centre for Drugs and Drug Addiction, *New psychoactive substances in Europe: An update from the EU Early Warning System, March 2015*, Luxembourg, 2015, p. 10.

305 European Monitoring Centre for Drugs and Drug Addiction, *EMCDDA - Europol 2016 Annual Report on the implementation of Council Decision 2005/387/JHA*, EMCDDA and Europol, Lisbon, 2017, p. 16.

306 Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 424.

307 European Monitoring Centre for Drugs and Drug Addiction, *EMCDDA - Europol 2016 Annual Report on the implementation of Council Decision 2005/387/JHA*, EMCDDA and Europol, Lisbon, 2017, p. 15.

308 Unharm, *Submission*, no. 182, 17 March 2017, pp. 15-16; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 12.

309 Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, p. 17.

system would ‘effectively communicate the risks associated with new detected NPS’s, particularly those that have contributed to deaths reported to the coroner, or have resulted in a significant number of overdoses’.³¹⁰

Further, the VIFM suggested that such a system could enable analysis of trends in NPS-harm over time and could complement other surveillance systems in Australia, such as the IDRS, EDRS, therapeutic drug monitoring, and morbidity and mortality reporting.³¹¹

Dr Dimitri Gerostamoulos, the Chief Toxicologist and Head of Forensic Sciences at the VIFM also stated that the system, which could be national, would provide ‘real-time detection data, monitoring and information about what these drugs are and how they are being used in the community’.³¹² The information would be critical in understand harms from NPS, as well as from ‘traditional drugs that are often used in combination and what those harms are on people in our society’.³¹³

Ms Judith Abbott, Director of Community-based Health Policy and Programs, at the DHHS advised the Committee that some conversations are taking place with police about adopting enhanced information flows in relation to concerning substances:

The earlier conversation, which was at an officer level, has been about who might get the information first, how do you decide what is the trigger for it needing to be shared and how do you get around to everyone who might play a role in that, because it depends on where it is occurring as to whether it is ambulance, whether it is EDs [emergency departments], whether it is police or others. So that is where that is at the moment.³¹⁴

The Committee notes media reports in July 2017 suggesting that Victoria Police is considering ways to alert venues and patrons about substances of concern, particularly through text messages.³¹⁵ While there is not enough information for the Committee to comment on this, an EWS would provide an appropriate avenue for such information to be shared with relevant health authorities and key stakeholders. The Committee stresses the importance of ensuring the involvement of civil society in such a system to ensure responsible and accurate information would be shared quickly with the public by organisations working directly with people who use drugs and the broader community.

Dr Monica Barratt also informed the Committee that NDARC is currently undertaking a project regarding an EWS in Australia, however, this system would involve a three month time frame:

I know there is also a program that NDARC has almost finished at this point looking at what are all the available sources of data that we could use for an early warning system. I understand that that is currently happening, funded by the commonwealth. That will come to a reporting stage very soon. It will be an overview of: how quickly can we collate the information that is currently being collected anyway for administrative purposes across Australia into an early warning system?

³¹⁰ Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, p. 16.

³¹¹ Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, pp. 17-18.

³¹² Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 208.

³¹³ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 208.

³¹⁴ Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 326.

³¹⁵ Devic, A, ‘Push for phone drug warning’, *Herald Sun*, 3 July 2017.

When I spoke further with people about the early warning system, what they are talking about there is three months. They are not talking about the kind of thing that I would like to see, which is sort of ‘What is happening this weekend in terms of the party scene?’, so it is a different kind of early warning system. It is still really important. We need to have quicker access to the data that exists so we can get there quicker, rather than saying, ‘Well, this report comes out but it refers to data from two years previous’. What use is that? So I think it is important that we get earlier and earlier systems, but actually getting something that is responsive in a rapid or real-time manner is where I think we should look.³¹⁶

A few individuals who provided submissions to the inquiry also discussed the value of providing public health warnings about particular drugs. For example, Ms Melanie Audrey discussed that an EWS ‘to alert festival goers and the authorities of what’s doing the rounds, will save lives’.³¹⁷

Drug checking services as part of early warning systems

The Committee notes that some countries’ EWS are linked to their local drug checking services that engage members of the public to have their substances tested to ascertain its contents. Indeed, the examples of EWS outlined above from the Netherlands, Austria and Spain (and others that contribute to the European EWS) all include and rely on drug checking services to inform warnings or alerts about NPS and particular issues of concern. In Spain, for example, the drug checking service, Energy Control, reported that in 2015, it issued 158 alerts to consumers about toxic substances or high dosages. It also provided 49 reports to the Spanish EWS in 2015 (a growth from 11 reports in 2014).³¹⁸

Further, the EWS in the Netherlands is informed by a network of 30 drug checking services that are located throughout the country, relying on the samples provided by service users and which form the basis of a series of warnings that can be issued. The example of a public health warning issued on PMA in the Netherlands was only possible because of the drug checking services in that country. A number of stakeholders to the inquiry highlighted the benefits of the drug checking network in the Netherlands as a key mechanism of its EWS.³¹⁹ Drug checking is more specifically discussed in chapter 18.

A rapid clinical toxicology service and drug registry to underpin the early warning system

The submission of the VIFM also outlined that key supporting services to ascertain the toxicity and prevalence of NPS are currently unavailable:

³¹⁶ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 429.

³¹⁷ Melanie Audrey, *Submission*, no. 11, 16 February 2017.

³¹⁸ Energy Control, *Report on the Analyzed Substances in Spain by Energy Control During 2015*, Madrid, 2015, p. 9.

³¹⁹ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 29; Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 423; Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 115; National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 7; Unharm, *Submission*, no. 182, 17 March 2017, p. 16; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 12.

There is no toxico-vigilance or surveillance registry in Victoria or Australia to rapidly detect and monitor new substances, and to provide an evidence base to inform public health policy, healthcare practitioners, coroners, police and the community about the toxicity and prevalence of new psychoactive substances.³²⁰

The Victorian Institute of Forensic Medicine highlighted that there are only a limited range of toxicology tests performed at hospitals in cases of overdoses or emergencies involving drugs. This particularly impacts the ability to share information with the UNODC EWS because Australia is currently unable ‘to measure these drugs in hospitalisations or deaths in a rapid manner’.³²¹ Dr Gerostamoulos indicated that further work is currently being undertaken to access this important global NPS resource.³²²

Similarly, the Penington Institute’s submission highlighted that the current inability to access information about the content of drugs means that ‘clinicians are under-equipped to treat problems, especially in emergency situations’ and there is a lack of evidence on best practices within clinical settings.³²³

Further, the VIFM noted the lack of a national drug registry significantly impacts its capacity to detect and identify NPS. According to Professor Noel Woodford, Director of the VIFM, the VIFM can currently detect only 140 of the approximately 700 NPS that have emerged. This highlights a need for increased cooperation between agencies to share information to improve understanding of NPS in the community:

We cannot detect these drugs unless we know what we are looking for, and that is where better interagency cooperation and collaboration is, in our view, of paramount importance.

So when clandestine laboratories are uncovered or when the police seize pills, both in Victoria and around the country, how do the results of these analyses filter down to agencies such as ours so that we can develop methods for detection, share techniques and knowledge, and begin to develop a better understanding of their prevalence and also their clinicopathological effects? How do we develop a repository of this information, such as a national register of drugs, so that all involved in their detection can benefit, and how do we get the information out to those who need it most — doctors, health departments and the community — in a timely manner so that awareness is raised and harm can be prevented? What can we do to assist our clinical colleagues who are dealing with the effects of often unknown substances in emergency departments around the country with timely information about the drugs they are dealing with so that treatments can be tailored accordingly?³²⁴

Federally, the 2014 *Framework for a National Response to New Psychoactive Substances* foreshadowed the development of a Commonwealth Drug Monitoring System (DMS) that would contain information about identified NPS.³²⁵ According to the VIFM, while

³²⁰ Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, p. 3.

³²¹ Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, p. 17.

³²² Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 214.

³²³ Penington Institute, *Submission*, no. 209, 24 March 2017, pp. 19-20.

³²⁴ Professor Noel Woodford, Director, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, pp. 207-208.

³²⁵ Intergovernmental Committee on Drugs (IGCD), *Framework for a National Response to New Psychoactive Substances*, Canberra, 2014, p. 15.

there is a DMS managed by the AFP, this is largely focused on NPS identified during seizures and clandestine labs, but does not 'link back' to clinical and forensic matters, such as deaths and hospitalisations, which remains problematic.³²⁶

To address these issues, the VIFM recommended developing a drug registry and a rapid response clinical toxicology service to Victorian hospitals and poison centres to provide timely and improved understanding about the role of drugs in presentations at hospitals. Dr Dimitri Gerostamoulos indicated to the Committee that two Victorian hospitals (the Austin and Monash) have endorsed the initiative, and that a pilot would commence at these hospitals in July 2017:

The expertise and scope of the tox [toxicology] work under our organisation means that we are ideally placed to provide this timely data, and better treatment results in measurable efficiencies for the community in terms of better health outcomes, reduced days in hospital and more timely information regarding the relative dangers of these different drugs.³²⁷

According to the VIFM, the key issue with developing a rapid clinical toxicology service is ensuring adequate resourcing. Further, Dr Dimitri Gerostamoulos indicated that, while such a service would put Victoria 'ahead of the game' in terms of understanding NPS, doctors themselves may not necessarily want this information as they are able to treat patients based on their symptoms rather than requiring toxicological information. However, such information would 'build a database of knowledge', improving awareness of clinicians and the general public about the effects and harms of various NPS.³²⁸

The Committee inquired whether Alfred Health had a view on the usefulness of a rapid response toxicology service. Dr Helen Stergiou, Emergency and Trauma Physician, was supportive, and offered real life examples of how this could work in a hospital setting, particularly referencing an incident reported in the media in February 2017 where people were taken from the Sidney Myer Bowl to hospital for suspected overdoses:

The 24/7 toxicology service is very much about, 'This young man/young female has come in. This is what they have taken', and how many times when we have looked they are unconscious. One of the first things is exposure — 'Let's remove the clothing'. Nursing staff become so adept at looking through pockets to understand what is in there — 'Oh! Here's a little bit of green powder. What is that?'. If we had a 24/7 service, let us expeditiously get that over there or have them come to us. Let us look at what the constituents are, and then let us do a little bit of quick epidemiology. Where were they, what is the geography and what was the population there? We are seeing this. We are behind the eight ball currently.

Again I refer back to the Myer music bowl episode earlier this year, where we did not have a sense of what it was they had taken. Our ideas were it was a certain substance, but we had no data to back that up to therefore then be able to target perhaps some of the education a little bit more specifically, so we would be very keen for something like that.³²⁹

³²⁶ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 214.

³²⁷ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 208.

³²⁸ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, pp. 214-215.

³²⁹ Dr Helen Stergiou, Emergency and Trauma Physician, Alfred Health, *Transcript of evidence*, 19 June 2017, pp. 242-243.

The Committee agrees that an EWS should be established to enhance data collection and information sharing among all relevant agencies about NPS and other substances of concern. The Committee considers that the benefits of an EWS will include improved detection and identification of NPS, swift provision of responsive public health alerts and enhanced monitoring of the NPS market. The Committee also notes the importance of supporting structures for such a system, including a drug registry and a rapid response clinical toxicology service.

RECOMMENDATION 7: The Victorian Government establish an early warning system (EWS) to enable analysis, monitoring and public communications about new psychoactive substances (NPS) and other illicit substances of concern. This will require greater information sharing and collaboration between Victoria Police, the Victorian Institute of Forensic Medicine, the Department of Health and Human Services, coroners, hospitals, alcohol and other drug sector organisations (particularly harm reduction and peer based services) and other interested stakeholders. Essential components of the EWS should include:

- real time public health information and warnings where required
- developing a drug registry to understand the NPS market
- a rapid response clinical toxicology service for hospitals and poison centres.

5 Community attitudes and drugs

According to sociologist, Professor Robin Room, drug use and the associated harms are highly moralised, with some aspects of drug use attracting near universal disapproval and marginalisation.³³⁰ The Committee agrees with this view based on the evidence it received, both locally and internationally, noting the far-reaching discrimination and stereotypes of people with substance use disorders. In particular, the perception that a person's drug addiction is 'rooted in their bad choices'³³¹ has resulted in it being one of, if not the most, stigmatised health conditions. At the other end of the spectrum, there is a commonly held view that people with chronic addictions are sick and helpless. Neither stereotype is useful to the individual.

The Committee received extensive evidence about people's experience with negative labelling and discrimination; the detrimental and long-lasting impacts of this negativity, and why it remains an entrenched practice within the broader community.³³² This chapter explores these matters, and strategies to improve the way the community perceives and treats people who use drugs. The Committee believes this will contribute to people with substance use issues seeking and receiving assistance to create positive and healthy changes in their lives.

The Committee heard from various stakeholders that negative labelling, rejection and fear of rejection can lead people to withdraw and isolate themselves as a coping mechanism.³³³ In turn, they might be discouraged from seeking access to relevant services, may be limited in their ability to find and keep employment, and simply

³³⁰ Room, R, 'Stigma, social inequality and alcohol and drug use', *Drug and Alcohol Review*, vol. 24, no. 2, 2005, p. 143.

³³¹ Room, R, 'Stigma, social inequality and alcohol and drug use', *Drug and Alcohol Review*, vol. 24, no. 2, 2005, p. 146.

³³² Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 66; Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25; Demos Krousos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, pp. 151, 152, 158; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 48; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, pp. 196, 204; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 3; Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, pp. 170, 171, 174; Meghan Fitzgerald, Social Action, Policy and Reform Manager, Fitzroy Legal Service, *Transcript of evidence*, 28 June 2017, pp. 263, 265; Paul Bodisco, Secretary, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 89; Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, pp. 365, 366; Sonia Vignjevic, Acting Chairperson, Victorian Multicultural Commission, *Transcript of evidence*, 18 September 2017, pp. 380-381; Dr Stefan Gruener, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 163.

³³³ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 66; Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 106; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 198; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, pp. 2, 6; Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, pp. 129, 131; Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 366; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 228; Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 270.

struggle to participate in daily life. This enhanced social isolation is what creates the highest burden to people, increasing their risk of poor mental and physical health.³³⁴ Bevan Warner, Managing Director of Victoria Legal Aid (VLA) told the Committee:

What our current approach does, born of taboo, is this: it deters people from having conversations at home and with their friends, and from referring themselves to helpful programs early, and it stops friends, peers and colleagues from engaging people they see who are engaging in dangerous drug use in crucial conversations about choices and ways to minimise harm to self and to others.³³⁵

For example, Marion McConnell told the Committee of the devastating story of her son who died from a heroin overdose 25 years ago. She believes he was driven away from the help of health professionals and family because of the significant community disapproval of people who use drugs. She asserted that this, in addition to a specific police incident, were contributing factors to his death:

I say this because my son was driven away from the help of health professionals and his family by fear of threats from police who, I must add, were merely doing their job as expected under prohibition. But this policy played a major part in my son's death as did the shame and stigma instilled by prohibition that prevented my son from confiding his problems earlier with his family.³³⁶

5.1 Community attitudes to drug use

The key focus in this chapter is people with substance use disorders as they are the group typically at the receiving end of negative labelling and discrimination. However, it is also important to acknowledge that people who use substances recreationally can also be exposed to this. As recreational users are less inclined to use drugs in the public view, their experiences tend to differ from those who might have an addiction. In circumstances when this latter group are marginalised for other reasons (such as homelessness), they may find themselves less hidden from society, particularly when using drugs and are therefore more vulnerable to negative attitudes.

A commonly identified theme in the inquiry evidence is the significant negative labelling of people who inject drugs, particularly those who do so publicly. According to the Australian Injecting and Illicit Drug Users League (AIVL), this negativity largely originated from the perception that people who inject drugs pose a threat to the transmission of blood-borne viruses within the community. This arose from the 'fear of contagion' strategies that accompanied the HIV/AIDS epidemic in the 1980s and was further entrenched with the arrival of hepatitis C and B.³³⁷

The act of injecting also creates suspicion and anxieties, with a fear of needles a common phobia within the general public, in addition to a view that injecting is unnatural. Strongly aligned with the concept of injecting, is the identity of the 'junkie', an entrenched stereotype of drug users who engage in anti-social and destructive behaviours directed at themselves and those around them. Throughout

334 Ahern, J, et al., 'Stigma, discrimination and the health of illicit drug users', *Drug and Alcohol Dependence*, vol. 88, no. 2-3, 2007, p. 188; Hatzenbuehler, M, et al., 'Stigma as a Fundamental Cause of Population Health Inequalities', *American Journal of Public Health*, vol. 103, no. 5, 2013, p. 186.

335 Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 228.

336 Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, p. 129.

337 Australian Injecting and Illicit Drug Users League (AIVL), *Why wouldn't I discriminate against all of them?: A report on stigma and discrimination towards the injecting drug user community*, Canberra, 2011, p. 36.

the inquiry, these stereotypes were reinforced and played out in media and community dialogue regarding the heroin crisis in North Richmond, where there have been rising incidents of overdoses, public injecting and discarding of used needles. These issues were submitted to the Committee by numerous stakeholders, many of whom are local residents. As reflected in the below quotes, the comments were not necessarily negative towards people who inject drugs but they represented some of the broader community perceptions about how such people behave. There was also a general undertone about the helplessness of people who inject drugs, which in itself can have a reductive effect:

...I can say that without exception there is someone shooting up, loitering in a car dealing, someone lurching and swaying in a drug swoon threatening to pass out right in front of me. I see used needles and drug paraphernalia littered along the gutters or on the porches. Someone pinned will push past, racing frantically along the pavement. Dealers will be working from cars or along Victoria St and gathering junkies will be scanning and pacing.³³⁸

The IV drug addicts in my area are old – they look about 100 but they are probably only in their fifties. Many have been hooked on heroin their entire life. If telling them to move on, or trying to shame them by pointing out that there are kids nearby worked to get people off heroin, there would be no junkies left. They have a disease. They are more to be pitied than despised.³³⁹

Let me talk you through a normal day here – Monday 9am, out the front door to walk the dog, luckily my son is strapped in the pram, as a drug-affected man is walking up the street, I walk fast but I still spot two syringes in the gutter, one uncapped. That afternoon on the way to the shops, my son and I pass a woman sitting in the gutter between two cars, she is injecting into her groin...

Chatting with the receptionist at my son's daycare, I learned that the centre [he] attends has trained its staff to collect syringes, as they must complete a sweep of the grounds daily...That afternoon, when collecting him, one of the parents advised that there was an aggressive man 'shooting-up' in the centres car-park.³⁴⁰

Taking a different perspective, Dr Peta Malins, Lecturer of Justice and Legal Studies at RMIT University researched the impact of policing strategies on women who inject drugs in Melbourne. She spoke to the Committee about how those women responded to community attitudes, and why they chose certain public locations over others to use drugs in order to avoid connotations of a 'dirty junkie'. This offered a useful perspective to the Committee as it received no direct evidence from people who inject drugs and the impact of these negative attitudes on them. Dr Malins advised the Committee:

...one of the most interesting things about my research was the aspect of women talking about their social identity and the stigma associated with that sense of themselves as being a dirty junkie and trying to avoid that, if they could, at all costs. Certainly injecting somewhere that was seen to be dirty in that kind of stigmatised junkie way had impacts for their sense of self-worth, their mental health, their willingness to access services and their willingness to see themselves as somebody

338 Margot Foster, *Submission*, no. 96, 6 March 2017.

339 Sally Thompson, *Submission*, no. 117, 15 March 2017.

340 Name withheld, *Submission*, no. 101, 8 March 2017.

worthy of being helped as well. Also women said they could tell that other people saw them as a junkie and were less likely to help them if they overdosed and things like that. They had that strong sense of it...³⁴¹

Negative labelling and stereotypes are also commonly directed at people who use methamphetamine or 'ice'. It could be argued that people using this substance are currently experiencing similar, if not greater levels of demonisation in society, than people who inject drugs. This has been a growing phenomenon in Australia over the last ten years, as reflected in media reporting. Charles Henderson, Acting Executive Officer of Harm Reduction Victoria (HRV) advised the Committee:

The current levels of hysteria and misinformation associated with just about any media reporting or public discussion in relation to the use of methamphetamines is leading to extreme levels of harm and stigma for a group of people already highly marginalised within our community.³⁴²

The Committee acknowledges, however, that similar to commonly held views about people who inject drugs, the hysteria around people who use methamphetamines is loosely informed by people's experiences. For example, Michael Stephenson, Executive Director of Ambulance Victoria told the Committee that methamphetamine-related attendances had increased more so than any other drug, with paramedics finding themselves 'in the company of very violent, very aggressive patients, very hard to manage'.³⁴³ This was also reported by Victoria Police.³⁴⁴ Unfortunately, these are common experiences for first responders, such as police officers, paramedics, in addition to hospital emergency department staff. Depictions of unpredictable, aggressive and challenging behaviours among people who use crystal methamphetamine are to some extent accurate, although they are typically extreme cases and are often paired with mental health concerns. These are the cases that come to the attention of the authorities and which are so regularly depicted in the media. The Committee is aware that while there is an increased risk of psychosis among people who use methamphetamines, 75 per cent of people who use it regularly never have any type of psychotic experience or become aggressive while using it.³⁴⁵ In this context, it is true that some stereotypes are based on real experiences, although these often turn into generalisations rather than true representations of all people who use illicit substances.

As most people's awareness of people who use drugs is based on hearsay from others and the media rather than direct experiences or facts, the ease at which blame can be directed at people who use drugs is unsurprising. Further, people who use illicit substances and develop an addiction are not clearly 'blameless', in that they typically choose to use that substance in the first place, whether for pleasure or as a coping mechanism. There is limited community understanding, however, that the path to addiction is a 'complex nexus of genetic and environmental risk factors that develop over time',³⁴⁶ which can predispose some people to addiction. Without knowledge of these factors, it is difficult to ascertain the extent to which someone is deserving

341 Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 365.

342 Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 66.

343 Michael Stephenson, Executive Director, Ambulance Victoria, *Transcript of evidence*, 19 June 2017, p. 222.

344 Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p.449.

345 Lee, N, "Ice Wars' message is overblown and unhelpful", *The Conversation*, 14 February 2017, viewed 1 December 2017, <<https://theconversation.com/ice-wars-message-is-overblown-and-unhelpful-72719>>.

346 Lloyd, C, *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users*, UK Drug Policy Commission, London, 2010, p. 66.

of blame. John Rogerson, Chief Executive Officer (CEO) of the Alcohol and Drug Foundation, advised the Committee that society too often makes judgements about people without knowing anything about them:

The issue I talk a lot about with my staff is the whole issue of stigma and how we judge as a community. We make a judgement about someone who is using illicit drugs, but we know nothing about them. So we never get their backstory, and the backstory usually involves trauma or it involves socio-economic issues that they are trying to cope with. I think if we could change society's issue with people who are using illicit drugs to try to understand what sits in behind the use, then we would have some very different conversations and a different result around some of this illicit drug activity.³⁴⁷

Another important element to this discussion is the fact that many people are already highly marginalised and live with multiple layers of stereotyping and discrimination, in addition to that arising from their drug use. For example, women who inject drugs are more susceptible to these reactions from the broader community, not only because they do not '[transgress] social and legal norms but also gender norms in urban spaces'.³⁴⁸ Some people might be homeless, hence their public use of drugs. They may have a mental health condition, with evidence indicating that people who use drugs are twice as likely to have such a condition compared to those who do not use drugs.³⁴⁹ Some are Aboriginal and Torres Strait Islander (ASTI) people or from culturally and linguistically diverse (CALD) communities. All of these attributes attract stigma and discrimination in their own right but when coupled with addiction result in increased vulnerability, levels of social exclusion and increased risk of poor health outcomes.³⁵⁰

In its submission to the inquiry, the Fitzroy Legal Service (FLS) reported that its clients have experienced significant harms at young ages, including family violence of a physical or sexual nature. A number of clients have also been diagnosed with a mental illness. It advised that negative labelling 'does absolutely nothing to support our clients in addressing the suffering that has led to their dependence on drugs'³⁵¹:

The constant reinforcement that their lives are without equivalent value, and that the suffering they have experienced is something that they alone are substantially responsible may be the single most harmful impact of our current illicit drug strategy.³⁵²

5.2 Causes of negative attitudes and discrimination

Internationally, it is widely acknowledged that one of the unintended consequences of the drug control system, specifically the United Nations conventions, is the exclusion and marginalisation of people with substance use disorders.³⁵³

³⁴⁷ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 204.

³⁴⁸ Dr Peta Malins, *Submission*, no. 196, 17 March 2017, p. 5.

³⁴⁹ Beyond Blue, *Submission*, no. 175, 17 March 2017.

³⁵⁰ Australian Injecting and Illicit Drug Users League (AIVL), *Why wouldn't I discriminate against all of them?: A report on stigma and discrimination towards the injecting drug user community*, Canberra, 2011, p. 1.

³⁵¹ Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 3.

³⁵² Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 3.

³⁵³ United Nations Office on Drugs and Crime, *World Drug Report 2008*, United Nations, Vienna, 2008, p. 216.

There is a widely researched and accepted view that fears and attitudes about drugs are not necessarily about the drugs themselves, or their relative risk to health, but rather originate from the historical discourse surrounding prohibition both in Australia and internationally. This was a view expressed by many stakeholders who provided evidence to the Committee, including Living Positive Victoria. It noted in its submission that the impact of stigmatisation towards illicit drugs is disproportionate to the harm relating to drug use and that this stigmatisation is the result of the illicit nature of drugs. According to UNAIDS, the Joint United Nations Programme on HIV and AIDS, these fears and attitudes have been established during decades of the global war on drugs.³⁵⁴

A common theme in the evidence is that the introduction of prohibition had no basis in objective science, and to some extent was driven by prejudices against specific groups in society.³⁵⁵ Greg Denham, Executive Officer of the Yarra Drug and Health Forum (YDHF) spoke to the Committee on how prohibition has contributed to the growth of myths and stereotypes about drug use:

...and when I talk about prohibition I guess I am going back about 100 years. I am not going back to recent history; I am talking about 100 years ago when we first started to implement prohibition. Over that time we kind of built up this dialogue, this narrative, based around a whole lot of suspicions and misinformation and myths around drug use. I was only thinking about this the other day — in some respects it has kind of been like the science has been lost.³⁵⁶

As part of its overseas study tour, the Committee met with Art Way, the Colorado State Director of the Drug Policy Alliance who spoke in detail about the racial undertones of drug prohibition in the United States (US). Cocaine prohibition, for example, was introduced in order to control African-American communities following migration to Chicago post-slavery.³⁵⁷ Further, the availability and increased use of crack cocaine in the early 1980s, was accompanied by the introduction of the 1986 USA *Anti-Drug Abuse Act*. The Act introduced mandatory minimum sentences intended for traffickers, although it received widespread criticism for its rapid increase in imprisonment rates for low level offenders and significant racial disparities within prison populations. A key contributing factor was the difference in sentencing for different types of cocaine, with five grams of crack attracting a five year mandatory minimum sentence, while 500 grams of powder cocaine attracted the same sentence.³⁵⁸

In Australia, major policy decisions at state and national levels, particularly those based on 'Tough on Drugs' and 'Zero Tolerance' policies, have played a significant role in the way illicit drug use is perceived as immoral. At a structural level, laws and policies that instil these negative community attitudes can be used as a deterrent strategy, in that they send a message about what is deemed acceptable or

³⁵⁴ UNAIDS, *Do No Harm: Health, Human Rights and People Who Use Drugs*, Geneva, 2016.

³⁵⁵ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 93; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 48; Australian Injecting and Illicit Drug Users League (AIVL), *Why wouldn't I discriminate against all of them?: A report on stigma and discrimination towards the injecting drug user community*, Canberra, 2011, pp. 14-15; Lloyd, C., *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users*, UK Drug Policy Commission, London, 2010, p. 50; Students for Sensible Drug Policy Australia, *Submission*, no. 214, 29 March 2017.

³⁵⁶ Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 48.

³⁵⁷ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 68.

³⁵⁸ Devins, C and Kauffman, S, 'The Ultimate Crack Down: We Know Not What We Do', *NPR: 13.7 cosmos and culture*, 25 June 2012, viewed 4 December 2017, <<https://www.npr.org/sections/13.7/2012/06/25/155699660/the-ultimate-crack-down-we-know-not-what-we-do>>.

tolerable behaviour from a societal perspective. However, despite the overwhelming evidence that prohibitionist-based laws have done little to deter people from using illicit substances, governments continue to criminalise drug use.³⁵⁹ This policy environment has contributed to the ongoing negative labelling and discrimination of people who use drugs, often observed in the NIMBY (not in my backyard) response of local residents when governments attempt to determine an appropriate location for drug services in the community.³⁶⁰ The Committee's notes, however, there was widespread support within the local community for the establishment of a medically supervised injecting centre in North Richmond.

The attention directed at alcohol and tobacco from the broader community also provides a useful example of the disparity in the way legal and illegal drugs are moralised in society. For example, while both of these legal substances are associated with levels of addiction and harms that override all other drugs, sales of these products are regulated without criminalising the user and the industry. Further, social disapproval of people who smoke cigarettes or who are publicly intoxicated is not uncommon, although it is clearly of a different nature to the social disgrace and public disapproval reserved for people who use illicit substances.³⁶¹ Brenda Irwin of the Families and Friends for Drug Law Reform, whose daughter died of a heroin overdose when she was 18, reiterated this in her evidence to the Committee in the context of the criminality of drug use and it preventing her daughter from speaking out about her drug use:

It keeps it in the dark. It keeps it hidden. People are so ashamed, and a lot of the shame is mixed up in the fact that it is a crime. It is so hypocritical when drugs that have the same effects happen to be legal and there is no crime associated with that.³⁶²

Policing practices consistent with a zero tolerance approach to drug use are also argued to promote shame, with evidence of such practices discouraging people who use drugs to speak out about their drug use or seek assistance in fear of the possible legal ramifications. This was reflected in Marion McConnell's evidence to the Committee about her son's death:

Intervention of the police two weeks before this, drove us away from the help that we needed. I mean, he was taken by ambulance to the hospital and he was prepared to go to the hospital because he was relieved that we finally knew that he had a problem and he was surprised at our response to him, that we cared for him and we want to help him.

³⁵⁹ Dean Rossiter, Chapter President, LaTrobe University, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 308; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, pp. 103, 107; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 43; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 197; Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017, p. 78; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 305; Global Commission on Drug Policy, *Pathways to Drug Policies That Work: Addressing the Real Needs of People and Societies*, Geneva, 2014, p. 11; International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 8; Transform Drug Policy Foundation, *The Alternative World Drug Report*, Bristol, 2016, p. 9; Australian Drug Law Reform Foundation, *Submission*, no. 147, 17 March 2017, p. 2; Australian Drug Law Reform Foundation, *Submission*, no. 147 - attachment 1, 17 March 2017, p. 12; cohealth, *Submission*, no. 140, 16 March 2017; Penington Institute, *Submission*, no. 209, 24 March 2017, p. 11; Students for Sensible Drug Policy Australia, *Submission*, no. 214, 29 March 2017; Students for Sensible Drug Policy LaTrobe, *Submission*, no. 155, 17 March 2017.

³⁶⁰ Lloyd, C, *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users*, UK Drug Policy Commission, London, 2010, p. 54.

³⁶¹ Rolles, S, et al., *The Alternative World Drug Report - Counting the Costs of the War on Drugs: 2nd Edition*, Transform Drug Policy Foundation, London, 2016, p. 102.

³⁶² Brenda Irwin, Families and Friends for Drug Law Reform, *Transcript of evidence*, 18 September 2017, p. 392.

We weren't antagonistic towards him at all. But the police went to the hospital as well and we weren't allowed into the room. We weren't allowed in with him. The police went into his room and questioned him and frightened him because they wanted to know where he bought the drugs from and so he discharged himself. There was no help for my husband and I at that time. There was no - you know, the police didn't come up to us and say, "Look, you know, your son has got a problem and we're going to try and help," or whatever - nothing.³⁶³

It is no longer police policy to attend overdoses for criminal offence purposes, however, other currently used enforcement practices, such as drug detection dogs at music festivals and other public spaces, are reported to result in harms, including increased risky drug taking practices and experiences of shame among people who use drugs.³⁶⁴ This is discussed further in chapter 18.

5.3 Impacts of negative community attitudes

5.3.1 Health care

There was a strong consensus in the evidence presented to the Committee that negativity and fear of disapproval are significant barriers to accessing health care and treatment services among people who use drugs.³⁶⁵ In particular, it has shown to act as a considerable barrier to optimal identification and management of people with substance use disorders, in addition to completion of treatment, achieving full recovery and successful reintegration back into the community. Negative community attitudes can not only influence an individual's willingness to seek help but also the willingness of others to help them.³⁶⁶

Referring back to the role of the media in exacerbating fear and anxieties about illicit drugs, Professor Nicole Lee, Director of 360Edge, explained in her article '*Ice Wars' message is overblown and unhelpful* how the detrimental impact of stigma on people who use drugs arises:

There is one significant thing we have learned from hundreds of sessions of community education, thousands of hours of worker training and many sessions of treatment with people who use ice and their families: it is counterproductive and distressing for people who are affected when the media makes exaggerated negative claims, showing only the ugly side of drug use.

³⁶³ Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, p. 130.

³⁶⁴ Dr Peta Malins, *Submission*, no. 196, 17 March 2017, p. 3.

³⁶⁵ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 66; Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 106; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 198; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, pp. 2, 6; Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, pp. 129, 131; Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 366; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 228; Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 270.

³⁶⁶ Frances Mirabelli, Chief Executive Officer, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 259; Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 200; Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 325; Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 259; Australian Injecting & Illicit Drug Users League, *We Live With it Almost Every Day of our Lives - An AIVL Report into Experiences of Stigma & Discrimination*, Canberra, 2015, p. 5; Australian Injecting and Illicit Drug Users League (AIVL), *Why wouldn't I discriminate against all of them?: A report on stigma and discrimination towards the injecting drug user community*, Canberra, 2011, p. 62.

One of the greatest harms to people who use drugs is the fear and stigma generated by the exaggerated images, out of context “facts”, and name calling – “monsters”, “junkies”, “addicts”, “zombies”. We see it every day – fear drives good people to lock their doors and close their hearts. Families and individuals become isolated as a result, and communities outcast those who need to be pulled closer.³⁶⁷

People’s reluctance to seek help is often the result of them internalising the negative attitudes and labelling as shame and guilt, which in turn may lead them to isolate themselves.³⁶⁸ According to AIVL, there is also a tendency among people who inject drugs to adopt the negative stereotypes placed upon them to the point that they stop recognising when they are experiencing discrimination, and consider it to be ‘deserved behaviour’.³⁶⁹ As told to the Committee by Professor Dan Lubman, the Director of Turning Point:

The biggest issue we have in addiction is that, on average, from the time you develop a problem to a full recovery is 27 years. The reason that is is because on average it is a decade from when you develop a problem to when you actually seek help. That is largely because there is this massive stigma in the community, because we have a whole range of messages in the community that basically demonise you and tell you that you are a very bad person. It is very embarrassing to get help.³⁷⁰

The Committee also heard that the reluctance of people who use drugs to seek help extends beyond treatment for drug use and includes treatment for general physical health and other health conditions, such as hepatitis C. Charles Henderson of HRV advised the Committee that despite the availability of new treatments in Australia, the majority of people who inject drugs with chronic hepatitis C are disengaged from the health system. Fear of discrimination among this group has been shown to lead to delays in presentation to health services, which creates further unintended consequences of prolonged risk of transmission, poor treatment adherence and increased risk of disability.³⁷¹ In her evidence to the Committee, Melanie Eagle, CEO of Hepatitis Victoria also referred to the ‘harder to reach communities’ of people who inject drugs who access needle and syringe programs intermittently and continue to expose themselves to risk for a range of reasons:

Some are fatalistic about it, presume they have already got it — you know, this is the feedback — have been told for ages that there is no cure and still believe they are not going to be worthy recipients of treatment or do not engage in health services generally. Many of them are totally disconnected from many formal systems of service delivery. They might be homeless. They might be transient, so they do not make appointments certainly with doctors.³⁷²

In these circumstances, Charles Henderson spoke about the essential role of peer-based strategies to hepatitis C prevention and treatment, which could ‘support people across the HCV treatment journey and beyond’.³⁷³

³⁶⁷ Lee, N, ‘Ice Wars’ message is overblown and unhelpful’, *The Conversation*, 14 February 2017, viewed 1 December 2017, <<https://theconversation.com/ice-wars-message-is-overblown-and-unhelpful-72719>>.

³⁶⁸ van Olphen, J, et al., ‘Nowhere to go: How stigma limits the options of female drug users after release from jail’, *Substance Abuse Treatment, Prevention, and Policy*, vol. 4, no. 10, 2009

³⁶⁹ Australian Injecting and Illicit Drug Users League (AIVL), *Why wouldn’t I discriminate against all of them?: A report on stigma and discrimination towards the injecting drug user community*, Canberra, 2011.

³⁷⁰ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25.

³⁷¹ Heijnders, M and van der Meij, S, ‘The Fight Against Stigma: An Overview of Stigma-Reduction Strategies and Interventions’, *Psychology, Health and Medicine*, vol. 11, no. 3, 2006, p. 3.

³⁷² Melanie Eagle, Chief Executive Officer, Hepatitis Victoria, *Transcript of evidence*, 4 September 2017, p. 335.

³⁷³ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 66.

The Committee was surprised to learn that people's disengagement from health care services not only relates to their own feelings of shame and low self-esteem but also direct experiences of discrimination from healthcare professionals and other staff in those settings. A survey of people who use drugs commissioned by AIVL reported that healthcare settings stood out as the primary area in which respondents reported cases of discrimination. In particular, respondents indicated that once people disclosed their drug use or hepatitis C or B status, they experienced subsequent discrimination.³⁷⁴ This can lead people to hide their drug use, which is often the issue which they have the greatest need for care.³⁷⁵

The Committee acknowledges the many excellent healthcare providers who work tirelessly to help patients overcome their substance use issues. Although, the significant taboo linked with drug use issues means that some members of the medical profession avoid treating people with substance use disorders. This is clearly evident in the challenges associated with encouraging more general practitioners (GPs) and pharmacists to participate in the opioid substitution therapy (OST) program in Victoria. Market research of health professionals commissioned by AIVL found that they were concerned about the impact on their professional status or losing other patients if they allowed people who inject drugs into their clinic.³⁷⁶ This was a view also shared by the Australian Medical Association, which indicated that if GPs become known as a prescriber, they could lose their full-paying patients and become a bulk-billing clinic, resulting in a substantial loss of income for that GP.³⁷⁷ Judith Abbott, the Director of Community-Based Health Policy and Programs at the Department of Health and Human Services (DHHS), also advised the Committee that this was a significant challenge in encouraging health practitioners to participate in the pharmacotherapy program:

...what we hear is that the biggest barrier to people doing pharmacotherapy, the practitioners, is often the stigma of having people in their consulting room or in their pharmacy who are on methadone. It is a very good example of where the stigma associated with illicit drug use is very high.³⁷⁸

Similarly, Geoff Munro, the National Policy Manager at the ADF, advised the Committee that there is also an element of stigmatisation among pharmacists not wishing to participate in OST 'because having drug dependent people attend the service is not seen as something that they want to be involved with'.³⁷⁹ This undoubtedly relates to the expectation that people with substance use disorders are difficult to deal with, and may display volatile and unpredictable behaviour, particularly in healthcare settings.

These expectations are often informed by experiences of healthcare workers who find themselves in challenging situations with patients who are or have used illicit substances. However, the Committee was surprised by reports of some healthcare workers' lack of awareness or acknowledgement of the basis for these challenging

374 Australian Injecting & Illicit Drug Users League, *We Live With it Almost Every Day of our Lives - An AIVL Report into Experiences of Stigma & Discrimination*, Canberra, 2015, p. 5.

375 Ahern, J, et al., 'Stigma, discrimination and the health of illicit drug users', *Drug and Alcohol Dependence*, vol. 88, no. 2-3, 2007.

376 Australian Injecting and Illicit Drug Users League (AIVL), *Why wouldn't I discriminate against all of them?: A report on stigma and discrimination towards the injecting drug user community*, Canberra, 2011, p. 62.

377 Frances Mirabelli, Chief Executive Officer, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 259; Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 259.

378 Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 325.

379 Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 200.

behaviours, such as drug withdrawal or mental health concerns. The Committee was also surprised by the tendency of healthcare workers to apply these perceptions to all people who use drugs or people with substance use disorders. This is highly problematic when the quality of care that they receive is compromised or not provided in the first place, both clear examples of discriminatory behaviour. According to UNAIDS, judgemental feelings among healthcare providers is linked to lower-quality health care and lower health outcomes.³⁸⁰ As these conditions require high levels of medical care, without it can potentially be injurious to patients' physical and/or mental health.³⁸¹

The Committee acknowledges that GPs and other healthcare professionals require greater support to assist them provide adequate levels of care to people with substance use disorders and other people who use drugs. It is important that health professionals are compassionate and support all patients who seek their assistance. It is essential that they carry out their work in a non-judgemental way. This is addressed further in chapters 6, 12, 14 and 15.

5.3.2 Future opportunities

A number of stakeholders also advised the Committee of the difficulty for people who are no longer using illicit substances to reintegrate themselves back into the community.³⁸² This difficulty is heightened if they have a criminal record, with ongoing discrimination often arising from these convictions when attempting to find employment, voluntary opportunities, or travelling outside of Australia. As advised by the FLS in its submission to the Committee:

...the exclusion from employment those who have been charged with minor of possession play a significant role in further eliminating opportunities to engage in lives of contribution.³⁸³

This issue can also arise for people who use drugs recreationally and are caught with substances for their own personal use but are charged and end up with a criminal record. Tazmyn Jewell, Senior Lawyer at Victoria Legal Aid (VLA) indicated to the Committee that this is not uncommon and it often 'can have a flow-on stigma effect, such as in working with children's checks or police checks'.³⁸⁴

The Committee is aware that positive reintegration is an important component of a person's recovery journey, and significantly minimises risk of relapse. According to Meghan Fitzgerald, the Social Action, Policy and Reform Manager at the FLS, this is why diversion, rather than a criminal record, is important when a person is apprehended by police for use and personal possession of illicit substances:

In Victoria under current police policy any finding of guilt, including a no conviction record, will be released for 10 years if you are sentenced as an adult and five years if you are sentenced as a child. If you have a new prior, all of your priors will be

³⁸⁰ UNAIDS, *Do No Harm: Health, Human Rights and People Who Use Drugs*, Geneva, 2016, p. 33.

³⁸¹ Australian Injecting and Illicit Drug Users League (AIVL), *Why wouldn't I discriminate against all of them?: A report on stigma and discrimination towards the injecting drug user community*, Canberra, 2011, p. 68.

³⁸² Meghan Fitzgerald, Social Action, Policy and Reform Manager, Fitzroy Legal Service, *Transcript of evidence*, 28 June 2017, p. 263; Paul Bodisco, Secretary, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 89; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 161; Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 271.

³⁸³ Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 3.

³⁸⁴ Tazmyn Jewell, Senior Lawyer, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 228.

released. One of the issues is that if somebody has a finding of guilt for an illicit drug offence, that is highly stigmatising, even though it might be quite a poor indicator of future risk for an employer, and it is also a quite inaccurate indicator of who does and does not use drugs.³⁸⁵

The Committee believes these are important considerations when exploring the impact of the current criminal model on people who want to make changes in their life. How does ongoing negative labelling and discrimination associated with prior convictions affect an individual's capacity to find employment and contribute to society? If they cannot secure a job, what does this mean for their long-term recovery? These are important factors that can have a positive influence, or not, on people's journey to recovery.

5.4 Strategies to improve community understanding and reduce negative attitudes

Much of the narrative around illicit drug use is embedded in Australian society and will be challenging to redress, although the commitment to do so will positively influence people with substance use disorders who wish to address their drug use. It will also increase the effectiveness of broader prevention and early intervention initiatives, and enhance harm reduction efforts. John Ryan of the Pennington Institute highlighted to the Committee the importance of breaking the taboo around illicit drugs:

There are very few people with drug addiction issues who are willing to speak publicly about their personal story compared to the number of people who have got personal stories. It is highly taboo, and breaking that taboo is very important in terms of early intervention because it means that, A, we have got a more honest approach to drug use problems but, B, that honesty prevents people from successfully hiding their drug use because they can be called out for it.³⁸⁶

Addressing this negative narrative is required on numerous levels. The Committee believes that exploring how current drug laws and policies exacerbate these negative attitudes is a useful starting point. When combined with other initiatives, it will have flow on effects to the way people with substance use issues are treated in the community, and also how such people perceive themselves.

Laws and policies

The consensus in the broader literature and evidence received by the Committee is that exploring the impact of the criminalisation of drug use, and potentially reforming some of the accompanying laws and policies, is essential to dispelling this negative narrative. As referred to by Dr Kate Seear, Senior Lecturer in Law at Monash University in her submission, a key objective of Australia's *Fourth National Hepatitis C Strategy 2014-2017* is to eliminate the negative impact of discrimination on people's health. It also states that 'an enabling policy and legal environment that

³⁸⁵ Meghan Fitzgerald, Social Action, Policy and Reform Manager, Fitzroy Legal Service, *Transcript of evidence*, 28 June 2017, p. 263.

³⁸⁶ John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, pp. 8-9.

addresses criminalisation, stigma and discrimination and human rights issues will help to increase access to services and improve the health and lives of people with hepatitis C.³⁸⁷

In her submission, Dr Seear outlined a number of key Victorian legislative frameworks that she believes actively discriminates against people with a history of drug use. For example, the *Victims of Crime Assistance Act 1996* is intended to assist victims in their recovery, through financial compensation awards, from crimes perpetrated against them. However, section 54 of the Act states that when considering an application for an award of compensation, the Victims of Crime Assistance Tribunal (VOCAT) must have regard to a series of matters. Two in particular relate to consideration of their character and behaviour, such as past criminal activity and any findings of guilt or convictions; and any condition that directly or indirectly contributed to their injury or death.³⁸⁸

Dr Seear and her colleague, Suzanne Fraser's, review into the operation of this section demonstrated that in a number of cases, the victim's history of drug use, including their 'addiction' was relevant to VOCAT'S consideration about whether they should be compensated. A number of concerns were identified with this approach, one of which included that it risked punishing these victims of crime twice, for receiving a sentence for a drug offence in the first place and again through denial of compensation because of that offence. Dr Seear also asserted that it creates a distinction between 'deserving' and 'less deserving' victims.³⁸⁹

The Committee heard on numerous occasions that one of the key criminal offences that contributes largely to the stigmatisation of drug use and people who use drugs is the use and personal possession offences in the *Drugs, Poisons and Controlled Substances Act 1981*.³⁹⁰ This is explored further in chapter seven, although it is worthwhile recognising at this stage the high level of support received from stakeholders to orientate this approach to a health framework in order to effect

³⁸⁷ Dr Kate Seear, *Submission*, no. 126, 16 March 2017, p. 6.

³⁸⁸ Dr Kate Seear, *Submission*, no. 126, 16 March 2017, p. 6.

³⁸⁹ Dr Kate Seear, *Submission*, no. 126, 16 March 2017, p. 6.

³⁹⁰ Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 109; Caitlin Hughes, Senior Research Fellow, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 250; Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 151; Jon O'Brien, Head of Social Justice Forum, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, p. 128; Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, p. 170; Meghan Fitzgerald, Social Action, Policy and Reform Manager, Fitzroy Legal Service, *Transcript of evidence*, 28 June 2017, p. 263; Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 115; Paul Bodisco, Secretary, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 89; Stephanie Tzanetis, Program Coordinator, DanceWize, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 71; Tazmyn Jewell, Senior Lawyer, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 228.

positive outcomes for people who use drugs.³⁹¹ Many stakeholders referred to the example of Portugal, which adopted this approach with one of its key objectives being to decrease stigma around substance use and disorders in order to ‘promote primary prevention and pathways to health and treatment programs’.³⁹² As discussed in chapter seven, Portugal’s effectiveness in stabilising its opioid crisis and reducing harms arising from substance use was largely due to its health-orientated and socially integrated approach:

Portugal’s remarkable recovery, and the fact that it has held steady through several changes in government – including conservative leaders who would have preferred to return to the US-style war on drugs – could not have happened without an enormous cultural shift, and a change in how the country viewed drugs, addiction – and itself. In many ways, the law was merely a reflection of transformations that were already happening in clinics, in pharmacies and around kitchen tables across the country. The official policy of decriminalisation made it far easier for a broad range of services (health, psychiatry, employment, housing etc) that had been struggling to pool their resources and expertise, to work together more effectively to serve their communities.

The language began to shift, too. Those who had been referred to sneeringly as *drogados* (junkies) – became known more broadly, more sympathetically, and more accurately, as “people who use drugs” or “people with addiction disorders”. This, too, was crucial.³⁹³

In Victoria, the recent announcement of the Government’s approval for the establishment of a medically supervised injecting centre (MSIC) in North Richmond is a useful example of an objective, health and evidence-based response that will contribute to creating positive outcomes for people with substance use disorders. Beyond Blue stated in its submission that such facilities provide a safe and stigma-free environment:

³⁹¹ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017; Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017; Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017; Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017; Demos Krousos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017; Greg Chipp, CEO and Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017; Jon O’Brien, Head of Social Justice Forum, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017; Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017; Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017; Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017; Paul Bodisco, Secretary, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017; Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017; Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017; Australian Injecting & Illicit Drug Users League, *Submission*, no. 169, 17 March 2017; cohealth, *Submission*, no. 140, 16 March 2017; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017; Humanist Society of Victoria, *Submission*, no. 184, 17 March 2017; Justice Action, *Submission*, no. 207, 21 March 2017; Penington Institute, *Submission*, no. 209, 24 March 2017; Public Health Association Australia, *Submission*, no. 152, 17 March 2017; Unharm, *Submission*, no. 182, 17 March 2017; UnitingCare ReGen, *Submission*, no. 168, 17 March 2017; Victorian AIDS Council, *Submission*, no. 206, 21 March 2017; Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017.

³⁹² Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 43.

³⁹³ Ferreira, S, ‘The long read: Portugal’s radical drugs policy is working. Why hasn’t the world copied it?’, *The Guardian*, 5 December 2017, viewed 8 December 2017, <<https://www.theguardian.com/news/2017/dec/05/portugals-radical-drugs-policy-is-working-why-hasnt-the-world-copied-it>>.

Stress and stigma are major risk factors for depression and anxiety, and most injecting drug users lead lives far more stressful, degrading, stigmatised and dangerous than those of the general community. The constant threat of arrest, the possibility of overdosing and the difficulty of finding a private place to inject loom large for most injecting drug users.

Importantly, safe injecting facilities also link injecting drug users with medical professionals who help them connect with mental health, physical health, welfare and rehabilitation services they may never have otherwise accessed. Safe injecting facilities present an opportunity to connect marginalised and disadvantaged people to vital health care and other supports, including mental health care, often for the first time.³⁹⁴

In the context of women who inject drugs, Dr Malins from RMIT University advised in her submission that supervised injecting centres that are ‘discreet, clean, non-judgemental and welcoming, would also go a long way to reducing stigma, increasing self-esteem and enhancing social connectedness’.³⁹⁵

5.4.1 Objective and respectful language

Public dialogue around illicit drugs is very much influenced by the language used by governments, health professionals and the media, with research indicating that language influences cognitive biases, especially around drug use.³⁹⁶ That is why this report attempts to use only appropriate and non-judgemental language, as noted in chapter one.

The media is a significant influence in how the general public forms an understanding of the extent of drug use, the people who use those drugs and the associated harms. As reported by Dr Nicole Lee, sensationalist reporting in particular skew the facts and contributes to fears and anxieties in the community. Regarding ABC’s *Ice Wars*, she stated:

Most of what is reported in this four-part documentary is not incorrect, but it lacks nuance and context. It makes entertaining television, but it contains the type of sensational language that can create community fears leading to the stigmatisation of people who use drugs and knee jerk responses from policy makers.³⁹⁷

As these portrayals are what inform people’s views on people who use drugs, rather than direct experiences, myths and stereotypes tend to grow without question. As reported in the report *The Alternative World Drug Report*, the use of stigmatising language and inaccurate reporting continues to be extensive in the media, which fuels public apathy towards people who use drugs or who have substance use disorders:

While it is now rightly considered unacceptable to describe someone as with mental health problems as a “psycho” or “lunatic”, equivalently stigmatising language still persists in media descriptions of people who use drugs. Terms such as “junkie”, or “clean/dirty” to describe an individual’s drug using status, are still widely used, essentially as bywords for social deviance. Their effect is to dehumanise,

³⁹⁴ Beyond Blue, *Submission*, no. 175, 17 March 2017.

³⁹⁵ Dr Peta Malins, *Submission*, no. 196, 17 March 2017, p. 6.

³⁹⁶ BC Centre for Disease Control and Toward the Heart, *Respectful Language and Stigma: Regarding People Who Use Substances*, Vancouver, 2017.

³⁹⁷ Lee, N, “Ice Wars’ message is overblown and unhelpful’, *The Conversation*, 14 February 2017, viewed 1 December 2017, <<https://theconversation.com/ice-wars-message-is-overblown-and-unhelpful-72719>>.

implying that a person's drug use is the defining feature of their character. People with (prohibited) drug dependencies are one of the few populations that media commentators can still insult and demean with a large degree of impunity.³⁹⁸

In regard to health professionals, according to the British Columbia Centre for Substance Use (BCCCSU) in Canada, the historical use of language regarding substance use is a mix of medicine and morality. This is particularly pertinent with references to 'drug abuse', which share similar negative connotations to 'elder abuse' or 'child abuse'. Another example is the notion of being 'clean' when one is no longer using substances and represents the opposite to a 'dirty junkie'.³⁹⁹ On this basis, 'clean' is a value laden term used to describe the 'hygienic state of being drug free'.⁴⁰⁰ In her evidence to the Committee, State Coroner of Victoria, Judge Sara Hinchey advised of the need to avoid using blaming language, such as 'doctor shopper', which is commonly used in policy discussions regarding the real-time prescription monitoring system.⁴⁰¹

On its overseas study tour, the Committee's time in Vancouver reaffirmed the necessity to improve community understanding of people who use drugs, including those with chronic addictions, as part of a broader harm reduction approach to keep people alive. In 2016, the British Columbian Government declared a public health emergency arising from high numbers of opioid-related overdose deaths, increasing from 269 in 2012 to 931 in 2016. The Committee learnt from Vancouver Coastal Health (VCH), one of the leading health services in BC, that as 86 per cent of overdose deaths occur in private and other residences, it is difficult for VCH and other similar agencies to reach this user group, who are typically disenfranchised and disengaged from the healthcare sector.⁴⁰²

In response to the public health emergency, another lead agency, the BC Centre for Disease Control developed recommendations for healthcare professionals and the media to use language that is more respectful, objective and contributes to reducing negative labelling. The BC Centre for Disease Control advised the Committee, and as noted earlier, that as there is a tendency for people who use drugs to self-stigmatise, they are more inclined to isolate themselves and use their drugs privately, therefore increasing their risk of overdose. The BC Centre for Disease Control believes that through reversing the effects of negative labelling and discrimination, people will be more likely to seek help, whether that is through treatment or greater utilisation of harm reduction services, such as a MSIC. These are important outcomes that were identified as assisting overcome the overdose crisis.⁴⁰³ The recommendations for change comprise the following four guidelines for using non-judgemental language:

1. Use "people-first language"
2. Use language that reflects the medical nature of substance use disorders and treatment

³⁹⁸ Rolles, S, et al., *The Alternative World Drug Report - Counting the Costs of the War on Drugs: 2nd Edition*, Transform Drug Policy Foundation, London, 2016, p. 104.

³⁹⁹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 55.

⁴⁰⁰ Radcliffe, P and Stevens, A, 'Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities', *Social Science & Medicine*, vol. 67, no. 7, 2008, p. 1070.

⁴⁰¹ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 13.

⁴⁰² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 51.

⁴⁰³ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 58.

3. Use language that promotes recovery
4. Avoid slangs and idioms.⁴⁰⁴

The Committee strongly agrees with the need to use appropriate language in order to influence public discourse and enhance community understanding of substance use disorders and drug use. This is especially important as a strategy to remove the barrier for people who use drugs to access healthcare and other assistance. Reframing language around drug use will also work towards influencing the perceptions of healthcare workers and the public, as it will shift their understanding of addiction from a moral or criminal issue to a health issue. The Committee proposes that the Victorian Government develop similar guidelines for use by the broader public service, including Victoria Police, local media and healthcare professionals. This is a useful starting point for shifting the way Victorians think about people who use drugs.

RECOMMENDATION 8: The Victorian Government develop specific guidelines on the use of appropriate, objective and non-judgemental language regarding substance use disorders, addictions and those who use drugs for public policy-makers, law enforcement agencies, and health care professionals. The Government should consult with the appropriate agencies to ensure the guidelines are implemented throughout the working practices of these identified groups. In addition, the guidelines be conveyed to the media and non-government agencies.

5.4.2 Community attitudes

As part a broader strategy to reduce the negative narrative surrounding drug use, it is essential to directly bring into question the stereotypes, generalisations and negative attitudes and practices that exist in the community. This involves creating awareness about illicit drugs and enhancing knowledge of the facts that counter many of the false assumptions that these attitudes are based on. The Committee believes this requires ongoing advocacy and campaigning through population-based strategies, in the same way that governments have responded to other public health matters. John Ryan of the Penington Institute spoke to the Committee about the value of community education, particularly in the context of early intervention:

Our tendency culturally is to look the other way when we see that somebody's drug use is escalating, partly because of fear and partly because we do not actually as a community adequately understand the signs of a growing drug problem. That is why that community education is so important to understand better addiction, to understand better the signs of addiction, and also why that destigmatisation is so important that we need to talk about these issues in a similar way that we have had a journey as a community in relation to mental health issues.⁴⁰⁵

Similarly, Professor Dan Lubman of Turning Point, referred to the need to improve community perceptions in order to promote and enhance accessibility of treatment options and assist people to find the help they need:

I think there is a bigger question here about what we do about the stigma. How do we overcome the stigma? How do we change community attitudes? How do we make people get help quicker? How do we even make help accessible? We have all these treatment services. We have run DirectLine for 20 years. It has never, ever been

⁴⁰⁴ BC Centre for Disease Control and Toward the Heart, *Respectful Language and Stigma: Regarding People Who Use Substances*, Vancouver, 2017.

⁴⁰⁵ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 8.

advertised or promoted. If we look at all the messaging around gambling, around cancer, around smoking, there are messages everywhere, but in terms of alcohol and drugs we have never had a positive media campaign about the fact that there is help available — you know, ‘Ring this number. There’s lots of help available. Treatment works’. All we hear is essentially messages in the media that basically say, ‘If you use drugs, you are an evil person and you should call the police because people are dangerous’.⁴⁰⁶

Enhancing awareness in the community and essentially framing substance use disorders as a health rather than a criminal matter will remove the divide between ‘us’ and ‘them’. The Committee believes this will have a positive impact on people’s trajectory from addiction to recovery, including reducing the length of time that it can take for some people to reach that end-point. This may also potentially prevent people from developing a dependence through early intervention strategies as people will feel more comfortable seeking help. Destigmatising drug use will also encourage people, particularly health professionals, to provide that help.

Removing the taboo around drug use is likely to encourage people to speak more openly about their experiences, whether it is their own or a family member or friend’s use. Many stakeholders reaffirmed the value of sharing stories⁴⁰⁷ and acknowledging at the community level that drug use is not isolated to one particular section of society and ‘in fact it is about the children of people who are in parliament and their grandchildren and the friends of their children who are in this situation’.⁴⁰⁸ The Committee also heard that the indirect positive outcome of this is people feeling more comfortable about disclosing their substance use in self-reported surveys, therefore improving the accuracy of prevalence data. The limitations of Australia’s self-reported survey data was concerning to various stakeholders, many of whom acknowledged was due to drug use being ‘largely hidden behaviours’.⁴⁰⁹ The importance of reliable data to inform evidence-based policy was discussed in chapter four.

⁴⁰⁶ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25.

⁴⁰⁷ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, pp. 196, 204; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 163; Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 271; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 48.

⁴⁰⁸ Keith Hamilton, Senior Minister / Group CEO, Parramatta Mission of the Uniting Church of Australia, *Transcript of evidence*, 23 May 2017, p. 134.

⁴⁰⁹ Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, pp. 228, 231; Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 106; John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 198; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 2; Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, p. 129; Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 41.

PART B

The four pillars approach to drug policy

Prevention

6 Prevention and early intervention

Preventing illicit drug use is a universal objective of policymakers on a global level. It enjoys widespread political and community support, particularly when addressed to young people, as adolescence is when drug use and drug experimentation is most likely to begin.⁴⁰⁹ Prevention strategies are also essential to any good drug policy, which when done well can importantly reduce the demand for illicit substances in the community. Commander Bruce Hill, Manager of Organised Crime at the Australian Federal Police (AFP) was noted in chapter four as advising the Committee that allocating resources to prevention and rehabilitation is worthwhile as ‘the more we can put at that front end to stop the community taking drugs the better it is for all of us’.⁴¹⁰ It is also widely understood nowadays that prevention is more than simple information provision, and requires broader community strategies to address a range of factors that may contribute to the development of harmful drug use.

Drug use prevention strategies are typically understood to be interventions that ‘delay or prevent either the initiation of drug use or the probability of progressing from experimentation to regular drug use’.⁴¹¹ Prevention strategies are particularly important in the context of young people, a cohort identified as more inclined to experiment with drug use, in addition to vulnerable young people, whose life circumstances may lead to harmful drug use or later dependence. A key aspect of preventive drug policy and education is to reduce the risk factors that may lead to drug use while increasing the protective factors that can increase resilience and self-worth. The Committee also understands the value of early intervention strategies to prevent substance use shifting into harmful or dependent use. As stated by Allsop in *Perspectives on amphetamine-type stimulants*:

409 Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 105.

410 Commander Bruce Hill, Manager, Organised Crime, Australian Federal Police, *Transcript of evidence*, 13 November 2017, p. 443.

411 Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 101.

...there is no single approach to prevention and there is a need to consider diverse approaches and strategies targeting distinct issues, contexts, behaviours and/or populations. Effective prevention in relation to drug use is likely to include a range of strategies, from whole-of-community approaches that aim to prevent the uptake of drug use, to more targeted programs aimed at those who are currently using.⁴¹²

This chapter examines both types of prevention. It discusses a universal prevention strategy to enhance public awareness and community understanding of illicit drug use, as well as targeted prevention strategies for children and young people and other groups that may benefit from specific prevention approaches. It also analyses early intervention strategies, particularly in primary health care settings, to identify and intervene early in a person's substance use to stop it from progressing into harmful use.

The Committee also notes that while some prevention programs are discussed in this chapter, particularly those relating to school education and resilience building, prevention, as with drug treatment, were not major focuses of this inquiry. That said, the Committee strongly believes that they are both important components to addressing illicit drugs in the community.

6.1 Prevention at a policy level

As noted throughout this report, Australia's *National Drug Strategy 2017-2026* (NDS) is based on the three pillars of supply, demand and harm reduction, with prevention and education approaches sitting under the demand reduction pillar. Specifically, the NDS in this context is aimed at:

Preventing the uptake and/or delaying the onset of use of alcohol, tobacco and other drugs; reducing the misuse of alcohol, tobacco and other drugs in the community; and supporting people to recover from dependence through evidence informed treatment.⁴¹³

The Strategy states that the prevention of uptake reduces personal, family and community harms, allows better use of health and law enforcement resources, generates substantial social and economic benefits and produces a healthier workforce:

Demand reduction strategies that prevent drug use are more cost-effective than treating established drug-related problems.

Delaying first use can also lead to improved health and social outcomes. The earlier a person commences use, the greater their risk of harm. This includes mental and physical health problems and a greater risk of continued drug use. Strategies that delay the onset of use prevent longer-term harms and costs to the community.⁴¹⁴

The NDS also notes a range of demand reduction strategies including:

- reducing the availability and accessibility (such as price mechanisms for alcohol and tobacco);

⁴¹² Allsop, S, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm', in *Perspectives on amphetamine-type stimulants*, S Allsop and N Lee (eds), IP Communications, East Hawthorn, 2012, p. 174.

⁴¹³ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 1.

⁴¹⁴ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 8.

- improving community understanding and knowledge, reducing stigma and promoting help seeking;
- restrictions on marketing, including advertising and promotion;
- programs focused on building protective factors and social engagement;
- treatment services and brief intervention;
- targeted and culturally appropriate approaches to high prevalence population groups and regions at increased risk of exposure to and harm from alcohol, tobacco and other drugs;
- addressing underlying social, health and economic determinants of use; and
- diversion initiatives.⁴¹⁵

On a state level, under *Victoria's Ice Action Plan*, prevention strategies include investing in job opportunity creation, building on drug education school curriculums, and exploring ways to utilise technology. In terms of drug education, it states:

Victoria is proud to have a world-leading drug education curriculum and evidence-based resources that help schools develop resilient young people who make good decisions. The Victorian Government will also investigate a statewide awareness campaign in partnership with community and sporting groups. We know that scare tactics don't work. All campaigns will focus on targeting the groups we know are most at risk with credible messages.⁴¹⁶

Further, the Victorian Department of Education and Training (DET) has an official policy on alcohol and drug use and drug education. Under the *School Policy Advisory Guide*, schools must:

- provide all students with drug education prevention and intervention programs
- involve parents/guardians and the wider school community in drug-related curriculum and wellbeing issues
- prohibit possession, use, distribution and selling of illicit drugs and unsanctioned licit drugs on school premises or at any function or activity organised by the school
- develop or review policy to support the management of drug-related incidents
- make every effort to retain students in the education system because students are often at greater risk if disengaged from school.⁴¹⁷

These policies and programs are specifically based on a harm minimisation framework, and initiatives must be implemented that:

- are comprehensive and evidence based
- promote a positive school climate and relationships
- are targeted to needs and contexts identified through consultation with students, staff and parents
- embed timely, developmentally appropriate drug education programs within a curriculum framework that utilises effective pedagogy.⁴¹⁸

⁴¹⁵ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 9.

⁴¹⁶ State Government of Victoria, *Ice Action Plan*, Melbourne, 2015, p. 14.

⁴¹⁷ Department of Education and Training, 'School Policy Advisory Guide: Drug Use', viewed 12 January 2018, <<http://www.education.vic.gov.au/school/principals/spag/safety/Pages/druguse.aspx>>.

⁴¹⁸ Department of Education and Training, 'School Policy Advisory Guide: Drug Use', viewed 12 January 2018, <<http://www.education.vic.gov.au/school/principals/spag/safety/Pages/druguse.aspx>>.

Since 2017, Victorian public and Catholic schools are subject to the Victorian Curriculum F-10. It incorporates the national Australian Curriculum complemented by Victorian policies, standards and priorities.⁴¹⁹ Principals and school leaders have overall responsibility for the implementation of drug education programs, which includes issues such as ensuring an ongoing program, engaging students in activities, staff training and resources, and demonstrating an appreciation for the importance of drug education.⁴²⁰

6.2 Different models of prevention

The Committee understands that there are a variety of prevention models and ways to conceive of prevention efforts, many of which can co-exist with one another. For example, primary prevention strategies, as discussed below, can comprise both population-based and targeted initiatives.

Prevention programs are often based on universal prevention or population level approaches, particularly relevant with commonly used drugs such as alcohol or tobacco, and selective prevention or targeted approaches that focus on people who may be particularly at risk of developing drug related problems or have already commenced to experiment with illicit drugs.⁴²¹ One aspect of prevention at a population level is understanding why people, particularly young people, decide to experiment with or use drugs. John Rogerson, Chief Executive Officer (CEO) of the Alcohol and Drug Foundation (ADF) spoke to the *Report of the National Ice Taskforce* on this issue, stating that the report:

...looks at the reasons for continued illicit drug use by Australians aged over the age of 14. It shows that 10 per cent of people using illicit drugs use drugs to enhance their mood, 17 per cent are trying to do something that is more exciting by using illicit drugs and 32 per cent use drugs because they want to enhance their experience. Only 7.5 per cent of people who use illicit drugs are using drugs because they are dependent.

The point I am trying to make here is that, if you look at the work that the Alcohol and Drug Foundation does, it is around prevention. A lot of it is focused around primary prevention and those 60 per cent of people who are using drugs. They are not people who are dependent; they are people trying to have a good experience. I think there is a need for us to try and get some perspective around why people use illicit drugs in this country so we can then tackle it in a much more constructive way than we have in the past.⁴²²

In its submission, the ADF outlined the public health approach to prevention, based on three levels of interventions - primary, secondary and tertiary prevention:

⁴¹⁹ Department of Education and Training, 'Health and Physical Education: Drug Education', viewed 9 February 2018, <<http://www.education.vic.gov.au/school/teachers/teachingresources/discipline/physed/Pages/drugeducation.aspx?Redirect=1>>.

⁴²⁰ Department of Education and Training, 'Health and Physical Education: The Role of Principals in Drug Education', viewed 12 January 2018, <<http://www.education.vic.gov.au/school/teachers/teachingresources/discipline/physed/Pages/drugeducation2.aspx>>.

⁴²¹ Allsop, S, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm', in *Perspectives on amphetamine-type stimulants*, Allsop and Lee (eds), IP Communications, East Hawthorn, 2012, p. 174.

⁴²² John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 195.

PRIMARY PREVENTION

The goal of primary prevention is to protect people from developing an AOD-related problem or experiencing an accident or injury (Russell L. R., 2008). Examples of primary prevention include:

- informing and educating people about the effects and the harms associated with the use of AOD,
- making laws and regulations that govern sales of alcohol and tobacco,
- creating strongly bonded communities that promote connections between people
- providing positive role modelling of AOD use,
- promoting personal resilience, helping people to control and reduce stress, and
- developing safe environments that reduce the risk of AOD use.

SECONDARY PREVENTION

Secondary prevention is directed towards people who have a higher or specific risk of suffering an AOD problem. It responds to signals of a possible or emerging problem in order to prevent its development.

Examples include:

- helping tobacco smokers to cease smoking;
- providing education programs for drink drivers;
- offering counselling for people who use AOD at risky levels; and
- providing clean needles for people who inject drugs.

TERTIARY PREVENTION

The goal of tertiary prevention is to help people with an existing disease, disability or medical condition to overcome it, or to improve their quality of life. This includes

- AOD detoxification and withdrawal;
- cognitive-behavioural therapy;
- pharmacotherapy (substitute medication);
- twelve-step and other self-help programs;
- residential rehabilitation; and
- therapeutic communities.⁴²³

As can be seen from the above list, there is clearly great overlap between prevention, treatment and harm reduction approaches using such a schema. This was also observed in Portugal during the Committee's overseas study tour. The Committee met with Sandra Simoes, Clinical Psychologist of the Centro das Taipas, a treatment centre in Lisbon. She outlined that the prevention component of the Portuguese model comprises:

- universal measures – broader promotion of health in the community, media campaigns to reduce negative labelling of people who use drugs, and building resilience among young people

⁴²³ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, pp. 13-14.

- selective measures – considers risks and protective factors that have higher correlation with dependence and attempts to intervene with people displaying risk factors, particularly young people. In this instance, a network of agencies may work together to assist the person identified as at risk
- indicative measures – working specifically with people who are experiencing early signs of drug misuse to potentially minimise further dependence or risky associated behaviours.⁴²⁴

6.2.1 Prevention based on reducing risk and increasing protective factors

According to commentators, such as the International Drug Policy Consortium (IDPC) in its Drug Policy Guide, '[d]rug prevention should focus on minimising the risk factors and strengthening the protective factors in the lives of targeted individuals and/or groups'.⁴²⁵ In its submission, the ADF likened the focus on risks and protective factors to 'upstreaming':

The ADF advocates for the use of preventive strategies to shift the focus "upstream" – preventing people from commencing (or delaying) drug use rather than waiting for their drug use to become a problem that requires reactive "downstream" emergency assistance. An upstream approach means taking action to prevent people from getting into trouble with drugs, thus reducing the need for (subsequent) interventions by justice officers, emergency workers and the treatment sector. By strengthening and supporting protective factors (Hawkins, Catalano, & Miller, 1992) the likelihood that young people will engage in AOD use can be reduced, improving their life chances. These factors include young people forming positive relations with parents and other family members; enjoying school and completing school or leaving to take up employment pathways; having firm attachment to adult role models outside the home such as teachers, sporting coaches and/or youth leaders; developing future-oriented recreational pursuits and living in communities with lower levels of drug use. Thus there are key settings where upstream (primary) prevention is most relevant.⁴²⁶

Babor et al in the text, *Drug Policy and the Public Good*, provided a general description of the varied approaches to drug prevention utilised over past decades that go beyond simple information provision, and which focus on family and community-based interventions:

Contemporary school-based drug prevention programmes that focus on social influences or social skills include three major components – psychological inoculation, normative education, and resistance skills training (Botvin 2000) – and so are often called comprehensive programmes. Media programmes have generally followed the more traditional theories (e.g. emphasizing dangers), but they also seek to create association at a more reflexive level (e.g. sports heroes endorsing a drug-free lifestyle) or work indirectly (e.g. television messages target at parents, encouraging them to spend more time with their children). Family-based interventions tend to draw on problem behaviour models that stress the importance of protective factors (e.g. parents spending time with children) and risk factors (drug-using peers) that suggest ways to prevent the development of drug use. For example, a programme might try to increase family cohesion and its ability to manage emotions and conflict.

⁴²⁴ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 20.

⁴²⁵ International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 34.

⁴²⁶ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, pp. 14-15.

These interventions also include social skills components. Community programmes, on the other hand, are typically based on theories of community organization and participation. They are often multicomponent interventions that target schools, families, peers, and the wider community in an effort to shape drug use norms.⁴²⁷

These types of programs are expanded on in the following discussion.

Social determinants

The Committee notes the importance of understanding the social determinants of risks that may lead to harmful drug use when developing prevention strategies. These place an emphasis on community and environmental interventions to prevent harmful drug use at both an individual and population or community level. In its submission, the ADF noted a range of social determinants for people that develop substance use issues including: severe difficulties or experiences of trauma; issues of concern such as mental illness, poverty, unemployment or isolation; emotional distress or disengagement from society; young people not engaged with schools; young people without role models; and exposure to drug use within families or peer groups. Its submission further stated:

Understanding the social determinants of drug use suggests primary prevention for illicit drugs strengthens individuals' resilience, fostering healthy connections between people, and building strong communities which offer support to troubled people. By strengthening our communities, we reduce the prevalence of personal and social problems, including those related to drug use and mental ill-health, and the various costs associated with them.⁴²⁸

Similarly, the Australian Drug Law Reform Foundation reflected on the role of such social determinants in its submission:

Many young people feel pessimistic about their future. Drugs will continue to be a severe problem in Australia as long as large numbers of young people are attracted to a brief chemical vacation rather than deal with their poor housing, education, and employment opportunities. Their lives need to be improved and the severity and extent of poverty will have to be reduced.⁴²⁹

In the context of young people, a social determinants explanation for drug use works in conjunction with a developmental pathways model that places emphasis on influencing a young person's psychosocial development to prevent the uptake of licit or illicit drug use. While subtly different approaches, they complement each other in promoting positive factors that may reduce or discourage drug use while utilising approaches that reduce the risk factors that may lead to drug use.⁴³⁰

Developmental pathways approach

The developmental pathways approach explores the early pathways that lead to issues such as crime and mental illness. It is particularly applicable to preventing the onset of drug misuse and antisocial behaviour in children and adolescents. It does

⁴²⁷ Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 106.

⁴²⁸ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 12.

⁴²⁹ Australian Drug Law Reform Foundation, *Submission*, no. 147, 17 March 2017, p. 3.

⁴³⁰ Toumbourou, J and Catalano, R, 'Chapter 2.4: Predicting Developmentally Harmful Substance Use', in *Preventing Harmful Substance Use: The Evidence Base for Policy and Practice*, T Stockwell, et al. (eds), John Wiley and Sons Ltd, Chichester, 2009, pp. 53-65.

not necessarily concentrate on alcohol or other drug use per se, rather it emphasises developing healthy and resilient children.⁴³¹ This approach includes a focus on risk and protective factors, which are defined as follows:

Developmental risk factors can be defined as prospective predictors that independently increase the probability that an individual or group will engage in patterns of drug use that have been linked to drug-related harm. Developmental protective factors are those factors that mediate or moderate the influence of risk factors (2005, p.53).

In his evidence to the Committee, Geoff Munro, National Policy Manager of the ADF discussed the importance of a developmental approach to primary drug prevention:

There is a good deal of research all around the world about primary prevention, because we know that the people who are most at risk of using drugs in the first place and developing drug problems are people who use drugs early. So the earlier people use drugs, the greater the risk there is of immediate or acute problems, and using drugs early, say, in the early teenage years, increases the risk that people will become a regular drug user and then develop a drug dependency. We know that those people are people who are alienated, who do not feel that they have a place in the community. They are people who are often at loggerheads with their parents. Sometimes they are not well cared for; they may be abused, they may be neglected. They often are struggling at school. This builds up into a situation where people do not feel loved or nurtured.

We know that the better the relationships children have with their parents is number one. Whatever we can do to improve parent-child relationships, particularly at an early time when there are signs that a young person is struggling or is not doing well, is where we need to be putting more resources into those early childhood years. I think that is number one. I think that is shown around the world. I think it is Norway that commits most of its social welfare funding to the zero to five years, because they say, 'If you get those early five years right, young people have a much better chance of developing into mature adults with fewer problems'.

We know that schools can do a lot to compensate for young people who are having a difficult time in those early years by identifying young people who may be struggling and helping them stay at school. Leaving school early, particularly when young people do not have a job or an apprenticeship, is certainly hazardous for their long-term future. We can do a heck of a lot in making sure young people are well connected to their families and know they have a place in the community.⁴³²

The Committee notes that the developmental model is strongly endorsed as part of the demand reduction measures of the NDS:

Approaches that seek to build protective factors and address issues underpinning social determinants of health in order to prevent the initial uptake of drugs can also enhance community health and wellbeing and reduce health inequalities among population groups who experience disproportionate risk of harm from alcohol, tobacco and other drugs. This includes social services and community groups

⁴³¹ Stockwell, T, et al. (eds.), *Preventing Harmful Substance Use: The evidence base for policy and practice*, John Wiley and Sons Ltd, Chichester, 2005; Loxley, W, et al., *The Prevention of Substance Use, Risk and Harm in Australia: a review of the evidence*, Australian Government, Canberra, 2004.

⁴³² Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, pp. 200-201.

collaborating to improve access to housing, education, vocational and employment support, as well as developing and enhancing family and social connectedness, and strategies to reduce the availability, accessibility and demand for drugs.⁴³³

While usually highlighted in the case of prevention for young people, a risk/protective factors approach can also be used to address harmful or potential drug use in adults. For example, Magistrate Tony Parsons of the Drug Court of Victoria said that understanding protective factors can be useful in assessing the pathways for those coming before the drug court on a drug treatment order:

We know if people are in good, supportive family relationships, then they are more likely to succeed than not. We know if they have got good housing, they are more likely to succeed than those that do not. We know if they have not got good medical and treatment support — it is what Patrick McGorry calls the scaffolds of supports, you know, in a mental health forum — if they do not have those scaffolds of supports, they are not going to succeed with their mental health struggles, and it is exactly the same for drug addiction. So the joy of the Drug Court is that we are resourced to provide those resources, and we do.⁴³⁴

Drug treatment specialist Dr John Sherman also told the Committee that many of his patients have underlying psychiatric issues. He advised that if these concerns had been addressed earlier, their substance use issues may have been prevented:

My last point is with regards to prevention for that group who make up over a third of my patients, those who have psychiatric problems which can be picked up very early with school psychologists, and I think we should be aiming to have psychologists in every school to pick up all these children who have behavioural issues or who have mental illness, anxiety, depression, obsessive behaviour, bipolar disorder. I have got them all in my clinic. They find self-medication with drugs, and as such they are the group who are daily committed to addiction.⁴³⁵

It is also important to note the cumulative effect of multiple risk factors. According to Toumbourou and Catalano in their text, *Preventing Harmful Substance Use: The Evidence Base for Policy and Practice*, the higher number of risk factors, the greater the chance that children may subsequently progress to harmful drug use.⁴³⁶ Conversely, however, if interventions are implemented to reduce or eradicate one risk factor, this may prevent the acceleration or accumulation of consequent problems:

For example, the reduction of a risk factor such as academic failure is likely to lead to greater completion of high school, increased attendance at college and greater job opportunities, all of which can be costed as benefits of early school-based prevention efforts. Likewise, pre and postnatal home visits by public/community health nurses not only reduce material substance use and arrest rates, of the mother and eventually the child, but also reduce rates of substantiated child abuse and neglect that represent additional cost savings of this approach.⁴³⁷

⁴³³ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 9.

⁴³⁴ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 147.

⁴³⁵ Dr John Sherman, Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 290.

⁴³⁶ Toumbourou, J and Catalano, R, 'Chapter 2.4: Predicting Developmentally Harmful Substance Use', in *Preventing Harmful Substance Use: The Evidence Base for Policy and Practice*, Stockwell, et al. (eds), John Wiley and Sons Ltd, Chichester, 2005, p. 53.

⁴³⁷ Loxley, W, et al., *The Prevention of Substance Use, Risk and Harm in Australia: a review of the evidence*, Australian Government, Canberra, 2004, p. 243.

6.3 Universal prevention

Mass media campaigns are widely used to expose large populations to a variety of health-related messages through media such as television, radio, newspapers, billboards and increasingly social media.⁴³⁸ While the effectiveness of such campaigns is equivocal, it is suggested that mass media campaigns in the drug field are likely to be more effective when:

They are well resourced and enduring; target a clearly defined audience; have a basis in advanced marketing strategies that effectively target, communicate with and have relevance for and credibility with the desired audience; and provide a credible message to which the audience is frequently exposed. Mass media campaigns [should] be best conceived as one component of a multifaceted approach. For example, a mass media campaign on alcohol impaired driving might be valuable when it is combined with highly visible roadside breath testing. It is a challenge however to find such comprehensive approaches in the illicit drug domain, let alone in relation to amphetamine type stimulant use.⁴³⁹

As first raised in chapter five regarding community attitudes about drugs, the Committee is of the view that a population-based prevention strategy is required to enhance knowledge of the facts on illicit drug use to counter false assumptions and improve community understanding. Raising awareness in this area is important for health prevention and early intervention messages around drug use to reach the greatest number of people. In particular, as discussed in chapter one, there is a need for open and frank conversations about drug use. Professor Dan Lubman, Director of Turning Point told the Committee that community perceptions of drug use need to change in a similar way to how attitudes have changed towards cancer:

I trained as a doctor, and when I started training I used to see people come and present to me when I was doing, say, general surgery training. Women used to come and present with end-stage breast cancer. They would come with big fungating breast tumours. That is largely because there was so much stigma around cancer in those days and people did not feel there was an adequate treatment, so people used to be so embarrassed about it and used to cover up and not seek treatment. We used to have this huge delay between people recognising they were having problems and overcoming that stigma and coming to seek treatment.

In the last 34 years people have been raising money for cancer. They are always proud, everyone is out, everyone is talking about it, and now we are into early intervention people want to get to treatment as fast as possible. We have seen this massive change around stigma and around cancer. If we look at skin cancer and how people respond to skin cancer, we have seen these massive changes.⁴⁴⁰

John Ryan, CEO of the Penington Institute discussed that social infrastructure can contribute to enhancing community conversations, using the example of mental health:

There are lots of different opportunities for early intervention, whether it is through workplaces and work colleagues talking openly about drug use issues and talking with their colleagues about their drug use, whether it is through sporting clubs et

⁴³⁸ Wakefield, Lokin & Hornik 2010; Durkin, Brennan & Wakefield 2012

⁴³⁹ Allsop, S, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm', in *Perspectives on amphetamine-type stimulants*, Allsop and Lee (eds), IP Communications, East Hawthorn, 2012, p. 175.

⁴⁴⁰ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25.

cetera. So there is lots of social infrastructure where drug use issues should be spoken about more honestly and openly, providing the opportunity for people to call out escalating drug problems.⁴⁴¹

Similarly, John Rogerson of the ADF advised the Committee:

I think what is most important is that we have different conversations with the community, because we have actually done some really good work around mental health in this country and started to change how the community looks at this issue. It is time that politicians right across this country started to do more on this issue. If we have been able to do it with mental health, we must be able to do it with illicit drugs as well, because with the stigmatisation of people who use drugs, particularly those people who are dependent, what sits behind their drug use is generally either some factor associated with trauma or something to do with socio-economic disadvantage. They are the issues really as a conversation that we need to start having with the community.⁴⁴²

As an example, a public awareness campaign was launched in Vancouver by the British Columbia (BC) Ministry of Mental Health and Addictions in January 2018, particularly in response to the opioid overdose crisis (see chapter 17 for further details). As noted in the media release for the program:

“Stigma around addiction is killing people,” said Judy Darcy, Minister of Mental Health and Addictions. “Addiction is often a response to deep pain or trauma, and stigma drives our loved ones to act and live in dark silence. We need to knock down the walls of silence and encourage courageous conversations between friends, family and co-workers struggling with substance use, so they feel supported in seeking treatment and recovery.”

The public awareness campaign discredits false stereotypes by showing that addiction can affect people from all walks of life. It serves as a call to action for all British Columbians to stop seeing addiction as a moral failure and start seeing it as a health issue that deserves compassion and support.

“There are multiple studies showing how stigma associated with drug use drives people to use alone or in settings where people may be unwilling to call 911 for emergency assistance,” said Dr. Bonnie Henry, incoming provincial health officer. “In order to encourage people to reach out for help – stigma, guilt and shame must be removed from the equation.”⁴⁴³

It noted that the campaign will involve television, online, social media, and billboard channels, as well as the involvement of a major sports team through their support for the campaign at games and other events until June 2018. The following posters are part of the campaign:

⁴⁴¹ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 8.

⁴⁴² John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, pp. 195-196.

⁴⁴³ Ministry of Mental Health and Addictions, *New campaign aims to save lives by eliminating stigma*, Media release, BC Gov News, 29 January 2018.

Figure 6.1 StopOverdoseBC.ca campaign posters



Source: BC Ministry of Mental Health and Addictions, 'Co-Worker Teammate Drug User Hockey Fan', viewed 27 February 2018, <https://scontent.fmel5-1.fna.fbcdn.net/v/t31.0-8/27173436_10154927278076627_2893485699940732241_o.png?oh=4e7d86c3bfeaaba869c3fb5c49b65eb&oe=5AFFAE9F>; BC Ministry of Mental Health and Addictions, 'Cousin Student Drug User Friend', viewed 27 February 2018, <https://scontent.fmel5-1.fna.fbcdn.net/v/t31.0-8/27173930_1762415340456751_6723429181211700534_o.jpg?oh=bd3e71a548899d33a91eb727314fb5f9&oe=5B3E9C48>.

Public awareness campaigns, when designed well and targeted effectively, can play a vital role in changing community conversations and improving prevention and early intervention efforts. While the Vancouver example above is in response to the high number of overdose deaths, the Committee considers that such a campaign would be equally useful in preventing such an event from occurring here. The Committee also notes that inquiry stakeholders likened such efforts as similar to successful public health campaigns for issues such as cancer and mental health. There is no reason why a comparable approach should not be adopted to prevent harmful drug use. It would also raise awareness about substance use disorders, including the understanding that they are health conditions, and that, as drug use could affect anyone, people should feel comfortable talking to a range of people, including family, peers and general practitioners (GPs), about any substance use issues. This would also compliment an early intervention approach.

RECOMMENDATION 9: The Victorian Government develop a public awareness campaign on substance use and disorders in order to reduce negative labelling of people who use substances, both illicit and prescription medications, and to reduce the harms associated with substance misuse.

6.4 Prevention strategies for children and young people

As noted, preventing or delaying the uptake of drug use is particularly important in the context of children and young people. Most efforts to reduce or prevent the uptake of alcohol, tobacco and illicit drug use in childhood and adolescence take place in the schools and education sector. For example, the Department of Health and Human Service (DHHS) *Program guidelines: Alcohol and other drugs* referred to the Prevent Alcohol and Risk-related Trauma in Youth (PARTY) program as a key prevention measure targeting young people. It is:

...a full-day, in-hospital education program that aims to reduce risky AOD-taking behaviour among secondary school students by helping them to understand risks, choice and consequences. Delivered at the Royal Melbourne and The Alfred hospitals, the PARTY program covers the trauma, injury and poor health that can result from risk-taking behaviour and poor decision making, including AOD misuse. As part of the program, students are given first-hand experience in established trauma centres, hear from senior staff about what AOD can do to the body and brain, and have the opportunity to talk to patients and families that have been impacted by injuries resulting from risky behaviour.

The PARTY program at The Alfred has been expanded beyond a school-based education initiative to also reach young repeat offenders, navy trainees and youth in regional areas through their various outreach programs.⁴⁴⁴

The Committee also heard from Dr Helen Stergiou, an Emergency and Trauma Physician at Alfred Health about the value of this program:

Certainly at the Alfred and at a couple of other centres around town, kids are brought in — 15, 16, 17-year-olds — and they have some lectures and some didactic elements. They meet patients in intensive care. They are taken through the trauma centre. They don the clothes, they look at the bells and whistles and listen to them. It is what we call the teachable moment. One of those kids, next time they are about to get into a car and they have had a few too many, will stop and think. There is literature to show that that makes a difference.⁴⁴⁵

The Committee notes, however, that while education and information programs can be effective, they are not of themselves sufficient to reduce the demand for alcohol or illicit drugs.⁴⁴⁶ In this regard, Professor Margaret Hamilton, Australian drug policy expert, also advised the Committee:

Many people will say, ‘Well, surely we should just do prevention, and if we do prevention, both attacking supply’ and ‘Let’s not have the drugs’ and trying to socially inoculate young people from any desire to have drugs, that that is what we need. I think prevention, including education, does have an important part to play

⁴⁴⁴ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 8.

⁴⁴⁵ Dr Helen Stergiou, Emergency and Trauma Physician, Alfred Health, *Transcript of evidence*, 19 June 2017, p. 242.

⁴⁴⁶ Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010.

in preparing young people for decision-making about risky behaviours and a range of situations and products and opportunities that come their way. But we know that while it is necessary, it is not sufficient.⁴⁴⁷

For older adolescents and young adults, their involvement in either employment or vocational training has proven to reduce the risk of drug taking. This is also the case for younger adolescents and children positively engaged in education. On the other hand, disengagement from education is a significant risk factor. A child's experience of school can be either protective or exacerbate risks.⁴⁴⁸ The ADF in its submission stated:

In 2013, one in twelve families with young children (8 per cent) showed signs of unhealthy family functioning (Victorian Department of Education and Training, 2015). Children in this situation are significantly more likely to have behavioural difficulties such as inappropriate conduct, hyperactivity, problems with peers or emotional symptoms. These children face a subsequent vulnerability to drug use and drug problems as well as a range of other mental health problems, including developmental delays and restricted educational engagement and achievement. Schools provide a setting and a framework for interventions with those children that can improve the children's social and educational prospects including reducing the likelihood of alcohol and other drug involvement.⁴⁴⁹

In a related development, in August 2017, the Victorian Ombudsman released a report, *Investigation into Victorian government school expulsions*, which in part discussed school responses to drugs. In the Forward, the Victorian Ombudsman, Deborah Glass, stated:

Expulsion for drug use was also prevalent, for reasons ranging from a single instance of being under the influence, to dealing. In any event, as experts point out, expulsion is, at best, a short term solution, that does not address the underlying cause but shifts the problem elsewhere.⁴⁵⁰

The Committee acknowledges in these circumstances the importance of a prevention approach that focuses on addressing the underlying causes of drug use among young people, which would warrant consideration of ways to continue to engage them in educational or vocational opportunities, rather than punishing them.

6.4.1 Drug education in schools

School based drug education is one of the main ways in which young people receive information about drugs, although there are differing views regarding its effectiveness. For example, Drug Free Australia (DFA) in its submission noted the benefits of primary prevention programs based on education:

The laws in most jurisdictions need to be focused on primary prevention to prevent or intervene very early in the drug-taking practices of young people. This includes a comprehensive education strategy that not only explains the harms of these drugs, but also provides solutions for individuals and communities.⁴⁵¹

⁴⁴⁷ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 55.

⁴⁴⁸ Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria - Volume 2*, Parliament of Victoria, East Melbourne, 2014, p. 500.

⁴⁴⁹ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, pp. 15-16.

⁴⁵⁰ Victorian Ombudsman, *Investigation into Victorian government school expulsions*, Victorian Government, Melbourne, 2017, p. 3.

⁴⁵¹ Drug Free Australia, *Submission*, no. 132, 16 March 2017, p. 1.

Drug Free Australia recommended that there be mandatory drug education in schools in Victoria, as well as community education prevention programs.⁴⁵²

According to Babor et al, it is unclear whether education and information provision programs are effective without any other interventions to modify people's behaviour.⁴⁵³ Didactic 'just say no' or total abstinence approaches particularly for adults are widely viewed as ineffective. Some researchers argue that drug education has not been greatly successful, because many programs emphasise particularly at the school level that abstinence is the only acceptable goal. If the objective of a program is abstinence, then any use, no matter how little, constitutes a failure.⁴⁵⁴ In acknowledging these concerns, Josephine Baxter, Executive Director of DFA stated to the Committee:

You will hear a mantra from time to time that drug education does not work, but that is certainly not the case in my experience as a teacher in a secondary school and also in my work at Odyssey House, where we did community education programs and turned a lot of lives around. Education does work when it hits the mark, and each of the schools can have a say in what they need to do — but at least give them some resources and a chance to do it.⁴⁵⁵

In Australia, drug education is the responsibility of individual states and territories, although the Commonwealth Government has developed a useful evidence-based guide for planning and undertaking school drug education, *Principles for School Drug Education*. The 12 principles outlined below are embedded within a broader health promotion approach and informed by and support evidence-based practice.

452 Drug Free Australia, *Submission*, no. 132, 16 March 2017, p. 1.

453 Babor, T, et al., *Drug Policy and the Public Good*, Oxford University Press, Oxford, 2010, p. 110.

454 Midford, R, et al., 'Harm reduction in school drug education: developing an Australian approach', *Drug and Alcohol Review*, vol. 17, no. 3, 1998, p. 319.

455 Josephine Baxter, Executive Director, Drug Free Australia, *Transcript of evidence*, 21 August 2017, pp. 279-280.

Table 6.1 Principles for school drug education

Comprehensive and evidence-based practice		
Principle 1:	<i>School practice based in evidence</i>	Base drug education on sound theory and current research and use evaluation to inform decisions.
Principle 2:	<i>A whole school approach</i>	Embed drug education within a comprehensive whole school approach to promoting health and wellbeing.
Principle 3:	<i>Clear educational outcomes</i>	Establish drug education outcomes that are appropriate to the school context and contribute to the overall goal of minimising drug-related harm.
Positive school climate and relationships		
Principle 4:	<i>Safe and supportive environment</i>	Promote a safe, supportive and inclusive school environment as part of seeking to prevent or reduce drug-related harm.
Principle 5:	<i>Positive and collaborative relationships</i>	Promote collaborative relationships between students, staff, families and the broader community in the planning and implementation of school drug education.
Targeted to needs and context		
Principle 6:	<i>Culturally appropriate and targeted drug education</i>	Provide culturally appropriate, targeted and responsive drug education that addresses local needs, values and priorities.
Principle 7:	<i>Recognition of risk and protective factors</i>	Acknowledge that a range of risk and protective factors impact on health and education outcomes, and influence choices about drug use.
Principle 8:	<i>Consistent policy and practice</i>	Use consistent policy and practice to inform and manage responses to drug-related incidents and risks.
Effective pedagogy		
Principle 9:	<i>Timely programs within a curriculum framework</i>	Locate programs within a curriculum framework, thus providing timely, developmentally appropriate and ongoing drug education.
Principle 10:	<i>Programs delivered by teachers</i>	Ensure that teachers are resourced and supported in their central role in delivering drug education programs.
Principle 11:	<i>Interactive strategies and skills development</i>	Use student-centred, interactive strategies to develop students' knowledge, skills, attitudes and values.
Principle 12:	<i>Credible and meaningful learning activities</i>	Provide accurate information and meaningful learning activities that dispel myths about drug use and focus on real life contexts and challenges.

Source: Meyer, L and Cahill, H, *Principles for school drug education*, Commonwealth of Australia, Canberra, 2004, p. 9.

Resilience models

Approaches that promote resilience, reduce risk factors and enhance protective factors have shown promise.⁴⁵⁶ To this end, school drug education is discussed by the DET in terms of a holistic approach, which includes resilience:

School drug education utilises a whole school approach to health promotion, prevention and early intervention to student wellbeing and engagement, based on the principles of harm minimisation. It aims to promote resilience, and build on knowledge, skills and behaviours to enable young people to make responsible, healthy and safe choices.

⁴⁵⁶ Stockwell, T, et al. (eds.), *Preventing Harmful Substance Use: The evidence base for policy and practice*, John Wiley and Sons Ltd, Chichester, 2005; Allsop, S, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm', in *Perspectives on amphetamine-type stimulants*, Allsop and Lee (eds), IP Communications, East Hawthorn, 2012.

It encompasses all policies, practices, programs and initiatives connected with prevention and reduction of drug-related harm, and the building of resilience in individuals and school communities. Schools should implement relevant and comprehensive drug education for all students as an ongoing core component of the curriculum.⁴⁵⁷

The Commonwealth Government has also established programs and policies that seek to promote resilience in young people. These policies recognise that schools ‘play a vital role in promoting the social and emotional development and wellbeing of young Australians’:

Student resilience and wellbeing are essential for both academic and social development, and are optimised by safe, supportive and respectful learning environments. Schools share this responsibility with the whole community.

Not only do confident and resilient children with a capacity for emotional intelligence perform better academically, these skills can also contribute to their ability to create strong social bonds and supportive communities, and to maintain healthy relationships and responsible lifestyles.⁴⁵⁸

There was some support from inquiry stakeholders for education to be based on resilience and skills development. For example, Paul Aiken, Evaluation and Advocacy Team Leader of UnitingCare Regen spoke to the importance of this approach as opposed to didactic type programs on drugs per se:

— I just think there is not a need for alcohol and other drug specific interventions particularly in primary schools. That is not really the most effective thing. We hear this from seeing our non-residential rehab programs. People say, ‘If I had learned this sort of content, the CBT [cognitive behavioural therapy] and mood management content like managing emotions and that sort of thing, when I was in school, I would not be here now’.

The resilience work that is being done in schools now is teaching kids that work.⁴⁵⁹

Josephine Baxter of DFA told the Committee that resilience models, as well as a focus on providing young people with information on the dangers of drug use, is needed:

I think that there is no one silver bullet, and nothing can be siloed. I think that a lot of kids are misinformed about drugs, and that is where the correction needs to be made. It would be very easy to bring in an effective drug education program that did include the building of resilience and the building of independence and self-esteem — that kind of thing — and that helped kids to understand that they have a right to their own decisions. But if they have not got the facts about the dangerous substances in an effective way — of how it does impact on the brain, of how for some there is no turning back, particularly with ice — if they do not know that and are not exposed to that line of thinking, they cannot make complete choices that would be effective for their healthy way forward. While I agree with ReGen to a point, I think that by putting our heads in the sand about the facts — about the harms of these drugs — we are actually denying our kids an effective education program.⁴⁶⁰

457 Department of Education and Training, ‘School Policy Advisory Guide: Drug Prevention’, viewed 12 January 2018, <<http://www.education.vic.gov.au/school/principals/spag/safety/Pages/drugprevention.aspx>>.

458 Department of Education and Training, ‘Student Resilience and Wellbeing’, viewed 12 January 2018, <<https://www.education.gov.au/student-resilience-and-wellbeing>>.

459 Paul Aiken, Evaluation and Advocacy Team Leader, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 276.

460 Josephine Baxter, Executive Director, Drug Free Australia, *Transcript of evidence*, 21 August 2017, p. 282.

During the overseas study tour, Sandra Simoes from the Centro das Taipas in Lisbon told the Committee that the best prevention tool is building resilience among young people, and teachers are strongly trained in this area to use play to deconstruct ideas around drugs. There is also a clear sense of responsibility instilled throughout the community, which is taught from a young age in schools.⁴⁶¹ Similarly, Steve Rolles, Senior Policy Analyst of Transform in London, reaffirmed the value of building resilience among young people as a contributing factor to preventing drug use.⁴⁶²

Harm reduction messages in drug education

The Committee is aware that in some instances, there is value in presenting harm reduction messages as part of prevention programs in schools, in recognition that some young people do consume illicit substances.

The Australian Secondary Students' Alcohol and Drug Survey is conducted triennially to explore trends in tobacco, alcohol and licit and illicit drug use among secondary students between 12 to 17 years old. The 2014 survey of approximately 4,500 students found that 14 per cent of students had ever used cannabis, and such rates have been stable over 2008 and 2011 survey cycles. In terms of other illicit substances, the lifetime use rate was between one and two per cent. The only drug category where use rates changed between 2008 and 2014 was amphetamines and ecstasy, with decreases in amphetamines from three per cent to two percent, and decreases in ecstasy from four per cent to two percent.⁴⁶³ It is clear that, while small, there is still some prevailing substance use among this student group.

Some stakeholders considered that while drug education programs are now more sophisticated than simple 'just say no' programs, they may still not necessarily achieve prevention or provide young people with the skills and information to make the best decision for themselves. Specifically, Dr Peta Malins, Lecturer in Justice and Legal Studies at RMIT University, told the Committee:

...even though it is often framed as harm reduction, [is that] it is mainly set up in a way to basically give young people the skills to say no. So rather than being like the Reagan era 'Just say no' kind of approach — 'We're going to tell you how bad it is. Just say no' — it is now kind of done in such a way that it is, 'We're going to show you how bad it is, and then we're going to give you the skills to say no', but it still is kind of that same model underpinned by an abstinence approach.

We have reviewed quite a lot of different curriculums. Even the ones that are really framed as being very progressive, very skills based and very focused on progressive pedagogy but also progressive approaches around harm reduction still often boil down to that fundamental idea that we are going to teach people how to say no and not really give that space in the educational framework to actually give very practical, very context-based information about how to actually manage risks if they are using drugs. There is a kind of assumption that is underpinning that, that we are not going to talk about the fact that drugs are pleasurable, the fact that young people do use a range of different substances, that it is not just a few young kids who end up doing it,

⁴⁶¹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 20.

⁴⁶² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 27.

⁴⁶³ Williams, T, et al., *Tobacco, alcohol, over-the-counter and illicit substance use among Victorian secondary school students 2014: Results from the Victorian component of the 2014 Australian Secondary Students' Alcohol and Drug (ASSAD) Survey*, Cancer Council Victoria / Victorian Department of Health and Human Services, Melbourne, 2016, p. 1.

that it is actually quite widespread. There is this assumption that as long as we paint a negative picture about drugs and give the kids those skills of saying no, that that will solve the problem.⁴⁶⁴

Similarly, Nicholas Kent, Chapter President of the University of Melbourne Students for Sensible Drug Policy (SSDP) Australia summarised research undertaken by Dr Malins and others on drug education curriculums:

They are framed within this context of, ‘We don’t teach abstinence anymore — we’ve given up on that because obviously it doesn’t work — and we’re taking this more nuanced approach of communicating negative effects and positive effects in the context of health and all that sort of stuff’, which is a useful approach. But at the same time with all of these resources they are essentially just pushing a message of abstinence through a different lens.

So basically the ways in which they paint parties or instances of youth consumption are always inherently problematic. They are always inherently going to lead to some sort of risk, which is not the lived experience, I believe, of the majority of drug users. I think with that disconnect students who choose to use drugs either in or after high school straightaway feel that they have been lied to, because everything they have been told throughout high school does not fit with their lived experience of what a party actually is. They learn about what drug-taking behaviours happen in a textbook and that then switches them off from any kind of health message that you are trying to impose at any point along the line.⁴⁶⁵

Dr Malins suggested that peer-based harm reduction should be a focus in certain contexts, noting DanceWise, a program operated by Harm Reduction Victoria (HRV), could provide such education in schools. She acknowledged that there would be ‘a lot of fear around it’ and sensitivities with such an approach, but that what is being done currently may be more harmful than helpful.⁴⁶⁶

6.4.2 The role of families

Some stakeholders stressed the importance of addressing issues in family and community life as a prevention strategy. This is particularly important in the context of ensuring that protective factors are strengthened, and social determinants resulting in harmful drug use are minimised. Peter Wearne, Chair of the Yarra Drug and Health Forum (YDHF) told the Committee:

I met with a young man today that is doing some work for us out in the north, and he said, ‘What would you do, Peter, if you left YSAS?’. I said, ‘You know what I would like to do — I would like to go back and run a community group in a local community, working with mums and dads every day that have got kids that are in trouble, to try and intercept that before those kids end up in serious strife’. I would be amazed if the last thousand people that have died from an overdose did not have youth justice, child protection and out-of-home care in their background. I would be really shocked. I am not saying that the rich and the well off do not have that tragedy; they do. But the majority of people we see come from — I am sure, Bill, you know this — pretty distinctive backgrounds in terms of deprivation and lack of opportunity. That is really where the prevention has got to start.⁴⁶⁷

⁴⁶⁴ Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 366.

⁴⁶⁵ Nicholas Kent, Chapter President, University of Melbourne, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, pp. 313-314.

⁴⁶⁶ Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 367.

⁴⁶⁷ Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 52.

Associate Professor Nadine Ezard said that for some communities characterised by trauma, disengagement and dysfunction, strategies are needed at a very early stage:

Some of the responses need to be at a broader level: so even down to early childhood, some of those kind of early childhood support programs that you see in - Fitzroy Crossing has a great example.. where they are being providing support for the zero-to-threes, that actually encourages some prevention of intergenerational trauma passing on and providing some kind of structure for them, for the next generation coming through, as well as for the already-affected generation.⁴⁶⁸

Another important aspect is programs that enhance good parenting skills. In this regard, the ADF stated in its submission:

Parents are an important influence on the AOD use of their children. Parents' influence comes via role modelling of good behaviour, general discipline, good parent-child relationships based on communication, and parental involvement in their children's lives (Hawkins, Catalano, & Miller, 1992). For parents who experience difficulties, special parenting programs can help them improve their skills. One example of a successful program is the Triple P Positive Parenting Program which has five levels of intervention to accommodate the various needs of families whose function is disrupted, or whose children have behavioural problems, at different levels of severity (Ralph & Sanders, 2004). Another is the Resilient Families program, which combined school and family interventions in Melbourne schools and which led to reductions in adolescent drinking in the experimental schools compared to adolescents in the control schools (Toumbourou, Gregg, Shortt, Hutchinson, & Slaviero, 2013).⁴⁶⁹

The Committee notes that the Victorian DET policies on school drug education recognise that parents and caregivers are a crucial asset:

A significant body of research indicates that when parents participate in their children's education, the result is an increase in student achievement and an improvement of students' attitudes. Productive partnerships between schools, family and the community also provide a strong network of connections that can help protect young people against a range of harms including those associated with drugs, emotional distress and problem behaviors.⁴⁷⁰

The DET also highlights some examples of drug education programs that involve parents and families including the *Talking Tactics Together* program in primary school, and the *Creating Conversations* program in secondary schools.⁴⁷¹

⁴⁶⁸ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 122.

⁴⁶⁹ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 15.

⁴⁷⁰ Department of Education and Training, 'Drug Education: Engaging Parents in Drug Education', viewed 12 January 2018, <<http://www.education.vic.gov.au/school/teachers/teachingresources/discipline/physed/Pages/drugeduengage.aspx>>.

⁴⁷¹ Department of Education and Training, 'Child Health and Wellbeing: Drug Education', viewed 9 February 2018, <<http://www.education.vic.gov.au/school/parents/health/Pages/drugeduengage.aspx>>.

6.4.3 Community programs

There is some evidence that community programs, for example those relating to recreation and leisure, can have a positive role in prevention efforts.⁴⁷² Although such programs alone would not be effective in reducing the risks of drug taking, they can assist when they are part of a broader prevention strategy that also targets other areas of intervention.

In the context of sports programs, the ADF particularly highlighted its *Good Sports* program, which helps sporting clubs tackle illicit drug use. This program was a key project under the state *Ice Action Plan*, and is now being rolled out across the country with federal funding. The key objectives are to support sports clubs in policy development and implementation, build the confidence of leaders and members to address drug-related issues, develop networks and ongoing support, and promote healthier club environments.⁴⁷³

Youth in Iceland model

The Alcohol and Drug Foundation also endorsed a prevention approach from Iceland that emphasises recreational activities and other measures.⁴⁷⁴ In the 1990s, Iceland had a serious problem associated with teenage alcohol and other drug use, however, twenty years later, it now has one of the lowest levels of adolescent drug use in the world:

Today, Iceland tops the European table for the cleanest-living teens. The percentage of 15- and 16-year-olds who had been drunk in the previous month plummeted from 42 per cent in 1998 to 5 per cent in 2016. The percentage who have ever used cannabis is down from 17 per cent to 7 per cent. Those smoking cigarettes every day fell from 23 per cent to just 3 per cent.⁴⁷⁵

According to a recent media article on the Iceland model, Professor Inga Sigfusdottir, Director of the Icelandic Centre for Social Research, acknowledged that before the new model was introduced, Iceland had ‘all kinds of substance prevention efforts and programs’. However, these were based on somewhat didactic educational programs built on warning young people about the dangers of drink and drugs.⁴⁷⁶ The new model, however, shifted away from this traditional approach and more towards:

- communicating to parents the importance of emotional support, reasonable monitoring, and increasing the time they spend with their adolescent children;

⁴⁷² Bundick, M, ‘Extracurricular activities, positive youth development, and the role of meaningfulness of engagement’, *The Journal of Positive Psychology*, vol. 6, no. 1, 2011; Jackson, C, et al., ‘An overview of prevention of multiple risk behaviour in adolescence and young adulthood’, *Journal of Public Health*, vol. 34, no. S1, 2012; Hutchinson, S, *Physical Activity, Recreation, Leisure, and Sport: Essential Pieces of the Mental Health and Well-being Puzzle*, Recreation Nova Scotia, Lakeside, 2011; Walker, J and Donaldson, C, *Intervening to improve outcomes for vulnerable young people: a review of the evidence*, UK Government, Manchester, 2010.

⁴⁷³ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 17.

⁴⁷⁴ Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 201.

⁴⁷⁵ Young, E, ‘Iceland knows how to stop teen substance abuse but the rest of the world isn’t listening’, *Mosaic*, 17 January 2018, viewed 6 February 2018, <<https://mosaicscience.com/story/iceland-prevent-teen-substance-abuse>>.

⁴⁷⁶ Young, E, ‘Iceland knows how to stop teen substance abuse but the rest of the world isn’t listening’, *Mosaic*, 17 January 2018, viewed 6 February 2018, <<https://mosaicscience.com/story/iceland-prevent-teen-substance-abuse>>.

- encouraging youth to participate in organized recreational and extracurricular activities and sports and to increase opportunities for such participation; and
- working with local schools in order to strengthen the supportive network between schools, parents and other relevant agencies in the community to support substance use prevention efforts.⁴⁷⁷

Research into the model's effectiveness highlighted:

By focusing on peer influence, parental supervision and monitoring, and alternative youth activities in the community, primary prevention efforts that are organized around the kind of multi-level health promotion that Iceland is pursuing is likely to be more successful than single-focus efforts. Moreover, our transdisciplinary approach is based on social science theory that links community-level mobilization to individual behavior, coupled with an institutionalized capacity for collecting population-based data that have yielded a rich, dynamic and nuanced picture of the potentially modifiable risk and protective factors at the individual, family, community and societal levels. The evidence that our approach works, and is continuing to work, is promising.⁴⁷⁸

An earlier article in 2008 noted the reasons for its success included emphasising the role of the family; creating new activities to engage parents; ongoing community partnerships between stakeholders such as researchers, schools, parent groups, authorities, and recreational and other workers; and the small population size of Iceland (just over 300,000 people in total), making it more straightforward to implement. It also noted that this was a long term strategy, making it easier to address existing and emerging risks and protective factors within the community, but not necessarily with the aim of proving a direct causal relationship to changes in drug use.⁴⁷⁹

The Committee acknowledges that prevention through education alone is not sufficient, and that a range of evidence exists on a variety of prevention activities for children and young people. Strategies such as school-based education that focus on resilience and appropriate harm reduction messages, and which involve parents and families, in addition to recreational activities are well worth exploring. It remains to be seen whether strategies involving systemised recreational activities, such as what was undertaken in Iceland, can be easily achieved in Victoria. However, these issues should be considered as part of a prevention approach that does not solely focus on school drug education, but seeks to holistically incorporate various factors that may reduce the likelihood of harmful drug use in the long term for children and young people.

⁴⁷⁷ Sigfusdottir, I, et al., 'Substance use prevention through school and community-based health promotion: A transdisciplinary approach from Iceland', *Global Health Promotion*, vol. 18, no. 3, 2011, p. 25.

⁴⁷⁸ Sigfusdottir, I, et al., 'Substance use prevention through school and community-based health promotion: A transdisciplinary approach from Iceland', *Global Health Promotion*, vol. 18, no. 3, 2011, p. 26.

⁴⁷⁹ Sigfusdottir, I, et al., 'Substance use prevention for adolescents: the Icelandic Model', *Health Promotion International*, vol. 24, no. 1, 2008, p. 23.

RECOMMENDATION 10: The Victorian Government enhance its existing prevention measures that target children and young people including:

- School education programs and resources for young people around resilience and life training skills, in addition to appropriate, age-specific and evidence-based drug education programs that focus on preventing drug use, as well as being relevant to young people's real life experiences and perspectives. This should also include ensuring that school policies align with prevention goals.
- Specific programs within schools that aim to build protective factors, particularly for young people identified as at-risk or requiring enhanced support.
- Programs and resources for parents to build resilience and life skills, and enhance protective factors.
- Explore the effectiveness of the Iceland model further, particularly the role of communities and families in prevention, in addition to encouraging participation of young people in meaningful recreational opportunities.

6.5 Groups that may benefit from a targeted prevention focus

As well as prevention strategies for children and young people, it is also important to describe some of the groups with higher rates of drug use that may benefit from a targeted prevention approach, and the types of interventions that might be useful. While not discussed at length, this is important when considering the Committee's aim for prevention and early intervention to have a stronger focus in Victoria's overall drug policy.

Aboriginal and Torres Strait Islander people

While noting caution in the interpretation of results due to the small sample size involved, the National Drug Strategy Household Survey (NDSHS) 2016 reported that:

Other than ecstasy and cocaine, Indigenous Australians aged 14 or older used illicit drugs at a higher rate than the general population (Table 8.6). In 2016, Indigenous Australians were: 1.8 times as likely to use any illicit drug in the last 12 months; 1.9 times as likely to use cannabis; 2.2 times as likely to use meth/amphetamines; and 2.3 times as likely to misuse pharmaceuticals as non-Indigenous people.⁴⁸⁰

Under the NDS, Aboriginal and Torres Strait Islander (ATSI) people are highlighted as a priority population given the high prevalence of use and attendant harms, as well as commonly identified social determinant factors, such as 'cultural deprivation and disconnection to cultural values, and traditions, trauma, poverty, discrimination and lack of adequate access to services'.⁴⁸¹ There is also a sub-strategy under the NDS, the *National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019*, which aims to 'improve the health and wellbeing of Aboriginal and Torres Strait Islander people by preventing and reducing the harmful effect of alcohol and other drugs (AOD) on individuals, families and their communities'.⁴⁸²

⁴⁸⁰ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 108.

⁴⁸¹ Department of Health, *National Drug Strategy 2017–2026*, Commonwealth of Australia, Canberra, 2017, p. 26.

⁴⁸² Intergovernmental Committee on Drugs (IGCD), *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 - 2019: A sub-strategy of the National Drug Strategy 2010 - 2015*, Australian Government, Canberra, 2015, p. 3.

Some stakeholders discussed the complexities involved with providing culturally appropriate support, and particularly noted that the role of consultation directly with ATSI people is essential. For example, Demos Krouskos, CEO of North Richmond Community Health told the Committee:

These are people with strong family relationships, and we need to be very, very cognisant and aware of the nature of those relationships and what the impact of this is in terms of providing support to them. I do not think we have a very good understanding of those issues, and that is because we do not have a consumer-focused approach where we engage directly and we hear the voices of our Aboriginal community and ask them what it is that would be beneficial in providing support.⁴⁸³

Bevan Warner, Managing Director of Victoria Legal Aid (VLA) also stated:

I think top-down imposed solutions on communities have proven not to work wherever those communities exist. Working to build a strong capability with community leaders and with emerging leaders and with young people in communities is, I think, vital to the effectiveness of any government intervention or any government program. So I would be very much resisting a one-size-fits-all or a top-down approach.⁴⁸⁴

A 2016 report published by the Australian Indigenous HealthInfoNet, *Plain language review of illicit drug use among Aboriginal and Torres Strait Islander people*, outlined policies that could be used to address harmful substance use. In the area of prevention, this included:

- primary prevention activities such as organised recreation, education and health promotion campaigns and law enforcement strategies
- secondary prevention activities such as brief interventions in health care settings (discussed below), night patrols, sobering up shelters, needle and syringe programs and diversion from the criminal justice system
- tertiary prevention activities such as community-based treatment and residential rehabilitation.⁴⁸⁵

The Committee is aware that the Victorian DHHS provides a range of alcohol and other drug (AOD) services targeting ATSI communities. For example, ATSI AOD workers work with individuals and families regarding harmful AOD use in a number of Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Community Controlled Organisations (ACCOs). The purpose of this is:

[t]o provide Aboriginal people and families with a range of prevention, early intervention and group support services including counselling, brief intervention, referral to appropriate AOD services including withdrawal and rehabilitation treatment, care coordination and ongoing support.⁴⁸⁶

⁴⁸³ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 157.

⁴⁸⁴ Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 233.

⁴⁸⁵ Hoareau, J, 'Plain language review of illicit drug use among Aboriginal and Torres Strait Islander people', *Australian Indigenous Health Reviews*, no. 18, Edith Cowan University, 2016, viewed 9 February 2018, <<http://www.healthinonet.ecu.edu.au/uploads/docs/Illicit-drugs-pl-review-2015-web.pdf>>, pp. 15-19.

⁴⁸⁶ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 40.

People living in rural and regional areas

The NDSHS 2016 discussed heightened illicit drug use in remote areas of Australia:

People in *Remote and very remote* areas (25%) were more likely to have used an illicit drug in the last 12 months than people in *Major cities* (15.6%), *Inner regional areas* (14.9%) and *Outer regional areas* (14.4%). Recent use also increased among people in *Remote and very remote areas* from 18.7% in 2013 to 25% in 2016 but the increase was not significant.⁴⁸⁷

John Ryan of the Pennington Institute also noted:

...families and communities will be, I am sure, very vocal in pointing out that they do have drug problems in regional and rural Victoria as well as in the city. That is a change that has happened in the last 10 years. We did not have the ice problem in country Victoria 10 years ago. In fact country Victoria had cannabis consumption but not much more in the illicit space, and now it is often the case in small country towns that is easier to procure ice than it is to procure cannabis, a much less dangerous drug.⁴⁸⁸

A publication by the United Nations Office on Drugs and Crime (UNODC) in March 2017, *Prevention of Drug Use and Treatment of Drug Use Disorders in Rural Settings*, discussed evidence-based drug prevention strategies in rural settings, including working with high risk populations to develop targeted strategies; using technology such as telemedicine and the media, in recognition of limited resources and accessibility in rural areas; and ensuring that rural prevention strategies address cultural sensitivities within different populations. The report also noted the importance of community engagement.⁴⁸⁹

Culturally and linguistically diverse communities

Exact prevalence rates are difficult to establish within culturally and linguistically diverse (CALD) communities, as advised by the Victorian Multicultural Commission (VMC) in its submission to the inquiry. It stated that current evidence 'is both limited and conflicting', noting issues such as underrepresentation in studies and surveys being available only in English.⁴⁹⁰ In particular, it recommended in its submission:

...the commissioning of research to build the evidence base in relation to:

- a. illicit drug use prevalence among multicultural populations;
- b. the comorbidity of mental health and substance misuse in young people from migrant and refugee populations within the first 5 years of settlement; and
- c. suitable treatment and support service alternatives for migrants from non-English speaking backgrounds employing co-design principles.⁴⁹¹

A particular issue is that negative labelling creates a barrier to the uptake of services and engaging broader community conversations about drug use (also discussed in chapter five). Sonia Vignjevic, Acting Chairperson of the VMC advised the Committee:

⁴⁸⁷ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 100.

⁴⁸⁸ John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, p. 2.

⁴⁸⁹ United Nations Office on Drugs and Crime, *Prevention of Drug Use and Treatment of Drug Use Disorders in Rural Settings: Revised Version*, United Nations, Vienna, 2017, pp. 59-63.

⁴⁹⁰ Victorian Multicultural Commission, *Submission*, no. 210, 24 March 2017, p. 2.

⁴⁹¹ Victorian Multicultural Commission, *Submission*, no. 210, 24 March 2017, p. 5.

There has been evidence through our consultations that regardless, new arrivals or established communities, stigma is across the board. I think with the newly arrived communities their awareness is a lot less around access, whereas someone who has been in the community for a bit longer will potentially go and seek help through a GP or potentially a religious leader.⁴⁹²

She also stated:

Anecdotally the VMC has been informed by refugee health services that assess drug use in new arrivals that often drug use, both licit and illicit, emanates as a coping strategy for PTSD [post-traumatic stress disorder] and that this needs to be addressed early in settlement. The research demonstrates, however, that there are insufficient resources, a gap between early intervention and crisis youth services and a gap between mainstream and specialist services, including a lack of funding for longer term interventions. Thus the Victorian health system needs to be resourced to be culturally responsive to tackle the problem early in the settlement process.⁴⁹³

Specifically in terms of prevention and early intervention, a 2010 paper, *Prevention of alcohol and other drug problems in culturally and linguistically diverse communities*, reviewed primary prevention programs and made three key recommendations: prevention for this target group should be a priority for health services; prevention initiatives should take into account protective factors, include a family-based component, be based on relevant theories, and be delivered by culturally competent practitioners; and funding is required for outcome evaluations of programs in this area.⁴⁹⁴

The Committee also notes that the NDS 2017-2026 identifies these communities as a priority population:

Some culturally and linguistically diverse (CALD) populations have higher rates of, or are at higher risk of, alcohol, tobacco and other drug problems. For example, some members of new migrant populations from countries where alcohol is not commonly used may be at greater risk when they come into contact with Australia's more liberal drinking culture. Some types of drugs specific to cultural groups, such as kava and khat, can also contribute to problems in the Australian setting and some individuals may have experienced torture, trauma, grief and loss, making them vulnerable to alcohol, tobacco and other drug problems. Other factors that may make CALD groups susceptible to alcohol, tobacco and other drug problems include family stressors, unemployment, language barriers, lack of awareness of programs available, and limited access to programs that are culturally appropriate.⁴⁹⁵

Based on the limited understanding of the prevalence of substance use among CALD communities, the Committee believes that enhanced data collection in this area is essential. This will inform future prevention efforts, in addition to determining appropriate responses to harmful substance use. The Victorian Government should be informed by the expertise of the VMC in conducting this work, with the VMC potentially taking an active role in consulting with specific CALD communities as required.

⁴⁹² Sonia Vignjevic, Acting Chairperson, Victorian Multicultural Commission, *Transcript of evidence*, 18 September 2017, p. 381.

⁴⁹³ Sonia Vignjevic, Acting Chairperson, Victorian Multicultural Commission, *Transcript of evidence*, 18 September 2017, p. 379.

⁴⁹⁴ Browne, J and Renzaho, A, 'Prevention of alcohol and other drug problems in culturally and linguistically diverse communities', *Prevention research quarterly*, vol. 13, 2010, p. 9.

⁴⁹⁵ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 29.

RECOMMENDATION 11: The Victorian Government, in consultation with the Victorian Multicultural Commission, conduct research into substance use prevalence among culturally and linguistically diverse communities to inform the development of appropriate prevention measures.

People experiencing mental health issues

While the findings do not establish a causal link, the NDSHS 2016 noted a strong association between illicit drug use and mental health issues, with increasing rates of psychological distress reported among those who have recently used drugs. For example, there was an increase of high or very high psychological distress from 16.9 per cent in 2010 to 22.2 per cent in 2016 in those who had used any illicit drug in the past 12 months. There were also increased rates of those diagnosed or treated for mental illness. For example, the proportion of people diagnosed or treated for mental illness that had used an illicit drug in the past 12 months increased from 18.7 per cent in 2010 to 26.5 per cent in 2016.⁴⁹⁶ Under the NDS 2017-2026, people with co-morbid mental health conditions are a priority population:

The use of alcohol, tobacco and other drugs can interact with mental health in ways that create serious adverse effects on many areas of functioning, including work, relationships, health and safety. People with mental health conditions use alcohol, tobacco and other drugs for the same reasons as other people. However, they may also use because the immediate effect can provide an escape from symptoms.

Co-morbidity, or the co-occurrence of an alcohol, tobacco and other drug use disorder with one or more mental health conditions, complicates treatment and services for both conditions. They can also co-occur with physical health conditions (e.g., cirrhosis, hepatitis, heart disease, and diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain.⁴⁹⁷

Beyondblue noted in its submission the lack of funding for promotion, prevention and early intervention in this area, even though they are key for addressing comorbidity:

Taking a more macro view, it is clear that there are a range of risk factors that are common across mental health conditions and substance misuse that if addressed could assist with reducing the incidence of each. Furthermore, people with substance misuse and those with a mental health condition experience similar problems in life such as stigma and discrimination, difficulty accessing services, and maintaining employment and housing. But more so, many people experience social and economic hardship, evidenced by the proportion of drug users and people with certain mental health conditions who are unemployed.

At present, prevention activities are typically underfunded and focused on individual factors rather than the social determinants that underlie the problems. As a result they often have minimal impact on reducing the burden of mental health and alcohol and other drug conditions. However, in the longer term they are likely to be much more cost-effective, as well as more likely to result in these people living a 'contributing life'.⁴⁹⁸

⁴⁹⁶ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, pp. 111-113.

⁴⁹⁷ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 27.

⁴⁹⁸ Beyond Blue, *Submission*, no. 175, 17 March 2017.

6.6 Early intervention

The Committee also received evidence on the need to enhance early intervention in health care settings, where people engaging in substance use can be identified early and assisted to refrain from harmful use. A 2016 report by the United States (US) Surgeon-General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (US Surgeon General Report), noted the value of early intervention in these settings:

Early intervention services can be provided in a variety of settings (e.g., school clinics, primary care offices, mental health clinics) to people who have problematic use or mild substance use disorders. These services are usually provided when an individual presents for another medical condition or social service need and is not seeking treatment for a substance use disorder. The goals of early intervention are to reduce the harms associated with substance misuse, to reduce risk behaviors before they lead to injury, to improve health and social function, and to prevent progression to a disorder and subsequent need for specialty substances use disorder services. Early intervention consists of providing information about substance use risks, normal or safe levels of use, and strategies to quit or cut down on use and use-related risk behaviors, and facilitating patient initiation and engagement in treatment when needed. Early intervention services may be considered the bridge between prevention and treatment services. For individuals with more serious substance misuse, intervention in these settings can serve as a mechanism to engage them into treatment.⁴⁹⁹

This section focuses on the role of primary care, particularly general practitioners (GPs), in providing early intervention. As stated by the Penington Institute in its submission, 'GPs need to be empowered to lead collaborative, community-controlled responses to drugs' through early intervention.⁵⁰⁰ Evidence of effectiveness of this approach is mixed, given there are currently a range of barriers in place, for example time constraints and limited knowledge of substance use and disorders. However, there is a strong opportunity for this avenue to assist prevent substance use from becoming harmful if these barriers can be addressed.

6.6.1 Primary health care and early intervention strategy – brief intervention

A commonly discussed strategy in early intervention is the role of primary care settings, largely through GPs and other health professionals, to provide such services to the broader community. GPs are well-established throughout communities, and have a distinctive role in assessing and advising individuals about their general health, including the effects of drug use:

Primary care workers are in a unique position to identify and intervene with clients whose substance use is hazardous or harmful. Health promotion and disease prevention play an important role in the work of primary care workers, who are often already engaged in implementing activities around screening and prevention including immunisation, and detection of high blood pressure, obesity, smoking and other risk factors. Clients view primary care workers as a credible source of advice about health risks including substance use.⁵⁰¹

⁴⁹⁹ U.S. Department of Health and Human Services, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, Washington DC, 2016, pp. 4-5.

⁵⁰⁰ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 50.

⁵⁰¹ World Health Organization, *Brief Intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use: Manual for use in primary care*, Geneva, 2010, p. 5.

There has been a focus from international bodies on enhancing the role of primary care in this way. For example, in 2010 the World Health Organization (WHO) released a manual for primary care, *The ASSIST-linked brief intervention for hazardous and harmful substance use* (WHO ASSIST report). It discussed that, when a person presents to a primary care worker with health conditions relating to substance use, this is an opportunity to screen and deliver a brief intervention (called an ASSIST-linked brief intervention), noting the ongoing relationship the worker has with their patient and the ability for the patient to discuss sensitive issues with someone they trust.⁵⁰²

The ASSIST-linked brief intervention is a three to 15 minute intervention by the health worker, following a screening of the client's substance use which then determines a risk score (lower, moderate or high). Depending on the score, the client receives personalised feedback with the aim of counselling clients with moderate risk to change their substance use, and to refer those with high risk to treatment (brief interventions are not a stand-alone treatment for people at high risk⁵⁰³). The WHO ASSIST report stated:

The aim of the intervention is to help the client understand that their substance use is putting them at risk which may serve as a motivation for them to reduce or cease their substance use. Brief interventions should be personalized and offered in a supportive, non judgmental manner.⁵⁰⁴

The WHO ASSIST report provided detailed advice and information for primary care workers on screening and brief interventions including the various components, essential skills; giving feedback to clients, examples, dealing with issues such as injecting drug use and poly-drug use, and longer or multiple interventions.

The United Nations Office on Drugs and Crime 2015 *International Standards on Drug Use Prevention* also outlined drug prevention strategies supported by scientific evidence that could form part of health-centred prevention planning for jurisdictions, and noted brief interventions in primary care as a form of early intervention. It discussed the evidence base and concluded that such interventions can reduce substance use, both immediately after and in the long term.⁵⁰⁵ Similarly, a joint WHO and UNODC draft *International Standards for the Treatment of Drug Use Disorder* issued in 2017 stated:

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent drug use disorders, particularly in health settings, which are not specialized in the treatment of drug use disorders (i.e. primary care, emergency care, hospitalized patients, antenatal care, social welfare services, school health services, prison health services, mental health facilities etc.). Screening and Brief Interventions (SBI) can be implemented in a rapid and cost-efficient manner that causes minimal interference with the provision of other services (WHO, 2012).⁵⁰⁶

502 World Health Organization, *Brief Intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use: Manual for use in primary care*, Geneva, 2010, p. 5.

503 World Health Organization, *Brief Intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use: Manual for use in primary care*, Geneva, 2010, p. 3.

504 World Health Organization, *Brief Intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use: Manual for use in primary care*, Geneva, 2010, p. 4.

505 United Nations Office on Drugs and Crime, *International Standards on Drug Use Prevention*, United Nations, Vienna, 2015, pp. 23-24.

506 United Nations office on Drugs and Crime, *International Standards for the Treatment of Drug Use Disorders (Draft for Field Testing)* World Health Organization, Geneva, 2017, p. 20.

6.6.2 Effectiveness of brief interventions as an early intervention strategy

The Committee notes, however, the lack of strong evidence on the effectiveness of brief interventions for drug use in primary care. Initially developed as a tool to address harmful alcohol use, the evidence surrounding efficacy for drug use is less clear:

While the evidence in favor of brief interventions for alcohol use is strong, brief interventions for substance use within primary care settings have a smaller, but growing, evidence base. For example, Bernstein et al. (2005) found that a one-session peer-led intervention for cocaine and heroin users identified by screening during routine medical care produced increased abstinence for both substances at 6-month follow-up point. Similar results have been found with regular marijuana users (Copeland et al., 2001; Stephens et al., 2000).⁵⁰⁷

The WHO ASSIST report noted evidence for brief interventions to reduce alcohol use, and research suggesting they may be effective for cannabis, benzodiazepines, amphetamines, opiates and cocaine use. To inform the WHO ASSIST framework for brief interventions, the WHO conducted a randomised controlled trial between 2003 and 2007 in Australia, Brazil, India and the US:

The results showed that participants receiving a brief intervention for illicit substances demonstrated significant reduction in ASSIST scores after 3 months compared with control participants. Moreover, over 80% of participants reported attempting to cut down on their substance use after receiving the brief intervention, and many participants provided positive comments on the impact of the brief intervention on their health behaviour.⁵⁰⁸

However, the efficacy of brief interventions for drug use continues to be subject to debate. In the US, the Screening, Brief Intervention and Referral to Treatment (SBIRT) program was adopted in 2003 to encourage implementation of these methods in various medical settings across US jurisdictions. Some studies have shown efficacy, while others have not. For example, a randomized trial by Saitz et al in 2014 found that, despite significant investments and expansions to the program:

Brief intervention did not have efficacy for decreasing unhealthy drug use in primary care patients identified by screening. These results do not support widespread implementation of illicit drug use and prescription drug misuse screening and brief intervention.⁵⁰⁹

On the other hand, a 2017 study on patient outcomes from the program found decreases in illicit drug use after the intervention, concluding that:

Compared with previously published findings on the Screening, Brief Intervention and Referral to Treatment grant program, our estimates of substance use reduction were smaller, but still consistently large in absolute magnitude and within ranges of estimates from past trials of Screening, Brief Intervention and Referral to Treatment.⁵¹⁰

507 Hettema, J, et al., 'Brief Interventions and Motivational Interviewing', in *The Oxford Handbook of Substance Use and Substance Use Disorders: Volume 2*, K Sher (ed.). Oxford University Press, 2014.

508 World Health Organization, *Brief Intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use: Manual for use in primary care*, Geneva, 2010, p. 6.

509 Saitz, R, et al., 'Screening and Brief Intervention for Drug Use in Primary Care : The ASPIRE Randomized Clinical Trial', *JAMA* vol. 312, no. 5, 2014, p. 511.

510 Aldridge, A, et al., 'Substance use outcomes of patients served by a large US implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT)', *Addiction* vol. 112, no. S2, 2017, p. 43.

Similarly a study by Babor et al in 2017 on implications of the SBIRT program on policy and practice found:

The US Substance Abuse and Mental Health Services Administration’s Screening, Brief Intervention and Referral to Treatment (SBIRT) demonstration program was adapted successfully to the needs of early identification efforts for hazardous use of alcohol and illicit drugs. SBIRT is an innovative way to integrate the management of substance use disorders into primary care and general medicine. Screening, Brief Intervention and Referral to Treatment implementation was associated with improvements in treatment system equity, efficiency and economy.⁵¹¹

These issues should be kept in mind, particularly in terms of whether there is scope to expand the provision of brief interventions for drug use in Victorian primary care settings. This will ensure GPs across Victoria are adequately skilled to deliver brief interventions to ongoing patients, or patients they are seeing for the first time.

6.6.3 Other jurisdictions

While there is little current information on the use of this intervention in primary care globally, in 2008 the WHO reported that 6 per cent of countries reported routine implementation of screening and brief interventions for substance use and substance use disorders, including in Australia.⁵¹² As already noted, the US has adopted a relatively large approach to brief interventions and the US Surgeon General report also stated:

Health care professionals are being encouraged to offer prevention advice, screen patients for substance misuse and substance use disorders, and provide early interventions in the form of motivational approaches, when appropriate.

Primary care has a central role in this process, because it is the site for most preventive and ongoing clinical care for patients—the patient’s anchor in the health care system. For example, primary care settings can serve as a conduit to help patients engage in and maintain recovery. Also, approaches such as screening, brief intervention, and referral to treatment (SBIRT) provide primary care providers with tools for addressing patients’ substance misuse.⁵¹³

In the United Kingdom, the National Institute for Health and Care Excellence (NICE) published clinical guidance in February 2017 on *Drug misuse prevention: targeted interventions*. It discussed delivering drug prevention activities as part of existing services, including through ‘routine appointments and opportunistic contacts’ by GPs, nurses and health visitors. It suggested discussing a person’s circumstances and details of any drug use, considering their safety and any actions needed.⁵¹⁴ While not based on the language of ‘brief intervention’, it demonstrates how primary care settings can be used to initiate non-judgmental discussions about drug use.

511 Babor, T, et al., ‘Screening, Brief Intervention and Referral to Treatment: implications of SAMHSA’s SBIRT initiative for substance abuse policy and practice’, *Addiction* vol. 112, no. S2, 2017, p. 110.

512 World Health Organization, ‘Global Health Observatory (GHO) data’, viewed 9 February 2018, <http://www.who.int/gho/substance_abuse/prevention/screening_interventions/en>.

513 U.S. Department of Health and Human Services, *Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health*, Washington DC, 2016, pp. 6-8.

514 National Institute for Health and Care Excellence, *Drug misuse prevention: targeted interventions: NICE guideline*, Public Health England, London, 2017.

During the overseas study tour in Portugal, the Committee heard that training doctors in addiction, including GPs, was enhanced as part of its model. Family doctors in particular are recognised as being well placed to provide interventions to patients presenting with alcohol and drug issues. This training is provided by the General Directorate for Intervention on Addictive Behaviours and Dependencies.⁵¹⁵

6.6.4 Victoria

The Committee notes that this is not a new issue in the Victorian context. In 2008, the DHHS commissioned Turning Point to consider the delivery of brief interventions for both alcohol and other drug use in primary care, as well as to identify enablers and barriers. Turning Point's report, *Alcohol and other drug brief intervention in primary care*, found there was limited delivery owing to issues such as negative staff attitudes, time constraints of staff, lack of management support, client readiness for change and attitudes, the physical and emotional state of clients, client cultural backgrounds, and client literacy skills. Despite this, the report considered that improving brief interventions in these settings was 'essential':

Primary care settings offer early intervention opportunities to a significant population of clients. The capacity to intervene before AOD use becomes significant, entrenched and dependent is unique to this sector and can produce a marked positive impact on clients. As such, work towards enhancing the uptake of AOD BI across the primary care sector warrants immediate and ongoing attention.⁵¹⁶

Professor Dan Lubman of Turning Point further advised the Committee on the lack of knowledge within primary care of the AOD sector, which makes practitioners reluctant to engage in brief interventions or even ask the relevant questions:

We run the Drug and Alcohol Clinical Advisory Service for GPs and pharmacists, so I can tell you GPs who call us do not understand how the system works. They find it very challenging to refer to the system. They feel the system is unresponsive to their needs, and they find it very difficult to know what to recommend to their patients.

...

In the last 15 years, if I had wanted to train in medicine as a GP, I do no rotation to any alcohol and drug services, so I do not see any alcohol and drug patients. So when I see alcohol and drug patients coming to my practice, I have as much knowledge about treating addiction as the general public. Because of that, I do not know what to do, so typically what I do is I do not ask questions. What we know from surveys and working with general practitioners is they do not ask because then they do not have to find out so then they do not have to do something about it. If they do find out, they do not know what to do and often they are at a loss. Often it is about, 'Who can we move this on to, because we feel out of our depth?'.⁵¹⁷

The Committee heard a range of views on the extent to which primary care, particularly through GPs, should be prioritised in providing early intervention for drug use. On the one hand, John Ryan of the Pennington Institute stated:

⁵¹⁵ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 15.

⁵¹⁶ Swan, A, et al., *Alcohol and Other Drug Brief Interventions in Primary Care*, Turning Point, Fitzroy, 2008, pp. x-xi.

⁵¹⁷ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 26.

So we see a great opportunity, for example, in relation to general practice in small country towns. GPs are pillars of the community. There is a great opportunity in small country towns for GPs to be playing a leading role in relation to drug use issues. They have not traditionally been recognised to be doing that. They could be doing that with the collaboration of local police, the local hospital.⁵¹⁸

On the other hand, Professor Margaret Hamilton told the Committee that drug treatment services, rather than GPs, should be the priority given the difficulties in training GPs.⁵¹⁹ Similarly, Trevor King, Director of Programs at UnitingCare ReGen stated:

We have worked really hard to get GP involvement in providing brief and earlier interventions. But we find that some GPs are fantastic; others are not. This is not a client group that they particularly want to work with.⁵²⁰

On the issue of training GPs, the Penington Institute suggested in its submission that:

To be effective, this approach would necessitate appropriate training and support for doctors and a clear focus on early intervention, rather than managing severe dependency in general practice settings (which causes GPs concern). The RACGP [Royal Australian College of General Practitioners] has noted financial incentives for GPs to manage drug issues could be enhanced.⁵²¹

A range of chapters in this report discuss the enhanced role of GPs in various drug policy areas. For example, their role in providing opioid substitution therapy (OST) is discussed in chapter 14, and GPs' involvement in addressing pharmaceutical drug misuse is discussed in chapter 15. Given this, the Committee is of the view that better support for GPs to engage in early intervention is essential, as highlighted by Professor Dan Lubman of Turning Point:

There is a fundamental issue in the education of our primary care practitioners and a lack of knowledge, attitudes and skills in that space that fundamentally affects early detection and early support of people with addiction and family members as well. That is a fundamental issue I think that we are still yet to address.⁵²²

Associate Professor Nadine Ezard also told the Committee:

...I do support the strengthening of the primary care sector in managing early intervention and also providing some of the more advanced intervention such as opioid substitution therapy for less complex presentations with the support of a referral network.⁵²³

The Committee also notes that GPs would need to have sufficient time to engage in such interventions with their patients (noting current short consultation times), as well as sufficient training and skills development opportunities to be available.

⁵¹⁸ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 3.

⁵¹⁹ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 60.

⁵²⁰ Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 275.

⁵²¹ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 50.

⁵²² Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, pp. 26-27.

⁵²³ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 124.

There are some recent examples of attempts in Victoria to enhance the support provided and improve capacity of primary care in targeted early intervention. In February 2017, the Penington Institute launched a GP-centred, local model for harmful ice use in the regional area of Mansfield, with the following news item from the organisation quoting John Ryan:

A community controlled primary health system approach will allow those in need to quickly access appropriate support from their GP and other services to minimise or prevent problematic drug use as early as possible.

“The response works by intervening early – as soon as an individual’s ice use starts impacting on their life – and diverts the person into treatment or other health and social services,” said Mr Ryan.

For example, the individual might have been arrested for possessing a small amount of ice or for a property crime such as theft to finance their ice use. This might be the first time the person has ever been in trouble with the police. The response may divert the person away from the courts and towards a stint in treatment.

“The local GP would coordinate care in a seamless manner as the individual transitions from residential rehabilitation, potentially in a metropolitan area, to community-based rehabilitation,” said Mr Ryan.⁵²⁴

John Ryan further told the Committee:

It would be an early intervention in relation to drug use issues: catching people before their drug use escalates to become extremely problematic and therefore involving serious criminal offences. But moving that approach to that level of local community is something that would be new for Australia and something that is actually long overdue. There are many excellent GPs that are doing work in this area already that is often unrecognised.⁵²⁵

The Committee is also aware that the Eastern Melbourne public health network (PHN) is funding Cariniche to deliver AOD services at four GP clinics. Its website stated:

Eastern Melbourne PHN (EMPHN) has appointed drug and alcohol counselling service provider Cariniche to deliver a new \$250,000 Alcohol and Other Drugs (AOD) service at four GP clinics in the City of Whittlesea.

The AOD@theGP service will provide early intervention for patients with emerging problematic alcohol and drug use at the GP clinics, as well as telephone support to other GP clinics in north eastern Melbourne. The service aims to reduce ambulance call-outs, hospital admissions and chronic harm from substance abuse.

...

EMPHN CEO Robin Whyte said basing the AOD clinicians at general practices will provide a more holistic approach to health care for patients, bringing physical, mental, and drug and alcohol treatment together in one location.

“AOD@theGP aims to respond to research demonstrating people with alcohol and other drug problems are less likely to receive appropriate care than people with other health problems such as mental illness, smoking related ill-health or chronic disease,” she said.⁵²⁶

524 Penington Institute, *Calls for a dramatic change in the way we tackle problematic ice use in rural and regional communities*, Media release, Melbourne, 24 February 2017.

525 John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 3.

526 PHN Eastern Melbourne, ‘Early intervention at Whittlesea GP clinics for risky alcohol and drug use’, <<https://www.emphn.org.au/news-events/news/early-intervention-at-whittlesea-gp-clinics-for-risky-alcohol-and-drug-use>>.

Similarly, the Western Victoria PHN announced in May 2017 that it is investing \$1.6 million to close the gap between treatment and non-treatment services such as general practice:

“Often people will disclose their alcohol and other drug use to their GPs during consultations. This funding will empower GP’s to connect vulnerable people to treatment services in their local communities preventing their patients developing long-term addictions,” said Western Victoria PHN’s Acting CEO, Kate Barlow.

Funding will be used to:

- Deliver early intervention services for those people requiring assistance for substance use including families affected by use
- Build the capacity of the non-treatment sector to screen, identify use early and make timely referrals to treatment intervention services
- Integrate and coordinate early intervention services with primary, community and emergency services.⁵²⁷

There is also recognition in the Australian medical profession of the key role to be played by GPs. In particular, the 2017 Australian Medical Association (AMA) position statement, *Harmful substance use, dependence and behavioural addiction (Addiction)* discussed the role of GPs as a trusted source of advice for patients, but acknowledged the current barriers including perceptions about inquiring about patients’ drug use, lack of training, scepticism and pessimism about treatment effectiveness, perceptions about patient unwillingness, discomfort discussing these issues, time constraints, and perceptions that drug users are unruly.⁵²⁸

In related ways, Alfred Health also suggested that hospitals should be supported to enhance their role in addressing drug-related issues at an early stage:

Hospitals are often the first – and may be the only – place where drug users come into contact with the harms that they face or might cause. Hospitals are also centres of knowledge and research and hubs for services and can therefore be a place where new ideas can be trialled. Patients’ continuous presence also allows hospitals to monitor patients for withdrawal and side-effect such as respiratory depression. Finally, they are the primary location for the clinical education of young doctors and the clinical provider from which many GPs take their lead.⁵²⁹

Alfred Health indicated that hospitals currently play a reactive role, in that doctors respond to patients’ acute needs and have few immediate options to help prevent the patient from continuing to experience (or inflict) drug-related harms. It stated that ‘[t]hese lost opportunities can be crucial, especially if a hospital admission is the first time that a patient acknowledges the potential harms he or she faces’.⁵³⁰

Alfred Health proposed in its submission that hospital emergency departments and short stay units potentially undertake brief interventions with patients through cognitive behavioural therapy, strategic and interactional therapies, or even

⁵²⁷ PHN Western Victoria, *Tackling alcohol and drug use early*, Media release, 5 May 2017.

⁵²⁸ Australian Medical Association, ‘Harmful substance use, dependence and behavioural addiction (Addiction) - 2017: AMA Position’, 2 August 2017, viewed 9 February 2018, <<https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-2017>>.

⁵²⁹ Alfred Health, *Submission*, no. 173, 17 March 2017, p. 17.

⁵³⁰ Alfred Health, *Submission*, no. 173, 17 March 2017, p. 20.

short-term family therapy. It was suggested that a brief intervention might provide patients with an opportunity to identify and start to address their substance use, and could also act as a first step in the treatment process where appropriate.⁵³¹

Chapter four discussed the need for healthcare services in this area to be delivered in a non-judgmental way, and that GPs and other professionals require greater support for this. The Committee acknowledges that, if primary care workers are to take on a broader role in early intervention, such as through brief interventions, they must be equipped with the skills and the appropriate attitudes to do so effectively. The first step of this process should be a mapping exercise of Victoria to gain better understanding of the current role of primary care in this specific area. The mapping exercise should also identify the important existing work being done across the state to enhance primary practice as an early intervention point, as well as the barriers that limit GPs' capacity in this area. Such an exercise could be conducted by appropriate medical bodies, with the final intention of providing coordinated efforts towards strengthening the role of primary care settings in early intervention strategies.

RECOMMENDATION 12: With the intention to develop a primary health care early intervention strategy, the Victorian Government commission an appropriate peak medical body to review the network of general practitioners (GPs) and public hospitals across Victoria and their role in screening and intervening early in people presenting with substance use issues and guide them accordingly. This review should map the current network including identifying GPs knowledge of and attitudes towards substance use and disorders, and barriers to effectively respond to these issues. The strategy should comprise practical responses to overcome identified barriers.

531 Alfred Health, *Submission*, no. 173, 17 March 2017, p. 20.

Law enforcement

7 Personal use and possession offences

Law enforcement is key to addressing the prevalence of illicit substances in Australian communities. The *National Drug Strategy 2017-2026* (NDS) highlights a range of strategies to achieve supply reduction including border control, regulating or disrupting production or distribution, enforcing legislation, and intelligence cooperation and collaboration.⁵³² The role played by Victoria Police in this regard is essential.

During the inquiry, the Committee received evidence from Victoria Police and the Australian Federal Police (AFP) about the types of policing activities conducted to disrupt the drug trade, particularly the importation of illicit drugs by international organised crime groups. Commander Bruce Hill, Manager of Organised Crime at the AFP, discussed specific strategies aimed at preventing the supply of methamphetamine through ‘enhanc[ing] cooperation between Australian government agencies as well as regional and global partners...’⁵³³ and domestic partners, which has resulted in a number of achievements including improved intelligence exchange with partners such as Thailand, Cambodia and China (the first such partnership to occur with China).⁵³⁴

At the state level, Wendy Steendam, the Deputy Commissioner of Capability at Victoria Police told the Committee that as the organisation responsible for supply reduction, ‘Victoria Police’s responses are predominantly focused on strategies to prevent and reduce illicit drug availability and accessibility’, including strategies such as specialised task forces and investigations.⁵³⁵ The Committee also met with New Zealand Police where the importance of cross-border collaboration was emphasised, particularly given the globalised nature of organised crime and the illicit drug trade.

⁵³² Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, pp. 48-49.

⁵³³ Commander Bruce Hill, Manager, Organised Crime, Australian Federal Police, *Transcript of evidence*, 13 November 2017, p. 440.

⁵³⁴ Commander Bruce Hill, Manager, Organised Crime, Australian Federal Police, *Transcript of evidence*, 13 November 2017, p. 441.

⁵³⁵ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 448.

As well as its strong focus on reducing supply, Victoria Police also plays an important role in policing and enforcing laws relating to the use and possession of illicit drugs for personal use. This was a significant matter explored throughout the inquiry, both locally and internationally. In particular, there is growing recognition among law enforcement agencies and key stakeholders that responses to illicit drug use, as opposed to illicit drug supply, requires broader strategies than just policing. As stated by Commander Bruce Hill of the AFP, while police play a key role, ‘getting the balance between educating our young people and rehabilitating the people in the drug environment is also very important’.⁵³⁶ A number of stakeholders also emphasised this point,⁵³⁷ citing the well-known example of Ken Lay APM, former Chief Commissioner of Victoria Police, as Chair of the National Ice Taskforce who stated that ‘ice use is not a problem we can solve overnight, and not something we can simply arrest our way out of’.⁵³⁸ The harms arising from some of the existing laws and current approaches were also commonly identified to the Committee. For example, Mick Palmer AO APM, former AFP Commissioner, shed light on his own journey that led him to change his views about the policing of illicit drug use:

My position has changed fundamentally since my days as a young, operational police officer, as you would imagine. That has been a long, evolutionary journey for me - it’s not one that I suddenly became aware of after I retired. I became aware of it while I was still an operational detective, when all of a sudden I found myself dealing with issues and seeing the result of my endeavours as a detective that were really counter-productive to the very aims that we were trying to achieve. This included victimising and if you like branding the wrong people and causing enormous harm to people who had simply committed very minor offences and had strong and overwhelming social or dysfunctional mental health issues which had caused them to conduct the behaviour that had drawn our attention to them.⁵³⁹

With these issues in mind, this chapter considers the ways in which illicit drug use and possession offences are dealt with and enforced, and options for reform in this area, consistent with the health framework proposed in chapter four. The Committee believes that responses to illicit drug use, as opposed to supply, should punish criminal behaviour arising from illicit drug use but that people who use drugs be directed to a range of supports where necessary.

7.1 Victorian laws regarding illicit drugs

This section briefly details some of the key offences in Victoria relating to illicit drugs, termed ‘drugs of dependence’ under the *Drugs, Poisons and Controlled Substances Act 1981* (DPCSA).

⁵³⁶ Commander Bruce Hill, Manager, Organised Crime, Australian Federal Police, *Transcript of evidence*, 13 November 2017, p. 444.

⁵³⁷ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 195; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 5; Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 34; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 44; Australian Drug Law Reform Foundation, *Submission*, no. 147, 17 March 2017, p. 2; cohealth, *Submission*, no. 140, 16 March 2017; Drug Policy Australia, *Submission*, no. 192, 17 March 2017, p. 5; Penington Institute, *Submission*, no. 209, 24 March 2017, p. 11.

⁵³⁸ Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Commonwealth of Australia, Canberra, 2015, p. ii.

⁵³⁹ Mick Palmer AO APM, Vice President, Australia21, *Transcript of evidence*, 23 May 2017, p. 79.

Use

The use of a drug of dependence (unless authorised under medicinal cannabis laws) is a summary offence under section 75 of the DPCSA. It is defined under section 70 as smoking, inhaling fumes, or introducing a drug of dependence into one's body.

If the drug of dependence is cannabis, the maximum penalty is five penalty units. For other drugs of dependence, the maximum penalty is 30 penalty units and/or one year's imprisonment.

Possession

The possession of a drug of dependence (unless authorised under medicinal cannabis laws) is an indictable offence under section 73 of the DPCSA. The law regarding possession is complex and involves the operation of common law principles and the concept of 'deemed possession' under section five of the DPCSA. This states that substances are 'deemed' to be in the possession of a person when found on land or premises they are occupying or in places they use or control.⁵⁴⁰ For the purposes of this report, it is not necessary to outline these issues in detail.

More generally, the DPCSA states that if the substance in question is cannabis and the court is satisfied on the balance of probabilities that the quantity is 'small' and not possessed for trafficking purposes, the maximum penalty is five penalty units. For other substances, if the court is satisfied on the balance of probabilities that the offence was not committed for trafficking purposes, the maximum penalty is 30 penalty units and/or one year's imprisonment. In any other case (i.e. – where the court is not satisfied that the offence was not committed for trafficking purposes), the maximum penalty is 400 penalty units and/or five year's imprisonment.

Trafficking

The DPCSA contains a range of trafficking offences. Trafficking is defined as activities including preparing a drug for trafficking, manufacturing a drug or selling, exchanging, possessing a drug for sale or offering a drug for sale.⁵⁴¹ While the law relating to trafficking is complex and does not need to be comprehensively explained for the purposes of this report, a key feature to note is that the DPCSA establishes specific threshold quantities of drugs to distinguish between people who use drugs and traffickers:

Victoria has implemented threshold quantities for drug trafficking, as have most other states and territories. The purpose of which is to differentiate 'traffickers' from those who purchase drugs for their own personal use and consumption and who therefore should be sentenced more leniently (Hughes et al. 2014). These legal thresholds specify the quantities of drugs over which offenders will be presumed to have possessed the drugs for the purposes of supply and consequently sentenced as drug traffickers.⁵⁴²

Penalties that apply to trafficking differ depending on the amount of the substance involved, with the main categories of:

⁵⁴⁰ Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria: Volume 1*, Parliament of Victoria, Melbourne, 2014, pp. 381-382.

⁵⁴¹ *Drugs, Poisons and Controlled Substances Act 1981* (Vic), section 70.

⁵⁴² Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria: Volume 1*, Parliament of Victoria, Melbourne, 2014, pp. 382-383.

- small quantity – this is associated with low level drug offending, such as possession of drugs for personal use
- trafficable quantity
- commercial quantity
- large commercial quantity.⁵⁴³

For example, for cannabis, the specified small quantity is 50 grams, the trafficable quantity is 250 grams or 10 plants, the commercial quantity is 25 kilograms or 100 plants, and the large commercial quantity is 50 kilograms or 1000 plants. There are also specified quantities for a pure substance, and where it is mixed with others. For example, for heroin, the specified small quantity is one gram, the trafficable quantity is three grams, the commercial quantity when mixed is 500 grams, the commercial quantity on its own is 250 grams, the large commercial quantity when mixed is one kilogram, and the large commercial quantity on its own is 750 grams.⁵⁴⁴ Penalties for trafficking offences range from 15 years to life imprisonment, as well as the imposition of a range of financial penalties.

Sentencing

Under the *Sentencing Act 1991*, a range of criminal sentences can be imposed by the courts. For adults, some of the main sentences that can be imposed include:

- imprisonment – the most severe sentence in Victoria
- drug treatment orders – these are second only to imprisonment in terms of the hierarchy of sentencing options available. They are discussed in chapter eight
- community correction orders – an order served in the community on the basis of complying with a range of conditions
- fines – at the lower end of the scale, fines are the most common sentence
- adjourned undertakings – this involves postponing court proceedings and releasing a person on an undertaking that they will exhibit good behaviour.⁵⁴⁵

Recent legislative changes under the *Sentencing (Community Correction Order) and Other Acts Amendment Act 2016*, which commenced in March 2017, affect sentencing for some trafficking offences. It created two categories of serious offences - Category 1 and Category 2. For Category 1 offences, a court must impose a custodial sentence. This includes trafficking or cultivating a large commercial quantity of a drug of dependence or narcotic plant. For Category 2 offences, a court must impose a custodial sentence unless there are specified circumstances involved such as providing assistance to law enforcement or impaired mental function. This category includes trafficking or cultivating a commercial quantity of a drug of dependence or narcotic plant.⁵⁴⁶

⁵⁴³ *Drugs, Poisons and Controlled Substances Act 1981 (Vic)*, Schedule 11.

⁵⁴⁴ *Drugs, Poisons and Controlled Substances Act 1981 (Vic)*, Schedule 11.

⁵⁴⁵ Sentencing Advisory Council, *A Quick Guide to Sentencing*, State Government of Victoria, Melbourne, 2017, pp. 16-21.

⁵⁴⁶ *Sentencing (Community Correction Order) and Other Acts Amendment Act 2016 (Vic)*, 65.

7.2 Current trends in personal use and possession offences

Current trends demonstrate that, despite efforts to divert people out of the criminal justice system, there remains increasing numbers of charges for personal use and possession offences in Victoria. The Victorian Crime Statistics Agency (VCSA) published a series of research papers on drug and alcohol use and crime, including a 2015 paper analysing trends in recorded drug use and possession between 2005 and 2014. It found:

The number of recorded drug use and possession offences in Victoria has continued to increase over the past five years, while other evidence suggests that the number of people using drugs has remained stable. This exploratory study...found that the rate of offences has continued to rise since 2010. The rate of offenders has also risen, but to a lesser extent. Over the past two years, the increase in both the offence and offender rates has slowed. Seventy two percent of recorded drug use and possession offenders were only recorded for one use and possession offence incident between 2005 and 2014. The majority of recorded offenders were male (81.4%) and aged under 30 at the time of their first recorded offence in the dataset (62.7%).⁵⁴⁷

The vast majority of people were only recorded for one use and possession incident over the ten year period:

- one incident: 71.6 per cent (47,417 people)
- two incidents: 17 per cent (10,949 people)
- three offences: 6.1 per cent (4,024 people)
- four or more offences: 5.8 per cent (3,820 people)

However, the study also found that over the past six years the proportion of offenders with more than one recorded incident increased each year from 8.6 per cent in 2009 (704 people) to 14.6 per cent in 2014 (1,838 people). At the time of the first incident, the highest proportion of offenders were aged 20 to 24 years (27.6 per cent), followed by offenders aged 25 to 29 years (17.6 per cent). These relatively young age profiles remained largely constant over the time period analysed.⁵⁴⁸

Another VCSA paper in July 2016 analysed what drug types drove increases in drug use and possession offences in the last decade. It found that cannabis accounted for the majority of the offences (about half of all offences), but there were significant increases in ecstasy, methamphetamine, prescription and 'other' drug offences in the past ten years. As of March 2016, rates of amphetamine, cannabis, ecstasy and methamphetamine use and possession offences were higher in regional areas than in rural or metropolitan areas.⁵⁴⁹

These trends demonstrate increases in drug use and possession offences and a particular focus on cannabis. These are broadly reflected in Australia-wide statistics. The 2015/2016 Australian Bureau of Statistics (ABS) dataset on recorded crime and offenders highlighted that nationally, the most common principal offence related to illicit drugs at 20 per cent, with the number of offenders with such an offence

⁵⁴⁷ Millsteed, M and McDonald, C, *Recorded drug use and possession offences and offenders, 2005-2014*, Victorian Crime Statistics Agency, Melbourne, 2015, p. 1.

⁵⁴⁸ Millsteed, M and McDonald, C, *Recorded drug use and possession offences and offenders, 2005-2014*, Victorian Crime Statistics Agency, Melbourne, 2015, pp. 6-7.

⁵⁴⁹ Sutherland, P and Millsteed, M, *What drug types drove increases in drug use and possession offences over the past decade?*, Victorian Crime Statistics Agency, Melbourne, 2016, p. 1.

increasing by 48 per cent since the dataset began in 2008-2009. Further, the ABS noted that the principal offence for the majority of offenders in this group was possess and/or use illicit drugs, making up 67 per cent of all illicit drug offences.⁵⁵⁰

The Australian Criminal Intelligence Commission (ACIC) produces an annual *Illicit Drug Data Report* with information on national arrests. In 2015-16, national illicit drug arrests increased by 87.6 per cent from 82,389 in 2006-07 to 154,538. There was also a 15.4 per cent increase from the previous year.⁵⁵¹ The report identified arrests as either consumer arrests (i.e. - use and possession offences) or provider arrests (i.e. - supply offences such as importation, trafficking, selling, cultivation and manufacture). This is broken down in Table 7.1.

Table 7.1 Provider vs consumer arrests in Victoria and across Australia

	Victoria		Australia	
	number	%	number	%
Consumer arrests	25,683	93.8	135,037	88
Provider arrests	1,688	6.2	18,362	12

Source: Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2015-2016*, Canberra, June 2017, p. 195.

Outlined below in order from highest to lowest are the types of illicit drugs that contributed to these arrests:

- cannabis (51.6 per cent)
- amphetamine-type stimulants (30.8 per cent)
- other and unknown drugs (14 per cent)
- heroin and other opioids (1.9 per cent)
- cocaine (1.7 per cent).⁵⁵²

In Victoria, 39.8 per cent of arrests related to amphetamine-type stimulants, which was the highest proportion of all jurisdictions.⁵⁵³

In terms of court data, the ABS publishes a yearly dataset on criminal courts in Australia, with the 2015-2016 report showing that:

The number of defendants finalised for Illicit drug offences continued to rise. In 2015-16, 11% (63,541) of defendants finalised had a principal offence of Illicit drug offences, up from 10% (59,341) in 2014-15. More than half (59% or 37,201) of these defendants were charged with offences related to possession or use of illicit drugs.⁵⁵⁴

Further, the Magistrates' Court of Victoria Annual Report for 2015/2016 noted that possession/attempted possession of a drug of dependence was the sixth most common charge that year (18,146 charges), increasing 12 per cent from 2014/2015 (16,260 charges).⁵⁵⁵

⁵⁵⁰ 4519.0 - Recorded Crime - Offenders, 2015-16, Australian Bureau of Statistics, February 2017.

⁵⁵¹ Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2015-2016*, Canberra, June 2017, p. 8.

⁵⁵² Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2015-2016*, Canberra, June 2017, p. 11.

⁵⁵³ Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2015-2016*, Canberra, June 2017, p. 15.

⁵⁵⁴ 4513.0 - Criminal Courts, Australia, 2015-16, Australian Bureau of Statistics, March 2017.

⁵⁵⁵ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 78.

Based on this data, it can be argued that there is a strong focus on use and possession behaviour in Victoria, and a clear trend of increases in these charges. The Committee also notes, however, the anecdotal evidence regarding the extent to which people charged for personal use and possession relates to other offending such as theft, rather than solely for use or possession. Deputy Commissioner Wendy Steendam of Victoria Police stated:

When we deal with people that are committing crime we will have incidental people that will have possession of drugs and/or are using drugs. Where there are community harms occurring we will police and run operations that deal with the amenity issues that come from use and possess and those that are actually in that street environment. In different operational areas those operations will be specific to the issue that is manifesting itself in that area, and it is quite distinct for different PSAs and for different areas as to what those operating models need to attend to because it will be different drug types and different behaviours that are occurring in those environments.⁵⁵⁶

Demos Krouskos, Chief Executive Officer (CEO) of the North Richmond Community Health (NRCH) advised the Committee:

...in my experience, they are incarcerated for other activities associated with drug use: theft, burglaries and the like, to get money to buy drugs; and violence at times, associated with drug use — all of those very serious offences.⁵⁵⁷

Similarly, Dr Stefan Gruenert, CEO of Odyssey House Victoria (OHV) stated that '[m]ost of the crime and the resources and time of the police is not the result of simple drug possession. It is the crimes associated with drug use'.⁵⁵⁸

The Committee was interested to explore this anecdotal evidence further and requested specific data from Victoria Police regarding the number of people charged for both use and/or possession offences where it was related to other offences, and the number of people charged with use and/or possession offences only. However, Victoria Police advised that it does not collect such data, and directed the Committee to the Crime Statistics Agency.⁵⁵⁹

7.3 Impacts of criminalisation

Criminalisation of the use and possession of illicit drugs for personal use can result in a range of negative outcomes for individuals, and has been the subject of extensive review and discussion by a number of international bodies, including importantly with regard to public health issues. For example, the Joint United Nations Programme on HIV/AIDS (UNAIDS) noted that worldwide, the majority of people who use drugs 'have been criminalized by national legislation and marginalized by society':

⁵⁵⁶ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 451.

⁵⁵⁷ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 155.

⁵⁵⁸ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 163.

⁵⁵⁹ Deputy Commissioner Wendy Steendam, *Supplementary evidence*, Victoria Police, 1 February 2018, p. 2.

Many have been traumatized by violence, imprisoned for possession of small quantities of drugs for personal use or coerced to undergo drug dependence treatment. Women who use drugs have been forced to undergo sterilization or abortions, separated from their children and denied public housing and other benefits.⁵⁶⁰

It further stated that:

Criminalization has been shown to perpetuate risky forms of drug use, to increase the risk of illness (including HIV infection) among people who use drugs, to discourage people who use drugs from seeking health care, and to reinforce the marginalization by society of people who use drugs.⁵⁶¹

The Global Commission on Drug Policy (GCDP) has particularly highlighted the role of the war on drugs in ‘fuelling’ the HIV pandemic, in that the fear of arrest means people do not undertake HIV testing or access prevention services:

Aggressive drug law enforcement practices aimed at suppressing the drug market drive drug-addicted individuals away from public health services and into hidden environments where HIV risk becomes markedly elevated.⁵⁶²

Such outcomes are commonly exacerbated as a result of people who use drugs experiencing discrimination. This also contributes to limiting their access to health care, as discussed in chapter five. A clear articulation of how these issues come together was provided by the United Nations Office on Drugs and Crime (UNODC) in its report, *Making drug control ‘fit for purpose’: Building on the UNGASS decade*, which discussed one of the unintended consequences of the international drug control system:

The fifth unintended consequence is the way we perceive and deal with the users of illicit drugs. A system appears to have been created in which those who fall into the web of addiction find themselves excluded and marginalized from the social mainstream, tainted with a moral stigma, and often unable to find treatment even when they may be motivated to want it.⁵⁶³

Globally, criminalisation of drug use is associated with increased rates of incarceration, which places a significant burden on the criminal justice system to deal with large groups of people, many whom have complex needs. According to the 2016 GCDP report, *Advancing Drug Policy Reform: A New Approach to Decriminalization*, UNODC figures show that 18 per cent of the world’s prison population have been convicted of drug crimes, with ‘many of them from economically marginalized backgrounds’.⁵⁶⁴ This situation leads to overcrowding and detrimental impacts on health and wellbeing, particularly on vulnerable groups (for example, racial minority groups and women).⁵⁶⁵

⁵⁶⁰ UNAIDS, *Do No Harm: Health, Human Rights and People Who Use Drugs*, Geneva, 2016, p. 3.

⁵⁶¹ UNAIDS, *Do No Harm: Health, Human Rights and People Who Use Drugs*, Geneva, 2016, p. 4.

⁵⁶² Global Commission on Drug Policy, *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic*, Geneva, 2012, pp. 4-5.

⁵⁶³ Costa, A, *Making drug control ‘fit for purpose’: Building on the UNGASS decade*, Commission on Narcotic Drugs, E/CN.7/2008/CRP.17, 2008, p. 11.

⁵⁶⁴ Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization*, Geneva, 2016, p. 16.

⁵⁶⁵ Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization*, Geneva, 2016, p. 16.

Throughout the inquiry, various stakeholders raised many of these broader issues, in addition to the more practical implications arising from a person having a criminal conviction for drug use or possession in the Victorian context - noting that in Victoria, it is unlikely that a person charged solely with these offences would be imprisoned. The most significant impact presented to the Committee is on peoples' future employment opportunities. The National Drug and Alcohol Research Centre (NDARC) noted in its submission:

Employers across a range of industries may request a criminal records check as a condition of employment or at the application stage, and it is rare for applicants to be given the opportunity to explain any past offences as part of an interview process. There are particular barriers in Australia in professions which involve working with children, or becoming a doctor, nurse, lawyer, transport official, bouncer or security officer.⁵⁶⁶

Meghan Fitzgerald, Social Action, Policy and Reform Manager at the Fitzroy Legal Service (FLS) reiterated that 'any rehabilitation really requires positive reintegration into the community for employment and voluntary opportunities, and those are fairly reduced if you have priors for drug offending'.⁵⁶⁷ Fitzroy Legal Service also noted in supplementary evidence that, while use and/or possession convictions 'may be a poor indicator of risk in terms of future consumption of drugs or possible misconduct that would impact a future employer', it is considered 'a highly stigmatised prior offence'.⁵⁶⁸

Another significant impact highlighted to the Committee was the experience of discrimination by people who use drugs, particularly people who inject drugs, which forces them to hide their substance use. As discussed in chapter five, this can itself lead to further harms. Jon O'Brien, Head of the Social Justice Forum of the Uniting Church, Synod of NSW and ACT, alluded to some of the effects of stigma, including that it 'separates the person using drugs from family, friends and other supports'.⁵⁶⁹

In its submission, the Penington Institute advised that people in Australia 'consistently report that their conviction is a barrier to finding work, even when there is no clear risk relationship between the job and their conviction and when they have discontinued using drugs'. This then results in a range of economic and social harms for individuals, which may contribute to further offending and substance use issues.⁵⁷⁰

The Committee believes these issues are particularly concerning given the VCSA research that demonstrated people under the age of 30 are most commonly captured under use and possession for personal use offences. As discussed earlier in the report, many young people eventually age or mature out of drug-taking and continue to lead productive lives. It can be particularly detrimental if a criminal conviction stemming from behaviour at a young age impacts on peoples' future opportunities and potentially their life trajectory.

⁵⁶⁶ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 4.

⁵⁶⁷ Meghan Fitzgerald, Social Action, Policy and Reform Manager, Fitzroy Legal Service, *Transcript of evidence*, 28 June 2017, p. 263.

⁵⁶⁸ Jennifer Black, *Supplementary evidence*, Fitzroy Legal Service, 11 August 2017, p. 2.

⁵⁶⁹ Jon O'Brien, Head of Social Justice Forum, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, p. 127.

⁵⁷⁰ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 24.

Paul Bodisco, Secretary of the Australian Drug Law Reform Foundation (ADLRF), referred in his evidence to an example from a Sydney event, Harbour Life, where 80 young people were charged with possession. He was present at the Downing Centre Magistrates Court in Sydney when these 80 people appeared before the magistrate:

The magistrate came on to the bench and said, “Could it be called out, everybody from Harbour Life who’s here who’s been arrested? Come into the court now.” So 80 people came in and the magistrate asked them all to stand up. He made the sign of the cross and he said, “It’s a public health issue. I’m giving you all section 10, no conviction.” I can tell you, however, not one of those people would be working in the public service now if they had applied for a job, say, as a school teacher without disclosure of that. None of them would be working as a barrister without disclosure of that. None of those people would have been able to access a visa to the United States via the electronic admission of your visa processing through the consulate.

If they subsequently were to apply for a visa at the consulate they would be waiting more than six months as to whether or not the consular officials would exercise their discretion to allow them to have a visa. Those people all would have had to disclose the fact that they had received this dispensation in so many areas of their working lives. Some of them may have faced exposure in the newspapers and embarrassment that comes with that and some of them would have lost their jobs...⁵⁷¹

A number of stakeholders also highlighted to the Committee that disparities in inequality may exacerbate the impact of criminalisation for some groups. Gino Vumbaca, President of Harm Reduction Australia, stated in his evidence:

If you have the resources - if you’re wealthy enough and you have resources and connections and you can get a record of no conviction - if you have the right legal representation to do that then you can get away with it but if you’re poor and young, you’re unlikely to get that; to have the resources to get that. So the punishment is disproportionate as well to young and poor people.⁵⁷²

Gino Vumbaca also made the point that criminalisation of drug use disproportionately impacts young and poor people who do not have their own place to hide away their drug use and therefore use in public, making them more vulnerable to being apprehended by police.⁵⁷³ The Committee notes that this is also more likely to occur to people who are homeless and use drugs publicly.

Ashley Blackwell, Vice-President of Students for Sensible Drug Policy (SSDP) Australia, provided an interesting firsthand account of being charged for a drug offence, which demonstrates the inconsistencies that can arise from wealth inequality:

When I was 17 I was also charged with trafficking due to the nature of the paraphernalia that I had on me: selling a little bit of cannabis to friends, that kind of thing.

...

I was charged with trafficking, and because of the nature of who I am in society — middle class, supportive family, teachers that would write me a reference, I helped found my school’s debating club, a good student more or less. I also went into a

⁵⁷¹ Paul Bodisco, Secretary, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 94.

⁵⁷² Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 104.

⁵⁷³ Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 110.

counselling program in the lead-up to the hearing and provided clean urine samples to show that I was not using drugs. So I did all the things that you are supposed to do. I escaped that escapade with a fine but no conviction on my record.

And one of the reasons that I do what I do now is out of recognition of the privilege that I was in in that environment, because if I had not had the support of my family, if I had not had the money to hire a lawyer and advise me on how to navigate the legal system, like go to a counsellor and tick all the boxes and all the rest of it, well, I might have had a conviction. I might not have been able to travel. I might have been restricted from further access to jobs.⁵⁷⁴

7.4 Alternative policing through police diversion programs

The National Drug and Alcohol Research Centre's submission to the Committee provided the following useful explanation of the terminology regarding how drug use and possession offences are dealt with, both in law and in terms of practical enforcement of such laws:

- **Full prohibition** is where drug use, possession and supply are criminal offences and where penalties are enforced in practice.
- **Depenalisation** is where the severity of penalties is reduced (e.g. removing penalties of imprisonment and replacing them with fines; or diverting people who use drugs to treatment rather than charging them with a drug offence). Another depenalisation mechanism is where the criminal law is not enforced in practice (e.g. through the operation of police practice guidelines). This is also referred to as *de facto* decriminalisation (as opposed to *de jure* decriminalisation which removes penalties by law).
- **Decriminalisation** is where criminal penalties have been removed by law for specific offences e.g. use and possession. This does not mean legalisation: there remains no legal means to obtain drugs, but anyone caught will not receive a criminal record. In some models criminal penalties will be replaced with civil or administrative penalties (e.g. a fine but no criminal record). One example is cannabis expiation notice schemes, where possession is sanctioned with on-the-spot infringement notices rather than criminal law.
- **Legalisation of use/possession** is where drug use or possession is legal (neither a criminal nor a civil offence). Drug supply is a criminal offence.
- **Full legalisation** is where the use and sale of drugs is legal. Restrictions on use and sales often apply (e.g. there are age limits for the purchasing of drugs).⁵⁷⁵

As explained above, decriminalisation refers to the removal of criminal penalties for specific offences which, in this context, are illicit drug use and possession for personal use offences, and not supply offences such as trafficking. It differs from legalisation, as under decriminalisation, there remains 'no legal means to obtain drugs for personal use (if a person carrying drugs for their own use is apprehended by police, the drugs will be confiscated)'.⁵⁷⁶ Whereas under legalisation, drugs can be obtained through a regulated market.

⁵⁷⁴ Blackwell, A, Vic-President, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, pp. 314-315.

⁵⁷⁵ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 2.

⁵⁷⁶ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164 - attachment 1, 17 March 2017, p. 2.

According to NDARC, there are different types of decriminalisation models. The key distinction between the different models is whether criminal penalties remain in the law but are not enforced in practice (termed *de facto* decriminalisation, or depenalisation as described in the NDARC submission), or whether criminal penalties are removed altogether from the law, with non-criminal penalties established in their place (*de jure* decriminalisation).⁵⁷⁷ In both cases, the offence remains in the law but the differences lie in the penalties for offences.

7.4.1 Police diversion programs in Australia

One form of *de facto* decriminalisation that is common across Australia (also termed depenalisation) is the operation of police diversion programs, which can be accessed after a person is apprehended but before charges are laid. Under these programs, drug use and possession remain criminal offences, however, police have the ability to divert people away from the criminal justice system rather than lay charges for use and possession. An important characteristic of drug diversion programs in Australia is that they are therapeutic in nature, focusing not only on diverting people away from the criminal justice system, but also on diverting them into education and treatment.⁵⁷⁸

Diversion programs have been supported by Australian governments since the 1980s in response to: rising imprisonment rates for drug offences, limited effectiveness of criminal sanctions in preventing substance use or crime, and harms of imprisonment for people who use drugs.⁵⁷⁹ A particularly significant expansion of programs occurred in 1999 with the development of a national framework under the *Illicit Drug Diversion Initiative* (IDDI). It was recognised as ‘a major impetus to establish or enhance a raft of police-based drug diversion programs that use an individual’s contact with the justice system as a gateway to engage that individual in drug education, assessment and treatment’.⁵⁸⁰

Each Australian jurisdiction has at least one police diversion program in place and they all share the following broad similarities: the police act as the source of referrals; they focus on individuals found using or possessing small amounts of substances, but not if individuals are charged with other offences (even where the offences are linked to their drug use); there is an educational element involved, and largely also an assessment and treatment component for illicit drugs other than cannabis; and they operate as jurisdiction-wide programs. Differences between the models include: the types of illicit drugs captured and applicability to adults and/or young people; whether diversion is mandatory or discretionary; whether admission of guilt is required; and other eligibility criteria, such as whether previous convictions affect eligibility for diversion.⁵⁸¹

According to the FLS, the practical importance of diversion is that it does not form part of a released criminal record check. Diversion can also assist people address the underlying causes of their substance use:

⁵⁷⁷ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164 - attachment 1, 17 March 2017, p. 2.

⁵⁷⁸ Australian Institute of Health and Welfare, *Bulletin 125: Alcohol and other drug treatment and diversion from the Australian criminal justice system*, Canberra, 2014, p. 6.

⁵⁷⁹ Australian Institute of Health and Welfare, *Bulletin 125: Alcohol and other drug treatment and diversion from the Australian criminal justice system*, Canberra, 2014, p. 4.

⁵⁸⁰ Payne, J, et al., *Police drug diversion: a study of criminal offending outcomes*, Australian Institute of Criminology, Canberra, 2008, p. ix.

⁵⁸¹ Payne, J, et al., *Police drug diversion: a study of criminal offending outcomes*, Australian Institute of Criminology, Canberra, 2008, pp. ix - x.

Currently diversion dispositions are the only findings of guilt that are not released on a standard criminal record check. Under current Victorian Police Policy *any finding of guilt* (with or without conviction) is released for ten years under a standard criminal record check and five years if sentenced as a child. Moreover, if a person's last record qualifies to be released, every previous charge where there has been a finding of guilt will also be released. There are also over forty professions where more extensive criminal history will be released and the standard rule may not apply. Similarly, working with children checks will review a criminal history that includes records older than ten years.

...

Complex issues go hand in hand with addiction. Diversions may offer a positive opportunity to address underlying issues causing and/or exacerbating drug dependence, including for example homelessness, family violence, insecure or inappropriate housing, counselling for childhood trauma.⁵⁸²

Given the longstanding nature of police diversion programs in Australia, they have been evaluated on numerous occasions. A major review of all Australian programs conducted in 2008 by the Australian Institute of Criminology (AIC), *Police drug diversion: a study of criminal offending outcomes*, reported overall positive results Australia-wide. Strong levels of compliance with program requirements was reported, and the majority of people diverted did not reoffend following their participation in a program. For those that did, the majority re-offended only once.⁵⁸³

A 2014 report from the Australian Institute of Health and Welfare (AIHW), *Alcohol and other drug treatment and diversion from the Australian criminal justice system 2012-13*, examined the treatment activities associated with a person's diversion from the criminal justice system. It found that 25 per cent of all clients (24,002) in alcohol and other drug (AOD) treatment across Australia were diverted from the criminal justice system, through both police and court diversion programs. In the 10 years to 2012-2013, the number of treatment episodes provided to clients who were diverted more than doubled, while treatment episodes for other clients did not change significantly.⁵⁸⁴ This demonstrates the growth of diversion programs in Australia, as well as the significant way diversion can provide a connection point for people between the criminal justice system and the AOD sector.

The 2014 report also found that treatment as a result of diversion was most likely to be for cannabis (43 per cent), followed by alcohol (21 per cent), amphetamines (18 per cent) and heroin (7 per cent).⁵⁸⁵ Police diversion was associated with less intensive treatment options such as information, education and assessment, while court diversion was associated with interventions such as counselling, support and case management.⁵⁸⁶ In terms of completion of AOD treatment, 82 per cent of diversion treatment episodes were successfully completed.⁵⁸⁷

⁵⁸² Jennifer Black, *Supplementary evidence*, Fitzroy Legal Service, 11 August 2017, p. 2.

⁵⁸³ Payne, J, et al., *Police drug diversion: a study of criminal offending outcomes*, Australian Institute of Criminology, Canberra, 2008, pp. x - xi.

⁵⁸⁴ Australian Institute of Health and Welfare, *Bulletin 125: Alcohol and other drug treatment and diversion from the Australian criminal justice system*, Canberra, 2014, p. 1.

⁵⁸⁵ Australian Institute of Health and Welfare, *Bulletin 125: Alcohol and other drug treatment and diversion from the Australian criminal justice system*, Canberra, 2014, p. 2.

⁵⁸⁶ Australian Institute of Health and Welfare, *Bulletin 125: Alcohol and other drug treatment and diversion from the Australian criminal justice system*, Canberra, 2014, p. 2.

⁵⁸⁷ Australian Institute of Health and Welfare, *Bulletin 125: Alcohol and other drug treatment and diversion from the Australian criminal justice system*, Canberra, 2014, p. 14.

The latest AIHW report on AOD treatment in 2015/2016 mirrored the above findings. Referrals from police or court diversion accounted for 18 per cent of all clients receiving treatment for their substance use, and these clients were typically younger (21 per cent of episodes were for clients aged between 10 and 19 and 36 per cent for clients aged between 20 and 29). Diversion was the most common source of referral where cannabis was the principal drug of concern (36 per cent), and accounted for referrals in 73 per cent of episodes where ecstasy was the principal drug of concern.⁵⁸⁸

The *Final Report of the National Ice Taskforce*, published in December 2015, also highlighted a range of benefits of diversionary programs including reduced reoffending and significant cost savings for the justice system.⁵⁸⁹ The report recommended that Australian governments review their programs to determine best practice in order to improve and expand existing programs.⁵⁹⁰

Lastly, a recent 2017 study funded by the Australian National Drug Law Enforcement Research Fund, *Police diversion for cannabis offences: Assessing outcomes and cost-effectiveness*, noted that research thus far has shown a variety of potential benefits of diversion including: reduced recidivism rates; reduced drug use, including harmful use; improved health and wellbeing outcomes; and reduced use of criminal justice system resources.⁵⁹¹ This study focused exclusively on outcomes and cost-effectiveness of police diversion for cannabis. Using a national online survey, the report found that people who were diverted reduced their drug use and offending. Compared to a criminal justice response, diversion was also reported to be associated with positive social outcomes such as improved employment prospects, better relationships with families and others, and improved perceptions of police. In terms of costs, the study estimated that police cannabis diversion cost six to 15 times less than a criminal charge. Based on its findings, the study supported strengthening and expanding police diversion programs.⁵⁹²

7.4.2 Victoria Police diversion programs

Victoria Police operates two police diversion programs relating to drug use and personal possession offences – the Cannabis Cautioning Program and the Illicit Drug Diversion Program. The programs' operation rules are contained in the Victoria Police Manual, rather than legislation. Both programs are discretionary, and the person must admit to the offence and consent to participate. The offender cannot be given a caution or diversion if there were other offences involved, unless that offending can be dealt with by caution or infringement notice. Victoria is one of only two jurisdictions in Australia where prior convictions does not limit a person's ability to access police diversion.⁵⁹³ However, under both programs, participants cannot have had more than one previous caution or drug diversion. This means that a person can only access police diversion twice (two cautions, two diversions or one of each), and then will no longer be eligible.

⁵⁸⁸ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, pp. 53-54.

⁵⁸⁹ Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Commonwealth of Australia, Canberra, 2015, pp. 62-63.

⁵⁹⁰ Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Commonwealth of Australia, Canberra, 2015, pp. 146-147.

⁵⁹¹ Shanahan, M, et al., *Police diversion for cannabis offences: Assessing outcomes and cost-effectiveness*, Australian Institute of Criminology, Canberra, 2017, p. 1.

⁵⁹² Shanahan, M, et al., *Police diversion for cannabis offences: Assessing outcomes and cost-effectiveness*, Australian Institute of Criminology, Canberra, 2017, p. 11.

⁵⁹³ Hughes, C and Ritter, A, *Monograph 16: A Summary of Diversion Programs for Drug and Drug-Related Offenders in Australia*, National Drug and Alcohol Research Centre, Sydney, 2008, p. 17.

The Cannabis Cautioning Program applies to people aged 18 years and older for the use or possession of a small quantity of cannabis (less than 50 grams) for personal use. Following arrest and seizure of the cannabis, the person is given an official caution and information about a non-compulsory two-hour free education session called Cautious with Cannabis. These programs are also open to members of the public. Those under 18 go through a separate child caution process.⁵⁹⁴

The Drug Diversion Program applies to those aged 10 years and over for the use or possession of a small quantity of other illicit drugs for personal use. The person is given an official drug diversion caution, and they are required to attend an appointment for assessment and at least one treatment session (usually counselling).⁵⁹⁵ The assessment should take place within five days of arrest, and treatment session within 28 days.

The 2008 AIC study that was referred to earlier found that compliance rates with Victoria's Drug Diversion Program was 75 per cent, and 100 per cent for the Cannabis Cautioning Program. For those diverted under the Cannabis Cautioning Program, 26 per cent reoffended, with 54 per cent of those people committing only one further offence in the following 18 months. Under the Drug Diversion Program, 33 per cent reoffended with 41 per cent of those people committing only one further offence in the 18 months following diversion. The report also found that for offenders with a recent criminal history before diversion, 66 per cent committed fewer offences following diversion. For those that did not have a recent criminal history before diversion, 81 per cent did not reoffend.⁵⁹⁶

In 2014, Victoria Police provided a submission to the Parliamentary Law Reform, Drugs and Crime Prevention Committee's *Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria*. It stated that the Drug Diversion Program had remained effective since the 2008 AIC evaluation, advising that 80 per cent of offenders did not have further contact with the police. It also stated:

Utilisation of the program by police has increased by 17 per cent since 2010 to a yearly average of 49 per cent of those who are eligible being diverted. A record 1,634 Drug Diversions were issued in 2012-13. However, there is clearly scope to further increase use of the IDDI by police.

...

Most of the people who were diverted fell into the 18-35 age group, and the majority were male.⁵⁹⁷

The 2016/2017 Victoria Police Annual Report advised that caution and diversion policies are under review to provide 'more streamlined, consistent and equitable policing practices'.⁵⁹⁸ In her evidence to the Committee, Wendy Steendam, Deputy Commissioner of Victoria Police stated:

⁵⁹⁴ Hughes, C and Ritter, A, *Monograph 16: A Summary of Diversion Programs for Drug and Drug-Related Offenders in Australia*, National Drug and Alcohol Research Centre, Sydney, 2008, p. 63.

⁵⁹⁵ Department of Health and Human Services, 'Forensic services', viewed 5 December 2017, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/forensic-aod-services>>.

⁵⁹⁶ Payne, J, et al., *Police drug diversion: a study of criminal offending outcomes*, Australian Institute of Criminology, Canberra, 2008, p. xiii.

⁵⁹⁷ Victoria Police, *Submission*, no. 52, 4 November 2013, *Inquiry into the Supply and Use of Methamphetamines, Particularly 'Ice', in Victoria*, Law Reform, Drugs and Crime Prevention Committee, Parliament of Victoria, p. 21.

⁵⁹⁸ Victoria Police, *Annual Report: 2016-2017*, Melbourne, 2017, p. 30.

Through some of the drug response plan, there will be some active work about encouraging and making sure that we are using diversion programs where it is appropriate to do so, that our members understand the value of the diversion program and the cautioning program and that they are utilised to their full effectiveness.⁵⁹⁹

Deputy Commissioner Wendy Steendam reported that, through their e-referral system, they made 3,860 referrals to drug and alcohol services in the period of January to October 2016, although she noted that such referrals were not solely the result of diversion.⁶⁰⁰

7.4.3 Gaps in police diversionary programs in Victoria

Broadly, stakeholders to the inquiry were supportive of the Victorian police diversionary programs, but some highlighted current gaps in their operation, particularly regarding eligibility requirements and inconsistent access to programs across Victoria due to its discretionary nature.

Regarding eligibility requirements, NDARC stated in its submission:

...all drug diversion schemes have strict eligibility requirements (Hughes & Ritter, 2008), which limit access to programs, particularly to people who are more marginalised and/or in need of diversion into treatment and rehabilitation (Hughes, Shanahan, Ritter, McDonald, & Gray-Weale, 2014d).⁶⁰¹

Dr Caitlin Hughes, Senior Research Fellow of the Drug Policy Modelling Program at NDARC, provided further context to this point stating that these eligibility requirements mean 'large numbers of people continue to be policed and sanctioned for the use of drugs alone'. This wastes scarce resources within the criminal justice system, reduces employment opportunities, increases discrimination, and reduces access to treatment and harm reduction services.⁶⁰² Similarly, the FLS expressed concern in its submission about the limit of previous diversions that a person can accumulate, arguing that this fails to recognise substance dependence as a relapsing condition:

This process ignores the reality that substance addiction is unlikely to be a once off event, as relapse is common, and further that persons with addiction typically have many complex issues underlying their addictions which require tailored treatment plans.⁶⁰³

As well as concerns about eligibility, another issue raised by stakeholders is that the current programs rely on individual police discretion, rather than being a mandated policy. As outlined in Liberty Victoria's submission:

16. We are concerned that the current Victorian approach, characterised by de facto measures, unduly relies on the discretion of Victoria Police, and is not properly adapted to the situation presented by repeat offenders who are affected by drug addiction.

⁵⁹⁹ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 456.

⁶⁰⁰ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 456.

⁶⁰¹ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 5.

⁶⁰² Caitlin Hughes, Senior Research Fellow, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 248.

⁶⁰³ Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 9.

17. There is no mechanism for ensuring that the discretion of police officers to refuse to recommend diversion is applied consistently. In some instances that have come to our attention, police have denied diversion on the basis that a person gave a no comment record of interview — that is, that they exercised a common law right. Further there appear to be very different standards as to the kind of offences that are and are not suitable for diversion. In our view, this underscores the pressing need for legislative intervention.⁶⁰⁴

The Committee is also aware that, given its discretionary nature, there are varying views on the extent to which police diversion is used in practice. This issue was raised by a number of stakeholders, some of whom have direct legal experience in this area. For example, Tamzyn Jewell, Senior Lawyer at Victoria Legal Aid (VLA) stated:

...I think that the use of warnings, in my experience, is somewhat limited. I think that people are charged. Even if they are found with small amounts, they are generally charged. There is drug diversion, which is available for small quantities; however, I have got numerous examples where young people might have above the 3 gram quantity for ice or MDMA, but for personal possession, and that then means that they end up having a criminal record that can have a flow-on stigma effect, such as in working with children's checks or police checks...⁶⁰⁵

Meghan Fitzgerald from the FLS similarly stated:

Anecdotally for us, we have met very few people who have been offered a drug diversion. My understanding, through my work — we have done work with Harm Reduction Victoria's DanceWize — is that that may be an operational decision that happens around raves and that sort of thing, but there is no presumption towards issuing a drug diversion within the police force. It is just an option that is available.⁶⁰⁶

Paul Aiken, the Evaluation and Advocacy Team Leader and Trevor King, Director of Programs at Uniting Care ReGen, an organisation that provides many of the diversion programs, also referred to their discretionary nature, in addition to the impact of resourcing between metropolitan and country regions:

Mr AIKEN — Certainly what we have seen at a local level is that with police cautioning schemes and diversion programs they often rely on a local commander at a local station and what their attitude is. They shape the culture within their station and their officers follow their lead. So you can get a wide range in approaches across different stations and different areas within the state and the same system.⁶⁰⁷

...

Mr KING — If the diversion is for an assessment and possibly counselling and other programs, I think they are available right across metro and country regions. Access varies considerably. Some of the psychoeducational programs we run are drink-drive, drug-drive education programs. Others that magistrates refer to — Cautious with Cannabis is an example. DDAL [Drug Diversion Appointment Line], people would have spoken about previously, where police caution someone, usually at a music festival. Turning Point is the organisation that then refers people on to services like ours that people are required to attend for an assessment and a brief intervention. There is a lot of variability.

⁶⁰⁴ Liberty Victoria, *Submission*, no. 205, 21 March 2017, pp. 6-7.

⁶⁰⁵ Tamzyn Jewell, Senior Lawyer, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 228.

⁶⁰⁶ Meghan Fitzgerald, Social Action, Policy and Reform Manager, Fitzroy Legal Service, *Transcript of evidence*, 28 June 2017, p. 264.

⁶⁰⁷ Paul Aiken, Evaluation and Advocacy Team Leader, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, pp. 271-272.

Now those sorts of programs are typically metro-based, and that is a shame, I think. But that is a resourcing issue.⁶⁰⁸

On the other hand, Demos Krouskos from NRCH stated:

The police take a very pragmatic approach, in my view, to personal use. Usually people with small amounts of illicit drugs are given a warning and the drugs are confiscated, and they have been very helpful in that regard.⁶⁰⁹

Dr Stefan Gruenert from OHV commented that the current situation is a 'postcode lottery' in relation to how a person will be dealt with, and further:

In most cases, particularly for drugs like cannabis, absolutely, you are getting diverted, but with all sorts of other drugs, depending on who you have got and what capacity they have at the time, you may in fact end up with a criminal record and you may in fact have some legal sanctions as a result of being caught with possession of that drug, even as a user.⁶¹⁰

The Committee notes a lack of information on the way diversion is used in practice, evidenced by the differing opinions received on this issue. The Penington Institute proposed in its submission the public reporting of: the outcomes of diversion; what proportion of those eligible for diversion are actually diverted; the reasons why, if eligible, they would not be diverted; the trajectories of those who are not diverted, for example whether they then participate in a court diversion program; and variances between regions.⁶¹¹

Overall, the Committee was encouraged to learn that Victoria has a longstanding history of applying diversionary policies designed to enable people who use or possess drugs for personal use to be dealt with by the health and treatment sector. The emphasis on diversion has produced a number of associated positive benefits, however, issues remain with this approach, which result in some people still being subject to the effects of criminalisation.

7.5 Australian models of de jure decriminalisation for cannabis

As various Australian jurisdictions, including Victoria, already apply de facto decriminalisation through the use of diversion programs, some stakeholders raised the option of de jure decriminalisation. Under this model, offences for drug use and possession remain in law, but the criminal penalties associated with the offences are removed and replaced with non-criminal penalties. South Australia (SA), the Australian Capital Territory (ACT) and the Northern Territory (NT) have all implemented de jure decriminalisation for use and personal possession offences for cannabis, where criminal penalties have been removed and replaced with civil penalties through fines or infringement notices. Western Australia also adopted a similar scheme, however, in 2011 this policy was reversed. Similar models of de jure

⁶⁰⁸ Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 272.

⁶⁰⁹ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 155.

⁶¹⁰ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 163.

⁶¹¹ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 52.

decriminalisation for cannabis have been implemented elsewhere, for example in a number of United States jurisdictions. According to NDARC, over 25 countries have implemented this model, mostly for cannabis.⁶¹²

This section outlines Australian examples of de jure decriminalisation, limited to cannabis, and outcomes of such reforms where evidence is available.

7.5.1 South Australia

In 1987, SA introduced on the spot fines for simple cannabis offences, through the Cannabis Expiation Notice (CEN) scheme. Noting there have been some changes in the CEN scheme since its inception, simple cannabis offences are:

- the possession of cannabis up to 100 grams, or cannabis resin up to 20 grams
- smoking or consuming cannabis or cannabis resin in a private place
- the possession of equipment for smoking or consumption of cannabis (both public and private)
- the cultivation of one cannabis non-hydroponic cannabis plant for personal use.⁶¹³

Under the CEN scheme, an individual apprehended by police for a simple cannabis offence can pay a civil penalty (currently up to \$300) within 28 days:

If the individual pays the fine, no admission of guilt is recorded and there is no prosecution. If the individual fails to pay the fine they will be sent a reminder notice and an additional fee for the notice will be added to the original fine. If they subsequently do not pay the expiation fee and the reminder fee the matter will be referred to court which will administratively issue an enforcement notice. This results in an automatic conviction and enforcement of the outstanding fine.⁶¹⁴

Initially, the CEN scheme unexpectedly resulted in more people being sanctioned for cannabis possession than before the scheme commenced, with numbers increasing from 6,000 notices in 1987-1988 to 17,000 in 1993-1994. According to a 2016 report by the UK drug policy organisation Release, *A quiet revolution: drug decriminalisation across the globe*, this was attributed to the ‘net-widening’ effect, where more people were captured as the police processes for dealing with such activity became simpler through issuing CENs. There was also some confusion about payment methods, which may have contributed to more convictions being applied. In response, the SA Government changed payment methods, introduced community service as a substitute for fines, and made the requirements clearer. Release reported that these changes resulted in improved payment rates, reduced numbers of convictions and a drop in the number of CENs issued – by 2013, the number of notices issued were just over 9,000.⁶¹⁵

In terms of the scheme’s impact on cannabis use among the community, a 1999 study found that while there had been a greater increase in lifetime cannabis use in SA compared to other Australian jurisdictions, this was unlikely to be caused by the CEN system because:

⁶¹² National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, pp. 5-6.

⁶¹³ Legal Services Commission of South Australia, ‘Simple Cannabis Offences’, viewed 14 March 2018, <<https://www.lawhandbook.sa.gov.au/ch12s08s02.php>>.

⁶¹⁴ Eastwood, N, et al., *A quiet revolution: drug decriminalisation across the globe*, Release, March 2016, p. 14.

⁶¹⁵ Eastwood, N, et al., *A quiet revolution: drug decriminalisation across the globe*, Release, March 2016, p. 14.

(1) similar increases occurred in Tasmania and Victoria, where there was no change in the legal status of cannabis use; (2) there was no differential change in weekly cannabis use in South Australia as compared with the rest of Australia, and (3) there was no greater increase in cannabis use among young adults aged 14 to 29 years in South Australia. It is also possible that part of the observed increase in self-reported lifetime use in South Australia can be attributed to a greater willingness of people to admit to cannabis use in a population household survey, compared to jurisdictions with a total prohibition approach to minor cannabis offences.⁶¹⁶

The 2016 Release report similarly indicated there is mixed evidence on the effect on cannabis use rates. It indicated that while one study reported an increase in cannabis smoking prevalence, most studies did not indicate an increase in its use as a result of the scheme. Release also highlighted the following changes in recent cannabis use in SA from the 2013 *National Drug Strategy Household Survey* (NDSHS):

- a decrease from 17.6 per cent in 1998 to 10.8 per cent in 2007
- a small increase to 11 per cent in cannabis use in 2013.⁶¹⁷

The Committee notes that the 2016 NDSHS indicated a drop in prevalence from 11 per cent in 2013 to 10.7 per cent in 2016 in SA.⁶¹⁸

A number of stakeholders expressed support for the SA scheme for cannabis. The National Drug and Alcohol Research Centre provided some insights into the social benefits of this regime, as well as commenting on the ‘net widening’ effect:

...analysis of the South Australian cannabis decriminalisation scheme showed that individuals who avoided a criminal record were less likely to drop out of school early, be sacked or to be denied a job (Ali et al., 1999). They were also less likely to have fights with their partners, family or friends or to be evicted from their accommodation as a result of their police encounter. The only negative from decriminalisation is that in some programs there have been increases in the number of people who have ended up having contact with the criminal justice system (net-widening), due to the greater ease with which police can process minor drug offences (Shiner, 2015). This is however a factor of the specific model and implementation: not decriminalisation per se.⁶¹⁹

Magistrate Tony Parsons of the Drug Court of Victoria commented on the CEN scheme as it relates to young people:

That is smart for young people. Young people make all kinds of stupid decisions, and there but for the grace of God might I have gone...The fact is that young people make silly decisions. It would be a tragedy to mar their lives forever with a criminal record, and South Australia seems to be sensible about that.⁶²⁰

As well as de jure decriminalisation for cannabis, SA adopted a mandatory de facto decriminalisation scheme under legislation to deal with all other illicit drugs, the Police Drug Diversion Program. Fitzroy Legal Service outlined in its submission the key features of the program, which includes police, upon apprehending an offender,

616 Ali, R, et al., *The social impacts of the Cannabis Expiation Notice scheme in South Australia: summary report*, National Drug Strategy Committee, Canberra, 1999, p. 46.

617 Eastwood, N, et al., *A quiet revolution: drug decriminalisation across the globe*, Release, March 2016, p. 15.

618 Australian Institute of Health and Welfare, ‘National Drug Strategy Household Survey 2016: detailed findings: Data tables: Chapter 7 State and territory’, viewed 15 March 2018, <<https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data>>, p. Table 7.19.

619 National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 6.

620 Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 148.

mandatorily referring them to an assessment with a local health worker. The health worker can provide further referrals or treatment as required, and can place adults on an undertaking to attend treatment for up to six months. If a person has been diverted more than twice in the last 24 months, the undertaking is mandatory. If the offender participates, no further action is taken. If they do not, or do not comply with an undertaking, the person is referred back to the criminal justice system. If a person is diverted more than three times, they are seen by a panel of assessors on the fourth and subsequent diversion. Under this program, police do not have discretion whether to divert an individual and there is no limit on the number of times that a person can be diverted. Fitzroy Legal Service further advised that the rates of recidivism are low, as only one quarter are diverted more than once, 15 per cent twice, 5 per cent three times and four per cent four or more times.⁶²¹

Data on recorded crime in 2015/2016 from the ABS highlighted that South Australia's cannabis scheme, as well as mandatory diversionary system for other illicit substances, has resulted in a higher use of non-court actions compared to other jurisdictions⁶²²:

In South Australia, the most prevalent principal offence for non-court actions was Illicit drug offences (50% or 16,910 proceedings). In South Australia, police have the option of issuing Cannabis Expiation Notices (CENs) for minor drug possession and/or use offences. In addition, South Australia makes greater use of non-court proceedings via drug diversion schemes (counselling). This contributes to a higher proportion of Illicit drug offences in South Australia being proceeded against via non-court action than in other jurisdictions.⁶²³

360Edge, a specialist alcohol and other drug consultancy, discussed in its submission SA's 'long history of drug law reform' incorporating both de facto and de jure decriminalisation, and suggested these programs have not resulted in any adverse impacts on the use of illicit substances.⁶²⁴

Fitzroy Legal Service suggested that SA's Police Drug Diversion Program is a useful model to consider for reforms to Victoria's current diversionary programs.⁶²⁵

7.5.2 Northern Territory and Australian Capital Territory

Similar to SA, the NT and ACT have decriminalised the possession of small amounts of cannabis. In the NT since 1996, police can issue an infringement notice under the *Misuse of Drugs Act* for two offences – the possession of cannabis (up to 50 grams of cannabis, 10 grams of cannabis seed or resin, and one gram of cannabis oil) and the cultivation of two cannabis plants. Non-payment of the fine does not result in a criminal conviction or record but becomes a debt owed to the state.⁶²⁶

⁶²¹ Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 9.

⁶²² The ABS explains that court actions largely comprise the laying of charges, where people may be taken into custody, granted bail or issued with a summons for these charges. Non-court actions comprise legal actions such as cautions/warnings, conferencing, counselling, drug diversion, or penalty notices.

⁶²³ Australian Bureau of Statistics, '4519.0 - Recorded Crime - Offenders, 2015-16: Police Proceedings, Selected States and Territories', viewed 19 January 2018, <<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4519.0-2015-16-Main%20Features-Police%20proceedings,%20selected%20states%20and%20territories-6>>.

⁶²⁴ 360Edge, *Submission*, no. 229, 4 September 2017.

⁶²⁵ Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 9.

⁶²⁶ Eastwood, N, et al., *A quiet revolution: drug decriminalisation across the globe*, Release, March 2016, p. 15.

In the ACT, police issue a Simple Cannabis Offence Notice (SCON) to a person apprehended for a simple cannabis offence under the *Drugs of Dependence Act 1989*: possession of up to 50 grams of cannabis (increased in 2013 from 25 grams), cultivation of up to two non-artificial cannabis plants, and administering cannabis to oneself.⁶²⁷ If the person pays the \$100 fine within 60 days, no further action is taken. The SCON system also overlaps with police diversion programs, although due to concerns about non-payment of fines, since 2010 individuals are typically directed to the Drug Diversion Program, rather than given a SCON.⁶²⁸ An evaluation of these diversion programs found that, while there are some concerns with low levels of compliance and police resistance to the SCON scheme, it works well with low operating costs and a higher level of compliance compared to other cannabis expiation schemes in Australia.⁶²⁹

The Committee received a joint submission from the ACT Justice and Community Safety Directorate and ACT Health. In explaining the eligibility for a fine, it referred to the increase in the threshold for possession of cannabis from 25 grams to 50 grams as the result of evidence showing that a typical purchase for personal use was approximately 28 grams:

The previous threshold meant that cannabis users could have been subject to court proceedings for possessing the average amount purchased for personal use. The Government considered this issue was more appropriately handled by a discretionary fine. The scheme also reduces the cost to the community and police of taking the offence to court. The Government has also introduced an online portal to provide a simple, quick and convenient way for people to pay their fines.⁶³⁰

Section 7.7 discusses legislated thresholds for illicit drugs in further detail.

7.6 The removal of criminal penalties for personal use and possession offences for all illicit drugs

In recent years, the removal of criminal penalties for personal use and possession offences for all illicit drugs, as opposed to only cannabis, has been subject of much debate and support from a range of local and international bodies. The World Health Organization (WHO) in 2014 recommended the decriminalisation of injecting and other drug use to reduce incarceration rates in the context of HIV prevention.⁶³¹ It expanded on this proposal in 2017 in partnership with the United Nations, through a joint statement aimed at ending discrimination in health care. They specifically recommended the repeal of punitive laws that have negative health outcomes and which are not evidence-based. This included laws that criminalise drug use or possession for personal use.⁶³² In 2016, UNAIDS made a key policy recommendation that the objective of treating people who use drugs with support and care rather than punishment requires 'implementing alternatives to criminalization, such as decriminalization and stopping incarceration for people for the consumption and

⁶²⁷ *Drugs of Dependence Act 1989* (ACT).

⁶²⁸ Hughes, C, et al., *Evaluation of the Australian Capital Territory Drug Diversion Programs*, Canberra, 2013, pp. 29-30.

⁶²⁹ Hughes, C, et al., *Evaluation of the Australian Capital Territory Drug Diversion Programs*, Canberra, 2013, p. 91.

⁶³⁰ Justice and Community Safety Directorate (JACS) and ACT Health, *Submission*, no. 185, 17 March 2017.

⁶³¹ World Health Organization, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations: 2016 update*, Geneva, 2016, p. 87.

⁶³² Joint WHO/UN statement, *Joint United Nations statement on ending discrimination in health care settings*, Media release, World Health Organization, Geneva, 27 June 2017.

possession of drugs for personal use'.⁶³³ The Global Commission on Drug Policy has long supported such an approach, and recently advocated going even further by recommending that 'there must be no penalty whatsoever imposed for low-level possession and/or consumption offenses'.⁶³⁴

This broad support across international bodies is the result of growing recognition of the harms arising from punitive criminal penalties such as reduced access to health care, high rates of incarceration and a high burden on the criminal justice system. As noted in NDARC's submission, '[t]here is now global recognition of the need for a more public health oriented approach to drug laws' that would:

- 1) deemphasise 'criminalisation' of drug use, 2) be more proportionate in its response to drugs by focusing on the drugs and criminal activities that cause the most harm (e.g. trafficking and particularly high-level drug trafficking), 3) recognise and reduce unintended negative impacts of laws and policies, and 4) embrace laws that ensure the rights of people who use drugs, including rights to healthcare and harm reduction for people who use drugs (Babor et al., 2010; Caulkins & Reuter, 2016; Costa, 2008; LSE Expert Group on the Economics of Drug Policy, 2014; Ritter et al., 2016).⁶³⁵

Discussed in more depth in chapter three, it is understood that the international drug control system allows countries some flexibility to adopt alternatives to criminal penalties for personal use and possession. The former President of the International Narcotics Control Board (INCB), Werner Sipp, in a 2015 speech outlined the framework that allows this to occur, while noting that the retention of criminal offences for possession is required (except for medical or scientific purposes). He indicated that determination of what constitutes a 'punishable offence' is flexible:

The obligation to establish specific behaviours as "punishable offences" contains several limitations:

- a) It is generally subject to the constitutional limitations of the State Party.
- b) Regarding possession for personal consumption, it is subject not only to constitutional limitations, but also to the basic concepts of the legal system of the State.
- c) If serious offences shall be liable to adequate punishment, we can infer that offences of a minor nature - as for example possession of small quantities for personal consumption - must not necessarily be liable to punishment.

These limitations give State Parties a certain flexibility and discretion in the choice of legal and policy measures they deem appropriate to react to unlawful behaviour, namely to possession for personal consumption.⁶³⁶

The speech also highlighted that, importantly, the conventions allow countries to provide 'as an alternative or in addition to conviction or punishment, that abusers undergo measures of treatment, education, after-care, rehabilitation and social integration'.⁶³⁷

⁶³³ UNAIDS, *Do No Harm: Health, Human Rights and People Who Use Drugs*, Geneva, 2016, p. 7.

⁶³⁴ Global Commission on Drug Policy, *Advancing Drug Policy Reform: A New Approach to Decriminalization*, Geneva, 2016, p. 7.

⁶³⁵ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 5.

⁶³⁶ United Nations International Narcotics Control Board, 'Statement of the President of the International Narcotics Control Board (INCB), Mr. Werner Sipp', Paper presented at the *Reconvened fifty-eighth session of the CND; Special Event: A public health approach as a base for drugs policy: The Portuguese case*, United Nations International Narcotics Control Board, Vienna, 2015, p. 3.

⁶³⁷ United Nations International Narcotics Control Board, 'Statement of the President of the International Narcotics Control Board (INCB), Mr. Werner Sipp', Paper presented at the *Reconvened fifty-eighth session of the CND; Special Event: A public health approach as a base for drugs policy: The Portuguese case*, United Nations International Narcotics Control Board, Vienna, 2015, p. 4.

The forward to the INCB's 2016 Annual Report by former President Sipp similarly stated:

As we have often pointed out, the conventions provide for a certain flexibility at the national level, particularly with respect to determining appropriate sanctions, including non-punitive or non-custodial measures, for minor offences, for example for possession of drugs for personal use.⁶³⁸

Reflecting on these themes, there was significant support among inquiry stakeholders for Victoria to remove criminal penalties for all illicit drug use and personal possession offences as a key area for drug law reform.⁶³⁹ This was specifically in recognition of the progress already achieved through Victoria's police diversionary programs, thus meaning that the likelihood of incarceration for these offences is extremely unlikely, but that these efforts should be scaled up and formalised. For example, Dr Stefan Gruenert from OHV advised:

As an organisation the first thing we support is the extension and formalisation in Victoria of decriminalisation such that people are not getting a criminal record, which we know, as a treatment organisation that supports more than 8000 people every year, makes your efforts of achieving recovery and re-entering mainstream society much more difficult. We understand there is a de facto approach to most drugs by most jurisdictions around Victoria, but that is really up to the discretion often of individual officers. We would like to see that extended to all drugs and certainly formalised.⁶⁴⁰

Trevor King of Uniting Care ReGen considered that such a reform would free up police resources, enable focus on more harmful substances and address resourcing imbalances that favour law enforcement approaches:

We think that could free up police resources. You would have heard many times before that something like 20 per cent of arrests at the moment are for traffickers, the more serious offenders, and about 80 per cent remain people who are detected with drugs, essentially for their own personal use.

We also think this would allow a shift from the least to the most harmful drugs. We know again — and you will have heard before, many times I am sure — that the emphasis on cannabis is prominent. I think something like 47 per cent of the arrests are for people who are using cannabis.

⁶³⁸ International Narcotics Control Board, *Report of the International Narcotics Control Board for 2016*, United Nations, New York, 2017, p. iii.

⁶³⁹ 360Edge, *Submission*, no. 229, 4 September 2017; Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017; Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 5; cohealth, *Submission*, no. 140, 16 March 2017; Dr Kate Seear, *Submission*, no. 126, 16 March 2017, p. 19; Drug Policy Australia, *Submission*, no. 192, 17 March 2017, p. 5; Families and Friends for Drug Law Reform, *Submission*, no. 123, 16 March 2017, p. 25; Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 8; Australian Drug Law Reform Foundation, *Submission*, no. 147, 17 March 2017, p. 4; Harm Reduction Australia / Family Drug Support, *Submission*, no. 112, 15 March 2017; Humanist Society of Victoria, *Submission*, no. 184, 17 March 2017; Justice Action, *Submission*, no. 207, 21 March 2017, p. 2; Liberty Victoria, *Submission*, no. 205, 21 March 2017, p. 8; Living Positive Victoria, *Submission*, no. 213, 28 March 2017, p. 2; North Richmond Community Health, *Submission*, no. 162, 17 March 2017; Rationalist Society of Australia, *Submission*, no. 200, 20 March 2017, p. 4; Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017, p. 3; Springvale Monash Legal Service Inc., *Submission*, no. 160, 17 March 2017, p. 17; Students for Sensible Drug Policy Australia, *Submission*, no. 214, 29 March 2017; Students for Sensible Drug Policy LaTrobe, *Submission*, no. 155, 17 March 2017; Students for Sensible Drug Policy UniMelb, *Submission*, no. 191, 17 March 2017, p. 2; The Australian Psychedelic Society, *Submission*, no. 187, 17 March 2017, p. 9; Turning Point, *Submission*, no. 116, 15 March 2017; Unharm, *Submission*, no. 182, 17 March 2017, p. 20; Victoria Legal Aid, *Submission*, no. 204, 21 March 2017; Victorian AIDS Council, *Submission*, no. 206, 21 March 2017, p. 4; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 15.

⁶⁴⁰ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 161.

We think this could also assist in rebalancing Australia's harm minimisation policy and the resource allocation. We do know that the vast majority of funds — something like 60 per cent of funds — go into law enforcement, into supply reduction strategies. One of the issues with that is that harm reduction, prevention and treatment programs we believe are chronically underfunded.⁶⁴¹

Stakeholders were clear in their view that this approach in Victoria would be one of the most effective ways to reorient the way people who use drugs are dealt with from a criminal justice framework to a health-based one. For example, the Royal Australasian College of Physicians (RACP) stated in its submission that governments 'need to move away from the dominant paradigm of criminality', and increase focus on health and wellbeing, through the removal and replacement of criminal penalties, and health interventions, to target 'an individual's use of a drug where no serious harm is caused to others'.⁶⁴² Bevan Warner, Managing Director of VLA, also considered that this would be a mechanism to achieve a public health approach in dealing with people who use drugs:

The first approach should be to direct people into the public health system rather than into the criminal justice system. If that includes decriminalisation of certain drugs or certain quantities or of certain behaviour, then we believe that we should follow the evidence of what works.⁶⁴³

Throughout the inquiry, the Committee heard time and time again about the experience of Portugal, which decriminalised the personal use and possession of all illicit drugs in 2001. It is particularly pertinent to note that, despite strong reservations from the INCB when the policy was first introduced, former President Werner Sipp stated in a 2015 speech that Portugal represents a model of best practice:

It shows that a drug policy which is fully committed to the principles of the Drug Control Conventions, putting health and welfare at its centre and applying a balanced, comprehensive and integrated approach, based on the principle of proportionality and the respect for human rights, can have positive results - within the existing drug control system and without legalising the use of drugs.⁶⁴⁴

As part of its overseas study tour, the Committee spent time in Portugal to learn more about the mechanics and effectiveness of its approach to illicit drugs. This and evidence received from stakeholders and the broader literature are outlined below to provide a brief overview of the Portuguese model, in addition to the impacts and perceived unintended consequences arising from the model.

7.6.1 Portugal

Under the authoritarian dictatorship of Antonio Salazar after the Second World War, Portugal was 'a firmly Catholic, traditional, conservative society' that was 'closed to new ideas, changes in Western societies, and new trends in culture and customs'.⁶⁴⁵ However, significant changes in the late 1970s, particularly the end of the Salazar

⁶⁴¹ Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 270.

⁶⁴² Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017, p. 3.

⁶⁴³ Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 228.

⁶⁴⁴ United Nations International Narcotics Control Board, 'Statement of the President of the International Narcotics Control Board (INCB), Mr. Werner Sipp', Paper presented at the *Reconvened fifty-eighth session of the CND; Special Event: A public health approach as a base for drugs policy: The Portuguese case*, United Nations International Narcotics Control Board, Vienna, 2015, p. 5.

⁶⁴⁵ Domsławski, A, *Drug Policy in Portugal - the Benefits of Decriminalising Drug Use*, Global Drug Policy Program, Open Society Foundations, Warsaw, 2011, p. 17.

regime and end of the colonial war in Africa with people returning from the colonies, resulted in rising drug use rates as a consequence of ‘a very closed country quickly opening to the world’.⁶⁴⁶

While general prevalence rates of substance use in Portugal remained low, a range of public health challenges emerged in the 1980s and 1990s from problematic drug use, particularly intravenous heroin use, including rising rates of HIV, AIDS, TB and hepatitis B and C. By 1999, the problem had escalated to the point where Portugal had ‘the highest rate of drug-related AIDS in the European Union and the second highest prevalence of HIV among injecting drug users’, as well as reaching a peak in drug-related deaths.⁶⁴⁷

Further, the emergence of open-air drug markets became a particular source of concern, and also drew media attention to these issues:

Open-air drug markets emerged in Portugal, the most infamous of which was Casal Ventoso, a slum located on the outskirts of the capital city of Lisbon (Chaves, 1999; Fugas, 2001), which developed into the biggest open-air drug market in Europe (Miguel, 1997). Casal Ventoso attracted up to 5,000 drug users daily in search of drugs and had extremely high rates of infectious diseases, homelessness and social marginalisation: 60% were HIV positive (Gabinete de Apoio ao Toxicodependente, 2003), and 74% HCV positive (Valle and Coutinho, 2001). Eight hundred dependent users lived permanently in the slum. Television and newspaper coverage about illicit drugs increased during 1997 and 1998; an almost daily coverage depicted Casal Ventoso’s public health and humanitarian crisis.⁶⁴⁸

In parallel to these societal changes were a range of legal changes that aimed to shift the policy focus from a criminal justice framework to a health one. A law in 1983 retained the use of illicit substances as a crime, but ‘recognised the drug user as a patient in need of medical care, stating that the priority was to treat and not to punish’.⁶⁴⁹ A further law in 1993 contained a preamble that drug users were to be sanctioned ‘in a quasi-symbolic manner, in which the contact with the formal justice system is designed to encourage him or her to seek treatment’.⁶⁵⁰

In 1998, the issue of drugs became a key political issue in response to a rise in further harms and growing recognition ‘from many areas of society including the law enforcement and health sectors that the criminalization of drug use was increasingly part of the problem, not the solution’.⁶⁵¹ The Committee is also aware that the drug problem penetrated all levels and all groups in society – a key factor that mobilised communities for change. As discussed by Dr João Goulão, the Director-General for the Portuguese General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD) and widely seen as the mainstay for the reforms:

“These social movements take time,” Goulão told me. “The fact that this happened across the board in a conservative society such as ours had some impact.” If the heroin epidemic had been restricted only to Portugal’s lower classes or racialized

⁶⁴⁶ Domoslawski, A, *Drug Policy in Portugal - the Benefits of Decriminalising Drug Use*, Global Drug Policy Program, Open Society Foundations, Warsaw, 2011, p. 17.

⁶⁴⁷ Hughes, C and Steven, A, ‘What we can learn from the Portugese Decriminalization of Illicit Drugs?’, *The British Journal of Criminology*, vol. 50, no. 6, 2010, p. 1001.

⁶⁴⁸ Hughes, C, ‘Portuguese Drug Policy’, in *European Drug Policies: The Ways of Reform*, R Colson and H Bergeron (eds), Routledge, New York, 2017, pp. 170-171.

⁶⁴⁹ European Monitoring Centre for Drugs and Drug Addiction, *Drug Policy Profiles - Portugal*, Lisbon, 2011, p. 11.

⁶⁵⁰ European Monitoring Centre for Drugs and Drug Addiction, *Drug Policy Profiles - Portugal*, Lisbon, 2011, p. 12.

⁶⁵¹ Hughes, C and Steven, A, ‘What we can learn from the Portugese Decriminalization of Illicit Drugs?’, *The British Journal of Criminology*, vol. 50, no. 6, 2010, pp. 1001-1002.

minorities, sparing the middle and upper classes, he doubts the conversation around drugs, addiction, and harm reduction would have taken shape in the same way. “There was a point where you could not find a single Portuguese family that wasn’t affected. Every family had their addict, or addicts. This was transversal in a way that the society felt, ‘we have to do something.’”⁶⁵²

Socially integrated policy

In 1998, the Portuguese Government appointed an expert commission, the *Commission for the National Strategy to Fight Against Drugs*, with a wide mandate to consider drug policy issues such as prevention, treatment and risk reduction. The Commission’s report contained recommendations for 12 areas of drug policy, including a recommendation to decriminalise personal drug use. The recommendations were adopted in full under Portugal’s first national drug strategy, the *National Strategy for the Fight Against Drugs* (NSFAD) in 1999.

Decriminalisation was implemented as part of a much broader social integrated policy through the NSFAD under eight key principles, such as humanism, pragmatism and participation. The Strategy comprised 13 strategic areas, including: reinforce international cooperation, decriminalise illicit drug use; focus on primary prevention, ensure access to treatment, expand harm reduction, promote social integration, ensure treatment and harm reduction in prisons, treatment as an alternative to prison, expand research and training, ensure evaluation, streamline interdepartmental coordination, reinforce the focus on drug trafficking and money laundering, and double public investment in the drug field.⁶⁵³ An example of broader reforms that were implemented at the same time as decriminalisation was the expansion of harm reduction measures, which included drop-in centres, shelters, the provision of opioid substitution treatment, needle and syringe programs, and information units.⁶⁵⁴ Nowadays, these operate throughout the country in areas with high concentration of intensive drug use in order to prevent drug-related risks such as infectious diseases and social exclusion.

The Portuguese model was also characterised as one based on public health, rather than a form of legalisation or solely a harm reduction model.⁶⁵⁵ In this regard, decriminalisation provided ‘a more humane legal framework’ that was linked to enhanced resources in prevention, harm reduction, treatment, social reintegration and supply reduction in order to ‘open up new ways for the field to respond, such as through channelling minor drug offenders through the drug system’.⁶⁵⁶ On this basis, according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) report, *Drug Policy Profiles – Portugal*, decriminalisation ‘should be understood as only one element of a larger policy change’ that encompassed: moving responsibilities from the Ministry of Justice to the Ministry of Health, more integrated and detailed plans, prioritising evaluation, and bringing closer together alcohol and drug policy.⁶⁵⁷

652 Ferreira, S, ‘Decriminalization: A Love Story’, *The Common*, no. 14, 2017, viewed 19 January 2018, <<https://www.thecommononline.org/decriminalization-a-love-story/>>.

653 European Monitoring Centre for Drugs and Drug Addiction, *Drug Policy Profiles – Portugal*, Lisbon, 2011, pp. 15-16.

654 European Monitoring Centre for Drugs and Drug Addiction, *Drug Policy Profiles – Portugal*, Lisbon, 2011, p. 18.

655 European Monitoring Centre for Drugs and Drug Addiction, *Drug Policy Profiles – Portugal*, Lisbon, 2011, pp. 23-24.

656 Hughes, C and Steven, A, ‘What we can learn from the Portugese Decriminalization of Illicit Drugs?’, *The British Journal of Criminology*, vol. 50, no. 6, 2010, p. 1002.

657 European Monitoring Centre for Drugs and Drug Addiction, *Drug Policy Profiles – Portugal*, Lisbon, 2011, p. 23.

The Portuguese model's focus on treatment and social integration services was strongly supported among inquiry stakeholders. For example, Dr Christian Smyth, Special Adviser at Turning Point, considered that the integrated social policy was the most important aspect of the reforms, where 'linkages' were made for people into areas such as housing and employment, providing hope and life pathways to people rather than merely implementing 'bandaid solutions'.⁶⁵⁸

Dr Caitlin Hughes from the DPMP at NDARC, one of the world's foremost experts on Portuguese drug policy, noted in a 2017 book chapter, *Portuguese drug policy*, that important factors in the drive for reform in Portugal included: long-standing Portuguese values around human rights and using criminal law as a measure of last resort, improved local evidence and research on the Portuguese drug problem, the role of various stakeholders including criminal justice officials and health professionals, and political changes.⁶⁵⁹

The mechanics of the Portuguese model

Portuguese Law 30/2001 removed the criminal penalty of up to one year's imprisonment for the possession or acquisition of all illicit drugs for personal use. While the offences remained in law, criminal penalties were replaced with an administrative penalty regime for the possession of illicit substances at a quantity consistent with personal supply, prescribed as being up to ten days' worth of an illicit substance. Those found with more than this quantity would be charged with offences relating to trafficking or trafficking/consumption (more than ten days' worth of a drug but related to personal use).⁶⁶⁰ As well as trafficking and trafficking/consumption, manufacturing and cultivation of illicit drugs remained as criminal offences resulting in penalties processed before the courts.⁶⁶¹ Further, people committing crimes related to their drug use (for example, theft) were still processed by the courts.

The key component of Portugal's model was the establishment of a national system of 18 regional Commissions for the Dissuasion of Drug Addiction (CDTs), which people are required to attend within 72 hours of being apprehended. The CDTs each comprise a treatment professional, social worker and lawyer and are supported by a range of agencies in areas such as treatment, health, employment, child protection, social services and schools.⁶⁶² In discussions with Dr Nuno Capaz, Vice President of the Lisbon CDT, he confirmed that CDTs are placed under the responsibility of the Ministry of Health rather than the Ministry of Justice, reflecting the public health approach that views people who use illicit drugs as patients rather than criminals.⁶⁶³

Upon referral to a CDT, an interview is conducted to determine the person's history of substance use with a view to establishing whether the person is an occasional or dependent user and any other issues such as: mental health concerns; motivations

⁶⁵⁸ Dr Christian Smyth, Special Adviser, Turning Point, *Transcript of evidence*, 8 May 2017, p. 24.

⁶⁵⁹ Hughes, C, 'Portuguese Drug Policy', in *European Drug Policies: The Ways of Reform*, R Colson and H Bergeron (eds), Routledge, New York, 2017.

⁶⁶⁰ Hughes, C and Steven, A, 'What we can learn from the Portuguese Decriminalization of Illicit Drugs?', *The British Journal of Criminology*, vol. 50, no. 6, 2010, p. 1002.

⁶⁶¹ Hughes, C, 'Portuguese Drug Policy', in *European Drug Policies: The Ways of Reform*, R Colson and H Bergeron (eds), Routledge, New York, 2017, pp. 168-169.

⁶⁶² Hughes, C, 'Portuguese Drug Policy', in *European Drug Policies: The Ways of Reform*, R Colson and H Bergeron (eds), Routledge, New York, 2017, p. 168.

⁶⁶³ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 16.

to attend treatment; and referrals required for other social issues such as school, employment or housing.⁶⁶⁴ The CDT then provides an appropriate ruling or penalty based on these circumstances, which can include:

- provisional suspension of the process for those not requiring intervention (i.e.- they are not dependent users), or for dependent users that agree to seek treatment
- a warning
- banning the offender from certain areas or associating with particular people
- requiring the offender to regularly visit particular places such as treatment services
- removal of professional licenses or firearm licenses
- issuing a fine, however, this option is rarely applied for people who have dependence issues as the intention is to refer this user group into treatment.⁶⁶⁵

To determine the appropriate penalty, the CDT takes into account factors relating to the person's circumstances and nature of the incident including: the seriousness of the act, the type of substance used, the public or private nature of consumption, the nature of the person's substance use and their personal financial circumstances.⁶⁶⁶

A 2013 report from Portuguese authorities to the EMCDDA outlined data regarding the operation of the CDTs that reflected trends over a number of years. In 2013, the CDTs processed 7,528 cases. Suspension of sanctions was the main course of action taken - 70 per cent of cases resulted in a suspension where the person was not considered drug dependent, and 12 per cent of cases resulted in a suspension for people dependent on drugs that agreed to undertake treatment. Twelve per cent of decisions resulted in a punitive sanction, of which the majority were non-financial penalties. Most cases before the CDT involved just one drug (95 per cent), mainly cannabis (82 per cent in 2013), and heroin only accounted for six per cent. The CDTs found the person innocent in five per cent of cases.⁶⁶⁷

Dr Nuno Capaz advised the Committee that, for most first time clients, the outcome is typically a suspension where the case is put on hold for three months. There are low rates of recidivism, particularly among this group. For people who are dependent on drugs, the CDT outcome typically involves a referral to some type of treatment, although this is usually on a voluntary basis. In 85 to 90 per cent of cases, these are deemed positive referrals. Clients may also be required to regularly visit their family doctor, who over a period of time after building up trust with the client, could be in a position to undertake some form of intervention with them. In these circumstances, the case is suspended for nine months and the CDT follows up with the treatment service every three months regarding the client's progress. If the client has not been attending treatment, they are brought back before the CDT for a sanction. The

⁶⁶⁴ Hughes, C, 'Portuguese Drug Policy', in *European Drug Policies: The Ways of Reform*, R Colson and H Bergeron (eds), Routledge, New York, 2017, p. 168.

⁶⁶⁵ General-Directorate for Intervention on Addictive Behaviours and Dependencies, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, Ministry of Health - Portugal / SICAD, Lisbon, 2000.

⁶⁶⁶ General-Directorate for Intervention on Addictive Behaviours and Dependencies, *Decriminalisation: Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances*, Ministry of Health - Portugal / SICAD, Lisbon, 2000.

⁶⁶⁷ Reitox National Focal Point, *2014 National Report (2013 data) To The EMCDDA: "Portugal": New Developments, Trends*, European Monitoring Centre for Drugs and Drug Addiction and SICAD, Lisbon, 2014, pp. 105-106.

sanctions applied are appropriate to the client's circumstances. If a client continues to not comply with the CDT decision, they can receive an order of disobedience, which is dealt with through the courts.⁶⁶⁸

The Committee also learnt while visiting Portugal, that the social integrated model allowed Portugal to build a network of treatment and other social services, which have high utilisation rates. From 2001 to 2015, of the 98,697 clients referred to the CDTs, 50,438 were identified as non-problematic drug users and 11,877 were identified as problematic drug users. Of the non-problematic drug users, 13,343 received specialised support in other areas, such as welfare, employment and training services, education and health. Of the 11,877 problematic drug users, 9,373 received support from treatment teams and/or centres of integrated responses.⁶⁶⁹

7.6.2 The impact on illicit drug use and drug-related harms

Throughout the inquiry, a consistently voiced concern from the Committee was the likely unintended consequences arising from drug law reform. In particular, concerns were raised about whether the absence of criminal sanctions would lead to more drug use among the general community, or be seen to condone drug use. The Committee was also interested to investigate whether removing criminal penalties in practice would have a meaningful impact on reducing drug-related harms such health burdens, economic costs and social costs. This section explores these matters further.

Illicit drug use

A key concern within the broader community often expressed about removing criminal penalties in this area is that it may encourage drug use in the community by promoting an acceptance of such use. However, the Committee received evidence from submissions, public hearings, its overseas study tour and the broader literature which indicated otherwise.

In the context of Portugal, the Committee heard contested claims about the rates of illicit drug use following its reforms. Gary Christian, Research Director of Drug Free Australia (DFA), advised the Committee that drug use rose by nine per cent between 2001, when the reform was introduced, and 2007. He also noted that, while drug use decreased between 2007 and 2012 to levels lower than before 2001, 'these decreases were entirely in line with the decreases that they had across most of Europe'. He also indicated that use among high school students rose between 2001 and 2011 by 36 per cent.⁶⁷⁰

Dr Caitlin Hughes from NDARC and Professor Alex Stevens from the University of Kent have undertaken significant research on the Portuguese model. In their article, *A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs*, they confirmed clear increases in the rates of *lifetime* use between 2001 and 2007 for most age groups and types of illicit substances. However, they suggested that this indicator is not as meaningful as indicators of *recent* and *current* rates to determine the impact of the policy. Using these measures, Hughes and Stevens found there were 'minimal if any

⁶⁶⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 17.

⁶⁶⁹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 14-15.

⁶⁷⁰ Gary Christian, Research Director, Drug Free Australia, *Transcript of evidence*, 21 August 2017, p. 282.

changes' during this time period, and that while there were increases among some groups such as those aged 25 to 34, there were decreases in the pivotal age category of 15 to 24 – the group most at risk of starting and continuing drug use. Overall, they concluded that this 'gives grounds for arguing that while there was some growth in the scale of drug use in post-reform Portugal, there was an overall positive net benefit for the Portuguese community'.⁶⁷¹ Dr Caitlin Hughes, in reiterating these findings to the Committee, discussed that such rates have 'either been stable or actually decreased, particularly amongst the youth population'.⁶⁷²

In terms of cannabis use among high school students, another important indicator of the impact on young people, Hughes and Stevens in a 2016 paper acknowledged there were some increases, but these were small and not necessarily attributable to the reforms, as similar trends were observed elsewhere in Europe.⁶⁷³

Such findings have been supported widely, including a 2014 study commissioned by the United Kingdom Home Office, *Drugs: international comparators*, which stated:

Although levels of drug use rose between 2001 and 2007, use of most drugs has since fallen to below-2001 levels. It is clear that there has not been a lasting and significant increase in drug use in Portugal since 2001.⁶⁷⁴

The EMCDDA's 2017 monitoring report for Portugal discussed that it has a low rate of substance use compared to other European countries, including among students, and that substance use 'seems to have been on the decline over the past decade'.⁶⁷⁵

Given that Portugal experienced various public health challenges arising from problematic drug use rather than just general drug use, it is important to consider the evidence regarding this specific issue. Hughes and Stevens reported that the prevalence of problematic drug use declined following the reform and continues to do so.⁶⁷⁶

More broadly than Portugal, a range of international evidence demonstrates that similar reforms implemented elsewhere have not lead to increased drug use. Dr Caitlin Hughes from NDARC told the Committee:

...it is one of the most commonly raised fears, that if you decriminalise use and possession of one drug or multiple drugs, you will have increased drug use. What we are able to say is that there is an ample research body showing that this is not actually the case in practice. So drug use rates do not dramatically differ in nations that have decriminalised use versus those that have retained a criminalised response.⁶⁷⁷

⁶⁷¹ Hughes, C and Steven, A, 'A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs', *Drug and Alcohol Review*, vol. 31, no. 1, 2012, p. 105.

⁶⁷² Caitlin Hughes, Senior Research Fellow, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 249.

⁶⁷³ Stevens, A and Hughes, C, 'Decriminalisation and public health: the Portuguese approach to drug policy', *Mouvements (Paris) (pre proof, pre translation)*, no. 86, 2016, p. 4.

⁶⁷⁴ Home Office and The Rt Hon. N Baker, *Drugs: International Comparators*, UK Government, London, 2014, p. 47.

⁶⁷⁵ European Monitoring Centre for Drugs and Drug Addiction and Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD), *Portugal: Country Drug Report 2017*, Publications Office of the European Union, Lisbon, 2017, p. 5.

⁶⁷⁶ Stevens, A and Hughes, C, 'Decriminalisation and public health: the Portuguese approach to drug policy', *Mouvements (Paris) (pre proof, pre translation)*, no. 86, 2016, p. 5.

⁶⁷⁷ Caitlin Hughes, Senior Research Fellow, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 248.

The 2016 report by Transform, *Will drug use rise? Exploring a key concern about decriminalising or regulating drugs*, suggested that this policy would have ‘only a marginal impact on levels of drug use’ at most.⁶⁷⁸ The report outlined that levels of drug use are influenced by factors more complicated than simple legal changes:

Changes in the consumption of a given drug are influenced by far more than just legal status and enforcement practices. Drug use is more likely to rise and fall in line with broader cultural, social or economic trends; the number of users arrested or trafficking organisations destroyed, and the severity and certainty of punishment, seemingly make little difference.⁶⁷⁹

Transform also suggested that because drug use is influenced by these various factors, and criminal sanctions are not an effective measure to deter drug use, removing such sanctions should be pursued by governments. It considered that criminal sanctions represent ‘the most serious action that a state can take against its citizens’ and removing these would be more humane, cost-effective and result in improved health outcomes such as better access to HIV services.⁶⁸⁰

Similarly, another 2017 report by the EMCDDA on cannabis legislation in Europe considered whether changes in drug laws affected cannabis use rates among young adults aged 15 to 34 in selected countries. It found that ‘no simple association can be found between legal changes and the prevalence of cannabis use’.⁶⁸¹

Drug-related health harms

A significant amount of evidence from Portugal supports the argument that removing criminal penalties in this area contributes to a reduction in a range of drug-related health harms, particularly when accompanied with health and harm reduction service investments. In Portugal, noting the severe public health crisis it faced, Hughes and Stevens found there were ‘significant reductions in mortality, HIV, HCV and TB’ following the reforms.⁶⁸² New cases of HIV among people who inject drugs declined from 800 cases in 2003 to less than 100 in 2012, and injection rates have also declined since 2001. However, it has also been found that ‘it is difficult to disentangle the impact of the actual decriminalisation from that of the large scale-up of health and social services’.⁶⁸³

Similarly, Transform noted in a 2014 report that, despite contestation between groups about the success or otherwise of the Portuguese model, improvements cannot be attributed solely to the policy but to the broader health approach:

The reality is that Portugal’s drug situation has improved significantly in several key areas. Most notably, HIV infections and drug-related deaths have decreased, while the dramatic rise in use feared by some has failed to materialise. However, such improvements are not solely the result of the decriminalisation policy; Portugal’s

⁶⁷⁸ Murkin, G, *Will drug use rise? Exploring a key concern about decriminalising or regulating drugs*, Transform Drug Policy Foundation, London, 2016, p. 5.

⁶⁷⁹ Murkin, G, *Will drug use rise? Exploring a key concern about decriminalising or regulating drugs*, Transform Drug Policy Foundation, London, 2016, p. 29.

⁶⁸⁰ Murkin, G, *Will drug use rise? Exploring a key concern about decriminalising or regulating drugs*, Transform Drug Policy Foundation, London, 2016, p. 29.

⁶⁸¹ European Monitoring Centre for Drugs and Drug Addiction, *Cannabis legislation in Europe: an overview*, Publications Office of the European Union, Luxembourg, 2017, pp. 22-23.

⁶⁸² Stevens, A and Hughes, C, ‘Decriminalisation and public health: the Portuguese approach to drug policy’, *Mouvements (Paris) (pre proof, pre translation)*, no. 86, 2016, p. 5.

⁶⁸³ Csete, J, et al., ‘Public health and international drug policy’, *The Lancet Commissions*, vol. 387, no. 10026, 2016, p. 1463.

shift towards a more health-centred approach to drugs, as well as wider health and social policy changes, are equally, if not more, responsible for the positive changes observed.⁶⁸⁴

This was echoed by a range of inquiry stakeholders who noted the importance of the increased investment that accompanied the reforms – without it, reductions in health harms were unlikely to be so dramatic or sustained. For example, Dr Alex Wodak AM, President of the Australian Drug Law Reform Foundation (ADLRF) and Director of Australia21 told the Committee:

...can I point out that people talk a lot in Portugal about the changes that were made in reducing penalties and eliminating some penalties. What's not talked about quite so much, but is very important in Portugal, is that it made great efforts to expand and improve its drug treatment systems...People can have better access to vastly improved drug treatment systems so we need to do both.⁶⁸⁵

Similarly, cohealth's submission stated that:

Results of the Portuguese experience over the subsequent fifteen years demonstrate that drug decriminalisation – accompanied, critically, by the reinvestment of justice money into a significant expansion of treatment and harm reduction services – can significantly improve public safety and health.⁶⁸⁶

More broadly, a report published in 2016, *Public health and international drug policy*, considered that these reforms as implemented in various jurisdictions has also shown largely positive outcomes:

The long experiences in Portugal, the Czech Republic, and other countries with decriminalisation of minor drug offences demonstrate the benefits of treating minor infractions without recourse to criminal sanctions. These benefits include offerings of health and social support to people who might need them, reduction of incarceration of men, women, and young people and all the associated harms, and elimination of the wastefulness of the police's pursuit of minor offenders. Decriminalisation of minor offences also makes harder the use of drug laws as a weapon against racial or ethnic minorities or politically unfavoured groups. Decriminalisation should always be accompanied by measures to ensure the capacity of health and social services to address drug-related harms or problematic drug use as needed.⁶⁸⁷

One of the main factors for inquiry stakeholders' support for removing criminal penalties was that such a policy would help to address the prevalence of drug-related negativity and judgement among the broader community. Dr João Goulão of Portugal's SICAD, was quoted in a 2011 interview with the *British Medical Journal* as stating:

"It's very difficult to identify a causal link between decriminalisation by itself and the positive tendencies we've seen," he said. "It's a total package. The biggest effect has been to allow the stigma of drug addiction to fall, to let people speak clearly and to pursue professional help without fear."⁶⁸⁸

⁶⁸⁴ Murkin, G, *Drug Decriminalisation in Portugal: setting the record straight*, Transform Drug Policy Foundation, Bristol, 2014, p. 1.

⁶⁸⁵ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 88.

⁶⁸⁶ cohealth, *Submission*, no. 140, 16 March 2017.

⁶⁸⁷ Csete, J, et al., 'Public health and international drug policy', *The Lancet Commissions*, vol. 387, no. 10026, 2016, pp. 1468-1469.

⁶⁸⁸ Hawkes, N, 'Highs and lows of drug decriminalisation', *BMJ*, no. 343, 2011, viewed 19 January 2018, <<http://www.bmj.com/content/343/bmj.d6881>>.

This outcome from Portugal was consistent with evidence from inquiry stakeholders regarding their support for removing such criminal penalties. For example, Trevor King from UnitingCare Regen stated:

Most importantly we believe it would reduce stigmatisation, which currently prevents people and their families from seeking help. There would be a much greater opportunity to access harm reduction services to keep drug users alive and disease-free, particularly given that we do know that for many people there is a drug-using career and people can come out successfully at the other end. We want them to be as healthy as possible. We want to ensure that they have not got criminal charges if they can be avoided, because these are things that can certainly impact on the remainder of their lives.⁶⁸⁹

Specifically in terms of drug-related deaths, Hughes and Stevens found that despite some questions around the data, there were also decreases in this area. They indicated that such positive health outcomes are the result of expanded access to services, but also highlighted the role of decriminalisation in achieving this as ‘a key goal of the reform had been to reduce social stigma and thereby facilitate access to Portuguese drug treatment and harm reduction services’.⁶⁹⁰ This expanded access to treatment was a key factor in declines observed in drug-related deaths.

Criminal justice system

A key factor highlighted by local and international bodies regarding support for removing criminal penalties in this area is that it significantly reduces the burden on the criminal justice system. In 2016, Release reported that in Portugal there was a reduction in the number of drug offences from approximately 14,000 per year in 2000 to approximately 5,000 offences per year following the reform. It highlighted that:

This has led to a significant reduction in the proportion of individuals with drug-related offences in Portuguese prisons – in 1999, 44 per cent of prisoners were incarcerated for drug-related offences and by 2013, that figure had reduced to 24 per cent, resulting in a major reduction in prison overcrowding in Portuguese penitentiaries.⁶⁹¹

Portugal also experienced improvements in the capacity of law enforcement to focus on drug-relating offending such as trafficking, and relations with communities. The Release report stated:

Since decriminalisation, Portuguese law-enforcement statistics have also revealed an increase in operational capacity, resulting in more domestic drug trafficking seizures and an increase in international anti-trafficking collaborations that have provided for greater targeting of drug traffickers by sea. At a local level police officers who were initially resistant of the law reform now view decriminalisation as a positive change. Initially officers were worried that they would lose the ability to elicit information from those arrested for possession about other players in the trade, though this has not been the case with people more likely to cooperate with the police due to less fear of prosecution. Some police officers have even reported improved community relations as a result of the reforms.⁶⁹²

⁶⁸⁹ Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, pp. 270-271.

⁶⁹⁰ Hughes, C and Steven, A, ‘A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs’, *Drug and Alcohol Review*, vol. 31, no. 1, 2012, p. 108.

⁶⁹¹ Eastwood, N, et al., *A quiet revolution: drug decriminalisation across the globe*, Release, March 2016, p. 30.

⁶⁹² Eastwood, N, et al., *A quiet revolution: drug decriminalisation across the globe*, Release, March 2016, p. 30.

Regarding police operations, Hughes and Stevens found that, between 1997 and 2008 there was little change in the number of illicit drug seizures conducted, but there was an increase in the quantity of drugs seized. As these increases were not 'linear or constant', Hughes and Stevens suggested that there was 'increased law enforcement intervention as opposed to domestic growth in the market'.⁶⁹³

Further, Dr Nuno Capaz from the Lisbon CDT told the Committee that while people who use drugs are no longer a key interest group for police, police now apprehend more people and refer them to the CDT process. Before the reforms, police would apprehend the person, throw the substance away and let the person go.⁶⁹⁴ The Committee also met with José Carlos Bastos Leitão, Superintendent and Director of Criminal Investigation Department of the Public Security Police (PSP), the civil preventive police force in Portugal. The PSP confirmed that the previous practice of letting people go with a warning is less common now, and most people apprehended for personal use and possession are referred to a CDT. The PSP indicated that there is less paperwork required now, and they also work closely with health and social agencies. This includes participating in formal monthly meetings with the health department and engaging informally with various on-the-ground workers and agencies to prevent illicit drug use within particular communities and among young people identified as at-risk.⁶⁹⁵ This reaffirms the CDT process as a form of early intervention, with the potential to prevent substance use from becoming problematic, in addition to law enforcement's role in facilitating that early intervention.

In regard to addressing the supply and trafficking of illicit substances, the Committee is aware of the limitations of removing criminal penalties in this area. It does not impact or remove the illicit market for drugs, as the supply of drugs continues to be subject to criminal offences and penalties under this model. In this context, Dr Gruenert from OHV advised the Committee that such a reform would not remove 'the resources that are going into that criminal world and all the violence and crime that is associated with that'.⁶⁹⁶ This view was also shared by the Penington Institute and Gulliver McLean, a Member of SSDP Australia, who told the Committee that it would equally not address global and local drug supply chains.⁶⁹⁷

Jonathan Caulkins and Michael Lee, two prominent drug policy researchers from the Carnegie Mellon University's Heinz College, also described the pitfalls of removing criminal penalties in this regard. They stated that it is often seen as a 'middle path' for reform between prohibition and legalisation:

...decriminalization — meaning eliminating criminal penalties for users but not suppliers — combines aspects of the worst of both worlds. While holding obvious appeal to current users, the crime, violence, and high-level corruption that exist under today's prohibition regime could continue, and potentially be exacerbated by somewhat increased use and dependence. (Decriminalization's effects on use would be relatively modest precisely because it keeps production illegal, and so avoids the price collapse that would accompany full legalization.)⁶⁹⁸

⁶⁹³ Hughes, C and Steven, A, 'What we can learn from the Portuguese Decriminalization of Illicit Drugs?', *The British Journal of Criminology*, vol. 50, no. 6, 2010, p. 1011.

⁶⁹⁴ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 17.

⁶⁹⁵ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 23.

⁶⁹⁶ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 161.

⁶⁹⁷ Gulliver McLean, Member, University of Melbourne, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 311.

⁶⁹⁸ Caulkins, J and Lee, M, 'The Drug-Policy Roulette', *National Affairs*, no. 34, 2012, viewed 11 September 2017, <<https://www.nationalaffairs.com/publications/detail/the-drug-policy-roulette>>.

These issues, namely the supply of illicit drugs and particular options relating to the legalisation of cannabis, are discussed in more detail in chapter nine of this report.

Cost effectiveness

Portugal's implementation of its reforms over an extended period of time has provided recent opportunity to consider the long-term cost effectiveness of the reforms. A 2015 study analysed the social costs of the model, and demonstrated an average cost reduction of 12 per cent in the five years following the reform (2000 to 2004), particularly due to significant reductions in drug-related deaths. It also found an average reduction of 18 per cent in social costs in a ten-year timeframe (2000-2010), arising from reduced health costs, legal system costs and costs associated with lost income and lost productivity for those imprisoned.⁶⁹⁹

In its submission, the Burnet Institute highlighted that the Portuguese model 'allows for a reinvestment in demand reduction, drug treatment and rehabilitation', leading to reduced costs at both individual and societal levels. It proposed that exploring such options 'should be a priority for drug law reform in Victoria'.⁷⁰⁰

Some inquiry stakeholders considered that, if implemented in Victoria, this reform would have a positive impact on redressing the current imbalance of drug policy funding that heavily favours supply reduction efforts to the detriment of demand reduction and harm reduction. For example, Dr Gruenert from OHV advised the Committee that it may assist with a 'change of emphasis' in resource allocation:

But a change of emphasis from, I guess, some broader law reform policies that really divert the resources away from the supply reduction side will be that there are more resources available for treatment, and I think that has been the real change in places like Portugal. It is not simply having people whose drug use has been caught diverted out of the criminal justice system. It is really diverting the resources. Over many years we have put more and more into policing. Where treatment is made available, when someone needs it, when they are motivated, it is accessible, and that has really been the impact. That demand reduction is the way we are going to prevent all these other crimes associated with drug use occurring.⁷⁰¹

Overall evidence on the removal of criminal penalties in this area

It should be noted that, while the overwhelming evidence demonstrated the effectiveness of the model as implemented in Portugal and more generally, the Committee received some contrasting views, which were generally opposed to reform in this area. Drug Free Australia suggested in its submission that current diversion programs are adequate and should not be extended:

[T]he push to decriminalize more drugs is a trajectory that is highly dangerous and can only increase use. We already have in place, a drug diversion program which enables young drug taking offenders to by-pass the criminal justice system and attempts to change their patterns of behaviour through counselling and rehabilitation. This surely is not only fair, but sufficient. However expanding the concept to take the law enforcement intervention completely out of drug use would open a 'Pandora's box' and create far greater harm to our emerging generations.⁷⁰²

⁶⁹⁹ Goncalves, R, et al., 'A social cost perspective in the wake of the Portuguese strategy for the fight against drugs', *International Journal of Drug Policy*, vol. 26, no. 2, 2015.

⁷⁰⁰ Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 5.

⁷⁰¹ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 163.

⁷⁰² Drug Free Australia, *Submission*, no. 132, 16 March 2017, p. 1.

In response to a question about whether Victoria Police supports decriminalisation, Deputy Commissioner Wendy Steendam advised that ‘we support the current position and legislative environment in terms of use, possession and trafficking’.⁷⁰³ Interestingly, however, Commander Bruce Hill of the AFP discussed that Portugal ‘has been very successful on what they have said to date’, and also commented on the idea of the ‘war on drugs’:

When you go back to the original adage of calling it the war on drugs, my view is the war on drugs is those three pillars working together to try and stop people from taking drugs and wanting to take drugs, because that is the end result. Removing the demand will remove all the problems for everybody, but that is an extremely difficult, complicated problem. In a perfect world you could do that, but we are not in a perfect world.⁷⁰⁴

Aside from these views, the Committee generally notes the broad range of evidence demonstrating that negative impacts, such as increased drug use, has not eventuated in countries that have undertaken this reform, and that many positive outcomes have ensued. As suggested by NDARC in its submission:

...decriminalisation of use and possession is one of the most proven methods of drug law reform (Babor et al., 2010; Csete et al., 2016; Room & Reuter, 2012). In short, the research evidence indicates that decriminalisation of drug use:

- Reduces the demands on the criminal justice system: including police, courts and prison
- Reduces social costs to individuals, including improving employment prospects and relationships with significant others
- Reduces stigma and decriminalisation of people who use drugs
- Does not increase drug use
- Does not increase other crime.⁷⁰⁵

7.7 A related issue – legislated thresholds for drugs of dependence

A related issue raised by some stakeholders is the potential arbitrariness of the current legislative thresholds for quantities of drugs that determine possession as personal or for trafficking. As described earlier in this chapter, Victoria employs thresholds to determine whether people apprehended with illicit drugs possessed them for trafficking purposes or for personal possession. The categories for each drug listed in the DPCSA are small, trafficable, commercial and large commercial quantities. Over the trafficking threshold amounts, possession is ‘deemed supply.’ The National Drug and Alcohol Research Centre conducted research into the appropriateness of threshold levels across Australia, and found that people who use drugs may be unintentionally captured under the trafficker thresholds. In her evidence to the Committee, Dr Caitlin Hughes summarised the research:

⁷⁰³ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 455.

⁷⁰⁴ Commander Bruce Hill, Manager, Organised Crime, Australian Federal Police, *Transcript of evidence*, 13 November 2017, p. 445.

⁷⁰⁵ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 6.

Our basic premise has been to see to what extent Australian deemed supply laws are fit for purpose. These laws were introduced many years ago, back in the 1970s, under the premise that it is very hard to catch a trafficker in the act and so thresholds were set over which carrying a particular amount of drugs became grounds for charging someone with trafficking.

Some research that we did now a few years back that was funded by the Australian Institute of Criminology enabled us to take the threshold limits that had been established in Victoria and other states and territories and see to what extent these threshold limits actually take into account the practices of users. What we found is that often people who use drugs will carry or purchase or consume in a single session a quantity that exceed the existing threshold limits. By definition, these people are committing an offence that could make them liable to be charged as a drug trafficker when their intent is purely to use the drugs for their own personal use.⁷⁰⁶

The National Drug and Alcohol Research Centre referred to the specific example of methylenedioxymethamphetamine (MDMA). Research has shown that in Victoria, people that regularly use MDMA can consume up to 5.8 grams in a single drug-taking session, with reasons including drug-taking over several days and stockpiling. However, the trafficable quantity for MDMA set by the legislation is three grams. The National Drug and Alcohol Research Centre suggested that:

Poorly devised drug trafficking threshold laws have numerous adverse impacts:

1. They place drug users at risk of being sanctioned as a drug trafficker
2. They conflict with harm minimisation principles
3. They waste scarce criminal justice resources
4. They damage the perceived legitimacy of Australian drug laws.⁷⁰⁷

In calling for the repeal of 'deemed supply' laws in Victoria, Liberty Victoria also pointed to the NDARC research. It noted that 'deemed supply' laws are arbitrary and suggested that the risks involved with inaccurate trafficking thresholds were significant because (quoting the NDARC research):

- (1) The most marginalised drug users are the most likely to be caught around the margins of drug trafficking thresholds; and
- (2) An 'unjustified conviction for dealing will often impose social and individual harms which far exceed the harm associated with the drug in question'.⁷⁰⁸

In separate but related developments, the Victorian Government recently implemented reforms to decrease thresholds for large commercial quantities and commercial quantities for trafficking in methylamphetamine.⁷⁰⁹ UnitingCare ReGen noted these developments while also commenting on research regarding threshold quantities:

Hughes et al (2014) have identified inconsistencies (and arbitrariness) across Australian states and territories in the definition of what constitutes a trafficable quantity of individual drug types. By way of example, the Victorian Government recently announced that it was halving the quantity of methamphetamine that would trigger higher level penalties (Gordon, 2017).⁷¹⁰

⁷⁰⁶ Caitlin Hughes, Senior Research Fellow, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 249.

⁷⁰⁷ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 9.

⁷⁰⁸ Liberty Victoria, *Submission*, no. 205, 21 March 2017, p. 17.

⁷⁰⁹ Explanatory Memorandum, *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Bill 2017 (Vic)*.

⁷¹⁰ UnitingCare ReGen, *Submission*, no. 168, 17 March 2017, p. 3.

As part of the *Drug Rehabilitation Plan* released in October 2017, the Victorian Government announced its intention to introduce similar reforms to reduce commercial trafficking thresholds for heroin.⁷¹¹

To ensure that specified threshold quantities are fit for purpose, NDARC recommended that a comprehensive review be undertaken in Victoria to ensure people who use drugs are not inappropriately captured by thresholds. As explained by Dr Caitlin Hughes from NDARC:

What we have been suggesting is that the threshold limits should be revised to take into account the best practice knowledge about user practices so that the threshold limits do actually reflect what we know about drug traffickers and can actually be used to target drug trafficking rather than people who are using drugs for their personal use alone.⁷¹²

The National Drug and Alcohol Research Centre further explained in its submission that the ACT Government recently undertook such a process, resulting in changes to their legislative thresholds:

In 2014 the ACT became the first jurisdiction to update their drug law thresholds in line with the latest evidence on quantities of drugs consumed and purchased (Hughes, 2016). Specifically, they increased the threshold limits for MDMA and cocaine and reduced the legal threshold limits for methamphetamine and heroin: in line with the evidence of Hughes and Ritter (2011). As argued by the ACT Attorney General at the time, “these new amounts will ensure that serious drug offences target drug traffickers rather than drug users, consistent with a harm minimisation approach to drug policy.” It would be prudent for Victoria to similarly revise their thresholds particularly to increase the threshold limits for MDMA/ecstasy. This would ensure the laws are fit for purpose: and can target drug traffickers - not people who use drugs.⁷¹³

In its joint submission, the ACT JACS and ACT Health advised that in 2011, the State Government commissioned NDARC to determine the amounts ‘that would clearly and fairly distinguish’ between people who use drugs and those intending to sell drugs. It outlined that:

The research took into account a range of factors including the relative harms that different drugs are likely to cause, local research into the quantities of drugs ACT users were likely to use and purchase and legislation in other jurisdictions. The review process concluded that existing trafficable quantities for ecstasy and cocaine were disproportionately low, but trafficable quantities for heroin and methamphetamine were disproportionately high.

...

In 2014, the ACT Government accepted the recommendations of the review and amended the trafficable quantities in legislation. The changes reduce the risk of people who possess drugs for their own use and who are not engaged in the selling of those drugs for profit, being inadvertently convicted of a serious drug trafficking offence due to the quantity of the drug they possess.⁷¹⁴

⁷¹¹ Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017, p. 18.

⁷¹² Caitlin Hughes, Senior Research Fellow, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 249.

⁷¹³ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 9.

⁷¹⁴ Justice and Community Safety Directorate (JACS) and ACT Health, *Submission*, no. 185, 17 March 2017.

The Committee considers that Victoria should undertake a similar review of legislative threshold limits for illicit drugs, as recently conducted in the ACT. This will ensure that there is accurate information about patterns of illicit drug use to discriminate drug traffickers from people who use drugs. This will also ensure law enforcement efforts can be directed towards disrupting trafficking behaviour.

7.8 Committee position

In considering reform options in this area, the Committee analysed the range of submissions from various stakeholders, noting that the majority expressed support for removing criminal penalties for personal use and possession offences. The Committee also examined the available research and evidence, particularly from Portugal, which demonstrated that removing criminal penalties is an effective measure to address the use of illicit substances as a public health issue, although like all reforms in drug policy, it is not a 'silver bullet'. The Committee was impressed with the reforms as implemented in Portugal, which had bipartisan support and was accompanied by substantial investments in health and treatment, leading to improved outcomes across a range of social and health measures. The Committee's discussions with Portuguese health and police authorities confirmed that removing criminal penalties can work effectively in practice.

The Committee also considered the question of whether reform in this area will cause unintended consequences, for example as considered in this chapter at length, increased drug use among the general population or young people. However, as noted by Dr Kate Seear, Senior Lecturer in Law at Monash University, the current situation is itself causing a number of harms, and this needs to be balanced against a potential change to policy:

...unintended consequences perhaps need to be balanced against existing consequences which are themselves unintended and often catastrophic. So I said at the outset that I think as a committee you have a very difficult task of deciding how to balance those various consequences, weigh them up and decide what reforms, if any, are needed.⁷¹⁵

In light of these issues, the Committee is supportive of Victoria treating the offences of use and possession of illicit drugs for personal use as a health issue, rather than a criminal justice one. The focus should be on ensuring timely referral of people apprehended for these offences to treatment and/or other social services as required by their personal circumstances. Importantly, such a policy would not apply to any offences outside of illicit drug use and possession for personal use, meaning that offenders would still face the criminal justice system and relevant criminal penalties for any other crimes they commit (for example, theft to support their dependency or trafficking behaviour). The Committee believes that treating use and possession for personal use offences as a health issue is consistent with the health framework proposed in recommendation one, as it punishes criminal behaviour, while treating the drug use.

The Committee considers that one mechanism to achieve this could be the establishment of tribunals or panels similar to the CDTs in Portugal to manage each case and determine the referrals of people to treatment and health services. As highlighted by the former President of the INCB, Werner Sipp, the unique feature of the Portuguese model is 'the creation of a specific institution outside the criminal

⁷¹⁵ Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, p. 175.

justice system' to deal with people who use drugs.⁷¹⁶ Such a model would initially divert those apprehended for personal use and possession offences from the courts, which would provide significant savings of money, resources and time for the court system. It would also ensure consistency in how these offences are dealt with across Victoria, and that referrals are made to health and treatment services quickly and effectively where required. In instances where people do not comply with a directive from the tribunal, there could be options to have them redirected back to the criminal justice system. An example of what this model could look like in practice is outlined below:

Figure 7.1 Example of diversion model



An issue to be monitored in the design and implementation of this would be the avoidance of any 'net widening effect'. As noted by NDARC, this has been the only negative impact in other jurisdictions such as SA.⁷¹⁷ Further, the Committee is of the view that it is important to ensure the prioritisation of treatment and health as the goal, rather than the enforcement of fines. To avoid this concern, the Committee notes that, in relation to the Portuguese model, fines are rarely imposed and the priority is to encourage people to enter treatment. Further, in Portugal, the majority of cases coming before the CDTs are resolved quickly and without extensive impost on resources.

Another possible mechanism to achieve a health approach in this area would be to formalise and extend the current Victoria Police drug diversionary mechanisms by codifying and removing the discretionary elements currently in place. The Committee notes that, while police diversionary policies have been effective in diverting people away from the criminal justice system and into treatment, gaps remain with this policy. In particular, its discretionary operation means a number of people are still

⁷¹⁶ United Nations International Narcotics Control Board, 'Statement of the President of the International Narcotics Control Board (INCB), Mr. Werner Sipp', Paper presented at the *Reconvened fifty-eighth session of the CND; Special Event: A public health approach as a base for drugs policy: The Portuguese case*, United Nations International Narcotics Control Board, Vienna, 2015, p. 2.

⁷¹⁷ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 6.

not diverted from the criminal justice system. This is pronounced further by the fact that there are strict requirements for eligibility for diversion. The policy not being mandatory has also resulted in ‘postcode injustice’, where there is a lack of equitable access to diversion, and importantly treatment, across all parts of Victoria. Should these issues be addressed, this would be an important first step in establishing an effective and widespread health approach to the treatment of these offences.

The Committee acknowledges that substantial funding would be required to ensure the necessary AOD treatment, social services and other supporting infrastructures are in place to complement a health-centred approach. Importantly, the Committee believes that investment in these services will ensure the effectiveness of early intervention efforts that form part of this model, and in particular preventing young and/or recreational users from becoming dependent and using in more harmful ways. This objective is consistent with evidence from Commander Hill of the AFP about the essential need to reduce demand for illicit substances as a way to address the drug problem. This investment in funding is also consistent with the Committee’s recommendations to enhance the role of treatment and prevention interventions. As advised by John Ryan, CEO of the Penington Institute, such investment has been crucial to the success of the Portuguese model:

But the most important lesson, I think, from the Portuguese approach has been that they have significantly invested in therapeutic interventions for people who are detected as using drugs. So their therapeutic interventions include the traditional needle exchange-methadone pharmacotherapy services, but also an emphasis on wraparound services dealing with people’s employment, their housing and their psychosocial skills. That is actually a great lesson for us.⁷¹⁸

The Committee has considered whether this approach should apply to all illicit substances or only some, such as cannabis. It is of the view that it should apply to all illicit drugs. As stated by Dr Caitin Hughes from NDARC, particularly in relation to the Portuguese model:

...many people who use drugs are polydrug users, and if you have a response that only decriminalises, say, the use and possession of cannabis, then often you are excluding many of the more marginalised people who use drugs and continuing to criminalise those people and reduce their access to drug treatment and harm reduction services as well as employment services. The evidence base is increasingly strong that by providing a decriminalised response to the use and possession — just for personal use — of all illicit drugs, then you are really maximising the potential for a health and social response.⁷¹⁹

Contrary to concerns that these options would remove the role of law enforcement in addressing illicit drug use, effective policing will be crucial to its success. Police would be responsible for apprehending people, confiscating drugs and making referrals to ensure people are accessing treatment and health services where required. The Committee also considers that this will enable police to further enhance their focus on the supply of illicit drugs, including through targeting organised crime and disrupting supply chains.

The Committee considers that such steps will be a logical progression of the long-established approach in Australia that diverts people who use illicit drugs away from the criminal justice system, providing quicker assessments of individual circumstances and directing people into treatment where needed. It would also

⁷¹⁸ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 6.

⁷¹⁹ Caitlin Hughes, Senior Research Fellow, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 250.

formalise and extend policies already in place in Victoria, to ensure equity of access across the state to help as many Victorians as possible. The key objective is ensuring timely and appropriate referrals to health and treatment services, and greater investment in prevention, treatment and harm reduction areas of drug policy. The Committee strongly believes it will reduce many of the harms arising from illicit drug use and if implemented well, will make an important contribution to addressing some of the key drivers of drug use in the community.

Another key issue is ensuring that the public understands the need for this approach to be implemented widely across Victoria to reduce harms. In terms of current public opinion, *the National Drug Strategy Household Survey 2016* asked specific questions on the public's opinion of a range of policy options for tobacco, alcohol and illicit drugs. One of the questions related to actions taken against people found in possession of drugs, with results indicating that:

- for all drugs except cannabis, most support was for referral to treatment or an education program, while for cannabis the most popular action was a caution, warning or no action and this rose in 2016 (from 42% in 2013 to 47%)
- a higher proportion thought that possession of meth/amphetamine should result in a prison sentence (from 20% in 2013 to 24%)
- teenagers (aged 12–17) were generally more likely to support fines, community service or weekend detention and prison sentences than any other age group, and those aged 50 or older were more likely to support referral to treatment or an education program than other age groups (Table 9.31).⁷²⁰

Although most supported actions such as referrals to treatment or education, cautions, warnings or no actions, there are some key areas which would require broader community understanding and support. The Committee considers that one of the activities as part of a health-centred approach to these offences would be to undertake community education and awareness campaigns on the reasons for change and benefits.

RECOMMENDATION 13: The Victorian Government, while maintaining all current drug offences in law, treat the offences of personal use and possession for all illicit substances as a health issue rather than a criminal justice issue. This approach will ensure appropriate pathways are in place for the referral of people to health and treatment services in a timely manner where required. Mechanisms to achieve this should include:

- exploring alternative models for the treatment of these offences, such as the Portuguese model of reform
- removing the discretion involved with current Victoria Police drug diversion processes by codifying them
- reviewing all threshold amounts for drug quantities in order to appropriately distinguish between drug traffickers and people who possess illicit substances for personal use only
- conducting education and awareness programs to communicate with the public about the need to treat drug use as a health issue.

⁷²⁰ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 130.

8 Drug-related offending

While the previous chapter dealt solely with the law enforcement of use and personal possession offences in Victoria, it is equally important to consider how offending behaviour is dealt with where drug use is an underlying cause for other criminal activities. In some circumstances, this can result in a person's imprisonment, and while this would be entirely appropriate in many cases, there appears to be a disproportionate number of people who use drugs that are imprisoned, resulting in a range of individual, social and economic costs. As explained by the Burnet Institute:

The cost of imprisonment in Australia is \$100,000 per inmate per year (Glass, 2014), a figure that does not include indirect costs to social and health systems or families (Baldry, Dowse, McCausland, & Clarence, 2012). People who use drugs are grossly over-represented in Australian prisons and therefore make a disproportionate contribution to imprisonment costs. For example, people with a history of injecting drug use constitute up to 58% of the prisoner population (Reekie et al., 2014) and have extremely high reincarceration rates (the 10-year reincarceration rate among people who inject drugs (PWID) is 90% (Larney, Toson, Burns, & Dolan, 2012), compared with 40% for all Australian prisoners (Zhang & Webster, 2010)).⁷²¹

In this context, this chapter considers current approaches employed to reduce the rates of imprisonment among people who use drugs, most of whom are likely to have a substance use disorder, as well as options for reform in this area.

8.1 Court diversion programs

The previous chapter dealt with the use of diversionary practices by police in the context of personal use and possession charges. Diversion from the justice system can also occur once a charge is laid through the use of court diversion. These programs aim to address underlying substance use issues that often accompany other offences and do not typically deal with personal use and possession charges:

Court diversion occurs after a charge is laid. It usually applies for offences where criminal behaviour was related to drug use (for example, burglary or public order offence). Bail-based programs generally involve assessment and treatment, while pre- and post-sentence programs (including drug courts) tend to involve intensive treatment, and are aimed at repeat offenders.⁷²²

⁷²¹ Burnet Institute, *Submission*, no. 165, 17 March 2017, pp. 5-6.

⁷²² Australian Institute of Health and Welfare, *Bulletin 125: Alcohol and other drug treatment and diversion from the Australian criminal justice system*, Canberra, 2014, p. 4.

8.1.1 Current court support and diversion programs

The Magistrates' Court of Victoria, which sits at 51 metropolitan and regional locations throughout Victoria,⁷²³ currently operates a range of programs to address underlying causes of offending behaviour:

The Court provides a variety of services and programs that aim to assist accused with issues like substance abuse and mental illness and provide support for the magistrates dealing with such persons.

Accused are referred to and engage with various treatment and support services and programs within the community whilst being monitored by the Court. In many cases, the support services and programs offered by the Court can also provide assistance in the higher courts such as the County Court and the Court of Appeal. Such programs act to reinforce the link between the Court and the community and its service systems.⁷²⁴

Following are descriptions of key programs that specifically target illicit drug use as a cause, including the Court Integrated Services Program, the CREDIT/Bail Support Program, and the Criminal Justice Diversion Program.

Court Integrated Services Program

The Court Integrated Services Program (CISP) commenced in November 2006 and is a case management program that provides access to services to reduce reoffending rates and promote safety. It involves providing short-term assistance over four months before sentencing, such as case management, priority treatment access and community support. Three levels of support are offered, differing in intensity based on the needs of each participant. The CISP operates at the Latrobe Valley, Melbourne, Mildura and Sunshine Magistrates' Courts.

Various stakeholders can refer an accused person for consideration for the CISP such as police, lawyers, magistrates, court staff, support services, family, friends and the person themselves. In terms of eligibility, the participant must be on summons, bail or remand pending a bail hearing, and must consent to participate in the program. A key consideration is whether the person has a substance use disorder that contributed to their offending, and whether they are at risk of reoffending. There are no specific restrictions on the types of offences committed, and the person is not required to plead guilty to the offence to be eligible to participate.⁷²⁵

Connected to the CISP is a Koori Liaison Officer Program to work with Koori persons to maximise their chances of rehabilitation. There is also a CISP Remand Outreach Pilot, which works with prisoners on remand who have a realistic prospect of being granted bail provided the appropriate supports are in place.⁷²⁶

According to the Magistrates' Court's Annual Report for 2015/16 (the Annual Report), 2,170 referrals were made to the CISP in 2015/2016.⁷²⁷ Problems with illicit drugs was the most common reason for referral (1,824), noting there could be more than one reason such as mental illness, alcohol, anger management and accommodation

⁷²³ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 1.

⁷²⁴ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 22.

⁷²⁵ Magistrates' Court of Victoria, *Court Integrated Services Program (CISP)*, Melbourne, 2013.

⁷²⁶ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, pp. 55-56.

⁷²⁷ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 48.

issues. The main type of referrals provided as a part of the program was to alcohol and other drug (AOD) services including pharmacotherapy, with 1,721 referrals.⁷²⁸ Outlined in the text box below is a case study from the Annual Report which reflects how the CISP assists people:

CISP Case Study

Todd is aged 34 years. He did not have any convictions prior to being apprehended in relation to the charges which resulted in him being on remand. Prior to his offending, he was a fully employed tradesman in a stable relationship with a son aged 18 months.

Todd started using ice recreationally and this escalated to daily use of large quantities.

As his ice use escalated, Todd's financial situation became drastic, his work spasmodic, his behaviour erratic and he became unemployed. It was during this period that he perpetrated an act of violence towards his partner. An intervention order was applied for and obtained and Todd was required to leave the residence he had shared with his family. He breached the intervention order by contacting and threatening his former partner. As a result of this, the intervention order was varied and all contact with his child was ceased.

Todd was charged with serious indictable charges of trafficking ice and remanded in custody. At the time he was charged, Todd was on bail for the family violence intervention order breach and assault of his former partner. While on remand for the drug trafficking charges, Todd was assessed as suitable for CISP by a CISP Remand Outreach Pilot Worker.

After spending two weeks in custody, Todd came before the Court with the assessment for CISP and was bailed with strict conditions, including compliance with CISP. Todd presented before the magistrate who judicially monitored him on monthly CISP rollovers for a period of four months and met with his CISP case manager weekly.

While on CISP, a detoxification regime was implemented. This was fortified by an ongoing drug counselling program. Additionally, as Todd was homeless as a result of the relationship breakdown, assistance was provided to obtain emergency accommodation. Todd also attended a Men's Behaviour Change Program during the CISP episode.

During the four months on CISP, Todd became completely abstinent from ice and obtained new employment. Now in a better financial position, Todd was able to obtain independent rental housing. Additionally, he resumed a cordial relationship with his former partner such that he was able to resume contact with his son.

The serious indictable charges were withdrawn at the committal mention hearing. With respect to the summary criminal matters, he was placed on a Community Corrections Order.⁷²⁹

⁷²⁸ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 55.

⁷²⁹ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 49.

CREDIT/Bail Support Program

The CREDIT/Bail Support Programs were once distinct programs that merged in 2004. It is a pre-sentence program that aims to increase the likelihood of a person being granted bail, and then to successfully complete that bail period. Based on needs, participants are provided with services including case management, AOD treatment, transitional accommodation, health, welfare, legal and community support. Some of its key objectives are to reduce the number of people remanded into custody and to place people in AOD treatment programs as soon as possible. The Program currently operates in eight Magistrates' Courts: Ballarat, Broadmeadows, Frankston, Geelong, Heidelberg, Moorabin, Ringwood and Dandenong.

Similar to the CISP, referrals to the CREDIT/Bail Support Program can be made by a range of stakeholders including police, magistrates and lawyers. There are also no specific restrictions on the types of offences committed, and the person is not required to plead guilty to be eligible to participate. Any person eligible for a period of bail is eligible to be assessed for the Program.⁷³⁰

The Magistrates' Court Annual Report stated that 1,128 referrals were made to CREDIT and 1,141 referrals to the Bail Support Program in 2015/2016.⁷³¹ The most common reason for referral among both programs was problems with illicit drugs (1,115), noting there could be more than one reason for referral, such as mental illness, alcohol, anger management and accommodation issues. The main type of referrals provided was to AOD services including pharmacotherapy, with 887 referrals made.⁷³²

Criminal Justice Diversion Program

The Criminal Justice Diversion Program (CJDP) provides for legislated court diversion under section 59 of the *Criminal Procedure Act 2009*. It provides mainly first time offenders with the opportunity to avoid a criminal record by committing to a diversion plan and completing conditions such as apologising or providing restitution to victims, attending counselling and/or treatment, undertaking voluntary work or donating money. The CJDP operates throughout all Magistrates' Courts, with a Diversion Coordinator available in 13 courts.

To be eligible, the offence in question must be triable summarily (for example, some minor assaults or property offences), not be subject to minimum or fixed sentences or penalties (except for demerit points), the defendant must acknowledge responsibility for the offence and there should be enough evidence available for a conviction. Charges are adjourned while a person undertakes a diversion plan. While having prior convictions does not disqualify a person, this is taken into account by the court in considering whether diversion is appropriate.⁷³³

The CJDP can be utilised to divert people charged with personal use and/or possession offences, although research in 2008 found that the diversion plans were rarely used for these drug offences.⁷³⁴ The Annual Report stated that 6,872 referrals to the CJDP were made in 2015/2016.⁷³⁵ Among the types of activities undertaken,

⁷³⁰ Magistrates' Court of Victoria, *CREDIT/Bail Support Program*, Melbourne, 2013.

⁷³¹ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 48.

⁷³² Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 57.

⁷³³ Magistrates' Court of Victoria, *Criminal Justice Diversion Program*, Melbourne, 2013.

⁷³⁴ Fisher, G, *A Statistical Profile: The Criminal Justice Diversion Program in Victoria*, Sentencing Advisory Council, Melbourne, 2008, p. 6.

⁷³⁵ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 48.

38 offenders were ordered to undertake 502 hours of voluntary work, and 3,332 offenders undertook to pay approximately \$954,000 in donations to charities and local groups. A further \$634,000 was undertaken to be paid as restitution to victims. The Annual Report noted that 5,030 people successfully completed their diversion plan, which represented 90 per cent of all offenders on the CJDP.⁷³⁶ The Annual Report also stated that a review of the CJDP was completed and recommendations are in the process of implementation.⁷³⁷

Effectiveness of court programs

Victorian court programs have been shown to reduce reoffending while also resulting in significant cost savings by reducing prison costs.⁷³⁸ A 2010 evaluation of the CISP found it contributed to reduced recidivism across various measures and reduced recidivism overall by 10 per cent. The CISP was also found to be cost effective, as reductions in reoffending saved direct costs arising from crime and sentencing. There was also a reduction in custodial orders following participation in the CISP program. In monetary terms, \$1.98 million was saved per annum in avoided prison costs, approximately \$16 million savings from reduced reoffending over a projected 30-year period, and \$5.90 in savings for every \$1 spent on the CISP.⁷³⁹

In the 2015 report *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, the Victorian Ombudsman reported that the CJDP had a 94 per cent successful completion rate. Regarding the CREDIT/Bail Support Program, it was also reported that 2.5 per cent of successful participants received a custodial sentence compared to 30 per cent of non-participants.⁷⁴⁰

In May 2017 as part of the Bail Review commissioned by the Victorian Government, The Hon. Paul Coghlan QC discussed the value of the CISP in reducing rates of people remanded into custody, as well as broader benefits to the community. The Bail Review recommended that the CISP be allocated additional resources to provide services to more people across Victoria, and additional resources to employ more Koori case managers. It also recommended funding a longitudinal study to determine the effectiveness of the CISP.⁷⁴¹ The Review noted that the CISP and CREDIT/Bail Support Programs have recently been merged.⁷⁴²

Expanding court diversion programs

The Committee received evidence from stakeholders supporting increased access to the programs across Victoria. Penington Institute recounted in its submission the benefits of the CISP:

⁷³⁶ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 58.

⁷³⁷ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 50.

⁷³⁸ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 146.

⁷³⁹ Department of Justice, *Court Integrated Services Program: Tackling the causes of crime: Executive Summary Evaluation Report*, State Government of Victoria, Melbourne, 2010.

⁷⁴⁰ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 146.

⁷⁴¹ The Hon. Paul Coghlan QC, *Bail Review: Second advice to the Victorian Government*, Melbourne, 2017, pp. 30-38.

⁷⁴² The Hon. Paul Coghlan QC, *Bail Review: Second advice to the Victorian Government*, Melbourne, 2017, p. 31.

CISP is available as a support program for offenders (at the pre-trial and/or bail stage) who have not accessed diversion, linking them to services such as drug and alcohol treatment, crisis accommodation, disability services and mental health services. It thus provides an integrated service delivery model for addressing the underlying drivers of an individual's offending.

...

We can further conclude that, given drug offenders who succeed in CISP are more likely to stay out of prison into the future, a range of cyclical problems are likely to be averted.⁷⁴³

The Committee commends the Victorian Government's recent investments in the CISP Program, particularly the recent commitment to expand it and the CISP Remand Outreach Pilot, announced as part of the 2017/2018 Victorian Budget.⁷⁴⁴ The Committee is also aware, however, of the need for further investments and increased provision of appropriate support services to underpin the programs. Bevan Warner, Managing Director of Victoria Legal Aid (VLA) highlighted that there are current service gap provisions in outer metropolitan and rural areas:

Where we have CISP programs — the Court Integrated Services Program — where we have housing workers, where we have those relationships that are trusting and working, referrals work very, very well. But the problem is that there are not always places to refer people to, and we do not want to set anyone up to fail by having a referral to nowhere. We see big gaps in the outer metropolitan fringe. Generally speaking the large regional cities have a good constellation of services. Far-flung rural communities have real deficits, but there are real deficits in the outer metropolitan fringe, where we have poverty, where we have transport poverty as well, where we have low income, a constellation of social problems and often a deficit of services, sometimes a bit of outreach.⁷⁴⁵

Bevan Warner cautioned against the 'postcode injustice' of programs not being widely available:

We have concerns generally speaking about programs in the justice arena that are proven to work but that never get scaled up and are therefore not freely available to all Victorians right around the state.⁷⁴⁶

In relation to bail support programs such as the CISP, the FLS indicated in its submission that such programs 'are seriously undermined by the absence of funding support for the residential treatment of drug addictions'.⁷⁴⁷

An interesting issue raised was the potential to make programs available in the County Court. Liberty Victoria stated in its submission:

We note the very significant work undertaken by the CREDIT bail support program in the Magistrates' Court of Victoria, and would strongly recommend that it be expanded to the County Court of Victoria.⁷⁴⁸

⁷⁴³ Penington Institute, *Submission*, no. 209, 24 March 2017, pp. 26-27.

⁷⁴⁴ Premier of Victoria and Attorney-General, *Transforming our courts to keep victims of family violence safe*, Media release, Office of the Premier, Melbourne, 2 May 2017.

⁷⁴⁵ Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, pp. 232-233.

⁷⁴⁶ Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 228.

⁷⁴⁷ Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 7.

⁷⁴⁸ Liberty Victoria, *Submission*, no. 205, 21 March 2017, p. 7.

Similarly, the FLS referenced with support a submission by the Law Institute of Victoria to a different 2015 review, which recommended, among other things, expanding the CISP program into the County Court.⁷⁴⁹ The Bail Review report referred to earlier similarly recommended that the CISP be available for appropriate cases in the County Court jurisdiction, noting there is currently no bail support program.⁷⁵⁰

The Committee agrees that court diversion programs can be effective in reducing reoffending rates and achieving significant cost savings. The Committee also believes that such programs can assist people to address their drug use, which in turn may reduce their involvement in criminal behaviour. On this basis, access to such programs should not be restricted by geographical location or the limited availability of service providers to assist people with their substance use issues.

The Committee considers that the Victorian Government should work to address these current inequities in access to effective court programs. It also notes that the Parliamentary Law Reform, Drugs and Crime Prevention Committee 2014 *Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria* also recommended an expansion of the CISP.⁷⁵¹ While the Committee applauds recent expansions announced in the Budget, further work is required to ensure widespread and equitable access across the State.

RECOMMENDATION 14: The Victorian Government expand access to the Magistrates' Court of Victoria Court Integrated Services Program (CISP) and CREDIT/Bail Support Programs, to ensure consistency in access and equity throughout Victoria. This should be accompanied by enhanced funding to ensure that appropriate support services and alcohol and other drug treatment is available to people diverted from the court system into these programs. The expansion should also include exploring options for the CISP to be available in the County Court of Victoria.

8.1.2 Drug Court of Victoria

The Drug Court of Victoria has been in operation in Victoria since 2002 as a division of the Magistrates' Court of Victoria. It only operated out of the Dandenong Magistrates' Court until 2017 when a second court opened at the Melbourne Magistrates' Court (see below for a discussion of this expansion). The Drug Court's aim is to provide sentencing and supervision of offenders with a drug and/or alcohol dependency, who commit an offence under the influence of drugs or alcohol or to support their dependence. It draws on best practice evidence from existing drug courts worldwide:

The Victorian Drug Court initiative is a response to the failure of traditional criminal justice measures to adequately address drug use and related offending. The Victorian model has attempted to incorporate the best features of existing drug courts in order to establish a unique program addressing the specific needs of Victoria.⁷⁵²

Its main role is to administer drug treatment orders (DTOs) under section 18z of the *Sentencing Act 1991*:

⁷⁴⁹ Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 8.

⁷⁵⁰ The Hon. Paul Coghlan QC, *Bail Review: Second advice to the Victorian Government*, Melbourne, 2017, pp. 36-37.

⁷⁵¹ Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria - Volume 2*, Parliament of Victoria, East Melbourne, 2014, p. 486.

⁷⁵² Magistrates' Court of Victoria, 'Drug Court', viewed 5 December 2017, <<https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court>>.

Participants on a DTO receive a judicially supervised, therapeutically oriented, intensive and integrated drug supervision and treatment regime, which focuses on improving many aspects of their lives including drug dependency, physical and mental health, homelessness, education and employment, self-esteem and family and social relationships. A DTO is an innovative sentencing option which enables participants the opportunity to address a range of support needs within the community on the condition that they comply with the requirements of the order.⁷⁵³

The criteria that must be satisfied to be eligible for a DTO are:

- the accused pleads guilty to all referred offences, which must be within the jurisdiction of the Magistrates' Court and punishable upon conviction by imprisonment (the offences cannot be sexual or involve actual bodily harm)
- the accused lives in a postcode area gazetted as a Drug Court catchment
- a link is present between the offending behaviour and drug or alcohol dependence.⁷⁵⁴

A person is assessed against the criteria and a decision is made about their suitability for the program. A DTO comprises two parts – a treatment and supervision element, and a custodial element. Once a DTO is imposed, the custodial element is held in abeyance to allow for treatment and supervision in the community. If the person completes the DTO, they do not serve the custodial component. If they do not complete the DTO or commit a further offence, they can be ordered to serve the remaining custodial period or be resentenced. A DTO remains in operation for up to two years from when it is imposed, unless cancelled.⁷⁵⁵

The requirements of a person on a DTO can include: frequent urine drug testing and some breath testing; frequent attendance at Court Review Hearings, case management and clinical advisor appointments; alcohol and drug counselling; and any other conditions imposed by the Drug Court to assist a person to address their dependence. The Drug Court can also impose periods of imprisonment where a participant fails to comply with conditions or commits further offences, including cancelling the treatment and supervision element of the DTO.⁷⁵⁶

In his evidence to the Committee, Magistrate Tony Parsons of the Drug Court provided further information about the intensity of the program:

So in Victoria the model is that the drug treatment order is a jail sentence that is held over the person's head whilst they are on the program. It is a really intensive program that lasts for up to two years, unless people either breach their order seriously or graduate early. So it is a very intensive program. People on the program in the early months do urine screens three times a week, and they are supervised so they cannot be bodgie. They have a case manager from Corrections who sees them weekly and a clinical advisor who is a drug and alcohol clinician who designs the treatment and supervises them through treatment.

They have got to come and see me once a week. My role is a supervisory role and I motivate people along the right path.⁷⁵⁷

753 Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 61.

754 Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 61.

755 Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 61.

756 Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 61.

757 Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 143.

The DTO treatment and supervision element is structured into three phases. Phase one is the stabilisation phase that requires weekly appointments with various stakeholders, as well as urine tests three times a week. This intensive phase lasts for three to six months. If completed, the person moves to phase two which is less intensive. This is the consolidation phase that requires fortnightly meetings with various stakeholders, as well as urine tests two times a week, over a period of three to six months. Following completion of this phase, phase three, based on reintegration, requires monthly meetings as well as weekly urine tests. The minimum period for this phase is six months and its completion results in the person graduating from the order.⁷⁵⁸

Magistrate Tony Parsons provided further information to the Committee about how this works in practice, recognising that drug dependence is a relapsing condition:

...if they nail all the phases and get to all the mile posts, they can technically graduate after 12 months, but it very rarely happens. People have relapses. Drug addiction is a relapsing condition. I will bring them down a phase, and they will work their way back up. There is another cohort that do not actually graduate, but they get to the end of the two-year order. The evidence shows that even if they are still using, their drug addiction is dramatically reduced and anecdotally it is more likely to be cannabis than heroin or ice, and even if they are still coming to the attention of the police, we know — it is measurable — that it is for offences that are vastly less serious and happening less frequently.⁷⁵⁹

The Magistrates' Court Annual Report outlined that in 2015/2016 the Drug Court sentenced 63 people to a DTO (exceeding usual rates of 45 to 55 DTOs a year), and was monitoring 79 DTOs as at July 2016. It noted that of the 79 participants, 'a staggering 76 reported current or historical methamphetamine use'.⁷⁶⁰ In terms of the characteristics of participants, the average age was 35, and most participants were male and born in Australia. Eighty two per cent had education levels of less than Year 12, 94 per cent reported being unemployed and 62 per cent had 'deeply entrenched criminal behaviour and have been imprisoned previously on multiple occasions'. The majority of participants were also reported to have multiple and complex vulnerabilities and histories of poly-substance use.⁷⁶¹

Effectiveness of the Drug Court

The Magistrates' Court commissioned KPMG to evaluate the Drug Court, published in 2014. Despite the small numbers involved in the evaluation, it found 'significant improvements in the rate and severity of offending' by those in the Drug Court system as opposed to the control cohort. In particular, the evaluation reported:

- the reoffending rates for Drug Court participants was 31 per cent lower than the control group in the first 12 months
- the reoffending rates for Drug Court participants was 34 per cent lower than the control group within 24 months
- while there was a reduction in the seriousness of offences committed by both groups, reductions were larger for Drug Court participants (67 per cent compared to 47 per cent)

⁷⁵⁸ KPMG, *Evaluation of the Drug Court of Victoria: Final Report*, Magistrates' Court of Victoria, Melbourne, 2014, pp. 18-19.

⁷⁵⁹ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 144.

⁷⁶⁰ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 62.

⁷⁶¹ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 62.

- both cohorts had significant increases in theft offences.⁷⁶²

The Drug Court was shown to be more cost effective compared to imprisonment (a likely scenario for many participants), comparing a two year imprisonment sentence cost of \$197,000 to the unit cost of a DTO of \$26,000 plus Magistrate Court and other costs. The significant decrease in the frequency and severity of offending by Drug Court participants also contributed to substantial cost reductions. The number of days' imprisonment for Drug Court participants that reoffended totalled 6,125 compared to 10,617 days for the control group, representing a reduction of approximately \$1.2 million in reduced imprisonment costs.⁷⁶³

Magistrate Parsons advised the Committee of the practical impacts that the Drug Court can have on people's lives:

So people who graduate get through the three phases of the order and are completely sober for the last 90 days of the order. They are huge success stories. They are crime free, drug free and usually employed. The children that were in the Department of Health and Human Services are returned to them. They are fabulous and they sail on and contribute to the community rather than being a burden.⁷⁶⁴

Magistrate Parsons further stated that:

...drug courts are fantastic because they look at the reason why people find themselves in that cycle of addiction, jail, release, more drugs, more crime, back into jail, release, more drugs, more crime — it just goes around and around — and they deal with the problem; that is, they deal with the drug or alcohol issue. It is common sense, really, but it has been shown to work.⁷⁶⁵

Noting that roughly 60 per cent of people do not successfully complete the DTO, Magistrate Parsons indicated that even in these cases the program has provided some benefits:

We have not done significant longitudinal studies, but there is anecdotal evidence that suggests, even though people have failed, they often experience benefits from having gone through the program. It is anecdotal, but we have had people come back through the order and say, 'I blew my drug treatment order. I committed this offence. You locked me up, but when I got out of jail I went back to that counsellor, you showed me the pathway and I have been able to make real improvements in my life. I am now not committing offences or involved in illicit drugs'. So we do have that kind of anecdotal feedback, but we do need to do the longitudinal studies in Victoria just to measure the effect of the order.

There is good research that says that people who have got long-term retractable drug addictions often require a number of episodes of treatment before they are going to respond. So the drug treatment order is clearly one of those significant episodes, but they might require others before they respond.⁷⁶⁶

⁷⁶² KPMG, *Evaluation of the Drug Court of Victoria: Final Report*, Magistrates' Court of Victoria, Melbourne, 2014, p. 4.

⁷⁶³ KPMG, *Evaluation of the Drug Court of Victoria: Final Report*, Magistrates' Court of Victoria, Melbourne, 2014, pp. 5-6.

⁷⁶⁴ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 144.

⁷⁶⁵ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 143.

⁷⁶⁶ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 146.

The Annual Report outlined a number of benefits to Drug Court participants including breaking the cycle of offending, abstinence from substance use, improved health and wellbeing and improved prospects for employment and training. For the community, the benefits include costs savings, lower recidivism, fewer victims of crime, improved safety and reduced costs in health and welfare areas.⁷⁶⁷

WAYSS, a not-for-profit organisation, supports the Drug Court through its Drug Court Homelessness Assistance Program (DCHAP) and provides housing support services and transition accommodation to participants. It advised in its submission that it has 30 properties available, funded by the Department of Health and Human Services. WAYSS provided a case study of one its clients to demonstrate the positive impact of the Drug Court, as outlined in the text box:

Drug Court Case Study

Tony (not his real name) is a 45yr old male who was born in Melbourne; Tony has six children- the oldest being 22yrs and the youngest being 5yrs.

Tony was declared a 'ward of the state' age 6 and spent the next 10yrs at a notorious Melbourne boy's home.

Tony was subjected to a long history of sexual abuse at the boy's home.

Primary & Secondary education was carried out at the residential boy's home however due to abuse, Tony was unable to focus and learn.

Tony has an extensive drug and criminal history, dating back to the age of 17. Tony has served 15 periods of imprisonment for at times violent offences including assaults and armed robberies.

Tony typically committed crimes under the influence of drugs.

Tony first learnt Basic English skills in prison.

Before being referred to DCHAP Tony had never signed a lease and would often live in cars, at train stations, beaches, friend's couches or in prison.

Tony commenced his Drug Treatment Order (DTO) with the Dandenong Drug Court. Tony was residing with his mother, however their relationship soon deteriorated, and Tony was requested to leave his mother's house and find alternative accommodation.

Tony was referred to DCHAP; Tony declined to be accommodated into a rooming/boarding house due to declaring 'I will end up back in jail'.

Tony reluctantly moved back to his mother's until alternate accommodation became available.

2 months later Tony was assessed eligible and moved into DCHAP THM [Transitional Housing Management] accommodation

⁷⁶⁷ Magistrates' Court of Victoria, *Annual Report 2015-2016*, Melbourne, 2016, p. 61.

Tony has been able to re-establish contact with all his children, particularly his three younger sons. Tony has become very involved in their lives and has re-established his relationship with them as their father. His three youngest children are able to reside with him every weekend and they spend half of each school holiday period with him also.

Tony participates in numerous activities with his children, particularly at school and football.

Tony attended family support and counselling to further enhance his parenting skills.

While residing in the DCHAP THM Tony is reliable with his fortnightly rent payments, Tony also pays his bills when they are due.

Tony has a successful application for public housing and is awaiting allocation.

Tony successfully completed the Drug Courts photography course.

Tony has completed voluntary work at a nearby business & attended all DCHAP appointments & programs.

Tony successfully graduated from the Drug Treatment Order.

Tony successfully moved into public housing.

In Tony's words from a feedback form:

The DTO has been my saving grace. The impact on my life has been enormous, a mammoth task. I have had many challenging moments throughout my time with the Drug Court. It is by far the hardest task I have ever embarked on; yet, the greatest rewards are that of my own making. That there is the magic of the Drug Court.⁷⁶⁸

While acknowledging the benefits of the Victorian Drug Court, the Committee is also aware of broader concerns regarding the evaluation of such interventions. A 2016 article, *The effectiveness of Australia's drug courts*, suggested that:

While the indications are positive—including, significantly, when looking at the strongest evaluations—we still lack an 'unequivocal endorsement' (Indermaur & Roberts, 2003, p. 150) that the model is a comparatively effective method of reducing recidivism. Rigorous evaluation of Australia's drug courts remains necessary.

Three main concerns have been noted: a lack of randomised experiments; weak quasiexperiments; and short and poorly defined follow-up periods.⁷⁶⁹

Similarly, Springvale Monash Legal Service (SMLS) stated in its submission:

Despite positive evaluations published in favour of Drug Courts, critical literature indicates methodological flaws in many evaluations regarding the success of drug courts. Research indicates that evidence about the effectiveness of drug court

⁷⁶⁸ WAYSS Ltd, *Submission*, no. 153, 17 March 2017.

⁷⁶⁹ Kornhauser, R, 'The effectiveness of Australia's drug courts', *Australian & New Zealand Journal of Criminology*, 2016, viewed 5 December 2017, <<http://journals.sagepub.com/doi/pdf/10.1177/0004865816673412>>, p. 19.

programs in reducing participants' substance abuse was limited and mixed. Drug courts tend to be selective of which offenders they work with, excluding people who may fall outside their scope, skewing recidivism comparisons.⁷⁷⁰

However, the SMLS also reiterated its support for the Victorian Drug Court despite possible methodological issues in evaluations:

Despite these criticisms, it appears that the Dandenong Drug Court has contributed to reduce recidivism and many people appreciate this approach. SMLS also recognises that following a 2014 Inquiry regarding Methamphetamine use in Victoria, Drug Courts are likely to be rolled out in various locations across Victoria. Due to these factors, SMLS recognises the important role of Drug Courts in Victoria.⁷⁷¹

Expansion of the Drug Court

As noted, until 2017 the Drug Court operated only at the Dandenong Magistrates' Court. Under the *Ice Action Plan*, the Melbourne Drug Court became the second Victorian Drug Court in March 2017.⁷⁷² Magistrate Parsons explained that the reason the Drug Court is limited to gazetted postcode areas is because of its intensity:

They have got to live in our catchment area when the offences occur, and that is because we actually do test them three times a week. I see them once a week. They often have got three or four appointments a day, and if they lived on the other side of Melbourne, we would be setting them up to fail. It is also a way of managing demand, but I have been at Dandenong now for five years and I have never actually had to refuse anybody access to the Drug Court on the basis of demand. We have always kept the numbers right up but I have never actually had to turn people away, so it will be interesting to see how we go in Melbourne.⁷⁷³

Inquiry stakeholders were highly supportive of the Drug Court, but typically proposed its expansion to ensure sufficient access across Victoria.⁷⁷⁴ Victoria Legal Aid stated in its submission:

We strongly support further expansion of the Drug Court as an important means of responding to drug use and drug-related offending. An evaluation of the Drug Court undertaken by KPMG in 2015 confirms the success of the Drug Court in working effectively with individuals with severe drug and alcohol dependency to improve community safety and reduce crime.⁷⁷⁵

Josephine Baxter, Executive Director of Drug Free Australia also stated that 'another way for Victoria to lead the way is to extend the network of effective drug courts that do give people positive health outcomes'.⁷⁷⁶

Tazmyn Jewell, Senior Lawyer at VLA, considered that their lack of availability around Victoria contributes to the issue of 'postcode injustice':

⁷⁷⁰ Springvale Monash Legal Service Inc., *Submission*, no. 160, 17 March 2017, p. 13.

⁷⁷¹ Springvale Monash Legal Service Inc., *Submission*, no. 160, 17 March 2017, p. 13.

⁷⁷² Premier of Victoria, *New Drug Court to Drive Down Ice Use and Crime*, Media release, Office of the Premier, Melbourne, 30 March 2017.

⁷⁷³ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 145.

⁷⁷⁴ Australian Injecting & Illicit Drug Users League, *Submission*, no. 169, 17 March 2017; Beyond Blue, *Submission*, no. 175, 17 March 2017; Drug Policy Australia, *Submission*, no. 192, 17 March 2017, p. 6; Living Positive Victoria, *Submission*, no. 213, 28 March 2017, p. 5; Rationalist Society of Australia, *Submission*, no. 200, 20 March 2017, p. 9; WAYSS Ltd, *Submission*, no. 153, 17 March 2017.

⁷⁷⁵ Victoria Legal Aid, *Submission*, no. 204, 21 March 2017, p. 2.

⁷⁷⁶ Josephine Baxter, Executive Director, Drug Free Australia, *Transcript of evidence*, 21 August 2017, p. 284.

...I have had numerous clients with significant ice addictions throughout my years of practice who have been able to be referred to the Drug Court because of the location of their residence being in that Dandenong catchment, but conversely I have had clients — and I primarily practise in the outer eastern region — who have not been able to be referred. Looking at the course of whether or not other therapeutic options are available certainly it is beneficial for clients to have that option available and be able to be referred to the Drug Court. Also in my experience the long-term intensive case management is a really significant, important factor in helping people to move through the criminal justice system, as opposed to other types of sentences.⁷⁷⁷

The Committee was also advised that the current situation has human rights implications, particularly in regard to ensuring equality under the law. As discussed by the SMLS, ‘ensuring every person has equal access to the courts is one of the key elements’, and it is compromised by the lack of drug courts being available across the state.⁷⁷⁸ It proposed that regional Victoria requires Drug Courts. Bevan Warner of VLA suggested that Drug Courts be established in ‘[e]very headquarter court in Victoria, which would be the principal regional cities, and the principal headquarter courts dotted around the metropolitan area.’⁷⁷⁹ Magistrate Parsons of the Drug Court also proposed the following locations:

We need to capture Sunshine ... we definitely need a Drug Court in the Latrobe Valley, and a full-sized Drug Court would fit there very nicely. The Barwon region at Geelong could definitely have a drug court, and we think we could do half a drug court in places like Shepparton, Mildura, Ballarat and Bendigo, and we can scale it down and make it quite mobile and quite flexible, but yes, definitely we need to expand.

The good thing about the one in Melbourne is that it does cover a significant part of the population of the greater Melbourne area, and I think in Victoria we are lucky — our population is concentrated.⁷⁸⁰

A connected issue to the expansion of the Drug Court is ensuring the availability of support services that contribute to the Court’s effectiveness, and in particular assist people to address their substance use issues and reintegrate back into society. The Committee understands that this may present a barrier in particular areas. The Alcohol and Drug Foundation (ADF) suggested in its submission that the Drug Court should be expanded to rural areas.⁷⁸¹ However, Geoff Munro, National Policy Manager of the ADF, highlighted that a significant barrier to this occurring is the lack of support services:

Our understanding is that one of the problems, one of the barriers, to extending the Drug Court system to rural areas is a lack of support services. That would be a lack of people like psychologists and social workers who are able to work with the offender in the community while they are on the program. That is a crucial part of the system so that the person is checking in with a trained person who can assist them and can talk through the sorts of issues they might be having while they are in the drug treatment program and also trying to re-establish themselves in the community. From our reading that is a necessary part of the program, and it is a hurdle for rural and remote areas where those professionals are thin on the ground.⁷⁸²

777 Tazmyn Jewell, Senior Lawyer, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 229.

778 Springvale Monash Legal Service Inc., *Submission*, no. 160, 17 March 2017, p. 15.

779 Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 234.

780 Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 145.

781 Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 31.

782 Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 202.

Similarly, the SMLS outlined the range of infrastructure and support services within the community that must be available to support the work of the Drug Court:

Effective drug treatment requires not only drug and mental health treatment but also the availability of other support services. Comprehensive services including health, housing, education, employment, and social services are necessary to enhance the effectiveness of DTOs and the Drug Court. It is important to allocate resources to ensure the links to these support services are available in all the areas to which the Drug Court is expanded.⁷⁸³

Tazmyn Jewell from VLA similarly discussed the importance of ensuring services across the range of court programs including the Drug Court:

It is something that we struggle with on a daily basis, and I understand that even for the Drug Court or whether it be other therapeutic options that are available at court — for example, CISP or CREDIT — there still need to be those community-based referrals, and if there are long waits for beds for detox or for rehabilitation, which we all know there are, then that can really impact on someone's progress and rehabilitation.⁷⁸⁴

The Committee is of the view that the evidence presented during the inquiry demonstrates the significant benefits of the Drug Court of Victoria for individuals who use drugs, and also the broader community. The Committee commends the recent expansion of the Drug Court to Melbourne, and believes that further expansion, particularly in rural and regional areas, should be considered. Consistent with the Committee's views regarding relevant court support and diversion programs, increased investment in treatment and other services must accompany the expansion. Without such investment and appropriate infrastructure, the Drug Courts will be limited in their capacity to successfully help people to address their substance use and offending behaviour. It is also important to acknowledge the benefits to the community from improved public safety that will likely result from the Drug Courts' expansion.

RECOMMENDATION 15: The Victorian Government expand the number of Drug Courts in Victoria, accompanied by funding to ensure appropriate support services and alcohol and other drug treatment is available for program participants.

8.1.3 Hawaii Opportunity Probation with Enforcement (HOPE)-style program

The Committee also received evidence from the Drug Court of Victoria regarding a separate program that the Magistrates' Court is interested in trialling, based on the Hawaii Opportunity Probation with Enforcement (HOPE) program. The HOPE program is a probation regime that provides swift, certain and fair (SCF) responses for breaches of conditions, particularly drug use breaches. Its aims and outcomes were summarised in the 2015 *Final Report of the National Ice Taskforce*:

A new approach to probation being adopted in the United States focuses on swift and certain sanctions for probationers who fail random drug tests rather than mandatory treatment for all. The programme was originally trialled in Hawaii with very positive results for methamphetamine users.

⁷⁸³ Springvale Monash Legal Service Inc., *Submission*, no. 160, 17 March 2017, p. 15.

⁷⁸⁴ Tazmyn Jewell, Senior Lawyer, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 229.

The approach was developed after it was recognised that people on probation for drug offences tended to face inconsistent consequences for re-offending, often with long delays before the consequences came into effect. The Hawaii Opportunity Probation with Enforcement (HOPE) trial introduced random drug testing for probationers, with swift punishment for non-compliance—usually short jail terms issued within 72 hours. The vast majority of participants in the trial were methamphetamine users (69 per cent).

Under the HOPE trial, probationers were sentenced to drug treatment only if they continued to test positive for drug use or if they requested a treatment referral. This economical use of treatment freed up treatment places for those proven to need them. This avoided a situation in which clients in mandated-treatment crowded out clients in voluntary-treatment.⁷⁸⁵

The Final Report outlined that the HOPE trial resulted in reductions of positive drug tests by participants compared to those undergoing mandatory treatment, with positive drug tests for HOPE participants decreasing from 53 per cent to four per cent six months after the trial.⁷⁸⁶ The National Ice Taskforce recommended that a pilot program be undertaken in at least one state or territory. An October 2017 report by the Victorian Sentencing Advisory Council (SAC) that analysed the applicability of such programs to family violence contexts noted that a pilot is currently underway in the Northern Territory.⁷⁸⁷

Magistrate Tony Parsons advised the Committee of the Magistrates' Court of Victoria's interest in trialling this approach in the context of Community Correction Orders (CCOs):

Hawaii's Opportunity Probation with Enforcement (HOPE) is an incredibly successful program which delivers outstanding levels of probation and treatment compliance using the application of swift, certain and fair jail sanctions of between one and thirty days for non-compliance.

The Magistrates' Court of Victoria is enthusiastic about undertaking a confined pilot of HOPE in the context of Community Correction Orders for high risk offenders but is unable to do so without legislative amendment.

Whilst the Court has available to it a gaol sentence for infractions of CCO conditions, currently the power can only be exercised in response to breach proceedings. Such proceedings require the filing of a charge and service of a summons for an appearance at court not earlier than 28 days after service. It is impossible to deliver a sanction swiftly under this legislative regime.⁷⁸⁸

It should also be noted, however, that the recent SAC report stated there is 'mixed evidence for the effectiveness of SCF approaches to offenders with substance-abuse issues...'⁷⁸⁹ The report outlined that, while the HOPE program had positive outcomes, efforts to replicate the program in other United States jurisdictions did not result in more effective outcomes when compared to traditional probation. For example, it did not result in reduced recidivism or reduced time in jail.⁷⁹⁰

⁷⁸⁵ Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Commonwealth of Australia, Canberra, 2015, p. 145.

⁷⁸⁶ Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Commonwealth of Australia, Canberra, 2015, p. 146.

⁷⁸⁷ Sentencing Advisory Council, *Swift, Certain and Fair Approaches to Sentencing Family Violence Offenders Report*, Melbourne, 2017, p. 13.

⁷⁸⁸ Magistrate Tony Parsons, *Submission*, no. 220, 13 April 2017, p. 3.

⁷⁸⁹ Sentencing Advisory Council, *Swift, Certain and Fair Approaches to Sentencing Family Violence Offenders Report*, Melbourne, 2017, p. xi.

⁷⁹⁰ Sentencing Advisory Council, *Swift, Certain and Fair Approaches to Sentencing Family Violence Offenders Report*, Melbourne, 2017, p. 18.

In response to these concerns, Magistrate Parsons indicated that a trial of HOPE in Victoria would need to ensure that both aspects of HOPE – penalties and appropriate treatment supports - are in place for it to be successful, noting mixed results in various jurisdictions that have trialled a HOPE-style program:

It is also critical in the way that HOPE probation works that there are supports and there is treatment. That is what the probation officer does. So it is a partnership between the probation team that provides the support and, where people need it, treatment and the court that supervises it, and they have just had remarkable results. It is in 30 jurisdictions now in the United States of America. Some of the programs that have been set up that emulate HOPE have been working really well. Some have tried to set up programs that simply provide the compliance structure — they provide the penalties but not the treatment — and they do not work anywhere near as well. So we know now that it requires a marriage of probation and judicial supervision.⁷⁹¹

The Committee is of the view that a trial of a HOPE-style program should be explored as a mechanism to deal effectively with people with substance use issues, particularly to assist them address their issues as quickly as possible. The Committee notes that the Magistrates Court is already in discussions with Corrections Victoria about a trial, and is supportive of such considerations.⁷⁹² If a HOPE-style program is undertaken, it must be accompanied by an evaluation to ascertain its effectiveness. If the evaluation demonstrates positive outcomes, the program should be scaled up to ensure access throughout Victoria.

RECOMMENDATION 16: The Victorian Government explore other court programs for potential implementation in Victoria, including the Hawaii Opportunity Probation with Enforcement (HOPE program).

8.2 The parole system

Some inquiry stakeholders raised particular issues with the treatment of drug use while a person is on parole.⁷⁹³ The Adult Parole Board (the Board) is responsible for making parole decisions for individual prisoners, including decisions to grant, deny, revoke or cancel parole. The Board can also impose and vary a range of conditions on a parole order, including drug testing. The Board stated in its submission that:

While on parole, a prisoner is still under sentence (they are serving their sentence in the community rather than in prison). The purpose of parole is to provide a structured, supervised and supported transition to the community toward the end of a sentence, with the aim of reducing the risk of the prisoner re-offending.⁷⁹⁴

The parole system has undergone extensive changes following reviews due to public concern about people committing offences while on parole. Two reviews were conducted in 2011 and 2012 and, following a high profile murder by a person on parole in 2012, the Victorian Government requested another review of the parole system

⁷⁹¹ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, pp. 139-140.

⁷⁹² Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 140.

⁷⁹³ David Taylor, Policy and Media Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 302; Adult Parole Board Victoria, *Submission*, no. 171, 17 March 2017; Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 6; cohealth, *Submission*, no. 140, 16 March 2017; Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017, p. 6.

⁷⁹⁴ Adult Parole Board Victoria, *Submission*, no. 171, 17 March 2017.

by former High Court Justice Ian Callinan AC. The report was released in 2013 and contained 23 recommendations. His Honour, Judge Peter Couzens of the Board, advised the Committee that:

The result has been extremely positive. It is clear in my view, and the statistics support this, that the risks that the community are exposed to at the hands of parolees have been significantly reduced.⁷⁹⁵

Reductions in use of parole

A number of stakeholders noted that an impact of the reforms is a reduction in the number of people granted parole, which ultimately means that people are released from prison on the completion of their sentence without the supporting infrastructures of the parole system. In particular, the Burnet Institute stated:

Parole reform has led to increasing rates of rejected parole applications in prison, and therefore more prisoners being released at the completion of their sentences. These prisoners re-enter the community without the reporting requirements and controls that apply to those on parole and without access to support to broker access to community services. Already, most prisoners incarcerated on drug-related offences are released with their offending behaviour only partially addressed or neglected completely due to short sentences and the increased demands on prison programs.⁷⁹⁶

The Victorian Alcohol and Drug Association (VAADA) similarly highlighted that parole and bail reforms have contributed to the increased prison population in Victoria:

Victoria's prison population has increased by almost 50 percent from 2010 to 2016 (Corrections 2017), with much of that increase driven by a 145 percent increase in un-sentenced (remanded) prisoners. The unprecedented growth is likely the result of various sentencing reforms, including bail and parole and has necessitated a significant prison build resulting in the recurrent prison budget surpassing \$1 billion in 2015/16 well up from \$640 million in 2010/11.⁷⁹⁷

Judge Couzens agreed that parole numbers have reduced following reforms:

As far as parole is concerned... the numbers of people on parole have reduced markedly. I will remind you that in 2012 and 2013 there were 1646 parolees in the community. Last year there were 841. I do not shrink from what is often described as tougher parole, I much prefer to call it more demanding.⁷⁹⁸

The Burnet Institute and VAADA highlighted that these factors contribute to an increased need to provide more support to people upon their release from prison, in particular to address substance use issues that may not have been addressed during their sentence or may still require continued support to minimise possible relapse once a person is back in the community. This is discussed further in chapter 13.

⁷⁹⁵ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, p. 398.

⁷⁹⁶ Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 6.

⁷⁹⁷ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, pp. 8-9.

⁷⁹⁸ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, p. 401.

Cancellation of parole

Another issue arising from recent parole reforms is that the cancellation of parole due to failed drug tests has become a more common sanction. Under section 73A of the *Corrections Act 1986*, the Board is required to give paramount consideration to the safety and protection of the community in determining whether to make or vary a parole order, cancel a prisoner's parole, or revoke cancellation of parole. Judge Couzens informed the Committee that:

...where the index offending is drug-related, where there is a history of drug addiction and there is a re-engagement in drug use, despite all the supports that exist, the board must be mindful of the risk to the community, bearing in mind that consideration.

Although the board does everything — as do Corrections, for which I have the greatest respect in this regard — to caution or warn, at the corrections level directing people to the board, given corrections' concerns, often we are asked to warn or to require the parolee to show cause as to why parole should not be cancelled. Nevertheless, sadly, the re-use can often continue, so cancellation becomes the ultimate and the inevitable sanction.⁷⁹⁹

Melissa Westin, Assistant Commissioner from Corrections Victoria, similarly described how failed drug tests can, in certain circumstances, lead to cancellation:

...the drug testing regime for parolees is actually determined by the adult parole board and managed through community correctional services. The outcome of that can result in further conditions or cancellation of parole. There is a range of sanctions that can be imposed by the board. The same sorts of consequences can also arise if there has been an adulteration of a substance. If our test has come through as inconclusive and we think that the offender has potentially adulterated their sample, then they can be subject to the same sorts of sanctions and...in extreme cases the cancellation of their parole.⁸⁰⁰

As a consequence of these issues, the Burnet Institute's submission commented that these changes result in 'many individuals being reincarcerated for relatively minor breaches (unlikely to result in any community harm) that have not previously attracted such a punitive approach'.⁸⁰¹

The Board highlighted in its submission that drug use while a person is on parole is a significant concern in terms of community safety. For example, it can be linked with reoffending, erratic behaviour contributing to risks of reoffending, and can lead to a person engaging in criminal activity to fund their dependency.⁸⁰²

The effect of parole cancellation is that the person is arrested and returned to custody. Unless otherwise directed by the Board, any time a person has already spent on parole prior to cancellation will not count as time served under the sentence. A prisoner can apply to the Board to be re-paroled, which is a matter for the Board's consideration.⁸⁰³

The Board informed the Committee that in 2015/2016, it made 387 decisions to cancel parole. The most frequent reason for cancellation was drug use, noting that in 250 decisions (almost 65 per cent of all cancellation decisions) drug use was either

⁷⁹⁹ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, p. 400.

⁸⁰⁰ Assistant Commissioner Melissa Westin, Corrections Victoria, *Transcript of evidence*, 4 September 2017, p. 349.

⁸⁰¹ Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 6.

⁸⁰² Adult Parole Board Victoria, *Submission*, no. 171, 17 March 2017.

⁸⁰³ Adult Parole Board Victoria, *Submission*, no. 171, 17 March 2017.

the sole reason, or contributing reason. Of these 250 decisions, the predominant drug used was amphetamine or methylamphetamine, accounting for almost 67 per cent of cancellations involving drug use.⁸⁰⁴ The Board's submission noted that interim figures for 2016/2017 similarly reflected these trends. The Board's 2016/2017 Annual Report confirmed that it cancelled parole in 204 cases (a reduction of 47 per cent from the previous year) but that the trends in relation to drug use remained the same, with it being the most common reason for cancellation (involved in 70 per cent of decisions) and methylamphetamine was a particular cause of concern. In contrast, people who were charged or found guilty of reoffending while on parole accounted for 18 per cent of cancellations.⁸⁰⁵

Judge Couzens described the effects of cancellation on individuals:

Cancellation, albeit it serves the purpose of removing an escalating risk from the community, is extremely damaging for loss of self-esteem, loss of self-confidence, losing opportunities that might otherwise have existed in the community, home, employment et cetera, and it can be crushing to self-esteem.⁸⁰⁶

Judge Couzens also particularly noted that cancellations are quite high in the first six months of a person's parole period, and typically affect younger people:

What the board has found is that the difficulty of continuing to refrain from drug use, particularly of methamphetamine — or crystal methamphetamine — is extremely difficult, so the bulk of cancellations that occur in terms of parole occur in the first six months. The younger the parolee the more likely it is that there will be a breach. An explanation is I think fairly simple. Their offending relates to drug use; their drug use has preceded the offending. Often the offending for which the sentence is imposed is just one of a number of offences for which the person has been dealt with. Release back into the community, no matter how carefully structured and supervised, is filled with temptation.⁸⁰⁷

The Board's submission highlighted the significant costs that result from returning people to custody, including that they may need to serve any time already spent on parole:

Not only is this impact absorbed by the community through the cost of imprisoning parolees who return to custody and additional pressure on limited prison resources, but the impacts are also felt through the association of cancelled parolees with other convicted criminals and by keeping them separated from the community, making their eventual reintegration to the community (at the end of the sentence) more difficult.⁸⁰⁸

Power to suspend parole

In response to these issues, the Board recommended that it be given an alternative power to suspend parole, as an additional step before cancellation, in certain circumstances. In these cases, the person would be returned to custody to undergo treatment and after a certain period of time, the Board could assess whether the person's parole should be cancelled or if they could continue on their order:

⁸⁰⁴ Adult Parole Board Victoria, *Submission*, no. 171, 17 March 2017.

⁸⁰⁵ Adult Parole Board Victoria, *Annual Report 2016-17*, State Government of Victoria, Melbourne, 2017, p. 26.

⁸⁰⁶ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, p. 400.

⁸⁰⁷ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, p. 399.

⁸⁰⁸ Adult Parole Board Victoria, *Submission*, no. 171, 17 March 2017.

For appropriate cases (for example, drug use on parole without re-offending), suspension of parole could provide a “circuit break” for a limited period (for example, up to 3 months), with the parolee being removed from the community and offered relevant treatment as assessed.

As their parole would not be cancelled, they would not lose the time served on parole and have to reserve it in prison. They would not need to apply for re-parole, so their return to the community would occur faster than for an application for re-parole after cancellation. This would make it easier to avoid losing accommodation or employment. Importantly, they would not lose the incentive to complete parole, as can occur when parole is cancelled.⁸⁰⁹

Judge Couzens outlined that this would affect a small number of cases, but would provide those that have completed a substantial portion of parole an opportunity to continue:

We do not expect that there would be many people who would fit within the category who would be best served by suspension. Those who breach through drug use early would not be appropriate, because it is just too soon. But we are particularly mindful to those parolees who are on long periods of parole who do exceptionally well — and many do, as reflected in the 75 per cent who got through their parole last year — but for one or a combination of reasons lapse. It can be a breakdown of a relationship, it can be family breakdowns, it can be loss of employment, it can be an inadvertent reassociation with negative peers. Those people, we would like to think theoretically at least, are in the range of people who would benefit from a circuit-breaker. Albeit it does involve loss of liberty, but only for a relatively short period of time.⁸¹⁰

Judge Couzens also indicated that the Board might envisage returning a person to custody for between one to three months, where they would be able to participate in treatment programs to address their substance use issues. His Honour particularly noted that it would be ideal if this could occur in a prison such as Ravenhall, highlighting the new prison’s focus on mental health programs for prisoners.⁸¹¹ Following this period, the Board would assess whether the person can continue on parole, or if it should be cancelled depending on the circumstances (for example, due to poor behaviour or failure to engage in programs).⁸¹²

Judge Couzens also noted that similar powers of suspension exist in other Australian jurisdictions such as New South Wales and Queensland, however, a significant difference exists between the jurisdictions as parole in Victoria is exclusively a decision of the Board. In other jurisdictions, parole can also be granted by the courts.⁸¹³

Based on Judge Couzen’s evidence, the Committee believes that the power to suspend parole is worthy of implementation. The Committee agrees with Judge Couzens’ statement that this power would provide, in appropriate cases (which may only number 20 to 30 a year), ‘a more therapeutic as opposed to punitive approach’.⁸¹⁴

⁸⁰⁹ Adult Parole Board Victoria, *Submission*, no. 171, 17 March 2017.

⁸¹⁰ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, pp. 400-401.

⁸¹¹ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, pp. 401-402.

⁸¹² Adult Parole Board Victoria, *Submission*, no. 171, 17 March 2017.

⁸¹³ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, p. 403.

⁸¹⁴ His Honour Judge Peter Couzens, Chairperson, Adult Parole Board of Victoria, *Transcript of evidence*, 18 September 2017, p. 401.

Consistent with a number of recommendations in this report, a power to suspend parole would allow for a person's underlying substance use issues to be addressed in an effective and meaningful manner. The Committee importantly highlights that such a power of suspension would continue to operate within a legislative environment that requires community safety to be the paramount factor. This will continue to guide decision-making by the Board, including its exercise of the power to suspend parole.

RECOMMENDATION 17: As proposed by the Adult Parole Board of Victoria, the Victorian Government provide the Adult Parole Board with the power to suspend parole for longer-term parolees who have been found to use illicit substances but whom have not reoffended. Suspension could be up to three months, and parolees offered treatment during that time. Following the period of suspension, the Board would assess whether they can continue on parole.

9 Cannabis regulation

Cannabis is the most widely used and trafficked illicit substance globally. The *World Drug Report 2017* by the United Nations Office on Drugs and Crime (UNODC) stated that 3.8 per cent of the adult population, equating to 183 million people, used cannabis in the past year.⁸¹⁵ In terms of drug seizures, more than half of cases reported involved cannabis, and it is also ‘the most widely illicitly produced drug world-wide, both in terms of the size and geographical spread of the area under cultivation and the volume actually produced’.⁸¹⁶

Such trends are also reflected in Australia, with the *2016 National Drug Strategy Household Survey* (NDSHS) reporting that cannabis was the most common illicit drug used at least once in the past 12 months at a rate of 10.4 per cent (2.1 million people), with 35 per cent (6.9 million people) having ever used it in their lifetime.⁸¹⁷ Cannabis was also the most frequently used illicit drug, with a rate of weekly or more use at 36 per cent.⁸¹⁸ Regarding the illicit market, the *Illicit Drug Data Report 2015-16* by the Australian Criminal Intelligence Commission (ACIC) noted that ‘cannabis accounted for the greatest proportion of the number of national illicit drug seizures...’⁸¹⁹

A number of harms can arise from cannabis use, particularly regular and sustained use such as dependence; increased tolerance; and impacts on learning, memory and attention in heavy users. There is less evidence about the mental health effects of cannabis use, although there is an association between people who use cannabis and harms to mental functioning, depression, and anxiety disorders.⁸²⁰ In particular, studies have found frequent use as a risk factor for some mental illnesses, such as psychosis and schizophrenia.⁸²¹ On this issue, Dr Alex Wodak AM, Director of Australia21 and President of Australian Drug Law Reform Foundation (ADLRF) advised the Committee:

...there is still an academic debate about whether cannabis does in fact cause schizophrenia and there are reputable researchers on both sides of that debate. I think it’s fair to say that the majority view is that there is a relationship between cannabis use and schizophrenia but it’s been observed in a number of countries that the prevalence of cannabis use has increased dramatically from the 1960s,

⁸¹⁵ United Nations Office on Drugs and Crime, *World Drug Report 2017: Global Overview of Drug Demand and Supply: Latest trends, cross-cutting issues*, United Nations, Vienna, 2017, p. 13.

⁸¹⁶ United Nations Office on Drugs and Crime, *World Drug Report 2017: Global Overview of Drug Demand and Supply: Latest trends, cross-cutting issues*, United Nations, Vienna, 2017, p. 39.

⁸¹⁷ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 61.

⁸¹⁸ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 59.

⁸¹⁹ Australian Criminal Intelligence Commission, *Illicit Drug Data Report 2015-2016*, Canberra, June 2017, p. 8.

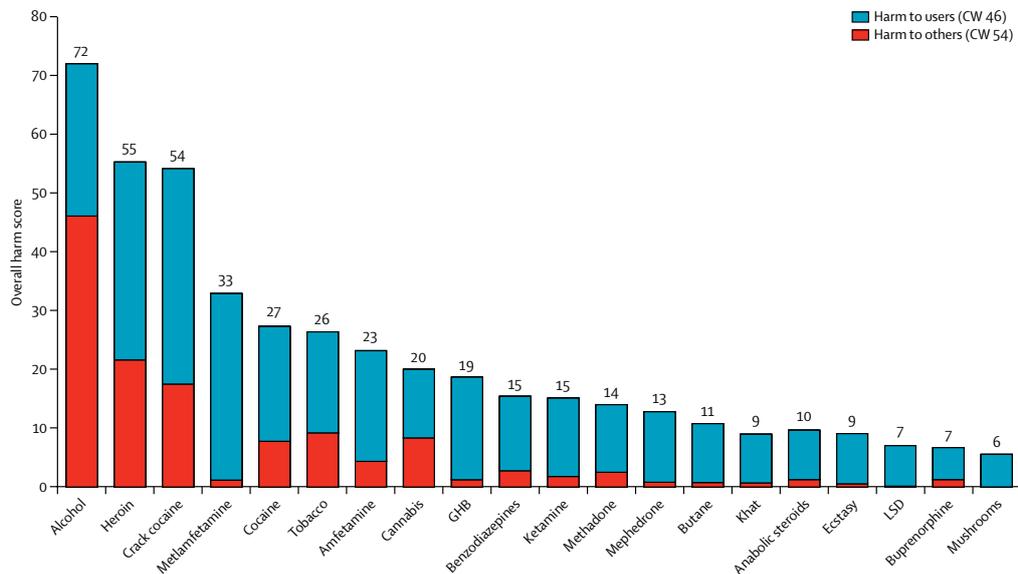
⁸²⁰ Australian Medical Association, ‘Cannabis Use and Health - 2014’, viewed 5 February 2018, <<https://ama.com.au/position-statement/cannabis-use-and-health-2014>>.

⁸²¹ Health Canada, *A Framework for the Legalization and Regulation of Cannabis in Canada: The Final Report of the Task Force on Cannabis Legalization and Regulation*, Government of Canada, Ottawa, 2016, p. 16.

from close to zero to much higher levels that we see today and that the prevalence of schizophrenia has remained the same or gone down, if anything, and that the schizophrenia we see in 2017 is not as severe as the schizophrenia we saw 50 years or so ago.⁸²²

The Committee notes advice that cannabis is one of the less harmful substances, even compared with alcohol and tobacco. A study by Professor David Nutt of the Imperial College London and others in 2010, *Drug harms in the UK: a multicriteria decision analysis*, found that of 20 drugs assessed for harms to individuals and others, cannabis ranked 8th (a score of 20 out of 100). On the other hand, alcohol was the most harmful (72), followed by heroin (55) and crack cocaine (54).⁸²³ The different scores for each substance are reflected in the below diagram.

Figure 9.1 Drugs ordered by their overall harms scores



Source: Nutt, D, et al., ‘Drug harms in the UK: a multicriteria decision analysis’, *The Lancet*, vol. 376, no. 9752, 2010, viewed 1 November 2010, <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61462-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/abstract)>, p. 1561.

A similar study across Europe confirmed the UK results were likewise applicable. It suggested policy measures should focus on more harmful drugs such as heroin, alcohol and tobacco, while less harmful drugs such as cannabis ‘should be given lower priority including a lower legal classification’.⁸²⁴

Given this growing evidence, countries around the world are considering the regulation and supply of cannabis, despite international treaties that prohibit cannabis. As noted in a 2016 report, *A Framework for the Legalization and Regulation of Cannabis in Canada*, commissioned by the Canadian Government on this issue:

Although the ultimate aim of the drug treaties is to ensure the “health and welfare of humankind,” there is growing recognition that cannabis prohibition has proven to be an ineffective strategy for reducing individual or social harms, including decreasing

⁸²² Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 96.

⁸²³ Nutt, D, et al., ‘Drug harms in the UK: a multicriteria decision analysis’, *The Lancet*, vol. 376, no. 9752, 2010, viewed 1 November 2010, <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61462-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/abstract)>, p. 1561.

⁸²⁴ van Amsterdam, J, et al., ‘European rating of drug harms’, *Journal of Psychopharmacology*, vol. 29, no. 6, 2015, p. 660.

burdens on criminal justice systems, limiting negative social and public health impacts, and minimizing the entrenchment of illicit markets, which in some cases support organized crime and violence.⁸²⁵

In Victoria as well as nationally, there are now arrangements in place for the use of medical-grade cannabis products for medical purposes, recognising that it has a role in the therapeutic treatment of some conditions. There is currently no intention at a state or federal level to legalise the non-medical use of cannabis, although it is an interesting area of drug law reform, particularly regarding the application of different regulatory models and as a potential form of revenue for governments, similar to alcohol and tobacco.

Compliance of cannabis regulatory models with the United Nations drug control treaties

It is useful to note that the supply of cannabis for medical purposes is a more widely accepted practice internationally than supply for adult use. A paper by the former Australian National Council on Drugs in 2014, *Medicinal use of cannabis: Background and Information Paper*, stated regarding the international treaties:

These do not prevent signatories from making cannabis (and other drugs) available for medical and scientific purposes (Working Party on the Use of Cannabis for Medical Purposes 2000). But they do have implications for how medicinal cannabis could be supplied and who may cultivate it, and have had an impact on domestic drug laws prohibiting cultivation, supply, possession, and use.⁸²⁶

In relation to the national regime underpinning medicinal cannabis and Australia's obligations under the international treaties, the Commonwealth Department of Health's *Guideline: Security of Medicinal Cannabis* issued in October 2016, stated:

The purpose of the Single Convention is to provide an international framework that recognises the medicinal value of narcotic drugs and ensures that narcotic drugs are available for such purposes while preventing their abuse and diversion. As a signatory to the Single Convention, Australia is committed to complying with the obligations within it, including designation of a single agency to licence and control cannabis cultivation and annual reporting to the International Narcotics Drug Control Board on volumes of production and manufacture.⁸²⁷

In its 2016 annual report, the International Narcotics Control Board (INCB) noted these developments in Australia:

The Board also notes the Government's efforts to ensure full compliance with the provisions of the 1961 Convention and to limit the amount of cannabis plant cultivated for medical cannabis products, to the quantity necessary to meet domestic demand.⁸²⁸

Internationally, the move towards the non-medical use, or adult use, of cannabis among various jurisdictions is clearly creating tensions with the drug control treaties. Although, those jurisdictions that have introduced regulatory models for

⁸²⁵ Health Canada, *A Framework for the Legalization and Regulation of Cannabis in Canada: The Final Report of the Task Force on Cannabis Legalization and Regulation*, Government of Canada, Ottawa, 2016, p. 10.

⁸²⁶ Australian National Council on Drugs, *Medicinal use of cannabis: Background and Information Paper*, Civic Square, 2014, p. 3.

⁸²⁷ Office of Drug Control, *Guideline: Security of Medicinal Cannabis*, Australian Government, Canberra, 2016, p. 6.

⁸²⁸ International Narcotics Control Board, *Report of the International Narcotics Control Board for 2016*, United Nations, New York, 2017, p. 25.

adult cannabis use have approached the issue in different ways. For example, in the context of the United States (US), it is argued that ‘state-level legalisation may be allowable under a “flexible interpretation” of the treaties’.⁸²⁹ Whereas in Uruguay, the government asserts that its regulatory model complies with the original objectives of the treaties but which have failed to be achieved:

... namely, the protection of the health and welfare of humankind. Uruguayan authorities have specifically argued that the creation of a regulated market for adult use of cannabis is driven by health and security imperatives and is therefore an issue of human rights.⁸³⁰

Despite these arguments, the INCB has clearly stated that these regulatory models do not comply with the treaties.⁸³¹ Chapter three of this report discussed in further detail the relationship between this area of law reform and the international framework.

9.1 Medicinal cannabis

Medicinal cannabis describes a range of cannabis products that are designed and grown for medical purposes, particularly ‘medical-grade herbal products or purified pharmaceuticals from extracts of the Cannabis Sativa plant’.⁸³²

A recent paper by the Victorian Government on Victoria’s medicinal cannabis industry, *Industry Development Plan: Developing a Medicinal Cannabis Industry in Victoria* (Victorian Industry Development Plan), noted that 30 countries allow the use of medicinal cannabis or products that contain cannabinoids.⁸³³ Each regime has its own features, and comparisons between models is difficult, particularly as this area has only emerged recently in the global context.

A background paper by Kilmer, *New developments in cannabis regulation*, published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), indicated that as at October 2017, 12 countries allowed the production of medicinal cannabis (including Canada). In the US, 28 states and the District of Columbia allow medicinal cannabis products (including Colorado and California), although it remains illegal under federal laws. It reported that four European countries have medicinal cannabis regimes. In the Netherlands, the Office of Medicinal Cannabis has licensed one producer, who submits the products to the government before they are supplied through pharmacists. In the United Kingdom (UK), plant material is not available for patient access but a private company is authorised to produce cannabis and doctors are able to prescribe extracts. The Czech Republic since 2013 allows for the local production of cannabis through the State Agency for Medicinal Cannabis, but prior to that imported products were allowed. In 2017, Germany expanded access to medicinal cannabis and also authorised its local production.⁸³⁴

⁸²⁹ International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 75.

⁸³⁰ Transnational Institute, *Cannabis regulation and the UN drug treaties: Strategies for reform*, Amsterdam, 2016, p. 14.

⁸³¹ Transnational Institute, *Cannabis regulation and the UN drug treaties: Strategies for reform*, Amsterdam, 2016, p. 5.

⁸³² Agriculture Victoria, *Industry Development Plan: Developing a Medicinal Cannabis Industry in Victoria*, State Government of Victoria, Melbourne, 2018, p. 6.

⁸³³ Agriculture Victoria, *Industry Development Plan: Developing a Medicinal Cannabis Industry in Victoria*, State Government of Victoria, Melbourne, 2018, p. 8.

⁸³⁴ Kilmer, B, *New developments in cannabis regulation*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2017, pp. 4-5.

A key issue globally is the lack of robust research evidence demonstrating the effectiveness of medicinal cannabis products to treat specific conditions. Cannabis has traditionally been a prohibited substance, making it difficult to research its therapeutic benefits and harms. This has resulted in limited clinical information for medical practitioners to safely prescribe and manage the treatment. The largely undeveloped evidence base is a barrier to expanding access, even where legal regimes have been established to enable the use of such treatment. There is also an issue of availability, as worldwide there are only four countries that export medicinal cannabis (the Netherlands, UK, US and Canada).⁸³⁵ This means supply of medical-grade medicinal cannabis is currently limited.

Victoria is considered a pioneer in access to medicinal cannabis, as the first Australian jurisdiction to do so in April 2016. This section focuses on the ways that patients can access medicinal cannabis under the Victorian regime and the recent development of Commonwealth pathways. It also outlines research on conditions that could be effectively treated by medicinal cannabis products.

9.1.1 Victorian regime

During 2015, the Victorian Law Reform Commission (VLRC) conducted a detailed inquiry into options for reform to allow people to access medicinal cannabis in exceptional circumstances. In its report tabled in October 2015, the VLRC made 42 recommendations on areas such as the use of cannabis for medical purposes; regulating supply and production, cultivation, manufacturing, distribution, quality control; and research and evaluation. Following the report, Victoria's *Access to Medicinal Cannabis Act 2016* (the Act) passed in April 2016, and the Government also established the Office of Medicinal Cannabis within the Department of Health and Human Services (DHHS) to oversee the framework.⁸³⁶

While it is not necessary to consider the VLRC report in detail, a key issue worth highlighting was its recommendation regarding patient eligibility for this treatment, and subsequent implementation under the Act. The VLRC reviewed the evidence available at the time to determine the types of conditions that should be captured, particularly considering therapeutic benefits, dangers, risks and side effects. The report found that eligibility should be in exceptional circumstances based on the person's conditions and symptoms, and initial medical conditions for inclusion should be: severe muscle spasms or pain from multiple sclerosis (MS); severe pain arising from cancer, HIV or AIDS; severe nausea, vomiting or wasting due to cancer, HIV or AIDS; severe seizures from epilepsy where other treatment has not been effective; and severe chronic pain where two specialists agree that medicinal cannabis would provide superior outcomes over other options. The VLRC also recommended the establishment of an Independent Medical Advisory Committee (IMAC) to provide ongoing advice about the eligibility of further conditions and symptoms.⁸³⁷

In responding to the VLRC report, the Victorian Government announced it would provide priority access for children with severe epilepsy as the first patient group, and that the newly established IMAC would advise on further eligibility.⁸³⁸ To this end, section 3 of the Act defines an eligible patient as:

⁸³⁵ Agriculture Victoria, *Industry Development Plan: Developing a Medicinal Cannabis Industry in Victoria*, State Government of Victoria, Melbourne, 2018, p. 8.

⁸³⁶ Minister for Agriculture and Minister for Health, *Medicinal Cannabis Legalised in Victoria*, Media release, State Government of Victoria, Melbourne, 12 April 2016.

⁸³⁷ Victorian Law Reform Commission, *Medicinal Cannabis*, Melbourne, 2015, pp. xxxiv-xxxv.

⁸³⁸ Premier of Victoria, *Medicinal Cannabis To Be Legalised In Victoria*, State Government of Victoria, Melbourne, 6 October 2015.

- (a) a patient who—
 - (i) is under 18 years of age; and
 - (ii) experiences severe seizures resulting from an epileptic condition in respect of which other treatment options have not proved effective or have generated intolerable side effects; and
 - (iii) meets the prescribed criteria in respect of that condition (if any); or
- (b) a patient who—
 - (i) has a prescribed medical condition; and
 - (ii) meets the prescribed criteria in respect of that condition (if any);⁸³⁹

The Explanatory Memorandum to the Bill noted that this definition ‘also allows for further categories of eligible patients to be prescribed in regulations’.⁸⁴⁰

Regarding the IMAC, in August 2016 the Victorian Government announced the appointment of Professor James Angus AO as the Chairperson, and that other members of the IMAC included specialists in areas such as cancer, addiction medicine, neurology, pain management and HIV/AIDS, and a consumer representative. It also announced that a horticultural trial had been completed, and cultivation of medicinal cannabis for the first patient group had commenced.⁸⁴¹

Following this, in March 2017 the Victorian Government announced it would provide early compassionate access to 29 children using imported products from Canada, ahead of Victorian products being available.⁸⁴² An update in January 2018 noted an additional 30 children would be provided with compassionate access and, once local product becomes available, 30 more children would also obtain access (a total of 90 children). The Victorian Government further released the Victorian Industry Development Plan, which aims for Victoria to supply half of Australia’s medicinal cannabis by 2028.⁸⁴³ It also discussed the potential for Victoria to become an exporter of medicinal cannabis, noting that only four jurisdictions worldwide are currently doing so.

Developments for patient access to medicinal cannabis more generally, including whether patients groups under the Victorian legislation will be expanded, have been somewhat succeeded by developments at a Commonwealth level as discussed below.

9.1.2 Commonwealth regime

Access to medicinal cannabis Australia-wide was enabled through the passage of the *Narcotics Control Amendment Act 2016* in February 2016, which commenced in October 2016. With this, the Commonwealth Government announced it had delivered ‘the “missing piece” for Australian patients and their doctors to access a

⁸³⁹ *Access to Medicinal Cannabis Act 2016* (Vic), 20.

⁸⁴⁰ *Access to Medicinal Cannabis Bill 2015: Explanatory Memorandum* (Vic), section 2.

⁸⁴¹ Minister for Agriculture and Minister for Health and Premier, *Medicinal Cannabis One Step Closer For Victorian Patients*, Media release, State Government of Victoria, Melbourne, 16 August 2016.

⁸⁴² Premier, *Fast-Tracked Medicinal Cannabis For Kids With Severe Epilepsy*, Media release, State Government of Victoria, Melbourne, 1 March 2017.

⁸⁴³ Minister for Agriculture and Minister for Health, *Victorian Medicinal Cannabis Industry Powers Ahead*, Media release, State Government of Victoria, Melbourne, 17 January 2018.

safe, legal and reliable supply of medicinal cannabis products for the management of painful and chronic conditions'.⁸⁴⁴ As a result, as stated in the Victorian Industry Development Plan:

All stages of the process from cultivation to manufacturing, distribution and patient access are tightly regulated, principally by the Commonwealth Government, to ensure that medicinal cannabis products of a reliable quality are available to patients who need them most.

Access to medicinal cannabis only occurs through licensed pharmacists to patients with a prescription from a medical practitioner.

As the industry develops over the coming years, legislation is expected to evolve.⁸⁴⁵

The INCB also noted Australian authorities' objective of aligning prescribing practices across the country, as well as the oversight mechanisms in place regarding patient access (discussed below).⁸⁴⁶

Under the arrangements, the Commonwealth is solely responsible for cultivation and production of medicinal cannabis, and manufacture and patient access is jointly administered by the Australian and state and territory governments.⁸⁴⁷ The Office of Drug Control (ODC) in the Commonwealth Department of Health oversees these issues, including import, export and domestic cultivation. As at February 2018, the ODC reported that 30 such licences had been granted, namely 14 cultivation and production licences, eight research licences and eight manufacture licences.⁸⁴⁸

Regarding the mechanism for patient access, cannabis was rescheduled from Schedule 9 (prohibited) to Schedule 8 (controlled) to allow cannabis to be prescribed for medical purposes from 1 November 2016.⁸⁴⁹ The Therapeutic Goods Administration (TGA), responsible for regulating medicines in Australia, oversees patient access as well as quality control over the manufacture of medicinal cannabis products.

Generally, all medicines in Australia are required to be listed on the Australian Register of Therapeutic Goods (ARTG), administered by the TGA. As there is only one medicinal cannabis product currently listed, most medicinal cannabis products are unregistered. The TGA regulates access to unregistered products through the pathways of the Authorised Prescriber (AP) Scheme, the Special Access Scheme (SAS) and clinical trials. Under the AP and SAS pathways, a patient's access to medicinal cannabis is not limited by particular medical conditions, and the TGA makes a decision to approve such treatment based on the circumstance of each application. It also involves the importation of products as there is yet no domestic product

⁸⁴⁴ Minister for Health, Minister for Aged Care, and Minister for Sport, *Historic medicinal cannabis legislation passes Parliament*, Media release, Commonwealth of Australia, Canberra, 24 February 2016.

⁸⁴⁵ Agriculture Victoria, *Industry Development Plan: Developing a Medicinal Cannabis Industry in Victoria*, State Government of Victoria, Melbourne, 2018, p. 6.

⁸⁴⁶ International Narcotics Control Board, *Report of the International Narcotics Control Board for 2016*, United Nations, New York, 2017, p. 25.

⁸⁴⁷ The Office of Drug Control, 'Medicinal cannabis cultivation and production licences and permits', viewed 7 February 2018, <<https://www.odc.gov.au/medicinal-cannabis-cultivation-and-production-licences-and-permits>>.

⁸⁴⁸ Department of Health, 'Summary of licences granted', viewed 14 March 2018, <<https://www.odc.gov.au/summary-licences-granted>>.

⁸⁴⁹ Therapeutic Goods Administration, 'Medicinal cannabis products: overview of regulation', viewed 24 August 2017, <<https://www.tga.gov.au/medicinal-cannabis-products-overview-regulation>>.

available. The TGA website states that obtaining medicinal cannabis products in this way 'is anticipated to be the major route for patient access to medicinal cannabis products over the next few years'.⁸⁵⁰

Medicinal cannabis is only allowed to be prescribed by Australian-registered medical practitioners. Under the AP scheme, an individual practitioner can apply to the TGA to become authorised, decided on a case-by-case basis. Under the SAS, access is organised by a medical practitioner with expertise in the condition notifying or applying for approval to import and supply such products to a patient. As well as complying with Commonwealth requirements, the medical practitioner must also satisfy state or territory requirements.⁸⁵¹ For example, in Victoria, if a product is captured as a Schedule 8 drug, it will require a permit to be issued by the DHHS unless there is an exemption.⁸⁵² Other jurisdictions are also at different stages of implementing their own requirements for granting approval for accessing medicinal cannabis. Once such requirements are met, medicinal cannabis can be supplied by the identified pharmacy or hospital, and the ODC has published a list of companies that have been authorised to import a stock of medicinal cannabis.⁸⁵³

Currently, no medicinal cannabis products are listed on the Pharmaceutical Benefits Scheme (PBS), meaning that patients must pay full costs for the treatment. In a January 2018 media release, the Victorian Government urged the Commonwealth Government to 'now accelerate the Pharmaceutical Benefits Scheme listing of medicinal cannabis products – making it affordable for every Australian who needs it'.⁸⁵⁴ Such issues demonstrate that policy discussions around medicinal cannabis in Australia have advanced a long way in a relatively short amount of time. Despite this, the Committee heard some concerning issues with the current scheme throughout the inquiry.

9.1.3 Issues with the current arrangements

Commonwealth and state regulation

Clearly, Commonwealth and state/territory requirements intersect in a complicated way under the current arrangements. The table below from the TGA shows how each component of the process is governed, including requirements at both levels that need to be followed:

⁸⁵⁰ Therapeutic Goods Administration, 'Medicinal cannabis products: overview of regulation', viewed 24 August 2017, <<https://www.tga.gov.au/medicinal-cannabis-products-overview-regulation>>.

⁸⁵¹ Therapeutic Goods Administration, *Guidance for the use of medicinal cannabis in Australia: Patient Information*, Australian Government, Canberra, 2017, pp. 2-3.

⁸⁵² health.vic, 'Prescribing Schedule 8 medicinal cannabis in Victoria', viewed 5 February 2018, <<https://www2.health.vic.gov.au/public-health/drugs-and-poisons/medicinal-cannabis/prescribing-in-victoria>>.

⁸⁵³ Therapeutic Goods Administration, *Guidance for the use of medicinal cannabis in Australia: Patient Information*, Australian Government, Canberra, 2017, p. 3.

⁸⁵⁴ Minister for Agriculture and Minister for Health, *Victorian Medicinal Cannabis Industry Powers Ahead*, Media release, State Government of Victoria, Melbourne, 17 January 2018.

Figure 9.2 Medicinal cannabis products: overview of regulation

Process step		Therapeutic Goods Act (TGA)	Narcotic Drugs Act (ODC)	States and territories involved?
Patient need	↓ Access ¹	✓ Special access scheme	✗ No	✓ Yes
Medical authorisation		OR ✓ Authorised prescriber		
Import (if obtaining from overseas)	↓ Import	✓ Responsibility of the sponsor	✓ Licence ² and permit ² to import controlled substances	✓ Yes
Distribution	PATIENT with medical authorisation	✗ No	✓ Responsibility of the licensee	✓ Yes
Manufacture of medicine in its dosage form	↑ Local cultivation and supply ²	✓ Licensable	✓ Licences and permits	✓ Yes
Manufacture of active ingredient		✓ Licensable	✓ Licences and permits ²	✓ Yes
Harvest (termed 'production' in the Narcotic Drugs Act)		✗ No	✓ Licences and permits	✗ No
Cultivation		✗ No	✓ Licences and permits ²	✗ No

Source: Therapeutic Goods Administration, 'Medicinal cannabis products: overview of regulation', viewed 24 August 2017, <<https://www.tga.gov.au/medicinal-cannabis-products-overview-regulation>>.

Many inquiry stakeholders were supportive of improving access to medicinal cannabis, noting the benefits and the controls that have been established.⁸⁵⁵ For example, Gary Christian, Research Director of Drug Free Australia stated:

We have always backed medicinal cannabis, but only in pharmaceutical form, which is where the federal government seems to be at the moment. We recognise that there are benefits. We think a lot of the benefits have been overstated by various players, but there are real benefits there and we look forward to the federal government and the state governments working together to get the right kind of formulations out.⁸⁵⁶

⁸⁵⁵ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, pp. 86-87; Dean Rossiter, Chapter President, LaTrobe University, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 309; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 49; Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, pp. 29-30; Australian Drug Law Reform Foundation, *Submission*, no. 147, 17 March 2017, p. 4; Living Positive Victoria, *Submission*, no. 213, 28 March 2017, pp. 5-6; Penington Institute, *Submission*, no. 209, 24 March 2017, pp. 39-40; Public Health Association Australia, *Submission*, no. 152, 17 March 2017, p. 8; UnitingCare ReGen, *Submission*, no. 168, 17 March 2017, p. 2.

⁸⁵⁶ Gary Christian, Research Director, Drug Free Australia, *Transcript of evidence*, 21 August 2017, p. 283.

However, the Committee was also told that the process of implementation is occurring too slowly, meaning that people are unable to access products that could assist to treat their conditions. Dr Alex Wodak AM of Australia21 and ADLRF told the Committee:

So there is also a significant role for accelerating the implementation of lawful, medicinal cannabis in Australia. In my view - and I know my colleagues agree with that — that implementation is occurring in Australia far too slowly.⁸⁵⁷

There has also been a range of similar media commentary on the speed of reforms, as well as the complexities involved. For example, an article in the *Guardian* in June 2017 noted comments from Associate Professor David Caldicott, a senior medical lecturer at the Australian National University, who conducted a workshop on medicinal cannabis for doctors:

“I’m not a lawyer but even I am struggling with this. If you go to different states in Australia you see very different responses. It is still incredibly cumbersome to get drugs to patients. There are still a lot of loopholes, and people are still regularly being prosecuted.”

...

Caldicott criticised the legal framework for medicinal cannabis for being cumbersome. “While it is technically legal to avail yourself of cannabis medicine, it is practically impossible,” he said.

“Australia is the only country in the world who have tried to drive home the square peg of medicinal cannabis through the round hole of traditional medical legislation. This framework was never designed for this scenario. It’s like trying to use an old railway gauge for a super-fast turbo train.”⁸⁵⁸

Also commonly reported are particular instances of individuals that have been unable to access medicinal cannabis due to complex regulations. An article from August 2017 noted the difficulties experienced by doctors in accessing products, which was also affecting patients and their wellbeing:

A mountain of red tape for legal medicinal cannabis is forcing the families of seriously ill patients back into the black market, according to doctors and advocates.

Sydney GP Brad McKay said he had tried at length to prescribe the medicine for his patients but had been blocked at every turn.

“It just seems that so many obstacles are being put in place of GPs and specialists that it’s creating an impossible situation,” Dr McKay told Lateline.

...

For two years, Brisbane father Steve Peek has been unable to get access to legal medicinal cannabis oil to relieve his daughter Suli’s seizures.

He told Lateline he had been left with no option but to administer an illegal product every six hours.

⁸⁵⁷ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 87.

⁸⁵⁸ Zhou, N, ‘Medical cannabis workshop: ‘incredibly cumbersome’ to get drugs to patients’, *The Guardian*, 23 June 2017, viewed 5 February 2018, <<https://www.theguardian.com/australia-news/2017/jun/23/medical-cannabis-workshop-incredibly-cumbersome-to-get-drugs-to-patients>>.

“They say it’s been legalised. It’s not legalised. You can’t get it no matter what you do,” he told Lateline.⁸⁵⁹

While noting that implementation of this complex scheme has only occurred relatively recently, the Committee is aware that the number of patients accessing medicinal cannabis is currently low. Adjunct Professor John Skerritt, Deputy Secretary of Health Products Regulation Group at the Commonwealth Department of Health, told a Senate Budget Estimates 2017-18 hearing in May 2017 that there were 25 doctors approved under the AP scheme throughout Australia, with none in Victoria.⁸⁶⁰ In supplementary evidence to the Committee, the Victorian DHHS informed the Committee of patient numbers, demonstrating that, while numbers are growing, they are still low:

As at 30 September 2017, the Commonwealth Therapeutic Goods Administration advised that it had approved a total of 70 applications for access to medicinal cannabis in Victoria (57 of those since November 2016). Most of these applications have been for Schedule 4 cannabidiol products, predominantly used for the treatment of epilepsy. Only products classified as Schedule 8 (those where more than 2 per cent of total cannabinoids are THC or cannabinoids other than cannabidiol) require additional state level approval.

The Office of Medicinal Cannabis has approved 14 applications for Schedule 8 Treatment Permits for medicinal cannabis. The patient condition was predominantly cancer (10 patients), followed by Multiple Sclerosis (2 patients) and other conditions (2 patients). Treatment of pain was specified as one of the symptoms for which treatment was being sought in 13 out of 14 cases.⁸⁶¹

The Department of Health and Human Services provided more insight to the Committee on how the situation has developed in terms of multiple levels of regulation, and the intersection of the Commonwealth pathways with the Victorian legislative scheme. In particular, Kym Peake, Secretary of the DHHS told the Committee:

It is worth explaining a little bit about what has happened over the journey with medicinal cannabis, because when we commenced the trial for children, or the work on the trial, there was no real other alternative for people to legally access medicinal cannabis. Since that work has commenced, the commonwealth has moved very rapidly to create through the Therapeutic Goods Administration the pathway, on a case-by-case basis, for people to apply for imported product, and there is no restriction on the medical conditions for which that imported product can be approved...

...

In terms of local product we have to make sure, obviously, that the local product is suitable for different indications, so we have an independent advisory group that has been established for the purpose of advising government on whether local product could be used for different patient cohorts. So there is governance and a mechanism for expanding access, but as the commonwealth TGA process expands and imported

⁸⁵⁹ Lipson, D, ‘Medicinal cannabis ‘red-tape’ pushing doctors and patients back to illegal products’, *ABC News*, 16 August 2017, viewed 5 February 2018, <<http://www.abc.net.au/news/2017-08-16/medicinal-cannabis-red-tape-government-doctors-black-market/8813962>>.

⁸⁶⁰ Adjunct Professor John Skerritt, Deputy Secretary, Health Products Regulation Group, *Transcript of evidence, Estimates, Community Affairs Legislation Committee, Commonwealth of Australia*, 29 May 2017, pp. 152-153.

⁸⁶¹ Kym Peake, *Supplementary evidence*, Department of Health and Human Services, 23 October 2017.

product becomes more available, we will just need to monitor whether that has utility and is helpful or whether actually those commonwealth pathways become the more convenient way for people with other conditions to access the product.⁸⁶²

While focused largely on industry matters such as cultivation and manufacturing, the Victorian Industry Development Plan anticipated that one of the key action areas for the Victorian Government will be to work with the TGA and the ODC to streamline Commonwealth and state regulations to avoid duplication and ensure clear roles. It noted that the benefits of this would be to '[a]void unnecessary administration for patients, industry and government' and '[r]educe confusion for patients and medical practitioners about access pathways'.⁸⁶³ It also noted that another action area will be the development of an online one-stop-shop for industry, doctors and patients to obtain information on all government processes, including approvals. One of the benefits of this would be to enhance 'patient access by providing up-to-date information and neutral clinical guidance for medical practitioners'.⁸⁶⁴

At a Commonwealth level, the Australian Advisory Council on the Medicinal Use of Cannabis (AACMC) has been established to advise the Minister for Health, also chaired by the Victorian IMAC Chair, Professor James Angus. At the time of writing this report, the AACMC had met four times, and in three meetings it discussed aligning jurisdictional requirements. For example, the communique for September 2017 meeting stated:

The Council noted ongoing work being conducted to align the jurisdictions, with working groups in place with representatives from all states and territories in three specialist areas: law enforcement, cultivation and production, and patient access.

The Council discussed ongoing concerns by some members of the public around the complexity of Commonwealth and state and territory processes in accessing medicinal cannabis.⁸⁶⁵

It agreed to initiatives to address these issues such as national data collection and working with medical professional organisations to improve communication.

Overall, this is a rapidly evolving area, with frequent developments at both Victorian and Commonwealth levels to progress this nascent policy. Given this situation, the Committee acknowledges the aim of the Victorian Government to work with the Commonwealth Government to streamline requirements for patient access and encourages this collaboration to continue and to be prioritised. Of course, this should also take into account patient safety and quality assurance of medicinal cannabis products, whether produced locally or imported. The Committee considers that such work should occur not only in relation to the development of a medicinal cannabis industry as outlined in the Victorian Industry Development Plan, but also regarding how doctors and patients access this form of treatment.

⁸⁶² Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 328.

⁸⁶³ Agriculture Victoria, *Industry Development Plan: Developing a Medicinal Cannabis Industry in Victoria*, State Government of Victoria, Melbourne, 2018, p. 17.

⁸⁶⁴ Agriculture Victoria, *Industry Development Plan: Developing a Medicinal Cannabis Industry in Victoria*, State Government of Victoria, Melbourne, 2018, p. 21.

⁸⁶⁵ The Office of Drug Control, 'AACMC Meeting 3, 14 September 2017', viewed 5 February 2018, <<https://www.odc.gov.au/aacmc-meeting-3-14-september-2017>>.

RECOMMENDATION 18: The Victorian Government work closely with the Commonwealth Government to improve patient access to medicinal cannabis products, particularly in relation to streamlining requirements at federal and state levels to ensure patients who will benefit from medicinal cannabis treatment in appropriate circumstances have proper access to it.

Guidance on appropriate medical conditions

As noted earlier, one of the main barriers for improved utilisation of medicinal cannabis treatment is limited information for the medical profession, as the key access point, on the circumstances in which such products should be prescribed and managed. Even though it is unclear how regulations for access to medicinal cannabis will take shape moving forward, it remains important to enhance understanding about the types of conditions and circumstances that may suit treatment using medicinal cannabis.

Given the current lack of clinical information, the medical profession has generally advocated for a cautious approach to the scheme. For example, Tony Bartone, Vice President of the Australian Medication Association (AMA) stated in June 2017:

...the usual guidelines and requirements for the introduction of new medications seem to have been forgotten in respect of medicinal cannabis. It seems that safety and concern for rigorous, clinically proven guidelines are dispensed with — all in the name of compassion for a patient population who are just as deserving of the same standard of care as the rest of the community when it comes to safety and harm minimisation. It seems that all the tenets of our world-class system have been forgotten and are suddenly archaic and of little value in the face of a voracious community perceived need. This is spurred on by numerous media stories featuring long-suffering patients and their families who are forced to access the illegal black market.

...

A lot has been achieved in a very short space of time. However, safety and reliability of product as well as clear clinical guidelines for use need to be firmly developed and supported by clear information sharing and training of doctors concerned. Politics should not be allowed to influence and certainly media and community information needs to be facilitated so that expectations do not exceed practicality.⁸⁶⁶

Similarly, the Royal Australasian College of Physician (RACP) stated in its submission:

Whilst there have been a number of claims made by various groups of the benefits associated with the therapeutic use of cannabis, the RACP is of the view that only well designed and conducted scientific trials can provide the necessary evidence to demonstrate whether particular cannabinoids that satisfy good manufacturing standards are effective in treating specific medical conditions and lead to improved quality of life.⁸⁶⁷

During the overseas study tour, the Committee heard in Colorado that it experienced similar concerns from the medical profession about the lack of evidence and guidance surrounding the use of medicinal cannabis. Taylor West from the National Cannabis

⁸⁶⁶ Bartone, T, 'Medicinal Cannabis - Still a lot of misinformation', *Australian Medical Association*, 23 June 2017, viewed 5 February 2018, <<https://ama.com.au/ausmed/medicinal-cannabis---still-lot-misinformation>>.

⁸⁶⁷ Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017, p. 5.

Industry Association (NCIA) told the Committee that there has been a slow take-up of physicians prescribing these products. She indicated that this is mostly a cultural issue, although some physicians are reluctant to rely on anecdotal evidence.⁸⁶⁸

Similarly, the Colorado Department of Public Health and Environment noted that physicians are more inclined to recommend rather than prescribe medicinal cannabis to treat medical conditions, as there is limited evidence about appropriate prescribing.⁸⁶⁹ The Council on Responsible Cannabis Regulation (CRCR) told the Committee that physicians are generally cautious about prescribing medicinal cannabis as a treatment option because of its illegal status under federal law, and there also remains many unknowns about its use and appropriate prescribing. There are some physicians, however, that specialise in this area, with paediatricians being the most active physicians in this area and those involved in child welfare.⁸⁷⁰

Recently, the Commonwealth Department of Health and the New South Wales (NSW), Victorian and Queensland state governments commissioned an extensive review of all available evidence on medicinal cannabis, coordinated by the National Drug and Alcohol Research Centre (NDARC). Following this, the TGA published in December 2017 a series of guidance documents, *Guidance for the use of medicinal cannabis in Australia* (the TGA guidance), for the medical profession and patients in the areas of palliative care; chemotherapy-induced nausea and vomiting; chronic pain; multiple sclerosis; and child and adult epilepsy. According to the TGA, its guidance is not considered the same as clinical guidelines. Clinical guidelines would: focus holistically on a particular condition and options for treatment; use studies with high strength of evidence; and be subject to detailed review by bodies such as the National Health and Medical Research Council, a process generally undertaken over three or more years. Instead, the TGA guidance provides advice and explanations, but is not considered binding.⁸⁷¹ The TGA guidance, intended to be updated regularly, stated:

Doctors rely on evidence to make informed decisions about the best medications for their patients. For medicinal cannabis, the amount of evidence is currently limited and the products, doses and research methods used vary between studies. This makes it difficult to come to firm conclusions about how best to use particular medicinal cannabis products.

There is also not much information available to help doctors determine the most appropriate and safe doses while minimising potential side-effects. Importantly, at the moment, relatively few studies compare the effects of medicinal cannabis products against currently approved treatments for various conditions and symptoms. In addition, most of the studies reported in the medical literature have either used purified pharmaceutical substances or smoked cannabis.

As there is limited scientific evidence to support the use of medicinal cannabis in most conditions, and in many cases the evidence is for its use together with other medicines, it should be used only when approved treatments have been tried and have failed to manage conditions and symptoms.⁸⁷²

⁸⁶⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 65.

⁸⁶⁹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 67.

⁸⁷⁰ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 71.

⁸⁷¹ Therapeutic Goods Administration, 'Access to medicinal cannabis products: Medicinal cannabis - guidance documents', viewed 21 December 2017, <<https://www.tga.gov.au/access-medicinal-cannabis-products>>.

⁸⁷² Therapeutic Goods Administration, *Guidance for the use of medicinal cannabis in Australia: Patient Information*, Australian Government, Canberra, 2017, p. 2.

The TGA guidance noted that ‘medicinal cannabis is not considered a first-line therapy for any indication’ and practitioners will need to determine whether the particular product is suitable for use depending on each circumstance, using the framework that ‘the less critical the clinical need for the proposed product, the higher the degree of evidence needed to support the use of that product’.⁸⁷³

In terms of suitable conditions, the TGA guidance is summarised as follows, noting that there is much more comprehensive information in the documents themselves:

- epilepsy in paediatric and adult patients - some evidence to support its use for certain childhood epilepsies
- multiple sclerosis (MS) - some low to moderate evidence for treating pain from MS
- chronic non-cancer pain - some evidence for reduced pain for MS-related and non-MS-related neuropathic (nerve damage) pain, but the reductions may be modest
- chemotherapy-induced nausea and vomiting - as the number of studies is small, and due to more effective prescription medications being available, medicinal cannabis products should only be used after other treatments have failed
- palliative care - no evidence to support that it has anti-cancer benefits or that it can slow progression of cancer.⁸⁷⁴

Similar reports on the evidence base for medicinal cannabis are also being prepared worldwide. For example, an extensive study in the US by the National Academies of Sciences, Engineering, and Medicine, *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*, also noted in the TGA guidance, was released in January 2017 and considered studies since 1999 about medicinal cannabis products.⁸⁷⁵ Similarly, in the UK in 2016, the All Party Parliamentary Group for Drug Policy Reform (APPG) commissioned a literature review of evidence on medicinal cannabis to support an APPG report calling for medicinal cannabis reform to take place in that jurisdiction.⁸⁷⁶

The Committee believes that, as an emerging area of medicine and practice, ongoing assistance and support for the medical profession will be required, particularly acknowledging its concerns about the lack of clinical information available on the safe and effective use of medicinal cannabis products. As discussed by the Yarra Drug and Health Forum (YDHF) in its submission, medicinal cannabis should ‘be made available for a much broader audience when it is judged by medical staff to be useful and efficacious for the purpose’.⁸⁷⁷ Guidance such as that produced by the TGA will assist by providing a foundation for practitioners to consider its use in certain circumstances, and offers a central repository where they can look to for information. However, the Committee considers that further support may also be required. For example, in January 2018 the NSW Government launched a targeted advisory service for NSW doctors to obtain guidance and information in the area of medicinal

⁸⁷³ Therapeutic Goods Administration, *Guidance for the use of medicinal cannabis in Australia: Overview*, Australian Government, Canberra, 2017, p. 3.

⁸⁷⁴ Therapeutic Goods Administration, *Guidance for the use of medicinal cannabis in Australia: Patient Information*, Australian Government, Canberra, 2017, pp. 4-7.

⁸⁷⁵ The National Academies of Sciences, Engineering, and Medicine, ‘News: For Immediate Release’, viewed 5 February 2018, <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=24625&_ga=1.166210365.208024799.1434990546>.

⁸⁷⁶ All-Party Parliamentary Group for Drug Policy Reform, *Access to medicinal cannabis: meeting patient needs*, September 2016.

⁸⁷⁷ Yarra Drug and Health Forum, *Submission*, no. 107, 14 March 2017, p. 8.

cannabis, the *NSW Cannabis Medicines Advisory Hotline*. As a mechanism to speed up patient access and provide support for doctors, Dr Kerry Chant, NSW Chief Health Officer was quoted in the accompanying media release as stating:

“We appreciate that, to date, many doctors have been unsure about whether, what or how to prescribe cannabis medicines,” Dr Chant said.

“This hotline – part of a \$21 million investment in cannabis medicines research – will simplify and speed up access for doctors whose patients may benefit from this type of treatment.”

Dr Chant said doctors anywhere in NSW can ring the hotline for guidance from leading clinicians in this emerging area of medicine.

The service will provide guidance for the use of cannabis medicines, including advice on clinical management, available medicines, and dosage information. The Service will also provide advice on symptom relief for palliative care patients.

“The Service will also have access to tests to help doctors monitor their patient’s progress whilst using cannabis medicines,” Dr Chant said.

“This information, together with findings from our clinical trials program, will accelerate our knowledge and understanding about the role of cannabis medicines and inform future practice.”⁸⁷⁸

The Victorian Industry Development Plan noted that a key action area for the Victorian Government will be to work with the Commonwealth Government to develop and disseminate clinical information and education materials about medicinal cannabis, with the goal of improving understanding and confidence of practitioners to use medicinal cannabis in appropriate cases.⁸⁷⁹ The Committee considers that such actions, as well as supporting practitioner education and training in this area, should be undertaken. To this end, the specific role of general practitioners (GPs) should be an area of focus given their potential to reach a broader patient group that could benefit from medicinal cannabis for particular conditions where appropriate. As a result of the complexities involved, these issues should be further considered by the proposed Victorian Advisory Council on Drugs Policy (recommended in chapter four), as it is best placed to consider up-to-date information as the area evolves and more research and clinical information becomes more available. It can also consider related issues, such as public education to improve community understanding about the evidence base around medicinal cannabis and efforts to enhance its use.

Further, as noted earlier, there has been limited clinical research conducted into the therapeutic benefits and harms of cannabis, although there have been improvements in recent times. As more clinical evidence is made available, this will enhance understanding of the application of medicinal cannabis to treat certain medical conditions, particularly among medical practitioners, and improve prescribing practices. This is discussed further below.

The Committee also notes that the Victorian IMAC has an important role in guiding the Victorian regime, and will continue to do so once Victorian-grown medicinal cannabis becomes available. The work and advice provided by the IMAC to the Victoria Government should be made publicly available to ensure greater community awareness about developments in this area.

⁸⁷⁸ Centre for Medicinal Cannabis Research and Innovation, *\$6 Million Cannabis Medicines Hotline Opens*, Media release, NSW Government, Sydney, 29 January 2018.

⁸⁷⁹ Agriculture Victoria, *Industry Development Plan: Developing a Medicinal Cannabis Industry in Victoria*, State Government of Victoria, Melbourne, 2018, p. 18.

RECOMMENDATION 19: The Victorian Government continue to work with the Commonwealth Government to explore ways to improve understanding among the medical profession and the public of the current evidence base and situations where medicinal cannabis products may be considered as an appropriate treatment option.

RECOMMENDATION 20: The proposed Advisory Council on Drugs Policy should investigate the role of general practitioners in providing access to medicinal cannabis, and consider how they can be best supported in this area.

RECOMMENDATION 21: To assist health professionals and patients to access this form of treatment, the work of the Independent Medical Advisory Committee be made publicly available.

Supporting continued research

Given the existing low base of evidence in relation to the use of medicinal cannabis, there was strong support among stakeholders for research to be enhanced. For example, the RACP supported 'ongoing further investments in high quality research and trials'.⁸⁸⁰ The need for more robust research is also reflected in recent reports, including the TGA guidance:

There is a significant need for larger, high-quality studies to better explore the potential benefits, limitations and safety issues associated with medicinal cannabis treatment across a range of health conditions and symptoms.

More research will:

- increase the amount and quality of evidence to either support or contradict the use of medicinal cannabis as an approved treatment
- give a more detailed understanding of the most effective cannabis products, doses and administration methods for treating various conditions
- compare medicinal cannabis with standard first line medication options currently used to treat various conditions
- build a strong knowledge base on how medicinal cannabis interacts with other drug treatments.

Prescribing doctors should also collect data based on first-hand patient experience. This will further inform our knowledge and understanding of how to use medicinal cannabis effectively and safely.⁸⁸¹

Such practitioner feedback is also being collected as part of the TGA pathways, as advised by the Victorian DHHS. Matthew McCrone, Director of Real-Time Prescription Monitoring Implementation stated:

One of the standard arrangements through the TGA is what is called adverse drug reaction reporting. Any doctor should know about the mechanism that the TGA has, and that is not just for unapproved medicines but for any medicine. If a doctor has prescribed a medicine and a patient has suffered an unusual event or an adverse event from the medicine, then there is an obligation on that doctor — and doctors know this well — to report back to the TGA about that adverse event. The TGA has a database which prescribers can access remotely through the TGA website so that that evidence base is built for adverse event reporting.

⁸⁸⁰ Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017, p. 6.

⁸⁸¹ Therapeutic Goods Administration, *Guidance for the use of medicinal cannabis in Australia: Patient Information*, Australian Government, Canberra, 2017, p. 11.

Ms PEAKE — In terms of feedback loops, that would then inform obviously the decisions the TGA makes about approvals in the future.⁸⁸²

The US National Academies of Sciences, Engineering, and Medicine study similarly recommended a national cannabis research agenda to develop the evidence base on health effects, involving a range of bodies such as public agencies, philanthropic and professional organisations, companies and research groups.⁸⁸³

The Committee is encouraged to note that important research activity is already underway in Australia, for example through the compassionate access scheme for children with severe epilepsy in Victoria. The NSW Government also established the Centre for Medicinal Cannabis Research and Innovation, which is conducting trials on childhood epilepsy, chemotherapy-induced nausea and vomiting, and palliative care.⁸⁸⁴

A key research issue raised by inquiry stakeholders, and increasingly discussed in the broader literature, is the potential role of medicinal cannabis to address chronic non-cancer pain.⁸⁸⁵ This is particularly important given rising overdose and death rates as a result of the overuse of prescription opioids to treat such issues (see chapter 15 for further details). The use of medicinal cannabis as a substitute or adjunct to opioids may help to reduce such harms, and there is a growing body of research from North America, that demonstrates this. For example, a 2014 study compared US states which had legal regimes for medicinal cannabis and those that did not from 1999 to 2010. The study found:

States with medical cannabis laws had a 24.8% lower mean annual opioid overdose mortality rate (95% CI, -37.5% to -9.5%; P = .003) compared with states without medical cannabis laws. Examination of the association between medical cannabis laws and opioid analgesic overdose mortality in each year after implementation of the law showed that such laws were associated with a lower rate of overdose mortality that generally strengthened over time...⁸⁸⁶

It suggested some reasons for these trends included:

- chronic pain patients may choose medicinal cannabis over opioid analgesics
- patients already using opioid analgesics who start using medicinal cannabis may decrease their use of opioid analgesics (reducing the risk of overdose)
- medical cannabis may lead to less polypharmacy (multiple medications taken concurrently), which may reduce the risk of overdose.⁸⁸⁷

⁸⁸² Matthew McCrone, Director, Real-time Prescription Monitoring Implementation, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 329.

⁸⁸³ The National Academies of Sciences, Engineering, and Medicine, *Report Highlights: The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*, Washington DC, 2017.

⁸⁸⁴ Centre for Medicinal Cannabis Research and Innovation, 'Clinical trials', viewed 5 February 2018, <<https://www.medicinalcannabis.nsw.gov.au/clinical-trials>>.

⁸⁸⁵ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 87; Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 49; Penington Institute, *Submission*, no. 209, 24 March 2017, pp. 39-40.

⁸⁸⁶ Bachhuber, M, et al., 'Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010', *JAMA Internal Medicine*, vol. 174, no. 10, 2014, p. 1668.

⁸⁸⁷ Bachhuber, M, et al., 'Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010', *JAMA Internal Medicine*, vol. 174, no. 10, 2014, p. 1671.

Similarly, a 2017 article *Rationale for cannabis-based interventions in the opioid overdose crisis* summarised a range of further studies that also found correlation between the availability of medicinal cannabis and opioid overdoses, noting:

In light of the growing overdose crisis in North America, these findings on cannabis substitution effect and the biological mechanisms behind it strongly suggest that cannabis could play a role in reducing the public health impacts of prescription and non-prescription opioids.⁸⁸⁸

While highlighting that cannabis is not a ‘silver bullet’ to solve the opioid overdose crisis, it suggested:

The growing body of research supporting the medical use of cannabis as an adjunct or substitute for opioids creates an evidence-based rationale for governments, health care providers, and academic researchers to seek the immediate implementation of cannabis-based interventions in the opioid crisis at the regional and national level, and to subsequently assess their potential impacts on public health and safety.⁸⁸⁹

It is also instructive to note that the US National Institute on Drug Abuse website cited studies it funded on this issue, advising that ‘data suggest that medical cannabis treatment may reduce the dose of opioids required for pain relief’.⁸⁹⁰ It is funding further research in this area.

During the Committee’s overseas study tour, it heard from stakeholders in North America that medicinal cannabis is currently being proactively considered as a response to the opioid crisis. For example, Taylor West from the National Cannabis Industry Association (NCIA) in Colorado informed the Committee there is growing recognition that there are significantly fewer harms from cannabis use than opioids, and that medicinal cannabis can work alongside opioids for pain management.⁸⁹¹ Vancouver Coastal Health (VCH) also mentioned broadening the availability of medicinal cannabis to reduce dependence on prescription opioids and the likely impact on overdoses.⁸⁹²

In Australia, the potential for medicinal cannabis to be utilised in this area should be explored. A 2015 study of 1,500 Australians by NDARC found that one in six people using prescribed opioids for chronic non-cancer pain also used cannabis. Further, it indicated that ‘[c]annabis use for pain relief purposes appears common among people living with chronic non-cancer pain, and users report greater pain relief in combination with opioids than when opioids are used alone’.⁸⁹³ The TGA guidance stated:

There is much interest at present as to whether cannabinoids are “opioid sparing” — in other words, whether use of medicinal cannabis products for pain can result in a reduction of use of strong opioids. If this were the case, deaths and incapacity

⁸⁸⁸ Lucas, P, ‘Rationale for cannabis-based interventions in the opioid overdose crisis’, *Harm Reduction Journal*, vol. 14, no. 58, 2017, p. 2.

⁸⁸⁹ Lucas, P, ‘Rationale for cannabis-based interventions in the opioid overdose crisis’, *Harm Reduction Journal*, vol. 14, no. 58, 2017, p. 5.

⁸⁹⁰ National Institute on Drug Abuse, ‘Is marijuana safe and effective as medicine?’, viewed 5 February 2018, <<https://www.drugabuse.gov/publications/marijuana/marijuana-safe-effective-medicine>>.

⁸⁹¹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 65.

⁸⁹² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 52.

⁸⁹³ Degenhardt, L, et al., ‘Experience of adjunctive cannabis use for chronic non-cancer pain: Findings from the Pain and Opioids IN Treatment (POINT) study’, *Drug and Alcohol Dependence*, vol. 147, 2015, p. 144.

from opioid overdoses could be reduced, given that cannabinoids have fewer adverse outcomes. While some individuals with pain have reported that their use of opioids has been reduced when they also use medicinal cannabis, clinical studies in this area are still ongoing.⁸⁹⁴

Overall, the Committee believes that enhanced research relating to the use of medicinal cannabis is required to ensure that public authorities, the medical profession and the general public gain a better understanding of the health effects of cannabis, whether beneficial or harmful, when used for therapeutic purposes. Given the significant progress already made in Victoria and nationally, such research, which has only been made possible recently given the previous prohibition of these products, will contribute to more informed practices for the use of medicinal cannabis. The Committee also believes that, based on evidence it received during the inquiry and overseas study tour, a particular area of research should be the role of medicinal cannabis in treating chronic non-cancer pain conditions, which may provide more positive outcomes than opioid-based treatments.

RECOMMENDATION 22: The Victorian Government facilitate continued investment for research and clinical trials into the use of medicinal cannabis and its effects, including its role in working alongside prescription opioids for pain management and reducing reliance and dosage levels of medication prescribed for pain relief.

9.2 Adult use of cannabis

Internationally, discussion regarding the legal regulation of cannabis for adult use is becoming more common. There is increasing recognition that despite extensive enforcement efforts, cannabis is the most widely used illicit drug in the world. In response, a growing number of jurisdictions have moved away from a prohibition model, and many other countries are exploring alternative approaches to control the substance, which also aims to minimise the scale and scope of the illicit drug market and deliver better health and social outcomes for the broader community.

In 2013, Uruguay was the first country to legalise and regulate cannabis for non-medical purposes. At the sub-national level, eight jurisdictions in the US, representing 20 per cent of the country's population, voted to do the same. In Canada, Bill C-45 or the Cannabis Act, which is also set to legalise cannabis, passed the House of Commons in the Federal Parliament in November 2017 and is currently under consideration by Senate committees, whom are due to report back to the Senate by 1 May 2018.⁸⁹⁵ While adopting different types of regulatory models to control cannabis, according to the Global Commission on Drug Policy (GCDP), a commonality is shared across the jurisdictions:

Drug markets that are subject to strict legal regulation are not 'free markets'. Nor does exploring alternatives to prohibition imply a drug market 'free for all', where access to drugs is unrestricted and availability is dramatically increased. Regulation is about taking control, so that governments, not criminals, make decisions on the availability and non-availability of different substances, in different environments.⁸⁹⁶

⁸⁹⁴ Therapeutic Goods Administration, *Guidance for the use of medicinal cannabis in Australia: Patient Information*, Australian Government, Canberra, 2017, p. 6.

⁸⁹⁵ The Senate of Canada, 'The Cannabis Act in the Senate', 27 February 2018, viewed 3 March 2018, <<https://sencanada.ca/en/sencaplus/news/cannabis-act/>>.

⁸⁹⁶ Global Commission on Drug Policy, *Taking Control: Pathways to Drug Policies That Work*, Geneva, 2014, p. 29.

This section focuses on some of the key aspects of these regulatory models.

The International Drug Policy Consortium (IDPC), a global network of non-government organisations concerned with drug law reform, states in its *Drug Policy Guide (3rd Edition)* that there are five basic models for regulating drug availability. The strictest model comprises medical prescription with optional supervised consumption facilities for the most risky substances (such as heroin). At the other end, the model with minimal regulation comprises unlicensed sales for products such as caffeine. Licensed retailing sits in the middle, which includes varying levels of regulation appropriate to product risk and local needs. According to the IDPC Drug Policy Guide, this model could be used for lower risk drugs such as cannabis.⁸⁹⁷ The Committee notes, however, that there is more to cannabis regulation than the retail component, with the cannabis supply chain beginning with production, including cultivation and manufacturing; distribution; and finally retail. This requires determining who or which agencies should have responsibility for these roles, such as governments (federal or state), businesses, and possibly individuals in the context of home grow provisions.

Before exploring these options, the first step is to determine the key objective of reforms, with this largely shaping all others decisions about the regulated supply of cannabis. In Uruguay, a key driver for legalising cannabis was to reduce harms arising from the criminal behaviour of Paraguayan drug distributors.⁸⁹⁸ The Uruguayan Government also wanted to limit the spread of pasta base, a crack-like substance being used predominantly in low-income urban neighbourhoods. It aimed to do this by minimising the contact of current cannabis users with the drug pasta base in the illicit market.⁸⁹⁹ Interestingly, this rationale originated in the context of the Dutch model on the basis that small-scale cannabis transactions in ‘coffee shops’ would minimise the number of adults experimenting with other, more dangerous substances available in the illicit market.⁹⁰⁰ The Committee also notes that in the Netherlands, while the coffee shop model is often referred to in discussions around cannabis legalisation, cannabis technically remains a prohibited substance in this country. However, law enforcement has tolerated the sale of it in coffee shops since 1979.⁹⁰¹

In the US, the objectives of cannabis reform differ somewhat between jurisdictions but can largely be grouped under reducing the size of the illicit market; reducing involvement of the criminal justice system; generating tax revenue; and regulating the testing, potency and labelling of cannabis products for public health purposes.⁹⁰² On the other hand, the Canadian Government established an extensive list of objectives under a purely public health framework to inform the development of the Cannabis Act. These are outlined in text box below.

⁸⁹⁷ International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 74.

⁸⁹⁸ Kilmer, B, *New developments in cannabis regulation*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2017, p. 13.

⁸⁹⁹ Walsh, J and Ramsey, G, ‘Uruguay’s Drug Policy: Major Innovations, Major Challenges’, *Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016*, Foreign Policy at Brookings, 2016, viewed 1 February 2018, <<https://www.brookings.edu/wp-content/uploads/2016/07/Walsh-Uruguay-final.pdf>>, p. 3.

⁹⁰⁰ European Monitoring Centre for Drugs and Drug Addiction, ‘Models for the legal supply of cannabis: recent developments’, *Perspectives on Drugs*, 2016, viewed 1 February 2018, <<http://www.emcdda.europa.eu/publications/pods/legal-supply-of-cannabis>>, p. 9.

⁹⁰¹ Kilmer, B, *New developments in cannabis regulation*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2017, p. 13.

⁹⁰² Kilmer, B, *New developments in cannabis regulation*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2017, p. 13.

Public health objectives to inform Canada's Cannabis Act

- Protect young Canadians by keeping cannabis out of the hands of children and youth
- Keep profits out of the hands of criminals, particularly organized crime
- Reduce the burdens on police and the justice system associated with simple possession of cannabis offences
- Prevent Canadians from entering the criminal justice system and receiving criminal records for simple cannabis possession offences
- Protect public health and safety by strengthening, where appropriate, laws and enforcement measures that deter and punish more serious cannabis offences, particularly selling and distributing to children and youth, selling outside of the regulatory framework, and operating a motor vehicle while under the influence of cannabis
- Ensure Canadians are well-informed through sustained and appropriate public health campaigns and, for youth in particular, ensure that risks are understood
- Establish and enforce a strict system of production, distribution and sales, taking a public health approach, with regulation of quality and safety (e.g., child-proof packaging, warning labels), restriction of access, and application of taxes, with programmatic support for addiction treatment, mental health support and education programs
- Provide access to quality-controlled cannabis for medical purposes consistent with federal policy and court decisions
- Enable ongoing data collection, including gathering baseline data, to monitor the impact of the new framework.⁹⁰³

9.2.1 Cannabis regulatory models

According to the IDPC, exploring appropriate regulatory models for the legal market of substances, such as cannabis, requires consideration of:

- The drug products themselves (dose, preparation, price, and packaging)
- Licensing of drug product vendors (vetting and training requirements)
- The outlets from which the drug products are available (location, outlet density, appearance)
- Marketing (advertising, branding and promotions)
- Availability and access (age controls, licensed buyers, club membership schemes, rationing)
- Where, when and how drugs can be consumed.⁹⁰⁴

⁹⁰³ Health Canada, *A Framework for the Legalization and Regulation of Cannabis in Canada: The Final Report of the Task Force on Cannabis Legalization and Regulation*, Government of Canada, Ottawa, 2016, p. 11.

⁹⁰⁴ International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 73.

In the broader literature, discussions regarding the most appropriate model for cannabis regulation typically focus on the examples of alcohol and tobacco, particularly in learning how to minimise the risks of over-commercialisation. Cannabis is often compared with alcohol, with both often perceived as a ‘social drug’ and alcohol having an existing regulatory model that could be applied to cannabis.⁹⁰⁵ However, there is broad acknowledgment that a few lessons can be taken from the mistakes made with alcohol regulation. One lesson in particular is the need to prioritise public health considerations when developing a model of cannabis regulation. This did not occur with alcohol, nor tobacco, with businesses seeking to maximise their profits, which led to increased and harmful use of these products and substantial social, health and economic harms. It has only been in the last two to three decades that public health models have been implemented after years of resistance from industry lobby groups.⁹⁰⁶

Throughout the inquiry, the Committee heard that governments have a ‘responsibility to ensure that public health is prioritised at all times over commercial interests when designing any new regulatory model’.⁹⁰⁷ In his evidence to the Committee, Dr Alex Wodak AM, of the ADLRF and Australia21 outlined some of the key public health considerations for cannabis regulation:

...well, I think we ban sales under a certain age and we require proof of age for people who claim to be above that age, modelled on what we do for alcohol. I think we have health warnings on packages.

...

I would hope people would not be smoking cannabis but would be vaping it - would be inhaling the vapour. I think we should have consumer protection information on the packet: “This packet contains 3.4 per cent THC and 6.2 per cent CBD.” That kind of information on the packet. I’d like to see health-seeking information required, so for people who want to stop or cut down and having difficulty doing that, I can ring this phone number or I can go to this website. I would like to see all advertising banned, personally. I would also like to see all donations to all political parties and politicians banned. I don’t know whether that’s practical but I would like to see it.⁹⁰⁸

As discussed below, the US jurisdictions that have regulated adult use of cannabis have predominantly implemented similar models to alcohol, with their regulatory frameworks closely related in terms of the distribution, sale and control of consumption.⁹⁰⁹

Uruguay

While experiences with the regulation of alcohol and tobacco are instructive, not all jurisdictions that legalised cannabis have taken this path. Uruguay, in particular, implemented a state controlled licensing and distribution system that places greater restrictions on use and fewer corporate and commercial incentives. For example, the national government oversees all cannabis production and directly contracts commercial cultivation, which is sold exclusively in licensed pharmacies. Further,

⁹⁰⁵ Homel, P and Brown, R, ‘Marijuana legalisation in the United States: An Australian perspective’, *Trends & issues in crime and criminal justice*, no. 535, Australian Institute of Criminology, 2017, p. 7.

⁹⁰⁶ International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 74.

⁹⁰⁷ International Drug Policy Consortium, *IDPC Drug Policy Guide: 3rd Edition*, London, 2016, p. 74.

⁹⁰⁸ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 95.

⁹⁰⁹ Homel, P and Brown, R, ‘Marijuana legalisation in the United States: An Australian perspective’, *Trends & issues in crime and criminal justice*, no. 535, 2017, p. 5.

advertising and promotion of cannabis is strictly banned and only Uruguayan citizens and permanent residents are permitted to purchase cannabis, therefore minimising cannabis tourism.⁹¹⁰

Uruguay's cannabis model comprises the following three legal methods to access the substance for people over the age of 18:

- (1) Individuals can purchase ten grams of cannabis per week in licensed pharmacies, with or without a prescription, although they must first register with the Institute for Regulation and Control of Cannabis (IRCCA). A limited number of commercial growers are specifically approved by the Government to produce the substance.
- (2) Individuals can grow up to six female flowering cannabis plants per household for their own consumption, although they are required to register their plants with the IRCCA. Annual production must not exceed 480 grams.
- (3) 'Cannabis enthusiasts' can join cooperatives, otherwise known as 'cannabis clubs' to collectively grow cannabis. The cooperatives must be registered with the IRCCA and can comprise between 15 to 45 members. They can plant up to 99 plants in the same space but cannot dispense more than 480 grams of cannabis to each of their members per year, with any surplus provided to the IRCCA.⁹¹¹

While commercial production of cannabis is currently limited to a maximum of five companies, it is predicted that this will rise as Uruguayan officials believe the annual demand will be around 18 to 22 tons per year.⁹¹²

United States

Colorado and Washington State were the first jurisdictions in the US where voters approved ballot initiatives to legalise the production and sale of non-medical cannabis in 2012, which then became operational in 2014. This was distinct from the medical cannabis markets that already existed in 18 US states, with the State of California being the first to introduce a medicinal cannabis market in 1996. Unlike Uruguay, Colorado and Washington State's cannabis regulatory models are commercially-based, with their respective laws permitting legal retail sales, cultivation sites, factories, and testing sites for recreational cannabis.

In November 2014, the states of Oregon and Alaska voted for similar regulatory systems, followed by California, Maine, Massachusetts and Nevada in 2016. In Washington DC, voters approved the recreational use of cannabis but not under a commercial model. Adults over the age of 21 years are allowed to grow cannabis and transfer it without payment.⁹¹³ Further, Vermont became the first state to legalise cannabis through a state legislature in January 2018.⁹¹⁴

⁹¹⁰ Walsh, J and Ramsey, G, 'Uruguay's Drug Policy: Major Innovations, Major Challenges', *Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016*, Foreign Policy at Brookings, 2016, viewed 1 February 2018, <<https://www.brookings.edu/wp-content/uploads/2016/07/Walsh-Uruguay-final.pdf>>, p. 9.

⁹¹¹ Walsh, J and Ramsey, G, 'Uruguay's Drug Policy: Major Innovations, Major Challenges', *Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016*, Foreign Policy at Brookings, 2016, viewed 1 February 2018, <<https://www.brookings.edu/wp-content/uploads/2016/07/Walsh-Uruguay-final.pdf>>, p. 7.

⁹¹² Walsh, J and Ramsey, G, 'Uruguay's Drug Policy: Major Innovations, Major Challenges', *Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016*, Foreign Policy at Brookings, 2016, viewed 1 February 2018, <<https://www.brookings.edu/wp-content/uploads/2016/07/Walsh-Uruguay-final.pdf>>, p. 8.

⁹¹³ Kilmer, B, *New developments in cannabis regulation: Background paper commissioned by the EMCDDA for Health and social responses to drug problems: a European guide*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2017, pp. 7-8.

⁹¹⁴ Drug Policy Alliance, 'From Prohibition to Progress: A Status Report on Marijuana Legalization', viewed 27 February 2018, <<http://www.drugpolicy.org/legalization-status-report>>.

As part of the overseas study tour, the Committee visited Denver and Sacramento to learn more about cannabis laws in the jurisdictions of Colorado and California. In its meeting with the Colorado DPHE, the Committee was advised that upon the approval of adult use of cannabis, the Department took a more active approach to address the public health components of legalisation, taking lessons from alcohol and tobacco policy. This included paying attention to unintentional consumption by young children, use among youth and pregnant women, and advertising and appropriate labelling. It also resulted in the following policies:

- cannabis smoking added to indoor smoking legislation
- advertising restrictions
- age limit of 21 for use, similar to alcohol
- child-proof packaging.⁹¹⁵

The Department also conducted various public awareness raising campaigns, including the *Good to Know* campaign. This campaign outlined the various laws relating to cannabis use in Colorado and provided information for adults (parents, teachers or other ‘trusted adults’) about how to talk to young people about cannabis and health effects. Another youth-oriented campaign was *Protect what’s next*, which also talked about the health effects and potential consequences of cannabis use among young people.⁹¹⁶

Further, the DPHE referred to the capacity of governments to control the quality of cannabis products in a regulated market, allowing them to remove pesticides, bacteria and other contaminants likely to be present in products purchased on the illicit drug market. This point was reaffirmed in a later meeting with the California State Legislature, where quality control was identified as paramount in the context of medicinal cannabis to ensure patients receive products that are safe and free of pesticides.⁹¹⁷

Unintended consequences

During its time in Denver, the Committee was advised on numerous occasions of various unintended consequences arising from the regulated supply of cannabis, although the flexibility of Colorado’s model allowed these issues to be rectified in a timely and effective manner.⁹¹⁸

The Department of Public Health and Environment advised the Committee that in the early days of regulation there was limited product quantity controls, which resulted in accidental overconsumption and overdoses from people ingesting cannabis edibles. This was compounded by the fact that smoking cannabis outdoors is illegal, and tourists in particular had nowhere to smoke or vaporise so they chose to ingest edible products. This was responded to quickly by both the Government and industry, with tightening of regulations regarding dosages and labelling. An information campaign was also implemented regarding safe storage of cannabis products and guidelines

⁹¹⁵ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 66.

⁹¹⁶ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 67.

⁹¹⁷ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 83.

⁹¹⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 64, 67, 70, 74.

about use, including the *Start low, go slow* campaign. All edibles are now packaged appropriately, with an imprinted symbol containing the letters ‘THC’, in addition to prohibiting packaging that is appealing to children.⁹¹⁹

The high concentration of cannabis in edible products was identified by numerous stakeholders as a useful case study for other countries considering regulating the supply of cannabis. For example, based on these experiences, the Canadian Task Force on Cannabis Regulation and Legalization made the following considerations in its framework report to the Federal Government:

In weighing the arguments for and against limitations on edibles, the majority of the Task Force concluded that allowing these products offers an opportunity to better address other health risks. Edible cannabis products offer the possibility of shifting consumers away from smoked cannabis and any associated lung-related harms. This is of benefit not just to the user but also to those around them who would otherwise be subject to second-hand smoke.

...

The Task Force is concerned by the reports of an increase of accidental ingestion by children in states where cannabis is legal. We acknowledge that a lack of regulation contributed to this risk. Should edibles be allowed for legal sale in Canada, they should, at a minimum, conform to the strictest packaging and labelling requirements for edibles currently in force in U.S. states. Since these measures are fairly recent, the markets (Canadian and U.S.) should be closely monitored to determine the effectiveness of these measures.⁹²⁰

According to the DPHE, there was also an increase in cannabis-related hospital presentations following cannabis legalisation in Colorado. A contributing factor was the rise in cannabis-related tourism, although this has since settled. It was suggested that the increase could also be due to the de-stigmatisation of cannabis use, resulting in more people feeling comfortable about seeking medical assistance when required. Similarly, medical staff now have greater awareness about how to address cannabis-related health effects.⁹²¹

When asked about their views on the regulated supply of cannabis, staff of the DPHE indicated that they preferred a slightly higher prevalence rate for cannabis use in a legal market that is supported by appropriate infrastructure, surveillance and monitoring, taxation revenue, public health campaigns and product control. In contrast, a lower prevalence rate in an illegal market does not have any of those support mechanisms, but has an unregulated product that could potentially lead to more harms.⁹²²

Pricing and taxation

During its time in North America, the Committee heard on numerous occasions about the need for appropriate pricing of cannabis products in a regulated market. The two economic arguments arising from this relate to undercutting the price of products in

⁹¹⁹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 67.

⁹²⁰ Health Canada, *A Framework for the Legalization and Regulation of Cannabis in Canada: The Final Report of the Task Force on Cannabis Legalization and Regulation*, Government of Canada, Ottawa, 2016, p. 11.

⁹²¹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 66, 70-71.

⁹²² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 67.

the illicit market and generating income through taxation for governments.⁹²³ On the first point, the Committee was advised that cannabis products need to be priced below that of illegal cannabis to undermine the illicit market, but also high enough to discourage young people from wanting to purchase it. Dr Alex Wodak AM of the ADLRF advised the Committee of the challenge in determining an appropriate price for products:

Parliaments are going to have to and governments are going to have to wrestle with the issue of pricing. If the price is too high that will simply perpetuate the black market. If the price is too low then that may encourage more use so we want to get the Goldilocks price that's not too hot and not too cold - that's right in the middle and that's going to take a bit of adjustment. We'll only be able to find that out by trial and error and presumably over time that will have to be modified now and then.⁹²⁴

The Canadian Task Force on Cannabis Regulation and Legalization raised a number of important considerations around pricing that prioritise public health and safety over revenues, including the need to:

- Establish a minimum price or tax based on potency levels, thereby driving consumers to less potent products;
- Encourage consistent prices and taxation levels across the country to avoid cross-border shopping. Some suggested considering additional taxes for tourists;
- Establish a Health and Safety Board to recommend and set prices;
- Consider using economic analyses to learn how different costs, and availability of substances, impact consumption patterns.⁹²⁵

The Committee notes that the income generation potential from taxes applied to recreational cannabis can be substantial. In Colorado, legislation directs how revenues are distributed, which enables the government to heavily invest in public education and social programs.⁹²⁶ A Marijuana Tax Cash Fund was developed for most of the sales tax revenue collected, with money used for educational prevention programs, data collection, treatment, diversionary programs and public health programs. A proportion of the sales tax revenue is distributed to local governments.⁹²⁷ The diagram below from the Colorado Department of Education summarises how taxation is distributed:

⁹²³ Homel, P and Brown, R, 'Marijuana legalisation in the United States: An Australian perspective', *Trends & issues in crime and criminal justice*, no. 535, Australian Institute of Criminology, 2017, p. 9.

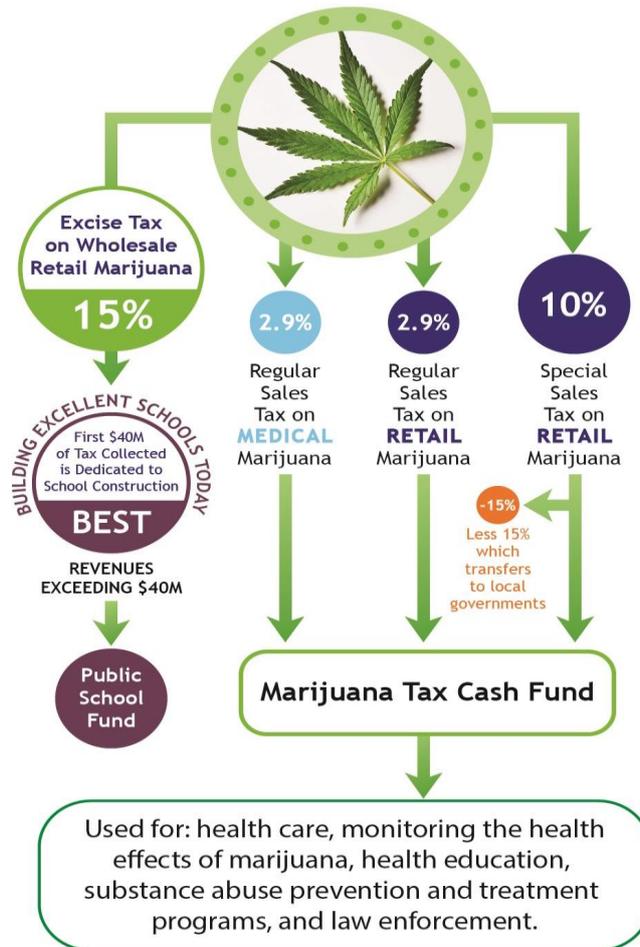
⁹²⁴ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 95.

⁹²⁵ Health Canada, *A Framework for the Legalization and Regulation of Cannabis in Canada: The Final Report of the Task Force on Cannabis Legalization and Regulation*, Government of Canada, Ottawa, 2016, p. 11.

⁹²⁶ Homel, P and Brown, R, 'Marijuana legalisation in the United States: An Australian perspective', *Trends & issues in crime and criminal justice*, no. 535, Australian Institute of Criminology, 2017, p. 10.

⁹²⁷ Colorado Department of Education, 'Marijuana Tax Revenue and Education', viewed 15 March 2018, <<http://www.cherrycreekschools.org/Documents/Marijuana%20Tax%20Revenue%20and%20Education%20Fact%20Sheet.pdf>>.

Figure 9.3 Marijuana Tax Cash Fund distribution



Source: Colorado Department of Education, *Fact Sheet: Marijuana Tax Revenue and Education*, Denver, 2016.

Further, the work of the Marijuana Enforcement Division within the Colorado Department of Revenue is funded through taxation revenues, ensuring that the direct cost of regulation is itself covered by cannabis revenue.

In its meeting with the Committee, the Colorado Department of Revenue advised that in 2016, \$240 million taxation revenue was received, increasing from \$141 million in 2015 and \$90 million in 2014. Departmental staff also indicated that while there had been a 15 per cent increase in market growth in 2016-2017, this had slowed down from growth of up to 30 per cent in previous years.⁹²⁸

According to Dr Alex Wodak AM of the ADLRF, the State of California estimated that the regulated supply of recreational cannabis will generate over \$1 billion a year.⁹²⁹ This will be allocated to justice reinvestment programs, with the aim of reducing crime and incarceration rates, in addition to addressing the impact of harmful drug laws in specific disadvantaged communities.

As shown in the below text box, revenue from cannabis sales in the US is predominantly allocated to social and education programs.

928 Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 74.
 929 Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 95.

States are allocating marijuana revenues for social good⁹³⁰

Colorado distributed \$230 million to the Colorado Department of Education between 2015 and 2017 to fund school construction, early literacy, bullying prevention, and behavioural health.

Oregon allocates 40% of marijuana tax revenue to its state school fund, depositing \$34 million into the fund so far. The state also distributes 20% to alcohol and drug treatment.

Nevada's 15% wholesale tax is projected to bring in \$56 million over the next two years to fund state schools.

Washington dedicates 25% to substance use disorder treatment, education and prevention. The state also distributes 55% of its marijuana tax revenues to fund basic health plans.

Alaska will collect an estimated \$12 million annually, which will fund drug treatment and community residential centres.

California and Massachusetts will invest a share of their marijuana tax revenues in the communities most adversely impacted by drug arrests and incarceration, particularly low-income communities of colour, to help repair the harms of unequal drug law enforcement.

Tracking the supply chain of cannabis markets

The Committee also heard in Denver and Sacramento about the importance of 'seed to sale' tracking systems, which cover the supply chain of cannabis products to ensure industry compliance. The Colorado Department of Revenue advised that the tracking system captures every aspect of the industry from cultivation, transportation to dispensary and sale, with all activity incorporated into the metrics system. The tracking system allows the Department to monitor and conduct risk analyses based on the behaviours of different players in the industry, and when someone is identified as not complying, they are locked out of the system while being investigated.

Tracking systems also allow to some extent an estimation of the size of the black and grey markets. While the black market refers to the 'illicit grow and distribution operations with no connection to medical or retail dispensary',⁹³¹ the grey market comprises the '[i]llegal distribution of marijuana products that are grown or acquired legally'. This includes sharing cannabis from home-grown production, or sharing cannabis purchased from a licensed marijuana dispensary or retail outlet.⁹³² The Colorado Department of Revenue advised the Committee that because of its

⁹³⁰ Drug Policy Alliance, 'From Prohibition to Progress: A Status Report on Marijuana Legalization', viewed 27 February 2018, <<http://www.drugpolicy.org/legalization-status-report>>.

⁹³¹ Light, M, et al., *Market size and demand for marijuana in Colorado*, Denver, 2014, p. 27.

⁹³² Light, M, et al., *Market size and demand for marijuana in Colorado*, Denver, 2014, p. 32.

contribution to the grey market, self-cultivation was being tightened to limit the number of plants allowed for home grow purposes. The Department highlighted to the Committee that this was a particularly difficult area to monitor and enforce.⁹³³

In the context of reducing the size of the illicit drug market, the Department indicated that based on anecdotal evidence, the regulated supply of cannabis is having a positive impact. The 2014 market demand study, *Market size and demand for marijuana in Colorado*, estimated demand of 130 metric tonnes from both local residents and visitors. The Department advised that as of July 2017, the regulatory market was meeting approximately 80 per cent of demand.⁹³⁴

In Sacramento, the California Bureau of Marijuana Control advised the Committee of concerns about reports of oversupply of cannabis grown in California, with predictions of 70 per cent of it being exported out of the State into the illicit drug market. While seed to sale tracking plays an important role in monitoring cultivation, it is difficult to capture it all and enforce accordingly.⁹³⁵ This has been an ongoing issue in US jurisdictions that have implemented a regulatory model for adult cannabis use, with reports of legalised cannabis being spilled into the illicit markets in other jurisdictions where adult cannabis use remains prohibited.

Conflicts between United States' federal and state laws

An important discussion point regarding the regulation of cannabis in the US is the relationship between federal and state laws. Federal law under the *Controlled Substances Act 1970* (CSA) unambiguously proscribes the use of cannabis or any other illicit drug listed in its attached schedules for medical or recreational reasons. As with most nations that have incorporated the three UN conventions into law, cannabis is placed in Schedule 1 as a highly addictive drug with no medical value, similar to heroin or amphetamine. Moreover, American constitutional law provides that where the federal government has primary jurisdiction over any given subject matter, these laws should prevail over those of the states to the extent that there are inconsistencies between them (the *supremacy clause*).

During the Obama presidency, the federal Department of Justice (DOJ) indicated it would defer to state law and entrust local authorities with cannabis-related enforcement but would intervene where necessary.⁹³⁶ In 2013, DOJ issued a directive to prosecutors (the Cole Memorandum) concerning federal cannabis enforcement, indicating that state legal medical cannabis cases 'is not a priority'. The directive included the following eight guidelines for prosecutors in determining federal enforcement priorities:

- (1) Preventing distribution of cannabis to minors;
- (2) Preventing revenue from the sale of cannabis from going to criminal enterprises, gangs or cartels;
- (3) Preventing the diversion of cannabis from states where it is legal under state law in some form to other states;
- (4) Preventing state-authorized cannabis activity from being used as a cover or a pretext to traffic other illegal drugs or other illegal activity;

⁹³³ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 74.

⁹³⁴ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017.

⁹³⁵ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 78.

⁹³⁶ Miron, J, *Working Paper: Marijuana Policy in Colorado*, Cato Institute, Washington DC, 2014, p. 10.

- (5) Preventing violence or the use of firearms in cultivation and distribution of cannabis;
- (6) Preventing drugged driving and the exacerbation of other adverse public health consequences associated with cannabis use;
- (7) Preventing the growing of cannabis on public lands and the attendant public safety and environment dangers posed by cannabis production on public lands; and
- (8) Preventing cannabis possession or use on federal property.⁹³⁷

With the Trump government, however, there has been a return to stronger enforcement of federal cannabis laws. In particular, on 4 January 2018, the federal Attorney-General, Jeff Sessions, issued a memorandum on cannabis enforcement announcing the rescission of previous guidance documents:

...Attorney General Jeff Sessions directs all U.S. Attorneys to enforce the laws enacted by Congress and to follow well-established principles when pursuing prosecutions related to marijuana activities. This return to the rule of law is also a return of trust and local control to federal prosecutors who know where and how to deploy Justice Department resources most effectively to reduce violent crime, stem the tide of the drug crisis, and dismantle criminal gangs.⁹³⁸

Aside from enforcement issues, various stakeholders advised the Committee during the overseas study tour that the federal ban on cannabis adversely impacts local cannabis industries in more direct ways. A key issue arising from the federal ban is that cannabis businesses are forced to operate in a cash economy due to the major banking institutions not willing to accept them as clients. Consequently, businesses transport and store large amounts of money, creating public safety concerns.⁹³⁹ Businesses are also unable to pay electronically for utility services, such as water and electricity, which is particularly problematic for larger scale businesses. For example, a medicinal cannabis business in Denver, Medicine Man, has a monthly electricity bill of \$40,000, which it is required to pay in cash.⁹⁴⁰ In addition, another medicinal cannabis business in Denver, Mary's Medicinals, pays up to 85 per cent taxes on all of its businesses as a result of the federal ban not allowing it to claim any deductions on its businesses expenses. This is in addition to the taxes it pays at state and local levels.⁹⁴¹

The federal ban has also resulted in limited scientific research on the health impacts of cannabis in the US. Further, Art Way, the Colorado State Director of Drug Policy Alliance, advised the Committee that individuals living in federally funded social and public housing, where cannabis use is banned, are unable to use medicinal cannabis for legitimate health purposes.⁹⁴²

⁹³⁷ Cole, J, 'Memorandum for all United States Attorneys: Guidance Regarding Marijuana Enforcement', viewed 19 March 2018, <<https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>>.

⁹³⁸ Office of Public Affairs, *Justice Department Issues Memo on Marijuana Enforcement*, Media release, United States Department of Justice, 4 January 2018.

⁹³⁹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 62, 63-64.

⁹⁴⁰ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 71.

⁹⁴¹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 76.

⁹⁴² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 69.

9.2.2 Monitoring outcomes of international cannabis regulatory models

The development and implementation of cannabis regulatory models for adult use is an area of drug law reform worthy of exploration, especially now that there are various models that can be monitored and reviewed. In particular, upon the enactment of Canada's cannabis legislation, it will be useful to observe its regulatory system in practice, including the numerous public health components that form part of its overall model and their impact in reducing the harms arising from cannabis use.

RECOMMENDATION 23: The proposed Advisory Council on Drugs Policy investigate international developments in the regulated supply of cannabis for adult use, and advise the Victorian Government on policy outcomes in areas such as prevalence rates, public safety, and reducing the scale and scope of the illicit drug market.

10 Drug driving and road safety

Another area where law enforcement plays an important role in addressing drugs in the community is enforcement of drug driving laws through roadside drug testing. Victoria, as a leader in road safety, was the first jurisdiction in the world to implement roadside drug testing in 2004. Similar to other drug laws in Victoria and throughout Australia, drug driving laws are based on a zero tolerance approach, in that detection of the presence of a proscribed substance in a driver is deemed an offence. Currently, police can test for the presence of cannabis (Tetrahydrocannabinol/THC), Methylendioxyamphetamine (MDMA) and methamphetamine.

It is difficult to determine the nature and scope of the drug driving problem in Victoria, although driving under the influence of drugs can impair driving-related skills. The Committee was advised that in Victoria 19.5 per cent of deceased drivers had methamphetamine detected, compared to 19 per cent of deceased drivers with a blood alcohol content (BAC) exceeding the prescribed limit of 0.05. For injured drivers, 18 per cent tested positive for stimulant substances and 16 per cent tested positive for cannabis, compared to 14 per cent of drivers with a BAC exceeding the prescribed limit.⁹⁴³

Internationally, drug testing of drivers is common, although not all employ a zero tolerance approach. Other approaches include setting legal limits, also known as 'per se laws' that establish fixed substance limits, similar to BAC of 0.05; and impairment legislation where it must be proven in each case that the driving skills of the driver have been affected.⁹⁴⁴ The purpose of this chapter is to explore Victoria's current approach, including its role in achieving safety on the roads, and to review other types of approaches that also aim to minimise the role of drugs on road crashes.

The Committee wishes to note that while the original terms of reference (ToR) for the inquiry specifically requested the Committee to review the effectiveness of roadside drug testing, the ToR were later refined and this ToR was removed to ensure completion of the inquiry in the agreed timeframes. Consequently, the Committee was not in a position to explore drug driving in a comprehensive manner. This chapter addresses the issue only briefly, although the Committee agrees that it requires closer examination as another area of drug policy where law reform could be beneficial.

943 Professor Noel Woodford, Director, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 207.

944 Schulze, H, et al., *Driving Under the Influence of Drugs, Alcohol and Medicines in Europe - findings from the DRUID project*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2012.

10.1 Random roadside drug testing

A key component of roadside testing is the random selection of motorists without suspicion from traffic passing through police checkpoints. This is similar to alcohol testing although they are independent from one another. Victoria was the first jurisdiction in Australia to introduce roadside drug tests, first as a trial in 2004 and permanently in 2006. Internationally, the Committee understands that random roadside testing for both drugs and alcohol is much less common. As noted in the *Roadside Drug Testing Scoping Study* commissioned by the Commonwealth Department of Infrastructure, Regional Development and Cities:

Interestingly many interviewees did not realise that the ability for police to randomly stop drivers for the purposes of an alcohol or drug test was not universal among developed western countries. On face value, it may appear many countries and jurisdictions (e.g., England, Germany, Netherlands, some states in the U.S.) operate random stops for alcohol and drug testing. However, the reality in many countries is that often the legal process is more complex and cumbersome than the Australian scenario and overall total tests per number of licenced drivers is significantly lower than Australia.⁹⁴⁵

Below is a table provided by Victoria Police in supplementary evidence, which reflects the number of roadside oral fluid tests for drug driving conducted over the last five years. As shown, in 2016, Victoria Police conducted 95,161 tests, with a confirmed detection of an illicit substance in 9.4 per cent (8,941) of cases. The number of roadside tests for drug driving has roughly doubled since 2012. Data provided to the Committee from Victoria Police reflects the increasing focus on drug driving through the administration of random oral fluid tests on Victorian roads.

Table 10.1 Number of preliminary Oral Fluid Test (POFT) and Oral Fluid Test (OFT) conducted in Victoria

Calendar year	POFTs	Confirmed OFTs	Ratio	Percentage OFTs v. POFTs (%)
2016	95,161	8,941	1:11	9.4
2015	106,503	7,342	1:15	6.9
2014	55,908	3,501	1:16	6.3
2013	39,471	2,523	1:16	6.4
2012	47,745	2,319	1:21	4.9

Source: Victoria Police, Supplementary Evidence received 1 February 2018, Appendix A.

10.2 Road Safety Act 1986

Part Five of the Victorian *Road Safety Act 1986* (the Act) outlines offences involving alcohol and other drugs. Section 47 details the purpose of Part Five, which is to:

- (a) reduce the number of motor vehicle collisions of which alcohol or other drugs are a cause; and
- (b) reduce the number of drivers whose driving is impaired by alcohol or other drugs; and

⁹⁴⁵ Davey, J, et al., *Roadside Drug Testing Scoping Study: Final Report*, Carrs-Q, Brisbane, 2017, p. 40.

- (c) provide a simple and effective means of establishing that there is present in the blood or breath of a driver more than the legal limit of alcohol; and
- (d) provide a simple and effective means of establishing the presence of a drug in the blood, urine or oral fluid of a driver.⁹⁴⁶

Drug driving laws differ widely from drink driving laws, with the former based on a detection threshold with the ‘prescribed concentration of drugs’ defined in the Act as ‘any concentration of the drug present in the blood or oral fluid of that person’.⁹⁴⁷ In contrast, drink driving laws are based on an impairment threshold. For drug driving offences, the Committee understands that at the roadside, if an oral fluid test result is positive, drivers are asked to undertake a further test, which if positive is sent to a laboratory for confirmation.⁹⁴⁸ These results form the basis for charging the driver. Further, Dr Dimitri Gerostamoulos, Chief Toxicologist and Head of Forensic Services at the Victorian Institute of Forensic Medicine (VIFM) advised the Committee that drivers can also be required to undergo an assessment of drug impairment, which comprises a preliminary assessment of physical factors, such as behaviour, balance and coordination, followed by blood and/or urine samples.

The impairment provision is actually covered by the taking of a blood sample and/or a urine sample in the event that that needs to happen. But blood certainly gives you an degree of whether someone is likely to be impaired. We have road safety experts who then provide opinions to Victoria Police as to the degree of impairment combined with the toxicology. That is one part of the Road Safety Act.⁹⁴⁹

The Committee understands that an impairment test is initiated when a police officer is concerned about an individual’s driving. The offences of failing a roadside drug test or driving while impaired are separate and attract different penalties. These penalties also vary depending on whether it is a first offence or if a driver has been caught before. These penalties are outlined in table 10.2.

⁹⁴⁶ *Road Safety Act 1986* (Vic), No.127., s 47

⁹⁴⁷ *Road Safety Act 1986* (Vic), No.127., s 3

⁹⁴⁸ Davey, J, et al., *Roadside Drug Testing Scoping Study: Final Report*, Carrs-Q, Brisbane, 2017, p. 11.

⁹⁴⁹ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 212.

Table 10.2 Victorian drug driving penalties

Offence	Penalties	
	Failing a roadside screening test	Driving while impaired by a drug
First drug-driving offence	<p><i>Received an infringement notice</i></p> <p>A driver will receive a:</p> <ul style="list-style-type: none"> • fine to the value of 3 penalty units, and • 3 months suspension of their licence or learner permit. <p><i>Go to court</i></p> <p>A driver will receive a:</p> <ul style="list-style-type: none"> • fine up to the value of 12 penalty units, and • minimum 3 months cancellation of their licence or learner permit. <p>The court may also record a conviction.</p>	<p>A driver's licence will be suspended immediately, and they will receive a:</p> <ul style="list-style-type: none"> • fine up to the value of 12 penalty units, and • minimum 12 months cancellation of their licence or learner permit. <p>The court may also record a conviction.</p>
Second drug-driving offence	<p>A driver will go to court and receive a:</p> <ul style="list-style-type: none"> • fine up to the value of 60 penalty units, and • minimum 6 months cancellation of their licence or learner permit. <p>The court may also record a conviction.</p>	<p>A driver's licence will be suspended immediately, and they will receive a:</p> <ul style="list-style-type: none"> • fine up to the value of 120 penalty units or 12 months imprisonment, and • minimum 2 years cancellation of their licence or learner permit. <p>The court may also record a conviction.</p>
More than two drug-driving offences	<p>A driver will go to court and receive a:</p> <ul style="list-style-type: none"> • fine up to the value of 120 penalty units, and • minimum 6 months cancellation of their licence or learner permit. <p>The court may also record a conviction.</p>	<p>A driver's licence will be suspended immediately, and they will receive a:</p> <ul style="list-style-type: none"> • fine up to the value of 180 penalty units or 18 months imprisonment, and • minimum 2 years cancellation of their licence or learner permit. <p>The court may also record a conviction.</p>

Source: VicRoads, 'Drug driving penalties', viewed 16 March 2018, <<https://www.vicroads.vic.gov.au/safety-and-road-rules/road-rules/penalties/drug-driving-penalties>>.

Impairment versus presence

The Committee learnt throughout the inquiry that the detection threshold system for drug driving is a highly contentious issue. Numerous stakeholders proposed to the Committee that the system undergo review on the basis that it has not been scientifically tested, particularly its effect on road crashes and as a deterrent strategy.⁹⁵⁰ This is dissimilar to the impairment threshold for alcohol, which is based on a historical science-based model that is accepted and implemented worldwide:

...based on decades of careful scientific research – specifically single-car crash and case-control studies – on how specific blood alcohol concentration increases relative crash risk. Based on such studies, there is a predictable, linear relationship between blood alcohol level and crash risk.⁹⁵¹

There have been calls for a similar system to be employed for drug driving, one that establishes the impact of prescribed substances on driving performance and is then reflected in established impairment thresholds. It was argued that this is in stark

950 Springvale Monash Legal Service Inc., *Submission*, no. 160, 17 March 2017, pp. 5-7; National Drug Research Institute, *Submission*, no. 136, 16 March 2017, p. 8; Dr Kate Seear, *Submission*, no. 126, 16 March 2017, pp. 13-14; Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 4.

951 Soltani, A, 'Policy Perspective: A Conversation with Andrea Roth', viewed 19 January 2018, <<https://www.aclunc.org/blog/marijuana-policy-perspective-how-much-too-much>>.

contrast to the current zero tolerance approach, which according to the Springvale Monash Legal Service, is more concerned with regulating the use of illicit substances than achieving road safety.⁹⁵²

Regulating the use of illicit substances has been identified as the basis for the United States' (US) drug driving laws (also zero tolerance), as discussed by Assistant Professor Andrea Roth in her article *The uneasy case for marijuana as chemical impairment under a science-based jurisprudence of dangerousness*. Assistant Professor Andrea Roth argues that drug driving laws have been 'justified under a jurisprudence of prohibition: the state could legitimately criminalize driving under the influence because it considered the drug use itself morally blameworthy'.⁹⁵³ Interestingly, she also notes that these laws provide the easiest standard to prove because they do not rely on the impact of the substance on the driver's ability to drive, a point that advocates of the laws also acknowledge:

The scientific community also candidly acknowledged that the zero-tolerance approach was a way to bypass the need for science to back up a dangerousness-based DUI [driving under the influence] law.⁹⁵⁴

In the context of the Victorian laws, Dr Kate Seear, Senior Lecturer in Law at Monash University, indicated that the *Road Safety Act 1986* will only be effective from a road safety perspective if it targets 'people who are actually impaired at the time of driving'.⁹⁵⁵ Similarly, Professor Alison Ritter, Director of the Drug Policy Modelling Program (DPMP) at the National Drug and Alcohol Research Centre (NDARC) asserted that the current zero tolerance approach undermines the legitimacy of the legislation:

...if this is about road safety, and we need to assess impairment or the likelihood of a risk of causing an accident or having an accident, and the presence of drugs in a bodily fluid, whether that is saliva or blood, is not associated inevitably with having an accident...It makes a mockery of road safety laws.⁹⁵⁶

Evidence received from Victoria Police and the VIFM emphasised, however, that the presence of a drug in a driver indicates a risk to the community. Wendy Steendam, Deputy Commissioner of Capability at Victoria Police advised in her evidence:

So the reason that we actually have presence versus impairment is because the evidence is very clear from a risk perspective that with the presence of those illicit drugs, you are at greater risk of having an accident and/or or causing community harm. It is a really strong evidence base that informs that position.⁹⁵⁷

The Committee notes, however, the insufficient evidence to support a causal relationship between specific concentration levels, particularly low levels, of illicit substances and driving impairment. While Deputy Commissioner Wendy Steendam advised the Committee that the 'mere presence actually creates the risk',⁹⁵⁸ the Committee believes this requires further examination.

⁹⁵² Springvale Monash Legal Service Inc., *Submission*, no. 160, 17 March 2017, p. 5.

⁹⁵³ Roth, A, 'The Uneasy Case for Marijuana as Chemical Impairment Under a Science-Based Jurisprudence of Dangerousness', *California Law Review*, vol. 103, no. 4, 2015, p. 844.

⁹⁵⁴ Roth, A, 'The Uneasy Case for Marijuana as Chemical Impairment Under a Science-Based Jurisprudence of Dangerousness', *California Law Review*, vol. 103, no. 4, 2015, p. 891.

⁹⁵⁵ Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, p. 176.

⁹⁵⁶ Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 251.

⁹⁵⁷ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 462.

⁹⁵⁸ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 462.

Research conducted in 2014 by the Curtin-Monash Accident Research Centre in Western Australia investigated the prevalence and characteristics of illicit drug driving through the analysis of data relating to driver and rider fatal crashes and drug driving offences. It found that one or more illicit substances were detected in 22.7 per cent of fatally injured drivers/riders, with cannabis the most frequently detected substance (64.8 per cent). The research also found that male and younger age drivers/riders and those that engage in risky driving behaviours, such as driving under the influence of alcohol (45 per cent) and unlicensed driving (46 per cent) were significantly more likely to test positive for illicit substances.⁹⁵⁹ Based on these findings, the researchers indicated that cannabis use represents a significant source of risk for crash involvement and injury.⁹⁶⁰ The Committee also notes the potential involvement of other crash risk factors. For example, the researchers stated that '[a]lcohol featured very strongly in this study's findings and reaffirms the concern that this 'legal' substance, alone and in association with other impairing substances, is a major risk factor'.⁹⁶¹

The Committee also refers to US based research by the National Highway Traffic Safety Administration (NHTSA) who investigated the alcohol and drug crash risk through the country's first large-scale case-control study. It demonstrated a significant increase in unadjusted crash risk for drivers who tested positive for illicit substances (1.21 times) and THC specifically (1.25 times). Similar to the Australian study, however, the NHTSA research identified other factors that also contributed to this crash risk. It concluded:

...analyses incorporating adjustments for age, gender, ethnicity, and alcohol concentration level did not show a significant increase in levels of crash risk associated with the presence of drugs. This finding indicates that these variables (age, gender, ethnicity and alcohol use) were highly correlated with drug use and account for much of the increased risk associated with the use of illegal drugs and with THC.⁹⁶²

The Committee acknowledges that without a better understanding of how individual substances effect impairment, their direct contribution to fatal and serious injury crashes, in comparison to other risk factors, remains unknown.

Stakeholders also advised the Committee that moving away from a drug detection threshold to an impairment threshold would facilitate the inclusion of other drugs in the testing regime, including pharmaceutical drugs, some of which are proven to adversely affect driving performance. In particular, benzodiazepines can have this impact, especially when combined with alcohol, in addition to opioids and first generation antihistamines.⁹⁶³ Dr Monica Barratt of the DPMP also made the point that because the current regime only tests for three illicit substances, some people may shift to other illicit substances to avoid detection while driving:

⁹⁵⁹ Palamara, P, et al., *Illicit drugs and driving: An investigation of fatalities and traffic offences in Western Australia*, Curtin-Monash Accident Research Centre, Bentley, 2014.

⁹⁶⁰ Palamara, P, et al., *Illicit drugs and driving: An investigation of fatalities and traffic offences in Western Australia*, Curtin-Monash Accident Research Centre, Bentley, 2014, p. 59.

⁹⁶¹ Palamara, P, et al., *Illicit drugs and driving: An investigation of fatalities and traffic offences in Western Australia*, Curtin-Monash Accident Research Centre, Bentley, 2014, p. 63.

⁹⁶² Compton, R and Berning, A, *Traffic Safety Facts: Research Note: Drug and Alcohol Crash Risk*, National Highway Traffic Safety Administration, Washington DC, 2015.

⁹⁶³ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 86; Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 251; Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 37.

One of the unintended consequences is that potential shift to other drugs. We look at cannabis, amphetamines, MDMA, and we do not look at this vast other list of psychoactive substances here in Victoria. So it is sort of saying, ‘Well, these are the most popular. Let’s look at these and let’s make sure people are not driving under the influence of these’. But certainly when it comes to festivals and people knowing, people are targeted as they leave festivals — LSD, cocaine, GHB, ketamine and a whole list of other drugs that can be taken in the festival environment, including the novel psychoactive substances. So is that what we are trying to do? I think that is an unintended consequence of the way the drug-driving testing laws are right now.⁹⁶⁴

The Committee is aware that Tasmania’s drug driving laws can test for 18 prescribed illicit substances, including cocaine, heroin, GHB, ketamine, LSD, morphine, PCP and magic mushrooms. However, these results are determined by a blood test, rather than an oral test as conducted in Victoria and other Australian jurisdictions, all of whom only test for the three illicit substances identified earlier. In the article, *Zero Tolerance’ Drug Driving Laws in Australia: A Gap Between Rationale and Form?*, Quilter and McNamara questioned the effectiveness of current drug driving laws in Australia on the basis of the various issues raised above, including only testing for three substances. They stated:

It appears that the *illicit* nature of drugs such as cannabis, ecstasy and speed has been seen to justify a type of ‘fast-forward’ from *presence* to *deemed impairment* without any requirement to establish and meet *prescribed concentration* thresholds of the sort that are both conventional in the *drink* driving context and essential to the normative legitimacy of drink driving laws. To drive while ‘drunk’ is regarded as unacceptable because the scientific evidence shows that this carries an elevated risk of accident due to diminished driver capacity (Fell and Voas 2014; Howat, Sleet and Smith 1991; Mann et al. 2001). By contrast, contemporary drug driving laws in Australia are not strongly linked to scientific evidence about the relationship between substance use and driver capacity. The road safety justification for treating the *presence* of a particular drug in a driver’s oral fluid as synonymous with impairment is open to question, just as it would be if the trace detection of a minute quantity of alcohol in any driver’s breath were to be regarded as a sufficient basis for criminal punishment. In addition, testing for only three illicit drugs is not consistent with a road safety/impairment paradigm.⁹⁶⁵

10.3 International evidence

The issue of drug driving has not been explored extensively in Australia, although internationally there are two key projects that have contributed largely to the broader discussion. The first is the *Driving Under the Influence of Drugs, Alcohol and Medicines* in Europe (DRUID), which was established in 2007 to estimate the extent of drug driving throughout Europe and review appropriate countermeasures. The DRUID project involved 17 European Union Member States and Norway and was conducted over a five-year period.⁹⁶⁶

In regard to establishing workable and effective drug driving laws, the project indicated that it is not realistic to develop cut off limits for all existing illicit substances, which it noted are more difficult to determine than limits for alcohol

⁹⁶⁴ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 428.

⁹⁶⁵ Quilter, J and McNamara, L, “Zero tolerance’ drug driving laws in Australia: A gap between rationale and form?”, *International Journal for Crime, Justice and Social Democracy*, vol. 6, no. 3, 2017, p. 61.

⁹⁶⁶ Schulze, H, et al., *Driving Under the Influence of Drugs, Alcohol and Medicines in Europe - findings from the DRUID project*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2012.

or medicines. It also noted that the growth of new psychoactive substances complicates this matter further. Although, based on epidemiological, experimental and meta-analytical approaches, the project was able to determine that THC is much less impairing and risky than most other substances examined, and that 3.8 ng/ml THC was shown to be as impairing as 0.5 g/l alcohol. On this basis, the project recommended the use of 'per se laws' that establish a fixed risk threshold for cannabis, and a two-tier approach for all other illicit substances that comprise both per se laws and an impairment component. In particular, the legal recommendations from the DRUID project included:

- Regulations should be based on scientific findings; if epidemiological and experimental data are not sufficient, an expert team should determine cut-offs taking into account other findings (e.g. pharmacokinetic profiles).
- There should be European harmonisation of drug analyses (e.g. analytical cut-off limits; standardised analysing procedures).
- A risk threshold should be introduced for THC, equivalent to 0.5g/l BAC, at 3.8 ng/ml serum, plus a value to take account of measurement errors and the confidence interval, and minus a value to take into account the metabolism between the stop/crash and sampling.
- For all other psychoactive drugs a two-tier system is advised: legal limits combined with an impairment approach. This system combines the advantages of the two legal regulations: a less severe sanction when drugs are present above the legal limit and a more severe sanction when the driver is also impaired.⁹⁶⁷

Another key report is *Driving under the influence of drugs*, conducted in the UK by the Expert Panel on Drug Driving for the Department for Transport. The purpose of the report was to review existing offences in the *Road Traffic Act 1988*, which were identified as having limited use in securing convictions for driving while unfit through drugs. Among other matters, the Expert Panel was required to determine the specific substances that should be captured under the legislation, the evidence required to establish the degree of road safety risks associated with specific substances, and identify the equivalent concentration for substances that would have an impairment effect similar to that of a BAC of 80mg / 100ml.⁹⁶⁸

Similar to the DRUID project, the Expert Panel recommended a per se approach with risk thresholds 'based on the detection of a drug in a driver above a defined cut-off concentration (threshold) in blood that could be related to the risk of a road traffic accident'.⁹⁶⁹ It made a number of recommendations regarding risk thresholds for various substances, including:

- a cannabis threshold of 5 µg/L
- a cocaine threshold of 80 µg/L
- an amphetamine threshold of 600 µg/L
- an MDMA threshold of 300 µg/L
- a ketamine threshold of 200 µg/L.⁹⁷⁰

⁹⁶⁷ Schulze, H, et al., *Driving Under the Influence of Drugs, Alcohol and Medicines in Europe - findings from the DRUID project*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2012, p. 48.

⁹⁶⁸ Wolff, K, et al., *Driving Under the Influence of Drugs*, Department for Transport UK, London, 2013.

⁹⁶⁹ Wolff, K, et al., *Driving Under the Influence of Drugs*, Department for Transport UK, London, 2013, p. 37.

⁹⁷⁰ Wolff, K, et al., *Driving Under the Influence of Drugs*, Department for Transport UK, London, 2013.

The Committee notes, however, that the UK Government did not adopt the recommendations for illicit substances, although it followed the Expert Panel's recommendations for medicinal drugs. For illicit substances, the Government employed a zero tolerance approach, with the limits set at levels so low that any consumption would be above the threshold. The aim of this was only to avoid claims of 'accidental exposure'.⁹⁷¹

10.4 International experience and its relevance to Victoria

Two countries that have implemented a legal limits approach for drug driving laws are Norway and the Netherlands, both countries with strong road safety records. Norway, in particular, has adopted a similar road safety policy to that of Victoria, a vision of zero fatalities and serious injuries.

Norway introduced per se limits for 20 'non-alcohol drugs' in 2012, 'representing drug concentrations in whole blood likely to be accompanied by a degree of impairment comparable to a BAC of 0.02 per cent'.⁹⁷² These limits are based on experimental studies of cognitive performance after single doses in 'drug naïve individuals'. Prior to 2012, an assessment of impairment was conducted for each case, with the judicial process requiring an expert witness. This system was deemed time consuming and expensive. According to the Norwegian Ministry of Transport and Communications, since the introduction of the legal limits, numerous cases have been prosecuted without an expert witness and are based solely on the reported drug concentrations.⁹⁷³

In the Netherlands, the current system for regulating drug driving was only implemented in July 2017, but similar to Norway, it comprises legal limits for single use of substances, including those used for medicinal purposes.⁹⁷⁴

It is also worth drawing attention to the current situation in the US in jurisdictions that have legalised recreational and/or medicinal cannabis use. The Committee understands that each of these states have introduced a similar drug driving model for cannabis to that of alcohol. This approach has received criticism, however, on the basis that rather than be informed by scientific evidence, threshold limits were randomly chosen, such as one, two or five nanograms per millilitre of THC in the blood. Assistant Professor Andrea Roth states in her article:

Haddon's established framework of BAC-specific single-car crash studies, BAC-specific case-control studies, and realistic and BAC-specific impairment studies bears no resemblance to the rushed and unscientific process that produced per se DUI marijuana laws. The well-acknowledged truth is that there is no known relationship between THC blood levels and increased relative crash risk documented by single-crash or classic case-control studies, and no known relationship between a driver's THC blood level and his level of driving impairment. To the extent single-car and case-control crash studies do exist, they suggest, if anything, that drivers with only THC in their blood are not causing a disproportionate number of fatal crashes.⁹⁷⁵

⁹⁷¹ UK Department of Transport, 'Drug Driving', viewed 16 June 2017, <<https://www.gov.uk/government/collections/drug-driving#table-of-drugs-and-limits>>.

⁹⁷² Norwegian Ministry of Transport and Communications, *Driving under the influence of non-alcohol drugs - legal limits implemented in Norway*, Oslo, 2014.

⁹⁷³ Norwegian Ministry of Transport and Communications, *Driving under the influence of non-alcohol drugs - legal limits implemented in Norway*, Oslo, 2014.

⁹⁷⁴ Mutze, F, *The Drug Driving Situation in The Netherlands*, European Transport Safety Council, Vienna, 2017.

⁹⁷⁵ Roth, A, 'The Uneasy Case for Marijuana as Chemical Impairment Under a Science-Based Jurisprudence of Dangerousness', *California Law Review*, vol. 103, no. 4, 2015.

Interestingly, Assistant Professor Andrea Roth also highlights in her article the challenges in determining the crash risk of cannabis on the basis that it is difficult to identify the proximity of use, the wide variance in dose-related psychoactive influence, and the limited ability to determine specific THC blood levels on driving. Regarding proximity of use, she referred to a Norway study which found that THC can be detected in saliva of frequent cannabis users for over eight days, and THC metabolites can be found in blood for over a month in chronic users.⁹⁷⁶ The Committee believes this has important implications for Victoria's drug driving regime, a point also made by Dr Kate Seear from Monash University who raised concerns with drivers being picked up by police for drug driving after consuming cannabis days before, and being charged under the Act. This occurred in New South Wales in June 2015 where a driver tested positive for cannabis nine days after he smoked the drug. The driver was arrested and charged, although the magistrate later acquitted him. In response, the driver's lawyer stated:

It's wrong, in my view, to be punishing people [by] taking their licences away when someone might have had a smoke or two of cannabis a few days before driving a car...It makes as much sense as taking someone's licence away for having a beer two or three days before driving a car. Unfortunately a lot of people would be at risk of falling foul of this legislation even though their experience of having used the drug would have zero effect on their ability of driving a car safely.⁹⁷⁷

The experience in the US also draws attention to how Victoria's drug driving laws will operate alongside the lawful use of medicinal cannabis, and specifically drivers testing positive in roadside tests for THC after lawfully using the drug.⁹⁷⁸ Anecdotal reports from the US indicate that chronic users of medicinal cannabis have tested positive for high THC blood levels but are not deemed to be impaired.⁹⁷⁹

The Committee believes this matter requires urgent attention from the Victorian Government, in addition to further exploration of the effects of drugs, both illicit and pharmaceutical drugs, on driving impairment. This is important to understanding whether the drug driving laws are fit for purpose and will contribute to achieving the road safety benefits as encapsulated in the objectives of Part 5 of the *Road Safety Act 1986*.

RECOMMENDATION 24: The proposed Advisory Council on Drugs Policy investigate the current drug driving laws and procedures to determine their effect on road crashes and as a deterrent strategy. The Council should also explore:

- alternative drug driving regimes that use impairment limits/thresholds, and their potential applicability in Victoria
- options for expanding the types of drugs captured under the regime
- likely changes to drug driving laws resulting from medicinal cannabis use in Victoria.

⁹⁷⁶ Roth, A, 'The Uneasy Case for Marijuana as Chemical Impairment Under a Science-Based Jurisprudence of Dangerousness', *California Law Review*, vol. 103, no. 4, 2015, p. 885.

⁹⁷⁷ Knowles, L and Branley, A, 'Acquittal of man caught drug-driving nine days after smoking cannabis throws NSW drug laws into doubt', *ABC News*, 3 February 2016, viewed 18 January 2018, <<http://www.abc.net.au/news/2016-02-02/man-caught-drug-driving-days-after-smoking-cannabis-acquitted/7133628>>.

⁹⁷⁸ Hughes, C and Wodak, A, *What can Australian learn from different approaches to drugs in Europe including especially Portugal, Switzerland, the Netherlands and Sweden?*, Australia21, Sydney, 2012.

⁹⁷⁹ Soltani, A, 'Marijuana Policy Perspective: How Much is Too Much?', *ACLU North California*, 20 April 2015, viewed 18 January 2018, <<https://www.aclunc.org/blog/marijuana-policy-perspective-how-much-too-much>>.

11

Legislative responses to new psychoactive substances

Both locally and internationally, the emergence and prevalence of new psychoactive substances (NPS) is a significant concern. The unprecedented growth in their number has been described as a global phenomenon that poses risks to public health, particularly given the lack of knowledge about their long and short-term effects. These substances are typically designed to mimic the effect of drugs that are controlled, such as cannabis, cocaine or methamphetamine. Throughout the inquiry, various stakeholders advised the Committee that the current approach of prohibiting traditional substances has led to the creation of these new, potentially more dangerous substances.⁹⁸⁰ For example, as advised by Dr Stefan Gruenert, the Chief Executive Officer (CEO) of Odyssey House Victoria (OHV):

...history has shown us whenever we crack down under a prohibitionist approach to drugs what we see is an emergence of newer drugs, often more potent and less understood drugs. For example, with the crackdown on opium we saw heroin emerging. In the 1920s we saw a crackdown on alcohol under Prohibition in the US and many people went away from using lighter alcohol products, such as beer and some wines, to much harder spirits. The same occurred with the move from speed at sort of 10 to 15 per cent — a crackdown on that and you move to ice at 80 to 90 per cent...

One of the unintended consequences of a prohibition approach and not a regulated supply approach is that you see the emergence of drugs like synthetic cannabis, and you will see a continuing effort of those who manufacture and those who demand those drugs to try and tweak and change the formulas to avoid detection and make it available. We certainly see at Odyssey many harms associated with synthetic cannabis which we are just starting to understand because it is a changing, moving drug that goes under the name of synthetic cannabis.⁹⁸¹

As indicated by Dr Gruenert, the Committee notes that in some instances, NPS are more harmful than the original substance. Internationally, a common and practical strategy to monitor and respond to the effects of NPS is the establishment of a flexible early warning system (EWS). The establishment of such a system in Victoria is addressed in chapter four.

In recent years, there have been numerous legislative attempts to control and reduce the emergence of NPS. The purpose of this chapter is to analyse the effectiveness of these legislative responses, particularly in the context of the challenges posed by NPS. These include their unknown health effects, the importance of distinguishing between intentional and unintentional use, and the evolving nature of the market.

⁹⁸⁰ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 299; Dean Rossiter, Chapter President, LaTrobe University, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 308.

⁹⁸¹ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 164.

These legislative responses are typically based on prohibiting such substances, including the Victorian Government's *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Act 2017*. As this Act is already in force, this chapter focuses on monitoring implementation and enforcement issues. The chapter also reviews the alternative approach employed in New Zealand (NZ), which aimed to regulate the sale of such substances.

11.1 Challenges in effectively dealing with new psychoactive substances

In July 2014, the Australian Government's Intergovernmental Committee on Drugs (IGCD)⁹⁸² released the *Framework for a National Response to New Psychoactive Substances* (The Australian Framework). The Australian Framework detailed key challenges and considerations, guiding principles and elements of a national response to NPS. These challenges include the rapidly changing nature of the NPS market, the largely unknown long-term health effects, and the prevalence of unintentional use of NPS. These are outlined below in the context of their impact on the effectiveness of legislative responses to the NPS market.

11.1.1 Health impacts

A significant issue with NPS is that the long-term health effects and harms are largely unknown. According to the World Health Organization (WHO) Expert Committee on Drug Dependence, some potential effects include: in the case of synthetic cannabinoids, tolerance, withdrawal symptoms and possible dependence; in the case of synthetic cathinones, high frequency drug injection and risk of the spread of blood-borne viruses such as HIV, emergency room admissions and deaths; and overdoses in the case of highly potent phenethylamine substances that are often sold as LSD.⁹⁸³ The health risks associated with NPS are particularly difficult to determine when products contain combinations. In 2013 in Europe, for example, there were reports of over 110 NPS products comprising up to seven NPS.⁹⁸⁴

In its submission, the Victorian Institute of Forensic Medicine (VIFM) referred to the lack of knowledge on the health effects of various NPS, but particularly for synthetic cannabinoids:

Some of the pharmacological effects of these substances are reportedly similar to existing drugs, however the physiological effects and long term-toxicity caused by these substances is mostly unknown.

This is especially true for a growing range of compounds known as synthetic cannabinoids. In collaboration with the State Coroner we recently identified a new synthetic cannabinoid called PB-22 and discovered its presence in three deaths over a four month period. In all three cases the cause of death was unascertained following the performance of a full autopsy with ancillary investigations. Our advanced toxicological methods were able to detect this substance, informed by the case circumstances, to establish the cause of death.⁹⁸⁵

⁹⁸² The former IGCD provided policy advice to ministers on drug-related issues and was responsible for the implementation of the National Drug Strategy 2010-2015.

⁹⁸³ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, p. 3.

⁹⁸⁴ United Nations Office on Drugs and Crime, *Global SMART Update: Post-UNGASS 2016: NPS trends, challenges and recommendations*, Vienna, 2016, p. 6.

⁹⁸⁵ Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, p. 8.

Similarly, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in its 2017 report *Health and social responses to drug problems: A European guide* noted that many synthetic cannabinoid products are more potent than THC, the main active ingredient in cannabis. It indicated that this might be the reason that harmful effects, such as fatal poisonings, are more commonly associated with synthetic cannabinoids than cannabis (as well as larger doses).⁹⁸⁶

The Committee is also aware that this level of risk cannot be assumed for all NPS, as some may have lower risks of harm. This issue was raised in the Australian Framework, which reiterated that the overall harms caused by NPS are fewer than illicit substances and less than licit ones:

While NPS create new challenges, it is important not to overstate their importance in the wider context of drug use in Australia. The NDS [National Drug Strategy] makes it clear that the drugs that cause the greatest harm to public health remain alcohol and tobacco. Equally, although individual NPS may be more harmful than some established illicit drugs, the overall harms of NPS – so far at least – remain slight in comparison with those of the established illicit drugs, particularly heroin, cocaine and ATS [amphetamine type substances].⁹⁸⁷

Further, as noted in the Australian Framework, there may be some legitimate uses of substances not yet known.⁹⁸⁸ However, a key consequence arising from the limited knowledge of a NPS' effects, harmful or otherwise, is lengthy assessments to determine the regulatory control required for the substance. This can directly impact the tailoring and speed of appropriate legislative responses. As explained by the Commission on Narcotic Drugs (CND):

Putting a potentially harmful substance under legal control may be a lengthy process that often requires evidence-gathering, a scientific review of harms and consultations. This means that a time lag is created from when an NPS comes into the market to when legal control is implemented. NPS manufacturers often exploit this inevitable time lag by developing and marketing alternative substances to circumvent established controls.⁹⁸⁹

The lack of knowledge on health impacts also has implications for drug treatment options, as advised by Kym Peake, Secretary of the Department of Health and Human Services (DHHS). A particular challenge is to:

...recognise that some of the damage because of just the mix of what is in or can be in a synthetic product might not actually be related to addiction and might instead be something that needs more of a clinical response that is going to address the medical impact of what has been consumed — ingested. So it is really presenting a significant challenge for us to be looking at quite a new drug with new and different sorts of patterns of usage.

⁹⁸⁶ European Monitoring Centre for Drugs and Drug Addiction, *Health and social responses to drug problems: A European Guide*, Publications Office of the European Union, Luxembourg, 2017, p. 81.

⁹⁸⁷ Intergovernmental Committee on Drugs (IGCD), *Framework for a National Response to New Psychoactive Substances*, Canberra, 2014, p. 9.

⁹⁸⁸ Intergovernmental Committee on Drugs (IGCD), *Framework for a National Response to New Psychoactive Substances*, Canberra, 2014, p. 7.

⁹⁸⁹ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, p. 8.

There will be some people who are using synthetic drugs like any other drug of dependence, but there are some people who are having pretty dire effects of one-off or recreational use, so the treatment model needs to be quite different for that sort of usage. So it is something where in working with Safer Care Victoria and with experts in the field there is some work going on to say what is the right service response.⁹⁹⁰

11.1.2 Intentional and unintentional use

A key point of difference between the use of NPS and illicit substances is that people are less likely to intentionally use NPS. Rather, as the Committee notes, they are used largely as a result of their contamination in traditional illicit substances. Professor Alison Ritter, Director of the Drug Policy Modelling Program (DPMP) at the National Drug and Alcohol Research Centre (NDARC) advised the Committee:

I think the other thing that is important about new psychoactive substances is to distinguish between intentional use versus unintentional use. There is a lot of unintentional use of these, where they are being sold as other substances, whether it is supposed to be ecstasy or MDMA and it is not and so on, and the policy levers for dealing with intentional use should be quite different, obviously, from the policy levers that are dealing with unintentional use.⁹⁹¹

The risk of unintentional use of NPS was brought starkly into focus in Melbourne in 2017, as reported on the United Nations Office on Drugs and Crime (UNODC) website:

...at least 20 hospitalisations that occurred in Melbourne from the 15-16 January 2017 have been associated with the use of capsules that were reportedly sold as “ecstasy”, but are suspected to have contained NPS in addition to MDMA. According to the Australian Capital Territory Investigation of Novel Substances (ACTINOS) Group, the contents of these capsules were similar to those analysed in association with another patient who suffered convulsions and required hospitalisation after having used “ecstasy” capsules that were found to contain the phenethylamines fluoroamphetamine (isomer not determined) and 25C-NBOMe. In February 2017, ACTINOS issued an alert warning of the potential harm in using such pink and clear capsules, purchased and consumed as “ecstasy”.⁹⁹²

Dr Monica Barratt, Research Fellow from the DPMP at NDARC, also commented on this incident, and the significant negative effects it had for people who unknowingly consumed NPS:

...for example, in January in Chapel Street where there were NBOMes sold as MDMA or ecstasy. These are strong hallucinogenic substances. I have spoken to a number of people who were, unfortunately, involved as consumers, and they experienced prolonged psychedelic trips that they had no intention of taking. Some of them ended up in hospital, but some of the ones I spoke with just managed it. They were very upset about what happened. When I asked that question, ‘If you’d known?’, they said, ‘Well, of course I wouldn’t have taken it’.⁹⁹³

990 Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 323.

991 Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 252.

992 UNODC Laboratory and Scientific Section Portals, ‘March 2017 - Australia: “Ecstasy” capsules containing NPS are related to several deaths and severe intoxications in Melbourne’, viewed 2 May 2017, <<https://www.unodc.org/LSS/Announcement/Details/48940b13-df58-4da2-a66b-d54a8f7362f7>>.

993 Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 428.

In most instances, people prefer the original substance that the NPS is trying to mimic, rather than the NPS itself. As indicated by Dr Barratt:

...when you actually talk to most people who use drugs about the new and novel substances, very few of them prefer those...We have looked at this issue on a number of occasions, and 80 to 90 per cent of people, if you ask them 'If you had these two drugs side by side, MDMA and a substitute MDMA, or cocaine and a synthetic substitute for cocaine, or cannabis and a synthetic substitute, which would you choose?', invariably choose the original traditional drug.⁹⁹⁴

The Committee also heard that when people use NPS intentionally, the reasons for doing so relates to the assumption that they are legal and somewhat safer than the illicit substances they are designed to mimic. In this context, it is argued that the current prohibitionist approach to illicit substances has contributed to people's use of NPS. Gino Vumbaca, President of Harm Reduction Australia told the Committee:

...if you speak to those people who are using drugs and they're caught with the novel psychoactive substances, most of them don't want to use synthetic drugs. They actually don't want to use those but they - rightly or wrongly - believe that they're safe to use because they're manufactured or that they're legal to use because they're outside the law. Most of them would not choose those drugs and the advice we'd probably give on a health basis is be very careful using those drugs because we don't actually know what they are.⁹⁹⁵

In their recent book chapter, *New Psychoactive Substances: The Regulatory Experience and Assessment of Options*, Reuter and Pardo from the University of Maryland referred to four niche groups that access the NPS market: those trying to avoid criminal sanctions, those wanting to avoid detection in drug tests, those seeking a new experience, and suppliers that adulterate or substitute NPS and sell these as traditional drugs. They considered that in 'policy analysis the four should be kept distinct, since they are driven by different dynamics'.⁹⁹⁶ By thinking of these groups separately, responses can be tailored to affect that circumstance, a point also highlighted by Dr Barratt who noted that demand reduction, rather than supply, is an area for consideration that has not yet been explored:

You can attack it from this direction, as in looking at supply, whereas you can turn around and look at demand and think, 'How can we affect demand? How can we actually make it so that people do not want to take these substances?'⁹⁹⁷

According to Dr Barratt, the decriminalisation of traditional illicit substances for personal possession would result in 'a lot less demand for novel substances in the first place'.⁹⁹⁸ This view is also reflected in NDARC's submission, which suggested that demand for NPS is driven by a desire to avoid criminal offences or workplace drug testing associated with traditional illicit substances, and such drivers may cease under a decriminalisation model.⁹⁹⁹

994 Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 428.

995 Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 102.

996 Reuter, P and Pardo, B, 'New Psychoactive Substances: The Regulatory Experience and Assessment of Options', in *Novel Psychoactive Substances*, O Corazza and A Roman-Urrestarazu (eds), Springer International Publishing, 2017, p. 159.

997 Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 428.

998 Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 423.

999 National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 11.

The unintentional (and intentional) use of synthetic opioids, such as fentanyl and fentanyl analogues, is also a significant cause for concern globally. In a recent report *Fentanyl and its analogues*, the UNODC identified the role of fentanyl in the current opioid overdose crises in North America. It outlined that pills and powders with fentanyl products in them are of variable quantity and potency, and ‘can prove particularly dangerous when sold as street heroin, together with heroin or as counterfeit prescription drugs, without the user’s knowledge’.¹⁰⁰⁰ As discussed in chapter 17, as part of its overseas study tour, the Committee witnessed the contributing factor of heroin laced with fentanyl or carfentanil in overdose deaths in Vancouver. Vancouver Coastal Health advised the Committee that the synthetic opioid contributed to 68 per cent of the 931 overdose deaths in 2016.¹⁰⁰¹

11.1.3 The resilience and rapidly evolving nature of the market

A significant challenge that impacts the speed of legislative responses is the resilience of the NPS market, with new NPS products emerging at a rapid rate of approximately one substance globally a week.¹⁰⁰² In particular, the composition of substances often changes at a quicker pace than the ability to detect and identify them. In its report, *New psychoactive substances in Europe: Innovative legal responses*, the EMCDDA explained that, in some instances, by the time laws are developed to control one substance, an alternative is available on the market. Further, lists that identify particular substances for control are used by manufacturers of NPS ‘simply as exclusions from their potentially vast product range...’¹⁰⁰³ The UNODC noted the following example of the evolution of various synthetic cannabinoids in response to legislative changes:

This group of substances evolves constantly in response to changes in national legislation. Chemical families with successive structural modifications evolve continuously to keep those substances in an ambiguous legal status. For instance, the emergence of the naphthoylindoles (e.g. JWH-018) was quickly followed by the emergence of naphthoylindazoles (e.g. THJ-018) and more recently of indazole carboxamides (e.g. AKB-48).¹⁰⁰⁴

In responding to the NPS market, the Australian Framework described the need to strengthen detection and identification capabilities across institutions such as law enforcement and health agencies.¹⁰⁰⁵

The Committee acknowledges that the challenges identified above affect the types and effectiveness of legislative responses to control NPS. For example, the speed at which legislation can keep pace with developments on the market becomes an important factor, as well as the capacity of agencies to monitor the health effects to inform assessments of particular substances. Throughout its investigations, the Committee did not identify one legislative model that addressed each of these challenges sufficiently.

¹⁰⁰⁰ United Nations Office on Drugs and Crime, ‘Fentanyl and its analogues - 50 years on’, *Global SMART Update*, vol. 17, 2017, p. 3.

¹⁰⁰¹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 51.

¹⁰⁰² Victorian Institute of Forensic Medicine, *Submission*, no. 216, 31 March 2017, p. 10.

¹⁰⁰³ European Monitoring Centre for Drugs and Drug Addiction, *New psychoactive substances in Europe: Innovative legal responses, June 2015*, Luxembourg, 2015, p. 4.

¹⁰⁰⁴ United Nations Office on Drugs and Crime, *Global SMART Update: Post-UNGASS 2016: NPS trends, challenges and recommendations*, Vienna, 2016, p. 6.

¹⁰⁰⁵ Intergovernmental Committee on Drugs (IGCD), *Framework for a National Response to New Psychoactive Substances*, Canberra, 2014, pp. 12-13.

11.2 Regulatory models to respond to new psychoactive substances

Given the challenges described above, various legislative tools have been employed internationally, nationally and in Victoria to control and reduce the availability of NPS. This section briefly highlights some of these models, and focuses on the recently passed *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Act 2017*. All of the approaches aim to control and prohibit these substances, with the exception of the NZ model that aims instead to regulate some low-risk substances.

11.2.1 Individual listing of substances

A common approach to dealing with NPS is for jurisdictions to add them to their controlled substances list once harms have been assessed, in the same way that the international drug conventions traditionally treat the emergence of substances of concern. In a review of 56 countries by the UNODC up to July 2015, 52 countries had amended existing legislation to add individual NPS to their drug schedule lists.¹⁰⁰⁶ According to the CND, this approach is typically used when there are a limited number of NPS on the market. Health risk assessments are undertaken using scientific and other data to confirm harmfulness. However, as noted earlier, it can be a long and complex process, adversely affecting the responsiveness of such legislation to existing NPS, and its capacity to prevent the emergence of other NPS in the meantime.¹⁰⁰⁷

In order to combat this issue, some jurisdictions use temporary bans or rapid response laws while the legislative process and risk assessment is underway. The Australian Framework encouraged Australian jurisdictions to employ such a response (noting some jurisdictions had already done so) to protect public safety while assessments are conducted on the NPS in question.¹⁰⁰⁸

In Victoria, the *Drugs, Poisons and Controlled Substances Amendment (Drugs of Dependence) Act 2011* implemented a temporary ban process via regulations for emerging NPS for a 12-month period. The Statement of Compatibility stated:

The bill amends the definition of ‘drugs of dependence’ in the *Drugs, Poisons and Controlled Substances Act 1981* (the act) to create a new regulation-making power to enable temporary amendments to the definition of ‘drug of dependence’ to be made from time to time, where this is necessary for public safety. The purpose of the regulation-making power is to allow the making of regulations to enable control of new forms of illegal drugs of dependence that may appear on the market in Victoria for an interim period until legislation to ban them can be introduced into Parliament.¹⁰⁰⁹

¹⁰⁰⁶ United Nations Office on Drugs and Crime, *Global SMART Update: Special Segment: Legal responses to NPS: Multiple approaches to a multi-faceted problem*, Vienna, 2015, p. 4.

¹⁰⁰⁷ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, p. 15.

¹⁰⁰⁸ Intergovernmental Committee on Drugs (IGCD), *Framework for a National Response to New Psychoactive Substances*, Canberra, 2014, pp. 16-17.

¹⁰⁰⁹ Statement of Compatibility, *Drugs, Poisons and Controlled Substances Amendment (Drugs of Dependence) Bill 2011 (Vic.)*.

11.2.2 Analogue and generic controls

These mechanisms complement individual listings by prohibiting substances with chemical or structural similarities to controlled substances or groups of substances, through analogue and general controls.¹⁰¹⁰ Analogues of drugs are those deemed to be chemically similar to a controlled drug, and generic controls are groups of substances referenced by core molecular structures that are also controlled. Substances identified as similar to controlled substances are not required to be individually named in the legislation, which eliminates the need for legislative change to prohibit individual substances or groups of substances.¹⁰¹¹

Victoria employed this approach with the *Drugs, Poisons and Controlled Substances Amendment Act 2012* including eight generic chemical classes of synthetic cannabinoids. In the Second Reading Speech for the Bill, then Minister for Police and Emergency Services, Peter Ryan MP, stated:

The aim is to capture all currently known synthetic cannabinoids, as well as emerging synthetic substances that fit within the identified classes.

Classes of synthetic cannabinoids are already controlled in Victoria as schedule 9 poisons under the national poisons standard and hence the unauthorised supply, possession and use of these substances is prohibited under Victoria's poisons control regime. By adding eight generic chemical classes of synthetic cannabinoids to schedule 11 of the *Drugs, Poisons and Controlled Substances Act 1981*, the bill aims to boost the deterrent effect of Victoria's controls by enabling the higher penalties applicable to the possession and trafficking of illicit drugs to be applied to synthetic cannabinoids.¹⁰¹²

In terms of analogue legislation in Victoria, the *Drugs, Poisons and Controlled Substances Amendment Act 2014* extended the definition of 'drug of dependence' in the Act to include analogues, as explained in the Explanatory Memorandum:

Drug analogues are synthetic substances that have structural similarities to illicit drugs. The definition of drug of dependence currently includes the salts, derivatives and isomers of drugs specified in Part 1 or Part 3 of Schedule 11, but does not refer to the analogues of those drugs. The amendments being made by this Part ensure that drug analogues are captured as drugs of dependence under the *Drugs, Poisons and Controlled Substances Act 1981*.¹⁰¹³

According to the CND, generic controls appear in countries with many NPS, as it enables control over substances at once and ahead of time to combat NPS that are yet to hit the market. It also identified various concerns with this approach that may limit its effectiveness, including:

- principles that a person should not be subject to criminal conviction without knowing in advance which substances are prohibited
- the NPS market is resilient and may be able to diversify beyond the generic categories
- substances with limited potential for misuse could be unintentionally covered by the legislation

¹⁰¹⁰ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, pp. 17-18.

¹⁰¹¹ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, pp. 17-19.

¹⁰¹² Second Reading, *Drugs, Poisons and Controlled Substances Amendment Bill 2012 (Vic.)*, pp. 3886-3887.

¹⁰¹³ Explanatory Memorandum, *Drugs, Poisons and Controlled Substances Amendment Bill 2013 (Vic.)*, pp. 1-2.

- medicines and substances used for research may also be unintentionally covered
- law enforcement authorities may be unsure of which substances are covered.¹⁰¹⁴

During the overseas study tour, the UK's Advisory Council on the Misuse of Drugs (AMCD) advised the Committee of the difficulties it has faced in creating generic definitions for substances, particularly synthetic cannabinoids, without unintentionally capturing legal and medical components that are used for legitimate research purposes.¹⁰¹⁵

11.2.3 Consumer protection and other laws

Consumer protection laws can be used to respond quickly to NPS. Italy was the first to do so in 2010 following intoxications caused by two synthetic cannabinoids. It used food labelling regulations to confiscate the products on the basis that they were not labelled in the national language. While information was collected about the substances, they were prohibited by the Minister of Health and withdrawn from the market. The substances were eventually placed under permanent control.¹⁰¹⁶

The Australian Framework acknowledged that consumer protection laws could be used to rapidly respond to emerging NPS, particularly as a tool to control the sale of NPS. It provided an example of how consumer protection laws were used in New South Wales (NSW) under the *Competition and Consumer Act 2010*, which enables bans on consumer products for up to 90 days in certain circumstances. Following adverse reports associated with 19 NPS products, an interim ban was imposed in NSW in June 2013 using their product names, followed by a Commonwealth national interim ban to enable NSW legislation to be updated. The Framework also stated, however, that 'NPS are more appropriately controlled through drug legislation administered by health and law enforcement agencies', and noted that bans based on NPS product names would be of limited effectiveness in the long term.¹⁰¹⁷

In Europe, legislation for regulating medicines had been used to classify NPS as medicines, making them subject to a range of conditions including licensing and distribution. However, the European Court of Justice in 2014 overruled this approach, as they do not fall under the definition of medicinal products.¹⁰¹⁸

11.2.4 Full regulatory approach – New Zealand

In contrast to other approaches that generally prohibit NPS (including the 'blanket ban' approach discussed below), NZ is the only country in the world that attempted to regulate the NPS market by establishing a process to approve the manufacture of certain low risk NPS that meet strict criteria. The *Psychoactive Substances Act 2013* introduced a pre-market approval regime for NPS that required manufacturers to prove the low risk of NPS prior to their manufacture and sale. Upon approval, a range of restrictions would be placed on the product, such as age, place of sale,

¹⁰¹⁴ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, pp. 17-18.

¹⁰¹⁵ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 31.

¹⁰¹⁶ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, p. 20.

¹⁰¹⁷ Intergovernmental Committee on Drugs (IGCD), *Framework for a National Response to New Psychoactive Substances*, Canberra, 2014, pp. 18-19.

¹⁰¹⁸ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, p. 20.

advertising and labelling.¹⁰¹⁹ Essentially, this approach aimed to allow some products to be legally regulated and accessed in certain situations. The NZ Ministry of Health suggested that the approval process would take up to 18 to 24 months, with costs to manufacturers of between \$1 million and \$2 million NZ dollars.¹⁰²⁰

The Bill passed the NZ Parliament with a convincing majority in July 2013 (119 votes for, and 1 vote against). Dr Alex Wodak, President of the Australian Law Reform Foundation (ADLRF) and Director of Australia21 advised the Committee of the widespread support for the Bill at the time, noting it was introduced by a conservative government and supported by police, as well as politicians from three political parties.¹⁰²¹

A report from the United Kingdom (UK) Home Office's Expert Panel on NPS, published in September 2014, examined the implementation of the NZ scheme during the transitional phase. It noted a marked reduction in the number of NPS products and retail stores:

Initially, while the new regime is in the transitional phase, the New Zealand Ministry of Health introduced a range of retail restrictions and an interim licensing regime for NPS products that had been on sale six months previously that had not demonstrated any harm to users. In addition, a product safety assessment framework was developed to determine whether or not a product should receive an interim licence. This led to 47 products being granted temporary licences. The initial impact was that the number of NPS retail outlets fell from 3,000–4,000, which were mainly convenience stores, to 156 specialist stores, and the number of legally available NPS products fell from 200 to 47.¹⁰²²

However, the report also explained that all temporary licences that had been issued were revoked in April 2014 'following reports of adverse effects from approved products and nuisance and crime around retail stores'.¹⁰²³ In May 2014, in introducing the Amendment Bill that revoked all interim licenses and approvals, the NZ Minister for Health provided further information for this decision:

Serious adverse reactions have been increasingly reported to the authorities including vomiting, seizures, and psychotic episodes. The problem that has become apparent is that it is often not possible to attribute reactions to a particular product. People call the poison centres or the centre for adverse reactions monitoring and say they took synthetic cannabis or legal highs. If the authority does not know what products caused the adverse effect, it cannot use its powers to intervene. So what we have are products that have not been tested and that are causing harm, and the Government having limited ability to intervene.

Last month Cabinet discussed this issue, not for the first time, and agreed that the Hon Peter Dunne would arrange for legislation to be drafted that would remove all products from the market immediately. It was always intended to allow only products that had passed rigorous testing and had been shown to pose only a low risk of harm. The interim period was intended to last only a few months while regulations were

¹⁰¹⁹ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, pp. 23-24.

¹⁰²⁰ The New Psychoactive Substances Review Expert Panel, *New Psychoactive Substances Review: Report of the Expert Panel*, UK Government, London, 2014, p. 39.

¹⁰²¹ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 98.

¹⁰²² The New Psychoactive Substances Review Expert Panel, *New Psychoactive Substances Review: Report of the Expert Panel*, UK Government, London, 2014, p. 40.

¹⁰²³ The New Psychoactive Substances Review Expert Panel, *New Psychoactive Substances Review: Report of the Expert Panel*, UK Government, London, 2014, p. 40.

prepared. However, we still have the products on the market that have not been through any testing and it is clearly no longer tenable for this situation to continue, given that the serious adverse effects continue to be reported and that the authority is unable to respond quickly.¹⁰²⁴

Affecting the future viability of the scheme, the Bill also imposed a ban on the use of any animal testing to support applications for NPS products. On this issue, the Minister for Health stated that the only circumstance in which overseas trials of animal testing could be used if they showed a product was *not* low risk, but would not be able to be considered to support the approval of a substance.¹⁰²⁵ In practical terms, this amendment resulted in the inability for any applications to be processed and NPS products to be legally sold. The Psychoactive Substances Regulatory Authority, which was established to oversee the regime, currently discourages applications on the basis of the animal testing ban.¹⁰²⁶

Aside from these key issues, the Committee believes it is important to contextualise the developments more broadly. It has been suggested that the sharp reduction in the number of outlets amplified attention on those that remained, which became the focus of significant negative public and media attention. As noted by Ross Bell, Executive Director of the NZ Drug Foundation, the interim regime was in operation for longer than intended and came across a variety of practical challenges such as the inability to check imports for purity as required, and '[i]t became difficult to say exactly what was in some products – the very opposite of what had been intended'.¹⁰²⁷ However, Ross Bell also identified the main problem as the banning of relatively harmless substances prior to the legislation being passed, which were not then able to be regulated under the new regime:

The interim period may have caused more problems than it solved. The delay in introducing a proper regulatory infrastructure was harmful. But more than that, New Zealand's experience has shown the perils of attempting to regulate new psychoactive substances without reviewing drug law as a whole. The first synthetic cannabis product, having been on the market for five years unnoticed and problem-free, was banned under the vague, sweeping analogue provisions of the country's Misuse of Drugs Act. How different might things have been if that product had still been around?

It makes little sense to deal with new substances in isolation. If there is a solution to the difficult problem of seeking alternatives to the war on drugs, it very likely lies not only in looking forward, as New Zealand attempted, but also looking back and reflecting on the laws we already have.¹⁰²⁸

Ross Bell also advised in an interview that, despite all products being officially banned following the Amendment Bill, they remain available:

¹⁰²⁴ *Psychoactive Substances Amendment Bill – First Reading, Second Reading, In Committee, Third Reading 2014 (NZ)*.

¹⁰²⁵ *Psychoactive Substances Amendment Bill – First Reading, Second Reading, In Committee, Third Reading 2014 (NZ)*.

¹⁰²⁶ Psychoactive Substances Regulatory Authority, 'Home page', viewed 2 May 2017, <<http://psychoactives.health.govt.nz>>.

¹⁰²⁷ Bell, R, 'War on drugs: The Kiwi comedown has lessons for all', *New Scientist*, 7 January 2015, viewed 9 May 2017, <<https://www.newscientist.com/article/mg22530030-200-war-on-drugs-the-kiwi-comedown-has-lessons-for-all>>.

¹⁰²⁸ Bell, R, 'War on drugs: The Kiwi comedown has lessons for all', *New Scientist*, 7 January 2015, viewed 9 May 2017, <<https://www.newscientist.com/article/mg22530030-200-war-on-drugs-the-kiwi-comedown-has-lessons-for-all>>.

“Even the Police say they’re still finding and seizing these products. Synthetic cannabinoids are being sold as incense, and there have been some pills and powders being sold as plant food – which is exactly what these things are being sold as in other parts of the world.

“What we are also seeing is people just buying whatever they want online and having it shipped over. That kind of stuff will continue. The Auckland City Mission has noted that, since synthetic cannabis products disappeared, a lot of their clients have reverted to huffing glues and solvents. There are lots of substitutes for these things – alcohol, natural cannabis, butane. People are still going to get high.

“I think we need the Psychoactive Substances Act to help mitigate all this weird, unknown stuff being available online. If you give New Zealanders an approved, legal substance, they’ll go for it.”¹⁰²⁹

Despite implementation challenges, some inquiry stakeholders advised the Committee of the value of NZ’s approach as a framework to regulate low-risk substances.¹⁰³⁰ Professor Paul Dietze, Director of Behaviours and Health Risks Program at the Burnet Institute stated:

I guess our approach is to always take an evidence-based approach, and we would be really interested to see what happens in New Zealand, but, as you said, New Zealand is not actually progressing at the moment. I think anywhere where you can regulate and control the environment, the substance and all of those things is fundamental; it will reduce harm. At the moment we have this relatively out-of-control, unregulated, uncontrolled market that is causing a lot of harm. I think we really should be exploring alternatives. If we do explore alternatives, we absolutely need to make sure we evaluate them well.¹⁰³¹

Students for Sensible Drug Policy Australia (SSDP) suggested in its submission that ‘rather than a knee-jerk reaction, a careful evaluation and regulation (perhaps similar to the proposed model in NZ) is suggested as a better approach’.¹⁰³² In a recent book chapter analysing innovative policy responses to NPS, *Exploring Innovative Policy Responses to NPS and ‘Legal Highs’ in New Zealand, Poland, Republic of Ireland and the UK*, Wilkins et al highlighted benefits that may be associated with a regulated market for low-risk substances such as shifting demand away from the illicit market, and providing reliable information to consumers about issues such as health risks and potency. It also suggested that:

[t]his regulated market approach offers a number of key advantages over traditional prohibition approaches, including requiring manufacturers to prove their products are low risk in advance of legal sale, improving the safety of products legally available and providing more nuanced regulatory control over the market, for example, age of purchase limits, licensing of sellers and health warnings on packaging (Wilkins 2014a).¹⁰³³

¹⁰²⁹ Brown, R, ‘Our ‘psycho’ psychoactive substances legislation’, *Matters of Substance*, vol. 25, no. 4, NZ Drug Foundation, 2014, viewed 17 January 2018, <<https://www.drugfoundation.org.nz/matters-of-substance/november-2014/our-psycho-psychoactive-legislation>>.

¹⁰³⁰ Yarra Drug and Health Forum, *Submission*, no. 107, 14 March 2017, p. 6; Eros Association, *Submission*, no. 186, 17 March 2017; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 305; Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, pp. 98-99.

¹⁰³¹ Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 40.

¹⁰³² Students for Sensible Drug Policy Australia, *Submission*, no. 214, 29 March 2017.

¹⁰³³ Wilkins, C, et al., ‘Exploring Innovative Policy Responses to NPS and ‘Legal Highs’ in New Zealand, Poland, Republic of Ireland and the UK’, in *Novel Psychoactive Substances*, O Corazza and A Roman-Urrestarazu (eds), Springer International Publishing, 2017, p. 69.

However, the Committee is also aware of the risks with such approaches, including whether it may result in greater rates of use, and whether the health burden would increase, similar to the experiences of regulation of substances such as alcohol or tobacco.¹⁰³⁴ Further, the experience in NZ, particularly the stalling of the *Psychoactive Substances Act 2013*, means there is still no evidence of how regulation can work effectively in this area.

The Committee travelled to NZ in October 2017 and met with various stakeholders, including health, law enforcement and civil society organisations. The Committee discussed the Act at various points, and it was confirmed that while the regime is not operational, it could be used in future if non-animal testing processes are developed. The Act is scheduled for review in 2018.

11.2.5 General prohibition approach

An emerging legislative model, increasingly followed in Australia, is to impose offences on the sale, import, export or advertisement of *all* psychoactive substances that are not specifically controlled or listed as a specific exception (such as food, medicinal products and controlled drugs), thereby banning all NPS. This is termed as a ‘blanket ban’ approach, which reverses the traditional approach to drug policy of banning particular substances. It is deemed proactive, as authorities no longer have to play ‘catch up’ as NPS emerge on the market and legislation does not continually require updating. Legislation usually determines that a substance is included where it has a ‘psychoactive effect’ – defined in various ways where it produces some form of change in function or causes dependence. Under this approach, personal possession of a psychoactive substance is not typically a criminal offence, but rather the aim is to target the open sale of these substances to reduce their availability.¹⁰³⁵ Internationally, this approach has been adopted in countries such as the UK and Ireland.

Ireland

In Ireland, the *Criminal Justice (Psychoactive Substances) Act 2010* responded to the growth of ‘headshops’, which were retailers selling NPS. The Act makes it an offence to sell, import, export or advertise psychoactive substances. It defines a ‘psychoactive substance’ as one that, when consumed, has the capacity to:

- (a) produce stimulation or depression of the central nervous system of the person, resulting in hallucinations or a significant disturbance in, or significant change to, motor function, thinking, behaviour, perception, awareness or mood, or
- (b) cause a state of dependence, including physical or psychological addiction.¹⁰³⁶

It excludes medicinal products, animal remedies, liquor, tobacco, food, controlled drugs, and other specified substances.

In 2013, the United Kingdom Home Office appointed the New Psychoactive Substances Review Expert Panel (the Expert Panel) to consider appropriate legislation for NPS. The Expert Panel’s report in September 2014 highlighted that in Ireland, while there has been no systemic assessment of the Act, the 102 headshops in the

¹⁰³⁴ Wilkins, C, et al., ‘Exploring Innovative Policy Responses to NPS and ‘Legal Highs’ in New Zealand, Poland, Republic of Ireland and the UK’, in *Novel Psychoactive Substances*, Corazza and Roman-Urrestarazu (eds), Springer International Publishing, 2017, p. 70.

¹⁰³⁵ Commission on Narcotic Drugs, *New psychoactive substances: overview of trends, challenges and legal approaches*, Vienna, 2016, pp. 22-23.

¹⁰³⁶ *Criminal Justice (Psychoactive Substances) Act 2010* (IE), s. 1.

country ‘virtually disappeared’ after it came into force. Further, no Irish-based internet websites were selling NPS, and the number of people attending treatment for NPS use declined. However, it identified potential concerns about people using other drugs instead, and the possible development of an illicit market for NPS. Further, a small European Commission survey of young people found 22 per cent of Irish respondents reported using NPS, compared to an EU average of 8 per cent.¹⁰³⁷

In its review of the Irish framework, the Australian Framework noted that, while the approach appeared to be successful in closing down retailers selling NPS, online sales of NPS was still of concern.¹⁰³⁸ The National Drug and Alcohol Research Centre further explained in its submission the implications of the online market for NPS:

Immediately following the implementation of the blanket ban in Ireland, most shops voluntarily closed their doors (Kavanagh & Power, 2014). Nevertheless, some surveys of Irish populations indicate that self-reported use of NPS is still high compared with other European countries (Reuter & Pardo, 2017), and it is conjectured that under a blanket ban NPS are likely to be supplied through websites based in other countries and through in-person dealer networks, which may increase drug harm. For example, some argue that shopfronts have better controls on product quality and limiting sales to adults (Reuter & Pardo, 2017).¹⁰³⁹

In terms of harms, recent analysis of national addiction treatment data found that NPS-related addiction treatment among young adults ‘declined progressively and substantially’ over the two years following the general prohibition approach, and there was no corresponding change in the rate of treatment for other substances.¹⁰⁴⁰

United Kingdom

The UK Expert Panel report recommended adopting the blanket ban approach, which led to the passage of the *Psychoactive Substances Act 2016* that came into force in May 2016. The Act provides for a range of offences in connection with psychoactive substances, including to produce, supply, possess with intent to supply, possess on custodial premises, and import or export any substance intended for human consumption that is capable of producing a psychoactive effect. A substance produces a ‘psychoactive effect’ if, by stimulating or depressing the person’s central nervous system, it affects the person’s mental functioning or emotional state. Exemptions include food, alcohol, tobacco, nicotine, caffeine, medical products and controlled drugs. Personal possession is not an offence, except in custodial settings.¹⁰⁴¹

The UK Bill faced criticism from a range of stakeholders. In particular, the Home Office’s ACMD, while supporting a ban on ‘new’ psychoactive substances, considered that a ban on all psychoactive substances was too broad, and that demonstrating the psychoactivity of a substance would be uncertain. The ACMD identified further concerns including that the legislation:

- ‘uncouples the concept of harm’ from the control of drugs, which means that substances with low or no harm would still be banned

¹⁰³⁷ The New Psychoactive Substances Review Expert Panel, *New Psychoactive Substances Review: Report of the Expert Panel*, UK Government, London, 2014, pp. 34-35.

¹⁰³⁸ Intergovernmental Committee on Drugs (IGCD), *Framework for a National Response to New Psychoactive Substances*, Canberra, 2014, p. 36.

¹⁰³⁹ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 10.

¹⁰⁴⁰ Smyth, B, et al., ‘Decline in new psychoactive substance use disorders following legislation targeting headshops: Evidence from national addiction treatment data’, *Drug and Alcohol Review*, vol. 36, no. 5, 2017, p. 609.

¹⁰⁴¹ *Psychoactive Substances Act 2016* (UK), Chapter 2.

- could have possible negative effects on carrying out research on psychoactive substances
- could entail disproportionate levels of criminal sanction relative to the harms caused
- could result in a displaced or illicit market, while acknowledging that it may close retail shops.¹⁰⁴²

Similar concerns were raised by other stakeholders such as the Beckley Foundation and Transform, both drug policy organisations, and Professor David Nutt, the Chair of the Independent Scientific Committee on Drugs and former Chair of the UK's AMCD. In particular, Professor Nutt considered that the rationale for the legislation was based on a false premise of the number of deaths attributed to NPS and called it 'arguably the worst piece of legislation in living memory.' Further, he stated:

The Act is therefore unnecessary and the penalties disproportionate to the real harms of legal highs. It also impedes medical and neuroscience research. By banning safe legal highs it moves the law from one that reduces harm to one that tries to control moral behaviour. I would argue this is the worst assault on personal freedom since the 1559 Supremacy Act decreed that the practice of Catholic beliefs was illegal. It should not have been allowed to come into law.¹⁰⁴³

There are some indications that the legislation has been successful in restricting open access to NPS. For example, the Home Office reported in December 2016 that during the first six months of implementation, 332 shops stopped selling such substances and 31 shops closed. Further, close to 500 arrests were made and four prison sentences had been handed down.¹⁰⁴⁴ Despite this, a 2017 report from UK DrugWise indicated that, while the Act generally achieved its purpose, concerns remain about NPS use among vulnerable groups:

A new survey of the street drug market in the UK by DrugWise the online drug information service, has concluded that the primary aims of the PSA which came into force in May 2016 have been achieved. Firstly to close down retail outlets for so-called 'legal highs' and second to stop the legal cat and mouse game whereby a drug would be banned only for the chemists to render the drug legal once more by slightly changing the formula. However, of the new drugs, synthetic cannabinoids collectively known as spice in particular, have become street drugs alongside heroin and crack causing continuing problems for vulnerable groups including the rough sleeping and homeless communities and those in prison.¹⁰⁴⁵

As part of its overseas study tour, the Committee received evidence to this effect, particularly from the Home Office's Drug and Alcohol Unit and the UK Metropolitan Police Service. They advised the Committee of the significant harms arising from NPS

¹⁰⁴² Correspondence from Advisory Council on the Misuse of Drugs, Letter Re: Psychoactive Substances Bill, To: Hon. Theresa May MP, 2 July 2015.

¹⁰⁴³ Nutt, D, 'Psychoactive Substances Bill - Flawed Rationale and Huge Potential for Increase in Harms', IPR Blog, 24 February 2016, viewed 17 January 2018, <<http://blogs.bath.ac.uk/iprblog/2016/02/24/professor-david-nutt-on-psychoactive-substances-bill-flawed-rationale-and-huge-potential-for-increase-in-harms>>

¹⁰⁴⁴ Home Office and Newton, S, *Psychoactive substances ban 6 months on: almost 500 arrests and first convictions*, 29 December 2016.

¹⁰⁴⁵ *New report reveals Psychoactive Substances Act working but vulnerable groups still affected*, DrugWise UK, United Kingdom, 7 February 2017.

use among vulnerable communities and prison populations.¹⁰⁴⁶ In Australia, VAADA advised the Committee of the need to consider these concerning trends in the local context.¹⁰⁴⁷

The UK Act is scheduled for review in 2018. The Committee strongly encourages the Victorian Government to closely monitor this review and explore the relevance of findings and potential recommendations for change to the Victorian legislation, which as discussed in the next section is based on a similar approach.

11.2.6 **Victorian *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Act 2017***

During the inquiry, the Victorian Government introduced and passed legislation directly impacting the legal status of NPS in Victoria. The *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Act 2017* passed in September 2017, and commenced on 1 November 2017. The Act implemented a general prohibition on such substances and introduced new offences to prohibit the production, sale, commercial supply and advertising of substances that have a psychoactive effect or are represented as having a psychoactive effect (with some exclusions). This specifically targeted synthetic substances sold as ‘legal highs’.¹⁰⁴⁸

The Act defines a psychoactive substance as one that: has a psychoactive effect when consumed; is represented as having a psychoactive effect, or such a substance mixed with another. A psychoactive effect is defined as:

- (a) stimulation or depression of the person’s central nervous system, resulting in hallucinations or in a significant disturbance in, or significant change to, motor function, thinking, behaviour, perception, awareness or mood; or
- (b) causing a state of dependence, including physical or psychological addiction;¹⁰⁴⁹

The Act excludes substances such as drugs of dependence, medicinal cannabis, certain therapeutic goods, food, liquor, tobacco, chemical products or substances prescribed under Regulations. The offences under the Act attract a maximum penalty of two years imprisonment and/or a fine of 240 penalty units. Personal possession of a psychoactive substance is not an offence under the Act, given the focus is on the supply of these substances.

In her Second Reading Speech for the Bill, the Minister for Police, Lisa Neville MP, stated:

There are currently 37 types of synthetic cannabinoids and 26 other new psychoactive substances or classes of substances currently prohibited under the act and its supporting regulations. However, the diversity of substances available and the speed with which new drugs are developed has frustrated the operation of Victoria’s schemes, creating ambiguity around what substances are prohibited and making enforcement costly and time-consuming.¹⁰⁵⁰

¹⁰⁴⁶ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 34.

¹⁰⁴⁷ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 13.

¹⁰⁴⁸ Victoria, *Parliamentary Debates*, Legislative Assembly, Thursday, 9 March 2017, p. 689 (Lisa Neville, Minister for Police).

¹⁰⁴⁹ *Drug, Poisons and Controlled Substances Miscellaneous Amendment Act 2017* (Vic), 40.

¹⁰⁵⁰ Victoria, *Parliamentary Debates*, Legislative Assembly, Thursday, 9 March 2017, p. 689 (Lisa Neville, Minister for Police).

The legislation therefore ‘shifts away from listing specific substances by their chemical composition and instead seeks to capture substances based on their effect or purported effect’.¹⁰⁵¹ It is based on similar provisions in jurisdictions such as Ireland, UK, NSW, Western Australia and South Australia. Wendy Steendam, Deputy Commissioner of Capability at Victoria Police, noted to the Committee that the Act ‘does fill a gap’.¹⁰⁵²

The Explanatory Notes to the Bill stated that offences are ‘intended to complement, not replace, the current approach of prohibiting specific synthetic drugs based on their chemical structure as drugs of dependence’.¹⁰⁵³ To this end, the Act added several synthetic drugs and classes of synthetic drugs already temporarily prohibited under Schedule 11 of the *Drugs, Poisons and Controlled Substances Act 1981*.

Numerous stakeholders to the inquiry discussed particular aspects of the legislation, and broader issues relating to prohibition, which remain important to raise. These are discussed below.

11.2.7 Focus on prohibition-based approaches

The Committee appreciates that the key motivation for the Victorian Government adopting this ‘blanket ban’ was based on the harms arising from NPS use, including an increased number of deaths and hospitalisations:

There is often no testing done to gauge the suitability of these synthetic chemicals for human consumption prior to distribution. As a result, the effect on drug users is unpredictable and potentially volatile, addictive and toxic, especially if mixed with other substances.¹⁰⁵⁴

However, as noted earlier in the chapter, the Committee was told on numerous occasions that the emergence of NPS was a product of prohibition. While reducing access to harmful substances is an appropriate aim of this legislative approach, it is necessary to consider the broader negative impacts of continuing with prohibition-based responses to substances. As explained in Wilkins et al, the experiences in a number of countries, including NZ and Ireland, demonstrates that the resilience of the market is unlikely to be controlled merely through prohibition, and could instead drive further harms. In NZ:

...users and sellers adapted to these new blanket controls over time by accessing products from international websites and from the black market. While this adaptation to new enforcement pressure will not surprise those familiar with the attempted control of illegal drug markets, a more disturbing unintended side effect appeared to be that the replacement compounds tended to be more powerful and toxic than the original ones.¹⁰⁵⁵

¹⁰⁵¹ Victoria, *Parliamentary Debates*, Legislative Assembly, Thursday, 9 March 2017, p. 689 (Lisa Neville, Minister for Police).

¹⁰⁵² Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 457.

¹⁰⁵³ Explanatory Memorandum, *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Bill 2017 (Vic)*, p. 1.

¹⁰⁵⁴ Victoria, *Parliamentary Debates*, Legislative Assembly, Thursday, 9 March 2017, p. 689 (Lisa Neville, Minister for Police).

¹⁰⁵⁵ Wilkins, C, et al., ‘Exploring Innovative Policy Responses to NPS and ‘Legal Highs’ in New Zealand, Poland, Republic of Ireland and the UK’, in *Novel Psychoactive Substances*, Corazza and Roman-Urrestarazu (eds), Springer International Publishing, 2017, p. 69.

The authors suggest that the reason for this ‘escalation in toxicity’ is that drug manufacturers start by using the least harmful compounds to ensure a returning customer base, but resort to more harmful compounds as others are banned.¹⁰⁵⁶ Sam Biondo, the Executive Officer of VAADA, similarly highlighted the impact of prohibiting substances more generally on drug markets:

We think that the new psychoactive substances bill and the increasing prohibition of substances highlights a fluidity in drug markets. Drug markets, as indicated before, are adaptable. They develop new and novel means of accessing at-risk substances. Substances are often more dangerous than what preceded them. Other jurisdictions which have implemented blanket bans have only experienced limited success. There are issues relating to the enforceability. The emergence of the dark web as a means of procuring substances has grown, and there is a transition to street-based illicit substances that can result from those sorts of reforms. So while well intentioned, the outcome can be much more negative.¹⁰⁵⁷

The Committee also heard that prohibition-based responses in Australia may have adversely influenced the types of retailers selling NPS. The Eros Association, representing adult retailers across Australia, advised the Committee that:

These approaches have led to the market we see today, which is largely dominated by wholesalers who are deceptive, secretive and often operate illegally. We have been locked out of conversations that could have created self-regulatory approaches and quickly removed dangerous products from the market and have heard hundreds of anecdotes from retailers and consumers about criminal elements moving into the market.¹⁰⁵⁸

As discussed in this chapter, addressing NPS should not only affect supply, but also the demand that drives the market. On this, Dr Monica Barratt from the DPMP at NDARC advised that the prohibition of NPS will not necessarily lead to diminished demand or use of substances, even though outright sales may reduce:

I think closing down the shopfronts and the advertising of so-called legal highs could certainly reduce harms by reducing supply in that area, and that is what these blanket bans will do. They have done that in other countries, for sure. But if the demand for intoxicants still exists, it will be filled elsewhere. So rather than assuming that the choice is between consuming a drug and not consuming a drug, the question we need to ask is, ‘Which drugs will be consumed when this blanket ban is enforced?’. Invariably there will be drugs available, so which ones are likely to cause the least harm?¹⁰⁵⁹

Referring back to the analysis of Reuter and Pardo from section 11.1.2, they considered that, of the four niche groups that use NPS, the only one that is targeted by the prohibition-based approach are those seeking to avoid criminal sanction. The other groups would continue to demand NPS, including those wanting to avoid detection for work purposes; those wanting new experiences; and those unintentionally taking NPS, therefore having little impact on the market. They considered that ‘[t]hus far, efforts to control NPS have approached the problem without giving

¹⁰⁵⁶ Wilkins, C, et al., ‘Exploring Innovative Policy Responses to NPS and ‘Legal Highs’ in New Zealand, Poland, Republic of Ireland and the UK’, in *Novel Psychoactive Substances*, Corazza and Roman-Urrestarazu (eds), Springer International Publishing, 2017, p. 69.

¹⁰⁵⁷ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 301.

¹⁰⁵⁸ Eros Association, *Submission*, no. 186, 17 March 2017.

¹⁰⁵⁹ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 423.

much consideration as to the distinct drivers behind the use and supply of these substances'.¹⁰⁶⁰ Dr Matthew Frei, Clinical Director of Turning Point similarly noted that the legislative attempts to catch up or control NPS might not necessarily address the issues of their harms or availability. He advised the Committee:

They more than anything challenge the kind of model of 'We've got to ban stuff' and 'We've got to regulate to keep this out of the hands of our young people and other people'. I think the issue around these novel psychoactive substances is quite interesting because legislation keeps trying to keep up with what is being developed offshore. In the UK they have had it very difficult, and I think here they find it very difficult. They are a good example of interconnectivity gone mad in that they are so accessible that people talk about these drugs, people order them online, and I think it is going to be very difficult to regulate them. My view is that we need to really think a bit more broadly and laterally about how to manage these new drugs, because I am not sure we will get on top of them by making them illegal.¹⁰⁶¹

Interestingly, Dr Barratt raised a concern that a general prohibition approach means 'there is no possibility of a low-risk, low-harm psychoactive substance that could be on a par with alcohol',¹⁰⁶² such as what was attempted in NZ.

Ultimately, various stakeholders asked the Committee to consider, particularly in reference to the NZ approach, whether the issue of NPS can be framed in a way not based solely on prohibition and reducing supply, but which also considers demand. The Committee considered the value of regulation that aimed to reduce harms and address the demand for psychoactive substances, while acknowledging the potential role of less harmful substances. While the Committee did not find evidence of an effective and practical model to achieve this, it remains a worthy proposition for further consideration.

It is also noted that the blanket ban approach to NPS focuses largely on 'restoring the power of prohibition', without reference to actual health or harm implications of individual substances. In effect, this could compromise the foundational premise of the international drug control regime:

The previous rationale for prohibiting a drug was supposedly that carefully accumulated scientific evidence of harm indicated the substance posed an unacceptable risk to users and wider public. Prohibition based merely on psychoactive effect eschews any need to assess health harms related to a drug and more closely resembles prohibition based on moral judgement. This suspicion is enhanced by the fact that a number of traditional psychoactive products with known health risks, such as tobacco and alcohol, are routinely exempt from catch-all legislation, seemingly only because their use is already normalised and commercialised in society.¹⁰⁶³

¹⁰⁶⁰ Reuter, P and Pardo, B, 'New Psychoactive Substances: The Regulatory Experience and Assessment of Options', in *Novel Psychoactive Substances*, Corazza and Roman-Urrestarazu (eds), Springer International Publishing, 2017, p. 160.

¹⁰⁶¹ Dr Matthew Frei, Clinical Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 29.

¹⁰⁶² Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 427.

¹⁰⁶³ Wilkins, C, et al., 'Exploring Innovative Policy Responses to NPS and 'Legal Highs' in New Zealand, Poland, Republic of Ireland and the UK', in *Novel Psychoactive Substances*, Corazza and Roman-Urrestarazu (eds), Springer International Publishing, 2017, p. 69.

11.2.8 Issues with the implementation of the Victorian Act

A concern raised by stakeholders regarding the Victorian legislation is that the definition of ‘psychoactive effect’ may be unclear. Dr Kate Seear, Senior Lecturer in Law at Monash University, advised that recent research indicates uncertainty about whether substances actually have predictable ‘psychoactive effects’. This could impact the Act’s implementation and enforceability:

I fully understand why the legislation has landed where it has, because of the shifting nature of what is a very complex area and trying to catch up, but I do think that that is particularly problematic in that there is a substantial body of literature emerging in the social sciences about the complexity of the notion that drugs have certain predictable effects. As you would be well aware, there are a range of factors that can shape how people consume and experience drugs and what kind of affects the experience from those affects.¹⁰⁶⁴

Similarly, Dr Dimitri Gerostamoulos, Chief Toxicologist and Head of Forensic Sciences at the VIFM identified in his evidence to the Committee the current lack of knowledge of psychoactivity of NPS, noting there is limited published information about the pharmacological activity of such substances.¹⁰⁶⁵ In its submission, the VIFM proposed the establishment of a rapid response clinical toxicology service to inform the legislation by providing an evidence base to address these issues.¹⁰⁶⁶ This is discussed further in chapter four.

Further, the Victorian definition of ‘psychoactive effect’, also used in other Australian jurisdictions, including the Commonwealth and New South Wales, assumes that a psychoactive effect is harmful. A 2017 article by Dr Seear, Dr Barratt and Dr Kari Lancaster explored similar Commonwealth legislation and, among other issues, noted:

A key presupposition of the definition in the legislation is that NPS are harmful (or likely to be harmful) even despite their fundamentally imprecise and ill-defined nature. While NPS may be associated with harms on some occasions and in some circumstances, the claims in the Act go further than this, portraying NPS as inherently dangerous, with a strong risk/harm profile.¹⁰⁶⁷

Prior to the Victorian legislation passing, Dr Barratt suggested to the Committee that the inclusion of ‘hallucinations’ in the definition may mean that substances that produce ‘even very, very minor perceptual changes’, for example coffee, could fall under the legislation (unless otherwise excluded). Further, she indicated that court scrutiny of this provision might reduce legitimacy of the legislation if someone attempted to prove that the substance did or did not have a psychoactive effect.¹⁰⁶⁸ In the UK, while the outcomes are yet unclear, there have been reports of unsuccessful

¹⁰⁶⁴ Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, p. 173.

¹⁰⁶⁵ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 208.

¹⁰⁶⁶ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 208.

¹⁰⁶⁷ Barratt, M, et al., ‘A critical examination of the definition of ‘psychoactive effect’ in Australian drug legislation’, *International Journal of Drug Policy*, vol. 40, 2016, p. 22.

¹⁰⁶⁸ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW, *Transcript of evidence*, 18 September 2017, p. 427.

prosecutions under the *Psychoactive Substances Act 2016* in relation to nitrous oxide (laughing gas), on the basis that medicinal products are exempt from the operation of the legislation.¹⁰⁶⁹

On the other hand, Catherine Quinn, the Assistant Director of Analytical Services at the Forensic Services Department of Victoria Police advised the Committee that products would only be on the market if they had such an effect:

If I was going to be really blunt, I would say that if it had no psychoactive effect, it would never end up on the market. The fact that it is on the market is because it does have an effect. The definition of a psychoactive effect in the current legislation is very broad. It is very broad, so there are a lot of things that can occur to that. It is not just a particular type of effect — a hallucination or whatever — it is the broad range of effects that a drug could have.

Really the fact that they are sold is because they have been demonstrated to have an effect, and that is what people are going to look for. The evidence of psychoactivity will be interesting. From a scientific point of view for us, and probably more for the forensic medical people, they will be talking about the nature of those drugs in relation to similar drugs and similar effects that they have on the body, because that is what a drug is: it has an effect. So there will always be some form of effect, but as we say these are new substances. Having literature, having long-term testing — none of that stuff exists.¹⁰⁷⁰

Noting that research in this area is fairly new, as are the legislative responses to NPS, it is difficult to determine the practical implications of these concerns. The Committee considers that, given the broad uncertainties involved and the potential for difficult enforceability, Victoria's definition should be monitored closely, for example through consideration of case law regarding implementation of the definition. Further, any developments in jurisdictions with similar definitions, such as the Commonwealth and NSW, should also be closely monitored.

A range of other issues that have arisen in jurisdictions with similar models, such as Ireland and the UK, should also be monitored. Particularly, the impact of the legislation in closing down retailers and the potential growth of an online market was raised by VAADA and the Burnet Institute,¹⁰⁷¹ and has been observed in Ireland. The Committee believes these issues should be considered when assessing the impact of the legislation.

As outlined earlier, there is evidence that various prohibition-based approaches may have a positive effect on reducing NPS-related harms. A recent study, *The impact of Australian legislative changes on synthetic cannabinoid exposures reported to the New South Wales Poisons Information Centre*, analysed the impact of legislative changes on synthetic cannabinoid exposures in NSW. It found that banning specific brand name products, using consumer protection legislation, rather than the general prohibition approach, was followed by a 'dramatic, sustained decrease' in exposures.¹⁰⁷²

¹⁰⁶⁹ Rawlinson, K, 'Laughing gas still illegal despite court decisions, UK government says', *The Guardian*, 31 August 2017, viewed 5 December 2017, <<https://www.theguardian.com/society/2017/aug/31/laughing-gas-still-illegal-despite-court-decisions-government-says>>.

¹⁰⁷⁰ Catherine Quinn, Assistant Director, Analytical Services, Forensic Services Department, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 457.

¹⁰⁷¹ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 13; Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 8.

¹⁰⁷² Cairns, R, et al., 'The impact of Australian legislative changes on synthetic cannabinoid exposures reported to the New South Wales Poisons Information Centre', *International Journal of Drug Policy*, vol. 43, 2017, p. 74.

Internationally, however, there is also evidence of increased harms from continued NPS use particularly among vulnerable groups, such as homeless people. Again, these issues should be closely monitored.

The UK's *Psychoactive Substances Act 2016* contains a provision for a review of its operation within 30 months of implementation. The UK 2017 Drug Strategy highlighted that the review (to be completed in late 2018) will analyse enforcement, sales and availability, prevalence and health and social harms. It will also consider any unintended consequences.¹⁰⁷³ Given the range of reflections that the Committee received during the inquiry, the Committee considers that a similar review of the Victorian legislation should be conducted and publicly reported on. As highlighted by VAADA in its submission:

The implementation and enforcement of this legislation should be carefully scrutinised with a view to identifying any perverse outcomes which may emerge through changes in substance consumption patterns and harms.¹⁰⁷⁴

In terms of timing, the Committee considers that 18 months is a sufficient period of operation for the review to occur.

A separate point regarding the Act worth identifying is that it does not contain any offences for the possession of psychoactive substances, but rather focuses on the production, sale, commercial supply and advertising of such substances. The Committee notes that this approach is consistent with a health response, rather than a criminal justice response, to the personal possession and use of illicit substances (see chapter seven for further details). However, in effect personal possession offences for drugs of dependence remain in place, while there is no possession offence for NPS. Depending on the response of the Victorian Government to the Committee's recommendation in chapter seven, it will need to consider the impact of this difference.

RECOMMENDATION 25: The Victorian Government review the implementation and enforcement of the recently enacted *Drugs, Poisons and Controlled Substances Miscellaneous Amendment Act 2017* in mid-2019 to evaluate its effectiveness in eliminating the emergence of new psychoactive substances (NPS), and identify any unintended consequences. Other areas for review should include enforcement, NPS-related harms, NPS availability and prevalence. It should also review the implementation and workability of the definition of 'psychoactive effect'.

¹⁰⁷³ Home Office, *2017 Drug Strategy*, UK Government, London, 2017, p. 17.

¹⁰⁷⁴ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 13.

Treatment

12 Victorian alcohol and other drug treatment sector

Treatment, along with prevention, harm reduction and law enforcement, plays an incredibly important role in responding to drugs in the community, and is essential to reducing demand for licit and illicit substances. While under the National Drug Strategy (NDS), treatment sits under demand reduction, the Committee proposed in recommendation two that it be treated as a separate pillar under a four pillars approach to illicit drugs.

There was an overwhelming consensus in the evidence that ‘treatment works’. Sam Biondo, Chief Executive Officer of the Victorian Alcohol and Drug Association (VAADA) told the Committee:

I would like to also put in a plug for our system — that is, that treatment works, and better investment in the AOD treatment system works for both the individual affected and the broader community. Treatment is cost-effective and prevents far more expensive justice and acute health demand and costs. There is up to an \$8 return on investment for each \$1 spent on AOD treatment and a \$4 return on investment for each \$1 spent on, say, needle and syringe programs, so these are fairly effective programs and initiatives. So it is really important to address impediments to timely access to alcohol and drug treatment support. It is not good enough to say we have got a system in place; it is about the timeliness of access that can make a difference.¹⁰⁷⁵

The Victorian alcohol and other drug (AOD) treatment sector is typically characterised as of a high standard, although there is broad acknowledgment that it is underfunded and ‘not flexible enough to respond to changing drug trends’.¹⁰⁷⁶ This issue is exacerbated by the fact that providing appropriate treatment to people who use drugs, and in a timely and effective way, can be challenging. Such challenges include: dealing with people with complex needs, who often experience both substance use disorders and mental health concerns; treating people who use a mix of drugs (poly-drug use); training staff specifically to treat addiction; developing and ensuring access to appropriate pharmacotherapy; and importantly, allocating sufficient resources to meet treatment demand. Further, there appears to be limited knowledge across the community about how to seek assistance for substance use issues or about

¹⁰⁷⁵ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 210.

¹⁰⁷⁶ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 55.

clear treatment pathways, even among some generalist health professionals. These challenges are discussed in this and the next chapter in the context of the Victorian AOD treatment sector.

To address some of these concerns, the Committee acknowledges recent Victorian Government funding announcements, both in the 2017-2018 budget and the *Drug Rehabilitation Plan*, which allocates over \$100 million to additional residential rehabilitation beds and other treatment options.¹⁰⁷⁷

It is also important to note at the outset that as the inquiry relates primarily to law reform, the area of treatment was not investigated as thoroughly as other areas. However, based on the evidence received, the themes identified in this and the next chapter reflect in part the current state of the Victorian AOD treatment sector and identify issues for further exploration.

12.1 Drug treatment in practice

The concept of treatment in the drug context involves a range of strategies, including case identification and diagnosis, assessment and treatment planning, withdrawal management and counselling, and management of other health and social problems that are caused by, or are experienced consequent to, substance use disorders. Sometimes treatment is provided on an inpatient basis and other times on an outpatient basis. Some people may benefit from a long-term residential service while others prefer a less intensive option. A key message from inquiry stakeholders who spoke about treatment is that a 'one size fits all' approach is inappropriate when delivering drug treatment.¹⁰⁷⁸

The Committee also heard that traditional treatment methods are not appropriate for everyone or for all types of substances. In this context, one cannot speak of treatment in overarching terms. While there are some commonalities in addressing substance use across various substance types, equally many differences exist between drug groups. For example, while heroin and opioid use can be treated through pharmacotherapies such as methadone or buprenorphine, comparative pharmacotherapies for drugs in the amphetamine class, particularly methamphetamine, are still in development. Equally what works for a particular client group, for example, 'mainstream' non-Aboriginal and Torres Strait Islander (ATSI) people, may not be culturally appropriate for ATSI people.

A number of stakeholders also advised the Committee of the relapsing nature of addiction and substance use disorders, and that relapse should not be deemed a failure but rather part of an individual's recovery journey. For example, Professor Margaret Hamilton, Australian drug policy expert, stated:

Treatment does work, it can work, but hardly ever first time, so for anyone to think that going into treatment is, 'We've got that person into treatment, great'. If any of you have ever been tobacco smokers, it is rare for a tobacco smoker to have given up the very first time they decide that they will. But each time they try, they tend to

¹⁰⁷⁷ Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017; Minister for Mental Health, *Taking action on ice and other drugs*, Media release, Victorian Government, Melbourne, 2 May 2017.

¹⁰⁷⁸ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017; Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017.

learn, ‘Oh, that was a bit silly last time. I thought I could be a social smoker, so when I was offered a really nice cigar at that function, I thought, oh, that will be fine. So I have learned I mustn’t have a cigar next time’. But next time it is something else. But over each trial they learn what triggers them to the risks to be smoking again, and eventually most people can stop their cigarette smoking. It is the same with all of these drugs, but we have to be willing to try, try and try again, and to accept and accept, and to make sure our treatment facilities and services are positive, supportive and tough but likeable so that people will come back. There is not much point making it so rugged, so tough, so nasty that somebody who might achieve for a bit and then relapses says, ‘I’m not going back there’. So we have got to be able to have that balance between attracting people into treatment but knowing that they may need to come back, so be careful how we treat them, and make sure we do it well.¹⁰⁷⁹

For these reasons, many clinicians argue that some people who use drugs require flexible, effective and accessible options to manage the continuum of adverse effects of their drug use.¹⁰⁸⁰ Support and treatment responses must be wide-ranging to be effective for the broad spectrum of people who use drugs, some of whom may not yet be dependent but are showing signs of moving into more chronic use. A ‘plurality’ of services that can respond to an individual as well as their families, friends and communities is therefore essential.

12.1.1 Victorian alcohol and other drug treatment sector

Alcohol and other drug treatment in Australia and Victoria is generally comprehensive and of high quality, although not without its challenges. In recent years, there have been major changes to the structure and governance of the treatment sector in this state, as a result of the recommissioning of the sector.

The recommissioning of treatment services for both the Victorian AOD and mental health sectors took place in 2013-2014.¹⁰⁸¹ A key objective was to strengthen the sector’s focus on person-centred, outcomes-based service delivery with better client access facilitated through a catchment-based system. Following this, the Department of Health and Human Services (DHHS) commissioned an independent review of the new arrangements, issued in September 2015 (the Aspex Review). It made recommendations including to: move the function of assessment from catchment-based intake services to treatment providers; develop program guidelines to set service delivery expectations, a workforce strategy and a performance management framework; and review drug treatment funding.¹⁰⁸²

Recent work has been undertaken to implement these recommendations, including that from 1 July 2017 assessment functions are now conducted by drug treatment providers to allow them to build therapeutic relationships with clients early, and to

¹⁰⁷⁹ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, pp. 58-59.

¹⁰⁸⁰ See 360Edge, *Submission*, no. 229, 4 September 2017.

¹⁰⁸¹ See Department of Health, *New directions for alcohol and drug treatment services: A framework for reform*, State Government of Victoria, Melbourne, 2013.

¹⁰⁸² Aspex Consulting, *Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services*, Victorian Department of Health and Human Services, East Melbourne, 2015, pp. 7-13.

reduce the number of times clients have to describe their circumstances. Program guidelines that establish service delivery expectations for the AOD sector were also issued in April 2017, and a workforce strategy is being developed.¹⁰⁸³

The AOD treatment sector has largely welcomed the changes that occurred as part of the recommissioning. However, a number of inquiry stakeholders considered that it did not resolve problems associated with a lack of sufficient funding, such as long wait times and insufficient treatment bed numbers.¹⁰⁸⁴

According to the DHHS, its current AOD treatment system is based on a recovery-oriented model, which acknowledges that relapse is common and can take a number of years and treatment attempts before people might achieve their treatment goals.¹⁰⁸⁵ In addition, the provision of AOD treatment is governed by a set of treatment principles that underpin the most optimal treatment interventions and are identified as ‘high level and aspirational’. They also emphasise a commitment to a harm minimisation framework. In abbreviated form, the principles are:

1. Substance dependence is a complex but treatable condition that affects brain function and influences behaviour
2. Treatment is accessible
3. Treatment is person-centred
4. Treatment involves people who are significant to the client
5. Policy and practice is evidence informed
6. Treatment involves integrated and holistic care responses
7. The treatment system provides for continuity of care
8. Treatment includes a variety of biopsychosocial approaches, interventions and modalities oriented towards people’s recovery
9. The lived experience of alcohol and other drug users and their families is embedded at all levels of the alcohol and other drug treatment system
10. The treatment system is responsive to diversity
11. Treatment is delivered by a suitably qualified and experienced workforce.¹⁰⁸⁶

The principles are complemented by and support the *Victorian Alcohol and other Drug Client Charter*, which outlines the rights and responsibilities of people who use AOD treatment services in Victoria. It also provides information about what clients can expect from the treatment services they are engaged in, and what is expected of them.¹⁰⁸⁷

¹⁰⁸³ Victorian Department of Health and Human Services, *New intake and assessment arrangements for alcohol and other drug services: Information for the Victorian alcohol and other drug workforce*, State Government of Victoria, Melbourne, 2017.

¹⁰⁸⁴ See for example, 360Edge, *Submission*, no. 229, 4 September 2017; Turning Point, *Submission*, no. 116, 15 March 2017; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017; Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017.

¹⁰⁸⁵ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 12.

¹⁰⁸⁶ Department of Health and Human Services, ‘Alcohol and other drug treatment principles’, viewed 12 September 2017, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-treatment-principles>>.

¹⁰⁸⁷ Department of Health and Human Services, ‘Alcohol and other drug client charter’, viewed 4 December 2017, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-client-charter>>.

A range of treatment options are available within the Victorian sector to ensure that people have access to the most appropriate care and support for them, and which can also be tailored to reflect the severity of their substance use disorder and other life circumstances. According to the DHHS, this may include ‘a mix of treatment services in their home, at a day program at a community organisation or at inpatient residential services in the community or in a hospital’.¹⁰⁸⁸

A key component of the Victorian sector is its emphasis on stepped care, which allows clients to move up or down between levels of care according to their needs.¹⁰⁸⁹ Stepped care comprises first offering the least intensive intervention likely to be effective, and then moving onto more intensive interventions only when the lesser intervention has proven insufficient.¹⁰⁹⁰ This is referred to as stepping up, whereas stepping down is moving from a higher level of care, such as a withdrawal setting in a hospital, down to a community residential withdrawal unit once an individual’s condition is stable.¹⁰⁹¹ This model is highly regarded in treating substance use issues because of its inherent flexibility and also because it allows the integration of new approaches as they become available, or referral to other health specialists as required.

The Victorian AOD sector mostly comprises services that are publicly funded, although private services are available and typically provided by private hospitals and health practitioners such as psychologists and psychiatrists. Alcohol and other drug treatment services provided through either of these public and private settings are subject to state and commonwealth regulations. The DHHS is responsible for ensuring that quality government-funded AOD services and programs are delivered to the Victorian community. This includes all public hospitals, specialist public AOD treatment facilities, registered private hospitals, and AOD treatment facilities in receipt of public funding. Service specifications exist for all Victorian funded AOD treatment streams, including objectives and functions of each treatment stream.¹⁰⁹²

Under the government funded sector, access to the AOD treatment system occurs through the catchment-based entry points across Victoria, which are responsible for client intake, triage and referral to treatment. The entry points provide local knowledge to assist people to navigate the treatment system and can also engage with treatment providers on behalf of, and in partnership with, clients and their families. The catchment-based entry points also work closely with the Victorian Government funded DirectLine, the telephone and online service that assists people seeking AOD information, advice, screening, brief interventions, or referral. When providing a facilitated referral, DirectLine links the client into a three-way telephone call with the appropriate catchment-based intake service.¹⁰⁹³

¹⁰⁸⁸ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 12.

¹⁰⁸⁹ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 15.

¹⁰⁹⁰ Baker, A, et al., ‘Stepped-care approaches for amphetamine-type stimulant problems’, in *Perspectives on Amphetamine-type Stimulants*, A Allsop and N Lee (eds), IP Communications, East Hawthorn, 2012.

¹⁰⁹¹ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 15.

¹⁰⁹² Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017.

¹⁰⁹³ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, pp. 11-12.

Assessment of clients is undertaken by treatment services, which allows the service to build therapeutic relationships with clients earlier. Treatment services then provide this assessment information to catchment-based intake services.¹⁰⁹⁴ Assessments may include setting initial goals for treatment, such as reducing use or becoming abstinent, repairing relationships, seeking employment, in addition to exploring the person's readiness and capacity to make the necessary changes to achieve these goals. Outcomes from assessments are then used to develop individualised treatment plans that should be regularly reviewed and updated.¹⁰⁹⁵

12.1.2 Treatment types

Following assessment and screening, clients can be referred to one of the treatment services within the Victorian AOD treatment system outlined below:

- Counselling – evidence-based therapeutic individual, group and family counselling interventions that aim to support behavioural change and recovery. Types of counselling include face-to-face, online and telephone consultations. A range of health professionals can provide counselling, such as general practitioners (GPs), counsellors, social workers, psychologists and psychiatrists.¹⁰⁹⁶
- Non-residential withdrawal – these services support people with a substance use disorder to reduce their use and to safely achieve 'neuroadaptation reversal from addiction'. It involves a clinical withdrawal assessment, withdrawal treatment and referral, and information provision, at a minimum. It is available in various settings and can be coordinated with other medical services, such as GPs, hospitals and addiction specialists.¹⁰⁹⁷
- Residential withdrawal – this service aims to achieve the same as the above, in terms of neuroadaptation reversal from addiction, but in a supervised residential or hospital facility. This service is appropriate for people with complex needs.¹⁰⁹⁸
- Therapeutic day rehabilitation – these programs provide a non-residential, intensive and structured intervention which aim to treat the 'psychosocial causes' of substance use disorders. They are typically suitable for clients who require more intensive support than counselling but where their housing, family and/or employment situations is part of them achieving sustainable

¹⁰⁹⁴ health.vic, 'Adult community based alcohol and other drug service provision review', viewed 14 February 2018, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/community-based-aod-treatment/adult-community-based-aod-service-review>>.

¹⁰⁹⁵ {health.vic, 2018 #1062}

¹⁰⁹⁶ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 18; Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 15.

¹⁰⁹⁷ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 20; Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 15.

¹⁰⁹⁸ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 22; Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 15.

recovery. Some people may require to undergo other processes prior to participating in such a program, such as withdrawal and stabilisation of use, or pharmacotherapy.¹⁰⁹⁹

- Residential rehabilitation – Similar to therapeutic day rehabilitation, residential rehabilitation aim to treat the psychosocial causes of substance use disorders but in a structured residential setting. Services comprise a mix of treatment interventions that vary in duration and intensity, with emphasis on self-help and reintegration into community living.¹¹⁰⁰
- Care and recovery coordination – this involves assisting people, particularly those with complex needs, to coordinate treatment planning, establish goals and offer support if they are waiting to access treatment. The duration and intensity of the service depends on the person’s needs, and is available before, during and following their treatment for up to 12 months.¹¹⁰¹
- Pharmacotherapy – the use of prescribed substitution medication to assist in the treatment of addiction. It is typically used to treat opioid addiction, and has proven to improve a participant’s stability, reduce involvement in offending behaviours, and reduce transmission of blood-borne viruses. It is provided through GPs, nurses, pharmacies and AOD treatment services.¹¹⁰² The use of pharmacotherapy to treat opioid dependency is specifically discussed in chapter 14.

The Victorian AOD treatment sector also provides population specific services, such as youth services, Aboriginal services and forensic services. There is also a strong focus on family support and ensuring that where appropriate, family members are considered and engaged in the development and review of a client’s recovery plan.¹¹⁰³

12.2 Alcohol and other drug treatment data 2015-2016

The data presented in this section is taken from the Australian Institute of Health and Welfare’s (AIHW) drug treatment series, *Alcohol and other drug treatment services in Australia 2015-16*. This report covers data for 2015-2016 and presents national and state information about publicly funded AOD treatment service agencies, the people and substances they treat, and the treatment provided.¹¹⁰⁴

¹⁰⁹⁹ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 25; Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 15.

¹¹⁰⁰ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 26; Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 16.

¹¹⁰¹ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 28; Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 16.

¹¹⁰² Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 30; Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 16.

¹¹⁰³ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 19.

¹¹⁰⁴ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, June 2017.

This information is supplemented by state based data sets including AODstats, which is an alcohol and drug interactive statistics and mapping service. AODstats provides information on the harms related to alcohol, illicit and pharmaceutical drug use in Victoria. Turning Point compiles these on behalf of the Victorian DHHS.

Despite being a fairly comprehensive data source, the AIHW cautions that a complete picture of drug treatment nationally and across the states and territories is not possible due to the variety of settings that people receive AOD treatment:

These include: services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding; hospitals, including admitted patient services, outpatient clinics and emergency departments; prisons, correctional facilities and detention centres; primary health-care services, including general practitioner settings, community-based care, Indigenous-specific primary health-care services, and dedicated substance use services; health promotion services (for example, needle and syringe programs); and accommodation services (for example, halfway houses and sobering-up shelters).¹¹⁰⁵

While some of these agencies collect and provide data, others do not, resulting in the official data providing a comprehensive but incomplete overview.

12.2.1 Overview of alcohol and other drug treatment in Australia and Victoria

According to the AIHW, an estimated 134,000 clients received treatment in 2015–16, reflecting an 11 per cent increase from 2013–14 (119,000):

This equates to a rate of 650 clients per 100,000 people, or about 1 in 180 people. About two-thirds of clients were male (67%), and half were aged 20–39 (55%). Despite only comprising 2.6% of the population, 1 in 7 (14%) clients were Aboriginal and Torres Strait Islander. This is a rate of 3,400 clients per 100,000 Indigenous Australians, compared with 540 clients per 100,000 non-Indigenous Australians.¹¹⁰⁶

In Victoria, an estimated 31,714 clients received treatment in 2015-16 in 61,158 treatment episodes, averaging 1.9 episodes per client.¹¹⁰⁷ This was higher than the national average of 1.5 episodes per client although AIHW explained that this is due to nuances of Victoria's data collection system where each treatment type is recorded as a separate treatment episode.¹¹⁰⁸ In Victoria, of the clients who received treatment in 2015-16, 15.9 per cent also received treatment in 2014-15 and 6.9 per cent received some form of treatment in 2013-14, 2014-15 and 2015-16.¹¹⁰⁹

Nationally, alcohol, cannabis, amphetamines, and heroin have remained the most common drugs of concern for clients since 2006–07:

¹¹⁰⁵ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. 3.

¹¹⁰⁶ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. vii.

¹¹⁰⁷ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. 8.

¹¹⁰⁸ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia: state and territory summaries* Canberra, 2017, p. 11.

¹¹⁰⁹ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia: state and territory summaries* Canberra, 2017, p. 11.

Nationally, alcohol was the most common principal drug of concern in 2015–16, accounting for 32% of episodes. Between 2011–12 and 2015–16, the number of treatment episodes with amphetamines as the principal drug of concern increased by 175%, and cannabis treatment episodes increased by 40%, while heroin treatment episodes fell by 15%, and alcohol treatment episodes fell by 6%. For clients aged 30 and over, alcohol was the most common principal drug of concern, while for clients aged 10–29, cannabis was the most common.¹¹¹⁰

In reference to the 175 per cent rise in amphetamine treatment episodes, the Committee notes this reflects an increase from 16,875 treatment episodes in 2011–12 to 46,441 in 2015–16.¹¹¹¹

In 2011, the most recent year for which firm figures are available, treatment for illicit drug use—including amphetamines, cannabis, cocaine, ecstasy, or opioids—cost an estimated \$298 million.¹¹¹² Kym Peake, Secretary of the DHHS advised the Committee that in Victoria, the most common primary drug of concern reported to treatment services was alcohol at 31 per cent, followed by amphetamines at 25 per cent and cannabis at 19 per cent. Kym Peake also reiterated, however, that the ‘majority of clients have problems with multiple substances, so poly-drug use’.¹¹¹³ She did not indicate the percentage of clients presenting with pharmaceutical drugs as the common primary drug of concern, although she highlighted that they are the greatest contributor to overdose deaths. Based on the AIHW data, pharmaceutical drugs were the primary drug of concern in 5 per cent of episodes in 2015–16 across the Australian AOD treatment sector:

Over the 10-years from 2006–07, the proportion of treatment episodes with a pharmaceutical drug as the principal drug of concern rose from 6% in 2006–07 to 8% in 2011–12, and then fell to 5% in 2015–16. The proportions of treatment episodes for morphine and benzodiazepines have been decreasing over the 10-year period, while the proportions for codeine, methadone, oxycodone, and buprenorphine have been increasing. Previously, benzodiazepines represented the largest proportion of [treatment] episodes for a single drug type within the pharmaceutical group (17%), but in 2015–16 reporting increased for methadone (19%), morphine (14%), codeine (14%), and oxycodone (10%).¹¹¹⁴

Key national overview data for the 2015-2016 period is summarised in figure 12.1.

¹¹¹⁰ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. vii.

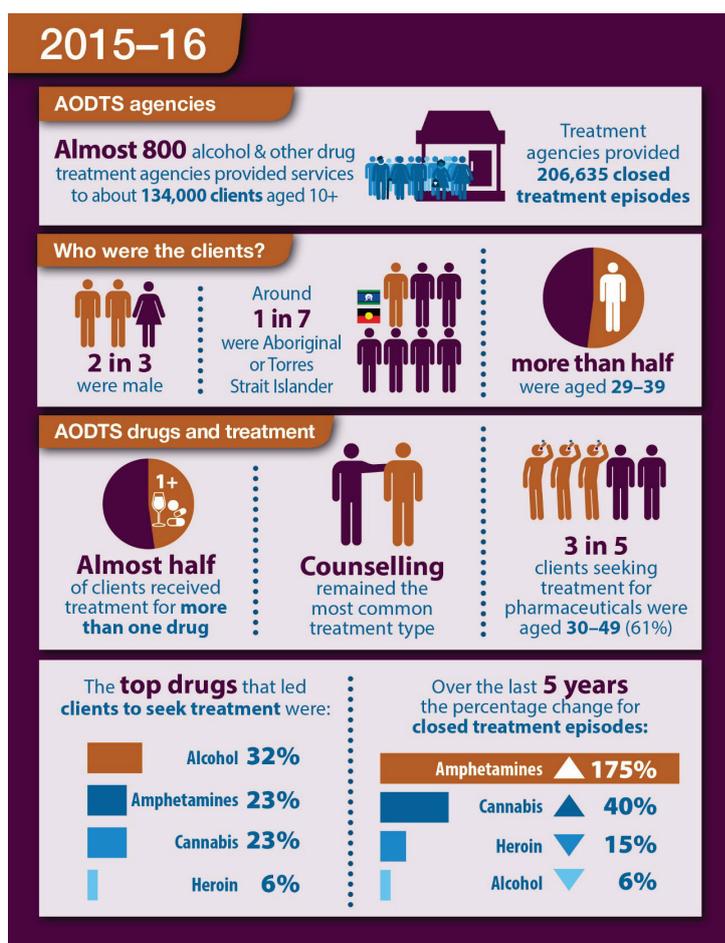
¹¹¹¹ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. vii.

¹¹¹² Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. 1.

¹¹¹³ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 319.

¹¹¹⁴ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. 41.

Figure 12.1 Overview of national AOD treatment services 2015-16



Source: Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. 6.

12.3 Challenges facing Victoria’s alcohol and other drug treatment sector

Inadequate funding allocated to the Victorian AOD treatment sector was a commonly identified theme by stakeholders throughout the inquiry.¹¹¹⁵ As discussed in chapter four, an imbalance in the allocation of resources to supply reduction measures compared to treatment, has led to a sector insufficiently funded to offer treatment to all those seeking it. In reference to research conducted by the National Drug and Alcohol Research Centre (NDARC), *New Horizons: the review of alcohol and other drug treatment services in Australia*, Sam Biondo of VAADA told the Committee that ‘there are at least 200 000 Australians who would be suitable to get into AOD treatment but

1115 David Taylor, Policy and Media Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 304; Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 251; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 303; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 162; 360Edge, *Submission*, no. 229, 4 September 2017; Penington Institute, *Submission*, no. 209, 24 March 2017, p. 47; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 6; Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017.

cannot access the sector'.¹¹¹⁶ According to the Penington Institute, this is concerning given that the failure to treat substance use issues quickly 'leads to more problematic drug use, acquisitive and violent crime'.¹¹¹⁷

Stakeholders drew attention to the various ways that insufficient funding adversely impacts the treatment sector. This includes extended wait times for preferred treatment services, particularly residential rehabilitation; inflexible and inadequate service provision; inequitable options, particularly in rural and regional areas; and inadequate support for addiction medicine and workforce capabilities.¹¹¹⁸ These issues are discussed further below.

Despite these challenges, the Committee also wishes to acknowledge the recent commitment of the Victorian Government to the AOD treatment sector, which many stakeholders also positively highlighted in their evidence. In particular, as part of the 2017-18 budget, the Government committed \$34.8 million to establish 30 new rehabilitation beds and other treatment and counselling services, in addition to \$9.7 million to acquire land in the regional areas of Gippsland, Hume and Barwon regions to build new rehabilitation facilities.¹¹¹⁹ This funding was further enhanced with the recent announcement of the *Drug Rehabilitation Plan*, that comprised an extra \$87 million to open 100 additional residential rehabilitation beds and to trial a new 28 day rapid withdrawal and rehabilitation model, among other key initiatives, such as the establishment of a medically supervised injecting centre in North Richmond.¹¹²⁰

12.3.1 Wait times

One of the key problems with the AOD treatment sector identified by inquiry stakeholders is the lengthy wait periods before a patient can enter treatment.¹¹²¹ There is currently insufficient data about exact wait times as the DDHS does not capture such information. However, Kym Peake of the DHHS advised the Committee that the Department is currently working with the sector to enhance data collection in this area.¹¹²²

Nonetheless, numerous inquiry stakeholders advised of long wait times and the fact that they can be a significant disincentive for people with substance use disorders to seek treatment.¹¹²³ The Committee understands that this is highly concerning as it is essential for treatment to be accessible when the client is ready for it, otherwise a window of opportunity may close.

¹¹¹⁶ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 300.

¹¹¹⁷ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 47.

¹¹¹⁸ See in particular: Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017; Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017.

¹¹¹⁹ Minister for Mental Health, *Taking action on ice and other drugs*, Media release, Victorian Government, Melbourne, 2 May 2017.

¹¹²⁰ health.vic, 'Drug rehabilitation plan', viewed 18 December 2017, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/drug-rehabilitation-plan>>.

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¹¹²² Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 328.

¹¹²³ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017; Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017; Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017.

Of particular concern to stakeholders was wait periods for residential rehabilitation due to insufficient bed numbers. The Victorian Alcohol and Drug Association stated in its submission that Victoria has the second lowest ratio of residential rehabilitation beds per head of population nationally.¹¹²⁴ Similarly, Dr Stefan Gruenert, Chief Executive Officer of Odyssey House and Dr Lorraine Baker, President of the Australian Medical Association (AMA) Victoria, while both welcoming recent funding increases, noted in their evidence that Victoria still lagged behind other parts of Australia. According to Dr Baker, '[i]t does not address the 10 years of shortfall in funding in this area...'¹¹²⁵

Windana, a Melbourne-based drug and alcohol treatment centre, highlighted in its submission the specific wait periods for some of its services and the impact this has on overall AOD treatment service delivery:

As one of the major providers of residential rehabilitation in Victoria, there are significant wait times which are acting as a deterrent to accessing this treatment type. At times, access to Windana's residential rehabilitation therapeutic community (TC) occurs after a 4-6 month wait time. We also are often required to close our books. The limitations in service capacity for TCs are felt keenly throughout Victoria and it should be noted that Victoria has far less beds than comparable jurisdictions (VAADA 2017).

...

The way that AOD services are funded has resulted in a number of bottlenecks in the system coupled with service gaps, particularly while waiting for assessment as well as accessing specific service types. In particular, there is often a significant wait time between the delivery of withdrawal services and necessary access to TC's immediately after withdrawal. This is further exacerbated by the need for extended withdrawal episodes for individuals experiencing methamphetamine dependence. Some service users require up to three weeks while the funded episode provides for seven to 10 days of withdrawal. These presentations are often further complicated by mental health symptoms, putting more pressure on staff and services.¹¹²⁶

To overcome the funding shortfall and lengthy wait periods, VAADA proposed that the Victorian Government improve their planning processes to increase the capacity of residential rehabilitation across the State, and that this be accompanied with adequate resourcing:

This significant commitment...will necessitate the development of a plan which will account for gaps in service, demand by region and opportunities evident through partnerships and existing capacity. It should account for the complexities apparent in providing these services, and further consultations should be given to the composition of, and expertise availed to running, these services. The plan should involve content on addressing the needs of specific cohorts, including CALD communities, older people and acute co-occurring mental health and AOD presentations. The plan should identify specific opportunities which can minimise establishment expenses.

This plan should provide for the staged increase in residential rehabilitation capacity over a five year period with a view to increase the capacity of the Victorian funded residential rehabilitation system to 1: 10,000 head of population, necessitating approximately 300 extra beds. Such an endeavour, which would provide for an

¹¹²⁴ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 7.

¹¹²⁵ Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 257.

¹¹²⁶ Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017.

additional 1200 service users annually, would result in Victoria having the third lowest number of residential rehabilitation beds per capita but well within the range of other jurisdictions in Australia.¹¹²⁷

The Penington Institute also recommended improved service planning but suggested a nationally coordinated approach to treatment quality and targeting, with the intention of necessitating effective monitoring of demand for services. It suggested this will contribute to a robust and flexible treatment system.¹¹²⁸

12.3.2 Rural and regional alcohol and other drug treatment options

According to the Penington Institute, the rate of overdose deaths in regional Victoria has grown 57 per cent, compared with 36 per cent for Victoria as a whole. In particular, Victorians aged between 30 to 60 years, particularly men in rural areas are most at risk of overdose.¹¹²⁹ Despite these acute risks, AOD treatment services are overwhelmingly located in metropolitan areas, making it burdensome and complex for people based in rural and sometimes regional areas to access such services. As identified in the previous section, this can influence people's willingness and capacity to seek treatment, and for some may lead to a tragic end.

In her evidence to the Committee, Dr Lorraine Baker of the AMA (Victoria) reaffirmed the impact of insufficient supports and long waiting times in rural and regional areas:

We urgently need more rehabilitation options within rural and regional communities. I have been on the road and I have heard from my colleagues working in those communities that the disruption and the chance of success to people being obliged, if you like, to access residential rehab well away from their community into a new setting, a new environment, a metropolitan setting and away from perhaps helpful community supports with their own local community is a real barrier to success. Nonetheless, obviously if they stay in their local communities for rehab, sometimes that is also one of the contributing factors. It is such a complex area, but the fact that there is no option for them in their own region is not just expensive and wasteful of resources in a setting where they are less likely to succeed but also puts incredible pressure on their families and the community in those areas to manage that and to manage the cost of relocating — a concerned parent travelling 200 kilometres to visit one of their offspring in residential rehab, for instance.¹¹³⁰

Similarly, the Penington Institute noted:

This insufficiency of drug treatment services is particularly bad for Australians living in the country: AOD services are overwhelmingly located in metropolitan and regional centres – despite recent waste water analysis indicating double the prevalence of methamphetamine in regional Victoria compared with Melbourne. The combined impact of these factors means regional and rural Australia is particularly susceptible to the adverse consequences of drug use: it is little surprise that country Australians now face the dual, growing harms of overdose and ice.¹¹³¹

1127 Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 8.

1128 Penington Institute, *Submission*, no. 209, 24 March 2017, p. 47.

1129 Penington Institute, *Submission*, no. 209, 24 March 2017, p. 20.

1130 Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 256.

1131 Penington Institute, *Submission*, no. 209, 24 March 2017, p. 47.

The Committee understands that many regional parts of Victoria are experiencing the consequences of methamphetamine or ‘ice’ more acutely than other parts of Victoria. As many of these areas are unlikely to have had significant issues with illicit drug use prior to this, local health care settings and AOD treatment services are insufficiently equipped to address growing prevalence rates and associated harms. This is further exacerbated by existing funding issues and limited service availability leading to long waiting periods for treatment and withdrawal. These issues were identified in the Victorian Government’s *Drug Rehabilitation Plan*, which included a specific focus on enhancing regional treatment and rehabilitation:

Over 50 per cent of additional residential rehabilitation beds are being delivered in rural and regional Victoria.

New therapeutic day rehabilitation programs are now available in seven regional locations, including Mildura, Warrnambool, Bendigo, Geelong, Shepparton, Moe and Ballarat...New residential rehabilitation beds will open in Bendigo in the coming months.

Recognising the impact of illicit drugs throughout regional Victoria, \$9.7 million has been provided to acquire land in Gippsland, Hume and Barwon to build new residential drug rehabilitation facilities.

Development of a new 20-bed residential rehabilitation facility in Ballarat will also start in early 2018, with this new service to commence from October 2018.¹¹³²

Anonymity and confidentiality issues

Another significant issue for people in rural communities is their desire for privacy and anonymity when seeking treatment in a small community.¹¹³³ In this context, the social dynamics of smaller communities, while often positive, can also be an obstacle in accessing services. People in rural and regional areas may be reluctant to disclose their drug use for fear of identification and discrimination.

A possible way to address issues pertaining to anonymity, or lack thereof, is to create ‘one stop shops’, such as a multidisciplinary and integrated health services. In addition to providing a needle and syringe program or opioid substitution therapy, these may also comprise general health services, counselling, social services and mental health services. In addition to addressing inadequate service delivery in rural and regional areas, a multidisciplinary health service would offer discrete AOD treatment options, which would be beneficial to those not wishing for others to be aware of their substance use issues. This option is discussed in section 12.3.6. Further, an outreach model may also be appropriate, where the worker meets the client on their own ‘territory’ and protects a client’s confidentiality.¹¹³⁴

¹¹³² Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017, p. 8.

¹¹³³ Wallace, C, et al., ‘Methamphetamine use, dependence and treatment access in rural and regional North Coast of New South Wales’, *Drug and Alcohol Review*, vol. 28, no. 6, 2009.

¹¹³⁴ For further discussion on confidentiality issues in the context of drug use in rural and regional Victoria, see Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria - Volume 1*, Parliament of Victoria, East Melbourne, 2014.

12.3.3 Inflexible and limited service availability

Inadequate funding has contributed to the treatment sector's inflexibility and incapacity to respond effectively to new drug trends, such as the increase over the last five years in the number of people presenting for treatment for methamphetamine use.¹¹³⁵ As noted in the 360Edge submission:

In the early stages of the changes in methamphetamine use patterns and treatment presentation numbers, services were struggling to know how to respond. Methamphetamine-related problems in Victoria have highlighted that the service system does not have enough flexibility to respond to changing trends. Currently methamphetamine is a key issue, but in future we need to be able to effectively respond to new trends and patterns of use as they arise.¹¹³⁶

Interestingly, the 360Edge submission indicated that the large majority of people who use methamphetamine are not at risk of dependence but are at risk of acute harms. However, because the Victorian AOD sector focuses predominantly on reducing use of substances over reducing harms, this has potentially led to a focus on residential rehabilitation at the expense of other treatment options.¹¹³⁷ This was apparent to the Committee throughout the inquiry, noting that when discussing treatment options in Victoria, most stakeholders typically referred to enhancing the number of residential rehabilitation beds. However, the Committee also heard from some key AOD treatment stakeholders that residential rehabilitation is not always appropriate for people with methamphetamine-related problems.

In its submission, consultancy firm 360Edge highlighted that in most instances, people who use methamphetamine do not require tertiary treatment services such as residential rehabilitation, which is 'very very intensive'.¹¹³⁸ It indicated that not everyone is ready for that type of treatment especially at the beginning of their treatment journey. It suggested the alternative of the therapeutic day rehabilitation program, which may 'address the high drop out rates from residential treatment among people who use methamphetamine'.¹¹³⁹ 360Edge is currently evaluating the program on behalf of the DHHS.

In his evidence to the Committee, Trevor King, the Director of Programs at UnitingCare ReGen identified that addressing a client's methamphetamine use requires a different approach than that traditionally used for heroin and alcohol, particularly in the context of detoxification:

When we saw this iteration of the methamphetamine issue, a lot of alcohol and drug services in Victoria had been dealing with alcohol, heroin and cannabis for many years, and the nature of the programs you need to offer are quite different to methamphetamine users. For example, we are pretty confident that for someone with an alcohol or heroin problem, we can bring them into a residential withdrawal facility, or indeed a non-residential program, and within about seven days they will be detoxed. We can withdraw them, and we can do that quite safely.

What we found with methamphetamine, though, was that we were getting people who were presenting much more agitated. We had people stay with us for detox, as I said, for around seven to 10 days. That was not enough for this group. We found that

¹¹³⁵ 360Edge, *Submission*, no. 229, 4 September 2017.

¹¹³⁶ 360Edge, *Submission*, no. 229, 4 September 2017.

¹¹³⁷ 360Edge, *Submission*, no. 229, 4 September 2017.

¹¹³⁸ 360Edge, *Submission*, no. 229, 4 September 2017.

¹¹³⁹ 360Edge, *Submission*, no. 229, 4 September 2017.

initially they were just crashing. So for the first three days all we were really able to do was just give good nursing care — you know, hydration and feeding them in a low stimulus environment. We also found that then after that three day period, for the first probably about seven days there is the more acute phase of the withdrawal, and then it can go on for a couple more weeks after that.

So we did a review of our practices. We had discussions with the Department of Health and Human Services and said, ‘We actually need to extend out the detox period for this group’. We also found that aggression was an issue, although we think that we are pretty good at managing it. We have not experienced huge problems. We found that a lot of other services were saying, ‘There is nothing we can really provide’. We felt that was an inappropriate response, so we have done a lot of work in this area.¹¹⁴⁰

The Committee is also aware of a specialised treatment option for methamphetamine use that currently exists in New South Wales (NSW), the Stimulant Treatment Program. Since 2006, the NSW State Government has funded two dedicated clinics, which provide outpatient counselling to people who use methamphetamine, in addition to education and support for clients and their families. The model is based on a stepped care approach, allowing for the intensity and nature of the clinical intervention to be modified depending on the client and their severity of use.¹¹⁴¹ An evaluation of the Program in 2012 found that clients reported significant reductions in their methamphetamine use at three to six months after participating in outpatient counselling, in addition to significant reductions in psychotic symptoms, hostility and disability associated with poor mental health. The evaluation also found that the Program was most effective with younger users, whereas older users who were also using heroin were least likely to respond to this treatment model.¹¹⁴²

The Committee is also aware that the NSW Program included a trial of pharmacotherapy using dexamphetamine for a small number of people heavily addicted to methamphetamines and whom were resistant to other treatment options.¹¹⁴³ In his submission, drug treatment specialist Dr John Sherman recommended that the Victorian Government consider trialling a dexamphetamine program to minimise risks to people who use methamphetamine and the community.¹¹⁴⁴ He also explained to the Committee how he ran a similar program 25 years ago, which despite its success was stopped by the Victorian Government.¹¹⁴⁵ When asked by the Committee about the use of pharmacotherapy to treat people who are addicted to methamphetamine in particular, Dr Nicole Lee responded with the following:

So these pharmacotherapies have all been trialled with people who use methamphetamine. We did a review for what was the ANCD a few years ago. It is now ANACAD, the federal government’s supervisory committee on drugs. And what we found was that these five drugs had some limited evidence of benefit — more than

¹¹⁴⁰ Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 274.

¹¹⁴¹ Worthington, E, ‘Ice treatment clinics and prescription drug replacement therapy access to expand across NSW’, *ABC News*, 16 July 2015, viewed 18 January 2018, <<http://www.abc.net.au/news/2015-07-16/ice-treatment-clinics-and-prescription-drug-replacement-therapy/6625948>>; Mayo, A, ‘Ice - where to from here’, viewed 14 March 2018, <<http://www.nswnma.asn.au/wp-content/uploads/2015/09/STP-StVincent-Hosp-Presentation-AMayo.pdf>>.

¹¹⁴² McKetin, R, et al., *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences: Monograph Series No. 13*, National Drug Law Enforcement Research Fund (NDLERF), Canberra, 2005.

¹¹⁴³ Ezard, N, et al., ‘Lisdexamfetamine: could it be safe to treat methamphetamine dependence? A study protocol’, viewed 14 March 2018, <<http://www.australiandrugsconference.org.au/wp-content/uploads/Assoc-Prof-Nadine-Ezard-Treatment-Efficacy.pdf>>.

¹¹⁴⁴ Dr John Sherman, *Submission*, no. 145, 17 March 2017.

¹¹⁴⁵ Dr John Sherman, Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 289.

the rest in the other two columns — but they did different things, so they did not all operate in the same way, as you have alluded to. But none of them were effective enough. Dexamphetamine, I know, gets a lot of press and it gets a lot of interest from the medical fraternity, but even dexamphetamine did not show particularly good outcomes. None of them showed enough effective outcomes to be recommended to be used widely. So they are being used off-label by some people. That is not to say that some people do not get some benefit from them. It is just that we could not recommend them at this stage as a routine treatment, as we can with buprenorphine and methadone for heroin dependence.¹¹⁴⁶

It is clear to the Committee that a range of services or treatment options are required to respond to the use of and dependence to various illicit and licit substances. As an example, Dr Lee reiterated the need for a range of treatment options from brief to intensive interventions to be available, as people who use methamphetamine often require more flexibility in their treatment options:

...they are much more likely to get benefit from a lighter touch treatment that is not abstinence-oriented necessarily, and eventually people do give up. So it is worth still providing a wide range of treatment options from very brief interventions to very intensive interventions. We know in the case of methamphetamine that even as little as two sessions can have a huge impact on increasing abstinence and reducing drug use and harms across the board.¹¹⁴⁷

Other problems identified regarding service availability relate to inflexible practices within treatment service delivery. For example, services may rigidly operate within 9 to 5 office hours which may not be suitable for those people who work. As noted by Dr Helen Stergiou, an Emergency and Trauma Physician at Alfred Health, in the context of the hospital's drug and alcohol service: 'the hours are limited. It is almost a context of 9 to 5. We know these issues are clearly not 9 to 5'.¹¹⁴⁸ Similarly, services may be located in hard to reach or inconveniently located centres, a problem particularly for those living in rural, and regional areas and/or who do not have convenient transport options. For example, Professor Alison Ritter, Director of the Drug Policy Modelling Program at NDARC stated:

One of the key challenges, I think, in terms of providing effective treatments for people is that it is all about right place and right time, and our systems are not set up to provide people with the help and support — and their family members — in the right place and at the right time. Everything is set up around booking systems and 9 to 5 and all of that sort of stuff. Emergency departments are not the place. They can respond to a medical emergency but they cannot respond necessarily with an effective treatment. So we need to rethink drug treatment in terms of right place, right time, for each person.¹¹⁴⁹

Aside from inflexibility in treatment options, VAADA highlighted in its submission that there are significant gaps in the provision of certain services types, such as care, recovery and coordination. It identified that 3194 courses in these areas are required to meet the additional demand estimates provided by the DHHS prior to recommissioning.¹¹⁵⁰ Further, Dr Nicole Lee and Windana indicated in their submissions the need for greater follow-up and aftercare services, with both reaffirming that this is another area significantly under resourced. Windana stated:

¹¹⁴⁶ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 373.

¹¹⁴⁷ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 372.

¹¹⁴⁸ Dr Helen Stergiou, Emergency and Trauma Physician, Alfred Health, *Transcript of evidence*, 19 June 2017, p. 239.

¹¹⁴⁹ Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, p. 252.

¹¹⁵⁰ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 7.

Aftercare is an essential component of the treatment program at Windana. Evidence shows that the recovery process can be sustained with continued aftercare programming beyond that of primary treatment (De Leon, 2012). The program has been substantially developed over the last 18 months and will continue to expand as the community grows. This type of program should be further supported and rolled out widely throughout the state. Additional capacity for care and recovery coordination. This necessary step is significantly under resourced.¹¹⁵¹

In the context of methamphetamine use, the 360Edge submission advised that post treatment support services ‘can reduce the risk of relapse’, but these services are not routinely funded in Victoria.¹¹⁵²

The Committee acknowledges the importance of follow-up services given that substance use disorders are, by nature chronic and relapsing conditions. People often require multiple attempts before they are able to fully meet their treatment goals. As advised by Professor Dan Lubman, Director of Turning Point, the average time it can take from when someone develops an addiction to a substance to when they achieve full recovery is 27 years.¹¹⁵³

Further, evidence from clinicians to the *Inquiry into the Supply and Use of Methamphetamines in Victoria* by the former Victorian Parliament’s Law Reform, Drugs and Crime Prevention Committee, advised that follow-up for missed appointments for all clients of AOD treatment services should ideally be a routine component of clinical practice.¹¹⁵⁴ Assertive follow-up practices are also important to use with potential clients who have been placed on waiting lists and for others who have been assessed by a service but required referral to a different service. These two client groups face a high risk of falling through service gaps. Follow up and aftercare services are also essential for people with substance use issues who have been released from prison, as discussed in the next chapter.

12.3.4 A lack of treatment specialists

Numerous stakeholders raised concerns with the Committee about the AOD treatment sector workforce, and in particular a lack of specialised addiction medicine capabilities in Victoria.¹¹⁵⁵ The Committee is aware that this is a result of Victoria having a more community-based response to addiction, which focuses on developing a clinical workforce.¹¹⁵⁶ In contrast, as advised by Professor Margaret Hamilton, most other states are decentralised and have funded special units through hospitals that provide an appealing career path to doctors who wish to specialise in this area.¹¹⁵⁷ Both Associate Professor Nadine Ezard and Turning Point advised that the NSW treatment

¹¹⁵¹ Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017.

¹¹⁵² 360Edge, *Submission*, no. 229, 4 September 2017.

¹¹⁵³ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25.

¹¹⁵⁴ Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria - Volume 2*, Parliament of Victoria, East Melbourne, 2014.

¹¹⁵⁵ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017; Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017; Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017; Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017; Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017; Turning Point, *Submission*, no. 116, 15 March 2017.

¹¹⁵⁶ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 326.

¹¹⁵⁷ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 61.

sector in particular is more supportive of addiction specialists, with more training positions available to those seeking specialist accreditation and better financial and other incentives in this area.¹¹⁵⁸ Turning Point stated in its submission:

Australian training for doctors specialising in the treatment of addiction is provided by the Chapter of Addiction Medicine (under the Royal Australasian College of Physicians or RACP) and the Royal Australian and New Zealand College of Psychiatry (RANZCP). However, numbers of trainees and qualified addiction specialists are low, particularly in Victoria, due to a lack of investment in training and specialist positions. New South Wales by way of contrast has almost 10 times the numbers of addiction doctors in training as Victoria, as well as a number of funded specialist positions within each health service. The lack of a career pathway for doctors interested in pursuing a career in addiction medicine or addiction psychiatry means that Victoria is facing a future without such expertise, with an exodus of specialists to funded positions interstate in recent years, and many of the remaining cohort of addiction specialists nearing retirement.¹¹⁵⁹

The Committee notes, however, that the DHHS is aware of this growing problem and is working with Turning Point on initiatives to map and enhance the capabilities of Victorian services in this area. Kym Peake of the DHHS told the Committee:

We have got a new director of training position to provide more support to existing trainees and strengthen those training pathways as well as a new accelerated specialist training program for psychiatrists, and we have got our first candidate, who has come in through that accelerated program at the moment.

We are also working with Turning Point at Eastern Health...by mapping what is the availability, what is the supply of addiction specialists currently, what is our capacity and what might be the alternative models to build up those services. We are working with both the Royal Australasian College of Physicians, who are the fellows of the chapter of addiction medicine, as well as with the Royal Australian and New Zealand College of Psychiatrists — so those two parts of the profession who could help us to build up this particular workforce.¹¹⁶⁰

In its submission, Turning Point further detailed the initiative, advising that the Director of Addiction Training will:

- teach and mentor addiction psychiatry and addiction medicine registrars
- train and mentor general practitioners (GPs), GP registrars and physicians/psychiatrists on addiction medicine placement
- support direct clinical placements and supervision.¹¹⁶¹

As part of its mapping exercise, Turning Point will prepare a report that summarises the short-term immediate gaps in this area of the workforce, with recommendations that consider future demand patterns and supply of addiction specialists over the next five years.¹¹⁶² The Committee believes this is an important initiative that will contribute to enhancing the Victorian AOD treatment sector. Professor Margaret Hamilton referred to the potential leadership role that addiction medicine specialists could employ in Victoria, and the benefits this would have on the broader AOD

¹¹⁵⁸ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 121; Turning Point, *Submission*, no. 116, 15 March 2017.

¹¹⁵⁹ Turning Point, *Submission*, no. 116, 15 March 2017.

¹¹⁶⁰ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 326.

¹¹⁶¹ Turning Point, *Submission*, no. 116, 15 March 2017.

¹¹⁶² Turning Point, *Submission*, no. 116, 15 March 2017.

treatment sector workforce.¹¹⁶³ At present, very few community based AOD programs have strong links to an addiction medicine specialist. This issue requires ongoing commitment from the Victorian Government to redress.

The Committee was also advised that a 2016 change to the Medicare billing system could further enhance the number of addiction medicine specialists. The change enables registered addiction medicine specialists to bill addiction services as a Medicare item. Associate Professor Nadine Ezard referred to this as ‘a big step forward’ but that it is difficult to say at this stage the difference it will make to the distribution of addiction specialists across Australia.¹¹⁶⁴ Kym Peake of the DHHS also commented on this Medicare change to the Committee:

...up until last year there was not a specific Medicare number. That meant that that was a bit of a disincentive for people to work in that specialist field because there were less opportunities for private practice. So that impediment having been removed we are doing quite a bit of work to look at how we build up the attractiveness and the pipeline of addiction specialists.¹¹⁶⁵

Most importantly, the Committee notes the need for specialist training positions in appropriate medical settings and a clear career pathway to encourage young doctors to train in this area. Dr Lorraine Baker of the AMA Victoria referred to the role of centres of excellence in facilitating opportunities to train people.¹¹⁶⁶ Professor Margaret Hamilton referred to her previous support for ‘medicos’ and trying to ensure they are ‘very well qualified and specialists in this area, providing scholarships if necessary – whatever it takes – because they are a lead profession in the environment’.¹¹⁶⁷ Dr John Sherman recommended in his submission that university drug and alcohol study courses be expanded.¹¹⁶⁸

Enhanced knowledge of treatment pathways among general health practitioners

As noted in the previous section, there is limited understanding among GPs about how to navigate the AOD treatment sector, particularly when they identify patients in need of referral to treatment. Professor Dan Lubman of Turning Point noted the difference between how AOD issues are dealt with, compared to how other health issues are managed:

I think an investment in developing clinical care pathways like we have for other disorders is needed. Again the analogy is: if I have a breast lump, I go to my GP. It is a really clear pathway of where I go, who I see, and everyone is aware of it. If I present to my GP with a methamphetamine issue, first of all I do not know whether he is going to see me or not, and if he does see me, I do not know what he is going to suggest and where he is going to send me. So there is a huge discrepancy in terms of clinical care pathways for other health disorders and for addiction.

...

¹¹⁶³ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 60.

¹¹⁶⁴ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 121.

¹¹⁶⁵ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 326.

¹¹⁶⁶ Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 260.

¹¹⁶⁷ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 60.

¹¹⁶⁸ Dr John Sherman, *Submission*, no. 145, 17 March 2017.

In every other area of health, if you have a problem, the standard model is that GPs refer to a specialist. They refer to a cardiologist, a respiratory physician or an oncologist. In the addiction space unfortunately there has been this disinvestment in the whole area of addiction medicine, so there are not clear addiction specialists to refer to. GPs are asked to refer to our kind of services, which are essentially faceless services to some degree. They do not have that personal relationship, and most of medicine works on the premise of having relationships — like in any other industry — knowing who you are referring to, having confidence in that person and knowing where to refer.¹¹⁶⁹

Turning Point also runs the Drug and Alcohol Clinical Advisory Service (DACAS), a 24-hour specialist telephone service for health professionals. This service could be enhanced as a key connection point between primary care settings and specialist AOD care, noting its role in advising health care workers across a broad range of substance use areas. The Committee considers that such a service is imperative and requires additional resourcing, as noted in Turning Point's submission.¹¹⁷⁰

Given these issues, the Committee considers that investments need to be made to provide GPs and other health professionals with support to navigate the AOD sector, as well as increased funding for DACAS to play a role in this. The development of clinical pathway tools may also assist in this regard, in addition to the development of a primary care early intervention strategy as proposed in recommendation 12.

RECOMMENDATION 26: The Victorian Government, in conjunction with Turning Point and other relevant agencies, develop a practice-friendly treatment pathway tool/resource for general practitioners (GPs) to enhance their awareness and understanding of referral to the alcohol and other drug treatment sector. To accompany this, the Victorian Government also review how Turning Point's Drug and Alcohol Clinical Advisory Service (DACAS) could be better utilised among GPs, including through increased funding.

12.3.5 Broader alcohol and other drug treatment workforce

Aside from addiction medicine specialists, the Victorian publicly funded AOD treatment sector workforce comprises approximately 1700 staff who work across 100 diverse agencies, including non-government organisations, public health services and community health services.¹¹⁷¹ The sector comprises a strong workforce and includes alcohol and drug workers, nurses, GPs, addiction medicine specialists, psychiatrists, psychologists, social workers, occupational therapists, researchers, trainers and administrators. The majority of staff have at least one or more qualifications such as a TAFE or university certificate or diploma, bachelor degree or postgraduate qualification.¹¹⁷² The Committee acknowledges the important role that the AOD workforce has in improving the health, community reintegration and connectedness of people with substance use issues.

The Committee understands that the sector's workforce capabilities has significantly improved from 15 years ago, where people were employed to work in the sector despite not being appropriately qualified. Professor Margaret Hamilton shared her observations regarding this issue from her time at Turning Point:

¹¹⁶⁹ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 30.

¹¹⁷⁰ Turning Point, *Submission*, no. 116, 15 March 2017.

¹¹⁷¹ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 4.

¹¹⁷² Department of health, *Victoria's alcohol and drug workforce framework: Strategic directions 2012-22*, Melbourne, 2012, p. 3.

In this arena we have historically not had well-qualified staff.

I can recall when I was the director of Turning Point insisting to the government that they bring in a policy that everybody had to at least have a certificate-level qualification as a bare minimum — so cert IIs and cert IVs. There was no way anyone should be working in a treatment service that did not have some training. I also argued that then those same people should be trained up, so they should get further qualifications, not only so they could do things better but that they had some kind of capacity to move between jobs and not always just drug treatment.¹¹⁷³

Since 2006, all AOD workers funded by the DHHS are required to comply with the Victorian Minimum Qualification Strategy (MQS), which aims to:

...ensure the development and maintenance of a consistently competent and professional AOD workforce. The Strategy's implementation mechanisms provide a consistent approach to learning and skills development based on minimum, nationally recognised competency standards.¹¹⁷⁴

In particular, the Strategy aims to increase the proportion of AOD workers who have relevant qualifications, as well as requiring workers without a qualification to obtain a specialist AOD or addiction studies qualifications. By 2009, the majority of AOD workers were meeting the minimum requirements and ongoing compliance has remained stable since then.¹¹⁷⁵

12.3.6 Enhancing the role of general medical clinics in alcohol and other drug treatment

In chapter six, the Committee discussed the potential role of GPs in undertaking early interventions with some patients who present with early signs of a substance use issues. Some inquiry stakeholders also suggested that GPs engaging in this type of AOD service would be highly beneficial, particularly for people living in rural and regional areas, where specific AOD treatment services are unlikely to be adequate to address their substance use needs, therefore exposing those local communities to continued and increasing drug-related harms. In this context, the Committee believes there is merit in exploring the viability of expanding medical services to incorporate other health and social services in rural and regional areas where there is significantly less support and access to services for people who use illicit substances or with dependency issues.

On these issues, the AMA Victoria similarly indicated in its submission that patients with an opiate addiction would benefit from access to multidisciplinary health teams that, in addition to access to OST, also include 'addiction medicine speciality teams, dual disorder mental health services, social workers and support services, and other allied health workers'. In particular, the AMA Victoria recommended the establishment of public multidisciplinary clinics in regional areas to provide such AOD services.¹¹⁷⁶

1173 Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 60.

1174 Department of Human Services, *The Victorian Alcohol and Other Drugs Workforce Development Strategy - Minimum Qualification Strategy*, State Government of Victoria, Melbourne, 2004, p. 5.

1175 <<https://www2.health.vic.gov.au/alcohol-and-drugs/alcohol-and-other-drug-workforce/aod-workforce-minimum-qualification-strategy>>.

1176 Australian Medical Association, *Submission*, no. 203, 20 March 2017, p. 3.

Dr Sherman also advised the Committee of First Step, the medical clinic that he practices at in St Kilda, which is an integrated health service that offers access to OST, two psychologists, a social worker, two psychiatric nurses, a legal service, a liver specialist, and a hepatitis nurse. These services are available on the one site in recognition that treatment should be a package. He stated '[w]hat is the point of giving methadone to someone who is homeless or sick?'.¹¹⁷⁷

The Committee understands that a number of multidisciplinary health clinics exist in Victoria, mainly in metropolitan areas. Aside from First Step in St Kilda, cohealth is another example of this model. It is a community health organisation that provides a range of health and social support services, including medical, dental, allied health, mental health, aged care and counselling. It offers these services across Melbourne, and northern and western suburbs.¹¹⁷⁸ The Committee also received evidence from Echuca Regional Health, which offers a broad range of services to its local community, including a pharmacotherapy program with GPs, nursing, AOD clinicians and a pharmacy.¹¹⁷⁹

12.3.7 Enhancing the role of public hospitals in alcohol and other drug treatment

The Committee received evidence that hospital medical staff, both emergency and non-emergency, can play an important role in addressing drug-related issues among their patients. In its submission, the Australasian College for Emergency Medicine (ACEM) highlighted that in the 2012/13 period, there were 7,091 pharmaceutical drug-related presentations (prescribed and non-prescribed) and 1,206 illicit drug-related presentations in Victorian emergency departments. The ACEM indicated that emergency departments act as frontline harm reduction services, offering a range of responses including 'treating acute drug intoxication and reversing overdose and poisoning, to managing acute and serious complications of chronic drug-related conditions'.¹¹⁸⁰

Further, in its evidence to the Committee, Dr Helen Stergiou and David Ruschena, General Counsel, both at Alfred Health, advised about the limited information available to hospital medical staff regarding AOD treatment options, despite the number of patients who present with substance use issues to hospital emergency rooms or general departments. Dr Helen Stergiou advised the Committee:

Talking about this with David last week, from my perspective as a clinician it is: what is that dream, what is that challenge for me to say to my junior colleagues, who are only coming in and they are wide-eyed and they are loving emergency because of all the bells and whistles, but they are also gently starting to see 'Hang on, there are patients for whom we don't have as many resources', whereas other patient groups, the minute they hit the door, this is their trajectory. They will have all of these resources, they will have the doors open for the acute length of stay, for the rehabilitation, for the ongoing resolution of their issues over the next year or two. With these issues here in our, I guess, patients subjecting themselves to these sorts of choices, they have the same needs and yet we are not providing that same level of input.¹¹⁸¹

¹¹⁷⁷ Dr John Sherman, Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 297.

¹¹⁷⁸ cohealth, 'Who we are', viewed 14 March 2018, <<https://www.cohealth.org.au/about>>.

¹¹⁷⁹ Echuca Regional Health, *Submission*, no. 170, 17 March 2017.

¹¹⁸⁰ Australasian College for Emergency Medicine, *Submission*, no. 223, 21 April 2017.

¹¹⁸¹ Dr Helen Stergiou, Emergency and Trauma Physician, Alfred Health, *Transcript of evidence*, 19 June 2017, p. 239.

They proposed enhanced coordination and integrated systems around substance use issues across Victorian hospitals, with appropriate links to the AOD treatment sector and GPs in the community. In particular, they recommended that it be coordinated by a single centralised hospital, similar to the Victorian State Trauma System. The objective of an integrated and centralised system would be to create more opportunities to refer patients presenting with substance use issues to the appropriate treatment service. It would also coordinate a patient's journey through pre-hospital, hospital and post-hospital services to ensure continuity of care. Dr Stergiou outlined to the Committee how such a proposal could work:

Giving the example, [of a] 28-year-old male, we have done what we need to acutely. It is 10 o'clock on a Monday morning. What do I have in front of me? So let us think about a resource. Let us think about a drug and alcohol system that is 24/7, funded and staffed. From that we can link them then into continuing an acute stay in hospital, but not under a general medical unit with our elderly patients with cognitive impairment issues, but in a specific space with some specific brief interventions [and] then let us see what the rehab or detox options are.

Clearly underpinning all of that is the patient's motivation, but that is also about 'Let's have the conversation. Let's have the discussion'. I am not saying that this is the panacea, but we do not even have that now for the patients who do show one iota of motivation to try and change the direction of their choices. Their social situations can be so complex that sometimes they look at me and say, 'I just need to stay in hospital overnight'. And yet unless they currently fit a specific medical diagnosis I can no longer do that. In the 1990s I could arrange a social admission — purely that. They need a roof over their heads. You cannot do that anymore. You have got to push very hard.

So for me it is continuing, if you like, that up-front work. Call it drug and alcohol and find a lovely acronym, which has a 24/7 basis and has the appropriate staff, which would be a combination of drug and alcohol workers, psychologists, psychiatrists, acute medicine and clearly social work — those sorts of groups — and then be riding this patient's journey over the next few days as a team, until such time as they make another decision.¹¹⁸²

The Committee believes this is an interesting model of care worthy of further exploration. The Committee is of the view that hospitals can play an active role in facilitating treatment of people misusing substances.

12.3.8 Alcohol and Other Drug Sector Reference Group

This chapter has examined the barriers and challenges facing a person who is seeking treatment for their drug use or drug dependence. Overall, the treatment services available are commonly acknowledged as effective. However, as evidence provided to the inquiry indicates, there are shortfalls and gaps in service provision. The Victorian Government recently expanded funding for the drug treatment sector, a welcomed move by those within the sector who gave evidence to the Committee. Nonetheless, it is generally recognised that more could be done. The Committee considers that one way of highlighting these gaps and addressing them is through the DHHS's current Alcohol and Other Drug Sector Reference Group, which was established in January 2016 to initially provide strategic advice on the implementation of the recommendations of the Aspex Review. As these recommendations are largely underway, the Reference Group's terms of reference could be expanded to explore the issues identified in this and the next chapter, including those identified in the following recommendation.

¹¹⁸² Dr Helen Stergiou, Emergency and Trauma Physician, Alfred Health, *Transcript of evidence*, 19 June 2017, p. 243.

RECOMMENDATION 27: The Victorian Government via the Alcohol and Other Drug Sector Reference Group provide expert advice to the Government, the alcohol and other drug (AOD) treatment sector, and the broader medical community on ways to enhance their capacity to effectively respond to people presenting with substance use issues. Specific areas for action might include:

- identify further funding options through mapping the current capacity and gaps within AOD service delivery against existing and future demand for services. Particular attention to be provided to all treatment options to ensure flexibility in service delivery, acknowledging diversity and differing needs among potential clients. Specific opportunities should be identified for different cohort groups, such as clients with co-existing mental health issues and substance use disorders, culturally and linguistically diverse communities, Aboriginal Torres Strait Islander communities, and those from rural and regional areas
- explore effective and workable measures to expand Victoria’s specialist addiction medicine capacity, in addition to ensuring the AOD treatment sector is adequately supported by its existing workforce
- explore options for a public multidisciplinary health clinic model that comprises access to opioid substitution therapy prescribing doctors, addiction specialists, mental health services, support and other allied health services
- develop a model of care for public hospitals when treating patients presenting with substance use issues, which could include medical staff undertaking drug screening and developing clear treatment pathways and reintegration with specialist AOD treatment services.

12.4 The non-regulated private sector

Another key issue commonly identified by inquiry stakeholders was the lack of appropriate regulations and standards in place for the provision of AOD treatment by private providers.¹¹⁸³ A number of stakeholders considered that a recent proliferation in private providers in this area is a direct result of funding issues causing delays for potential clients to access the public AOD treatment sector, as discussed in the previous sections. For example, Dr Christian Smyth, Special Adviser of Turning Point stated:

...bed occupancy rates are relatively low at the moment in public rehab and detox centres, but the number of private detox and rehab facilities are going up, and they can charge anywhere between \$5000, \$10 000, \$15 000 or \$20 000 a month for individuals to go through what is a very traumatic and challenging time for them. In this vacuum there are others who are circling and thus seeing an opportunity, and I think there is a duty of care for those individuals there.¹¹⁸⁴

Similarly, Paul Aiken and Trevor King of UnitingCare ReGen told the Committee:

Mr KING — You know, there are waiting lists, and again people want instant sort of access, and I understand that.

¹¹⁸³ Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 256; Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 56; Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, pp. 374-375; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 300; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, pp. 165-166; 360Edge, *Submission*, no. 229, 4 September 2017; Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017, pp. 4-5.

¹¹⁸⁴ Dr Christian Smyth, Special Adviser, Turning Point, *Transcript of evidence*, 8 May 2017, p. 31.

Mr AIKEN — And if people have to take out a second mortgage on their house to pay for a private rehab, if it means they get in this week as opposed to in three months time, that is what they will do.¹¹⁸⁵

Stakeholders also indicated that the rise in private AOD treatment providers may be related to emerging drug trends and limited flexibility in treatment options available in the public sector. For example, in its submission, Windana noted that changes in methamphetamine harms contributed to the increase:

Exacerbating this issue is the increased community concern regarding methamphetamine combined with the indisputable increase in methamphetamine related harms occurring in Victoria. Regrettably, this has resulted in the rapid rise of an unregulated, for profit private residential rehabilitation industry which many desperate community members feel is the only option for their loved ones.¹¹⁸⁶

Stakeholders discussed that of course not all private providers would fall foul of appropriate standards of care. However, addressing current regulatory gaps would ensure a consistent and evidence-based approach applies across all treatment services.

12.4.1 Governance of the public alcohol and other drug sector

As a starting point, it is useful to set out the key governance requirements in place for public AOD treatment providers, which are regulated at both Victorian and Commonwealth levels, noting that some of these requirements have been discussed in earlier sections.

Subject to service agreements, public sector agencies contracted to deliver AOD treatment must comply with a range of other Department policies including the Alcohol and other drug treatment principles, the Victorian alcohol and other drug client charter and the *Alcohol and other drugs - Program Guidelines 2017*.

Publicly funded AOD facilities must also provide regular data to both Commonwealth and Victorian health data collection and monitoring services on issues such as outputs.

Organisations that receive funding for delivering AOD treatment services are expected to adhere to any relevant quality framework or policy initiative required by the DHHS and Commonwealth bodies. Currently, publicly funded AOD agencies and their staff must be accredited where relevant by an entity that is certified by the International Society for Quality Health Care or the Joint Accreditation System of Australia and New Zealand.¹¹⁸⁷ Also, as noted earlier in the chapter, publicly funded AOD services must comply with the Victorian AOD workforce MQS.

Treatment services must also take into account the principles of the Australian Safety and Quality Framework for Health Care.¹¹⁸⁸

¹¹⁸⁵ Paul Aiken, Evaluation and Advocacy Team Leader, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 273; Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 273.

¹¹⁸⁶ Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017, pp. 4-5.

¹¹⁸⁷ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 3: quality, reporting and performance management*, State Government of Victoria, Melbourne, 2017, pp. 2-3.

¹¹⁸⁸ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 3: quality, reporting and performance management*, State Government of Victoria, Melbourne, 2017, p. 3.

Trevor King from UnitingCare ReGen told the Committee what these governance structures mean for public AOD treatment providers:

...what comes with being a funded alcohol and drug service or rehab service is that there is a whole range of compliance issues. This is, you know, all of the complying with legislation, aligning your practices with the evidence, having minimum standards in terms of the qualifications of your staff, and all of the things that we do routinely now that is around reporting child safety concerns and responding to a whole range of issues.¹¹⁸⁹

12.4.2 Concerns with the current approach

Concerns were expressed to the Committee about private drug treatment facilities that are unregistered. These concerns not only relate to the expense involved in accessing these services, but also the fact that such services are not subject to the ethical, quality and safety provisions of regulated services as outlined above. For example, Dr Nicole Lee of 360Edge advised the Committee:

The problem is that the whole sector is completely unregulated. So anybody in this room could set up a drug rehab without any qualification or any experience to do so. At least for publicly funded services they are required to report on outputs and some limited outcomes, and they are required to have some accreditation, and private hospitals are required to be registered. But other drug and alcohol centres have no such requirements. You can just set them up. Unfortunately then the general public do not have really the information to say what is good and what is not good and make a true judgement.¹¹⁹⁰

Similarly, Professor Margaret Hamilton stated:

We desperately need a system of accreditation for services claiming to be drug treatment services. Anyone at the moment can put up a shingle and say, 'I do drug treatment'. Some of them in my experience, which includes having been a health complaints investigator on drug treatment complaints for another jurisdiction, will charge \$50 000, \$100 000, to desperate families and provide mush — an absolutely appalling response that is not evidence-based, that has no support. Yes, they will have one, two, they might have 100 anecdotal 'We have cured them'. But if you follow those people long enough, not all of that 100 will remain clean, and anyway many of them could have achieved what was achieved with much more directed, specific and professional care.¹¹⁹¹

While recognising that private treatment facilities do have a role to play and can keep costs down in the public sector, Dr Stefan Gruenert of Odyssey House Victoria considered that a lack of regulation could result in some bad practices:

We welcome private providers for those who can afford them, because it does ease the pressure on the public system. The real problem, again, has some implications from a legal perspective — that is, there are very few regulations around the treatment provided by a private provider unless it is hospital auspiced. So you might get a

¹¹⁸⁹ Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, p. 272.

¹¹⁹⁰ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 374.

¹¹⁹¹ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 56.

good treatment, but you might just get a service that has no active ingredient in its treatment. It merely needs to comply with corporate law and consumer law, but it needs to really provide nothing by any standards to operate in the state of Victoria.¹¹⁹²

Similarly, Trevor King of UnitingCare ReGen told the Committee:

We have a very clear sense of what things work now. There is good research evidence around cognitive behaviour therapy approaches, motivational enhancement approaches, engaging with families, and if I do not see those things as part of the program then I think I am concerned already because there is not that alignment with the evidence. So one of the issues is there might be private programs out there that are doing great work but we simply do not know, and we are hearing some things about some that might not be that are very concerning.¹¹⁹³

Finally, Professor Dan Lubman from Turning Point emphasised the desperation and vulnerability of families seeking drug treatment for a loved one:

We have families that are desperate to find a solution. As you would have heard, particularly when we talk about private rehabs, there are a lot of people in this sector, particularly in the private sector, who make grandiose claims around the efficacy of their approaches.¹¹⁹⁴

Many other inquiry stakeholders expressed similar concerns and called for stricter regulation.¹¹⁹⁵

On the overseas study tour, the Committee was told of similar concerns in some jurisdictions regarding the oversight of private AOD treatment providers. For example, in Portugal, Dr João Goulão, General Director and National Drug Co-ordinator of the General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD) told the Committee that private centres used to charge high fees for their services. To deal with this, by 1990, all public and private treatment centres were managed through SICAD, with the creation of standards to ensure they operated according to best practice.¹¹⁹⁶ Private treatment providers are now licensed by the Ministry of Health and contracted to allocate 80 per cent of their beds to public patients and the remaining 20 per cent to private patients. Further, 80 per cent of treatment is funded through lotteries.¹¹⁹⁷

In Canada, staff of the British Columbia Mental Health and Substance Use Services (BCMHSUS) told the Committee that there are many unregulated residential treatment providers in BC, although the BCMHSUS is exploring ways to bring these providers in line with existing guidelines and evidence-based standards. There have been some high-profile cases in BC where people have died in private facilities. It is also acknowledged, however, that private services have capacity to respond to crises in a way that public services cannot.¹¹⁹⁸

¹¹⁹² Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 165.

¹¹⁹³ Trevor King, Director Programs, UnitingCare ReGen, *Transcript of evidence*, 21 August 2017, pp. 272-273.

¹¹⁹⁴ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 29.

¹¹⁹⁵ Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 256; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 300; Windana Drug and Alcohol Recover, *Submission*, no. 114, 15 March 2017.

¹¹⁹⁶ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 14.

¹¹⁹⁷ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 14.

¹¹⁹⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 40.

12.4.3 Developments in Victoria

The Committee is aware of two state level arrangements in place that ameliorate these concerns to an extent. Further, recent proposed changes may result in a greater degree of scrutiny of these unregistered treatment facilities in the future.

Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013

The first is the regulation of private hospitals and day procedure centres by the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013 (the Regulations), under the *Health Services Act 1988*.

According to the Regulations, all private hospitals and day procedure centres where the activity is surgical, medical or ‘speciality health services’ are required to be registered with the Victorian DHHS. It is an offence to operate an unregistered private facility that is covered by one of these categories. Speciality health services are those that are supervised by a specialist registered medical practitioner, and comprise 13 categories of speciality services including mental health, oncology, obstetrics and neonatal.¹¹⁹⁹ According to the submission of 360Edge, private AOD treatment providers are not captured by the definition of speciality health services,¹²⁰⁰ although arguably some aspects could fall under mental health services.

There are number of requirements for registration with the DHHS. In particular, the applicant (individual or corporate) must:

- be ‘fit and proper’
- have the financial capacity to carry on the business
- build to meet the Australasian Health Facilities Guidelines, which set out spatial and fit out requirements necessary to provide safe services
- have suitable arrangements for management and staffing of the facility
- have processes for maintaining the quality of health services provided at the facility
- have processes for improving the quality of health services.

In addition, the department requires (through a condition on registration) that each private hospital and day procedure centre is accredited to the National Safety and Quality Health Service Standards (National Standards) developed by the Australian Commission on the Safety and Quality of Health Care. Accreditation to the National Standards is assessed by a third party accreditation organisation.¹²⁰¹

In discussing this particular form of oversight of private AOD treatment providers, Kym Peake of the DHHS told the Committee:

¹¹⁹⁹ health.vic, ‘Registering a private health facility’, viewed 14 February 2018, <<https://www2.health.vic.gov.au/hospitals-and-health-services/private-hospitals/registration>>.

¹²⁰⁰ 360Edge, *Submission*, no. 229, 4 September 2017.

¹²⁰¹ Victorian Department of Health and Human Services, *Update to Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013*, State Government of Victoria, Melbourne, 2017, p. 8.

There are some clinics that are picked up under private hospital regulation, but it is not uniform. It depends very much on the nature of the service provider, and it is less about what they are delivering and more about the nature of the provider at the moment.¹²⁰²

In November 2017, the DHHS released a discussion paper regarding options for updating these Regulations, *Update to Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013*. Among a broader range of issues, it set out a proposal to change the list of current prescribed speciality health services to include alcohol and other drug withdrawal (detoxification), which would result in registration for services providing:

...treatment and care of patients undergoing the acute phase of withdrawal from alcohol and/or other drugs on which they are physically dependent, involving medical supervision where the patient is admitted overnight.¹²⁰³

The discussion paper considered that withdrawal (detoxification) treatment can be dangerous with a risk of death, and requires specialist medical management. Further, according to the discussion paper, there is a need for an appropriate clinical governance framework and safety measures to be in place. The paper suggested that, given these factors, withdrawal (detoxification) should be added as a prescribed 'speciality health service' under the Regulations. While considering that rehabilitation services alone would not be prescribed, the paper also stated that it would also capture services offering mixed withdrawal and rehabilitation services:

The department is aware there are mixed withdrawal (detoxification) and rehabilitation models of care currently being employed in some unregulated facilities. This combined model of care often does not involve a medical practitioner and in such facilities, patients undergoing withdrawal (detoxification) treatment are at significant risk of harm or death. The inclusion of alcohol and other drug withdrawal (detoxification) on the list of prescribed services would require all private facilities providing alcohol and other drug withdrawal (detoxification) services to patients undergoing the acute phase of withdrawal to be registered.¹²⁰⁴

The Committee acknowledges that changes such as these are a good starting point for stronger regulation of these services.

Health Complaints Act 2016

The second mode relates to the passage of the *Health Complaints Act 2016* in the Victorian Parliament in April 2016, which established the Health Complaints Commissioner as the new 'watchdog' to replace the former Health Services Commissioner. Under the Act, complaints can be made to the Commissioner about any AOD treatment providers in Victoria, including private providers, unregistered health service practitioners and individual practitioners and health service organisations. There is also a new power for the Commissioner to receive complaints about 'unregistered health service providers', a broad category including workers such as counsellors and psychotherapists. In terms of powers in relation to these complaints, the Commissioner can prohibit providers from practising and issue

¹²⁰² Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 322.

¹²⁰³ Victorian Department of Health and Human Services, *Update to Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013*, State Government of Victoria, Melbourne, 2017, p. 13.

¹²⁰⁴ Victorian Department of Health and Human Services, *Update to Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013*, State Government of Victoria, Melbourne, 2017, p. 14.

warnings to the public.¹²⁰⁵ The DHHS alcohol and other drugs program guidelines discussed the application of a code of conduct to all AOD treatment services, whether public or private:

Health services, including AOD services, are required to meet the code of conduct included in the *Health Complaints Act 2016*.

People who receive treatment from a private or publicly-funded health service, including an AOD service, are able to make a complaint to the Health Complaints Commissioner for consideration and possible investigation. A person's family, friends, carers and even other health services, are also able to make a complaint on another person's behalf.¹²⁰⁶

In a September 2017 report, *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system*, the Victorian Ombudsman noted that the developments under the Act may address some of the concerns regarding private AOD treatment providers:

Some of the issues raised, such as the lack of regulation over private providers and the quality of AOD reports are outside my jurisdiction; although I note the recent increase in jurisdiction granted to the Health Complaints Commissioner by the Health Complaints Act 2016, now extending to private AOD providers, which should provide for greater scrutiny in this area.¹²⁰⁷

Judith Abbott, Director of Community-based Health Policy and Programs at the DHHS also told the Committee:

The other thing that has happened in Victoria is the new Health Complaints Act scheme. What has happened is the definition of treatment in that act has been broadened, and that means the commissioner will now be able to look into private AOD treatment providers around a range of things. So there are things we are able to progress in Victoria now that we have not been able to do in the past, and it has been part of that work around how do you get quality and safety approaches into private and evolving areas — counselling is another classic area that has always been a challenge. So the health complaints commissioner has some broader powers now.¹²⁰⁸

The Victorian Government's *Drug Rehabilitation Plan* in October 2017 also noted the role of the Commissioner in this area in 'having additional supports to step up monitoring and investigations into several private drug and alcohol treatment providers'.¹²⁰⁹

Since beginning its work in February 2017 to December 2017, the Commissioner reported that it received 26 complaints regarding private AOD treatment services:

¹²⁰⁵ Victorian Department of Health and Human Services, *Factsheet: Health Complaints Act 2016: Implications for alcohol and other drug health service providers*, State Government of Victoria, Melbourne, 2016, pp. 1-2.

¹²⁰⁶ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 21.

¹²⁰⁷ Victorian Ombudsman, *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system* Melbourne, 2017, p. 18.

¹²⁰⁸ Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 322.

¹²⁰⁹ Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017, p. 17.

Health Complaints Commissioner Karen Cusack said the issues most commonly raised in these complaints were exploitative billing practices - sometimes involving treatments costing up to \$30,000 - and a lack of informed consent for financial and treatment decisions. Concerns about the safety and effectiveness of treatments, cleanliness of facilities and inappropriate discharge of patients have also been raised.

“We have been engaging with service providers to follow up on these complaints and to resolve outstanding matters wherever possible, with several of these cases ongoing,” Ms Cusack said.

“Due to our concerns regarding service quality at several private drug and alcohol rehabilitation clinics we are monitoring complaint issues closely across this sector.”¹²¹⁰

Commonwealth developments

Noting there have been some efforts to improve the oversight of private AOD treatment providers within Victoria, the Committee is also aware that a national approach to standards for private AOD treatment is important, particularly in terms of issues such as standards for the quality and effectiveness of treatment provided by these services. Dr Stefan Gruenert of Odyssey House Victoria told the Committee that ‘this is probably best done at a federal level with strong advocacy from the states’.¹²¹¹

Kym Peake of the DHHS advised the Committee that Victoria has been advocating for a number of years on these issues, and there has been some recent progress:

This is a space where for the last few years the Victorian government has been really advocating to the commonwealth that there should be a national quality scheme that does pick up private practitioners — so recognising that there is a gap in what is regulated currently. Late last year the commonwealth agreed to put the effort in to putting a national framework together, and it is due to report back to ministers late this year — the council of AOD ministers. So hopefully from that we will then have a basis for not just having the standards against which private providers should be assessed, but also part of that discussion will be how that assessment should take place — so where the locus of responsibility should be for both assessment and enforcement of clients against those standards. So there are clear gaps at the moment, but work is underway to address those in collaboration with our commonwealth colleagues.¹²¹²

Noting the lack of data currently received from private AOD treatment providers, Kym Peake also advised the Committee that such a scheme would result in better data collection:

...I would say that one of the secondary benefits of creating a tighter regulatory scheme will be that we will have the capacity to have a better understanding of the activities of those private providers. So we see that body of work as being really important for protecting the community but also for giving us better information to plan services going forward.¹²¹³

¹²¹⁰ Health Complaints Commissioner, *Private Drug and Alcohol Rehabilitation*, Media release, Melbourne, 1 December 2017.

¹²¹¹ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 165.

¹²¹² Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 321.

¹²¹³ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 322.

The Committee also notes a Communique from the national Ministerial Drug and Alcohol Forum from its meeting in November 2017, which advised of in-principle agreement for a National Quality Framework for Drug and Alcohol Treatment Services and other ongoing work, to be completed by April 2018.¹²¹⁴ Membership of this Forum comprises two ministers from each jurisdiction, one from the health or community services portfolios and one from the justice or law enforcement portfolios.¹²¹⁵

The *Drug Rehabilitation Plan* also stated, '[t]he Victorian Government will continue to look for ways to strengthen oversight of private providers, and will keep urging the Commonwealth to introduce minimum standards for these services'.¹²¹⁶

While the Committee believes the recent and proposed changes to the state-level arrangements are a welcome development, it also considers that more work is required in this area. Acknowledging that much of the jurisdiction covering the regulation of health and treatment services is federal, collaboration with the Commonwealth Government and all Australian jurisdictions is required to ensure an effective and consistent approach across the country.

RECOMMENDATION 28: The Victorian Government note ongoing considerable concerns within the community about private unregistered providers of alcohol and other drug (AOD) treatment and continue to advocate for the development of a national regulatory framework and standards for private AOD treatment.

¹²¹⁴ Department of Health, 'Ministerial Drug and Alcohol Forum Communique: 27 November 2017', viewed 14 February 2018, <[http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/\\$File/Ministerial%20Drug%20and%20Alcohol%20Forum%20Communique%20-%20Final.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/Ministerial%20Drug%20and%20Alcohol%20Forum%20Communique%20-%20Final.pdf)>.

¹²¹⁵ The Department of Health, 'Ministerial Drug and Alcohol Forum', viewed 16 February 2018, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/ministerial-drug-alcohol-forum>>.

¹²¹⁶ Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017, p. 17.

13 Treatment for specific drug user groups

A common theme in the inquiry evidence regarding the treatment of substance use disorders is that a ‘one size fits all’ approach is both ineffective and inappropriate. While there will always be commonalities in addressing the needs of people with substance use issues, it is equally true that in various circumstances, treatment should be adapted to meet the specific requirements of discrete user groups. Some groups to which this may apply include:

- people with co-morbid mental health conditions
- Aboriginal and Torres Strait Islander people (ATSI)
- people from culturally and linguistically diverse (CALD) communities
- young people
- prisoners.

The Committee is also aware that the concerns and needs of families of people undertaking alcohol and other drug (AOD) treatment can play an important role in treatment plans. The need to tailor treatment for specific groups is widely acknowledged in the AOD treatment sector, including in the Department of Health and Human Services’ (DHHS) *Alcohol and Drug Treatment Principles*. In particular, Principle Ten states:

Alcohol and other drug treatment and support should be culturally safe and responsive to people’s differing understandings of health and wellbeing. Consistent with notions of equity, treatment should be responsive to Aboriginal and Torres Strait Islander peoples and people from diverse cultural backgrounds, communities, religions, language groups, gender and sexual identities. The unique needs of forensic clients, young people, older people, those with a dual diagnosis, and vulnerable and disadvantaged people with complex needs should also be addressed.¹²¹⁷

This chapter provides an overview of some of the treatment needs of these discrete client groups as told to the Committee, in addition to current Victorian Government initiatives that respond to these needs. In particular, the chapter focuses on key treatment options available to prisoners with substance use issues, and ends with a brief discussion about the potential role of mandatory treatment in Victoria. As noted in the previous chapter’s introduction, this is not an area that the Committee investigated comprehensively. Although, these chapters draw attention to a number of matters within the AOD treatment system that the Victorian Government and the sector are aware of and continuously work to improve.

1217 Victorian Department of Health, *Victorian alcohol and drug treatment principles*, State Government of Victoria, Melbourne, 2013, p. 5.

13.1 People with co-morbid conditions

As discussed in chapter six, understanding harmful drug use from a social determinants perspective indicates that for many people drug use arises from complex health and social issues experienced by individuals. For instance, the Alcohol and Drug Foundation (ADF) submitted that the people most at risk of misusing drugs 'are those who experience a severe difficulty or trauma in their life (personal, social, economic, etc.). This often includes mental illness, poverty, unemployment, isolation, dispossession and stigmatisation'.¹²¹⁸ In particular, a common theme in evidence presented to the inquiry was the co-existence of mental health and substance use issues. Beyond Blue stated in its submission:

Substance use and misuse is highly correlated with a range of health and mental health conditions.

Mental health conditions are almost twice as high among illicit drug users (21%) than non-illicit drug users (13%). People who use illicit drugs also report high levels of psychological distress, which could be a marker of an undiagnosed mental health condition.

There is a well-established link between injecting drug use and depression and anxiety, and the risk of suicide. Within Australia and overseas, research has demonstrated high levels of comorbidity between substance use conditions and mental health conditions. Different studies provide different prevalence rates. Generally speaking, somewhere between 30-60% of people who inject opioids such as heroin, or amphetamines, have co-morbid depression or anxiety conditions. This is significantly higher than the 17% of people in the general population who are currently experiencing one of these conditions.¹²¹⁹

Many stakeholders who gave evidence to the Committee spoke about the accumulation of complex social problems due to a co-morbid condition. For example, Meghan Fitzgerald, Social Action, Policy and Reform Manager at the Fitzroy Legal Service spoke of the despair felt by some of her clients battling both mental health and substance use issues, most of whom have been charged with criminal offences:

The long-term users that I have worked with over the course of my career invariably have mental health conditions and often have experienced significant disadvantage and harm from childhood, so we do tend to deal with the pointy end of recidivist long-term drug users. It is not necessarily representative of the entire drug-using community, but mental health is a serious issue, and often people's drug use is connected to their inability to cope in a variety of ways. Poverty is also a very significant factor, so the visibility of our clients because they do not have homes is a reason why they might get picked up a lot more than somebody else. A lot of their stories are extremely — I do not want to say tragic, because that is an end point, and we are always hoping that things will move, but their situations are very, very distressing.¹²²⁰

Similarly, Sam Biondo, Executive Officer of Victorian Alcohol and Drug Association (VAADA) highlighted to the Committee that a lack of services available to people with co-existing substance use and mental health issues leaves them incredibly vulnerable. The problems for people with co-morbid conditions are arguably even greater if they are in prison:

¹²¹⁸ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 12..

¹²¹⁹ Beyond Blue, *Submission*, no. 175, 17 March 2017.

¹²²⁰ Meghan Fitzgerald, Social Action, Policy and Reform Manager, Fitzroy Legal Service, *Transcript of evidence*, 28 June 2017, pp. 267-268.

The prison system has become a holding pen for those with a mental illness and alcohol and drug issues. It is, I think, a stain on our community if that is the only solution we have got available to them. It is bad enough that we have got people with acquired brain injuries, who in many ways are innocent because they have got a brain injury, and that becomes the place where we put people. That is bad enough. But people with mental health and AOD issues that could be treated in other environments is really concerning.¹²²¹

In her evidence to the Committee, State Coroner of Victoria, Judge Sara Hinchey, referred to the general lack of support for co-morbid clients:

The complexities of the issues raised by the inquiry's terms of reference are brought into sharp relief by the coronial data on the intersection between mental ill health and drug dependence across fatal overdose, suicide and family violence homicide. The experience of Victorian coroners is that drug dependence and mental ill health often occur as dual diagnoses. Problems occur when, for example, one doctor provides opioid replacement therapy to a patient but refers the patient to other doctors for treatment of anxiety and depression. In this common scenario if any doctor changes a drug or dose provided to the patient but does not alert the other doctors involved in the patient's care, there is a potential for adverse drug interaction and overdose to occur. I would add to that observation something which was raised by the previous witness, and that is of course the area where patients are effectively shuttled between services — so they go for a drug or addiction treatment and are told, 'No, you have a mental health problem', and they attend for mental health intervention and are told, 'You need to get your drug addiction under control before we can help you'. So it is the coordination of care that is a theme that we see and that needs to be addressed as part of any solutions that are implemented.¹²²²

Over the years, Victorian Coroners have made numerous recommendations for more and improved services for dual diagnosis treatment, for example Coroner Parkinson recommended in one case:

- integrated dual diagnosis services in the public health system for those with mental illness and substance dependency be expanded by the provision of additional inpatient facilities.
- the operation of the provisions of the Mental Health Act and the Severe Substance Dependence Treatment Act be enhanced by the provision of additional long term inpatient voluntary and involuntary public treatment beds for persons with co-morbidity mental illness or disorder and alcohol and drug dependency.
- provisions of the Mental Health Act be amended to provide for the express power for mental health practitioners to detain persons who are diagnosed with substance abuse disorder and mental illness and that the Act be amended to enable for greater flexibility to enable assessment and treatment even when initial or florid psychotic symptoms have resolved.¹²²³

13.1.1 Working in silos

A key issue associated with delivering treatment to dual diagnosis clients is that services are often delivered in 'silos'. It is particularly problematic when there are separate intake and assessment pathways for drug treatment and mental health

¹²²¹ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 302.

¹²²² Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 14.

¹²²³ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, pp. 6-7.

services. This was reflected in evidence provided by Demos Krouskos, Chief Executive Officer (CEO) of North Richmond Community Health (NRCH) who told the Committee that many of its clients are often refused treatment in mental health facilities because their drug use has not been dealt with and vice versa.¹²²⁴ The Recommissioning Review conducted in 2014 (see chapter 12) was critical of siloisation in both AOD and mental health sectors and recommended a holistic needs assessment to achieve 'joined up' service planning for vulnerable clients with multiple service needs.¹²²⁵

The Committee also heard that the separate treatment streams for substance use and mental health services can be stressful and confusing for people from CALD communities. The Victorian Multicultural Commission (VMC) stated in its submission:

The way services are funded can add to the difficulties. For example, mental health and alcohol and other drug (AOD) services are generally separately funded and organised, with few specialist services focusing on the care and treatment of people affected by both disorders. As a result, individuals with comorbidity often fall through the gaps between relevant services. This may be heightened for multicultural communities, particularly those from non-English speaking backgrounds, due to the lack of understanding and awareness of the seriousness of drug issues, as well as how to recognise signs and symptoms.¹²²⁶

These service silos also impact people living in rural and regional areas of Victoria. Echuca Regional Health advised in its submission of the limited access to AOD and mental health programs for its clients. These difficulties are exacerbated for those clients who suffer from both conditions and are also involved in the criminal justice system. It provided the example of clients with acquired brain injury, mental health issues, intellectual disabilities and substance use issues rarely being screened for these conditions in pre-sentencing processes or while in prison.¹²²⁷

13.1.2 The need for integration

Most stakeholders who gave evidence on this issue stated that in going forward, it was crucial that treatment programs aimed at addressing co-morbidities do so as part of an integrated system. Beyond Blue advised:

Across the country, multiple reforms across mental health and drug use are being implemented concurrently. Service integration and consistency is key to the success of these major reforms. In Victoria, integration of the service system should enable people to be treated holistically, accessing services to recover from both mental health and substance use conditions with the right treatment and support.

Colocation of services and multidisciplinary teams of professionals should be the core of the system. Primary Health Networks (PHNs) provide a critical structure to help integrate policies, funding and services, across Commonwealth and Victorian initiatives.

¹²²⁴ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 152; Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017.

¹²²⁵ Aspex Consulting, *Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services*, Victorian Department of Health and Human Services, East Melbourne, 2015, pp. 28-29.

¹²²⁶ Victorian Multicultural Commission, *Submission*, no. 210, 24 March 2017, pp. 4-5.

¹²²⁷ Echuca Regional Health, *Submission*, no. 170, 17 March 2017, p. 1.

Treatment should be person-centred, encompassing comorbid mental health conditions, psychosocial risk factors and broader social determinants that are likely to impact on a successful outcome. This may include establishing links with the housing, employment and education sectors. Programs should be evidence based and accessible across the state. Access to culturally relevant and sensitive programs should be a priority to support Aboriginal and Torres Strait Islander people who misuse drugs. Meeting the needs of affected communities will be best determined by the communities themselves. Access to these programs should be extended to those in the justice system.¹²²⁸

Dr Lorraine Baker, President of the Australian Medical Association (AMA) Victoria made similar comments when she gave evidence to the Committee:

...addiction medicine services are chronically underfunded and often siloed away from mainstream medical practice and also mainstream psychiatric practice. We would see that as a very important aspect of ongoing change in the way we manage issues around drug law reform within the community. Comorbidities are the norm, not an individual problem with an addiction, not an individual problem with a psychiatric illness and not an individual problem with social alienation but they are inevitably pulled together in one space, and yet the treatment pathways are siloed. That is a major stumbling block over managing things well.

We would be looking to integrated services that can shift the care of someone across and with really good communication around the intentions of treatment.¹²²⁹

The Public Health Association of Australia (PHAA) also supported integrated treatment programs for comorbid mental illness and psychosocial risk factors. It suggested these programs be evidence-based, available for people who misuse prescription medicines as well as for people who use illicit drugs, accessible in regional parts of Victoria (where morbidity and mortality due to drug use is high), and that programs meet the needs of at risk groups'.¹²³⁰

The Committee is aware of the DHHS' Victorian Dual Diagnosis Initiative (VDDI), which receives funding from both state and commonwealth governments. It is a cross-sector initiative that contributes to the further development of mental health and drug and alcohol clinicians to recognise and respond effectively to clients with both substance use and mental health issues. The Victorian Dual Diagnosis Initiative comprises four metropolitan agencies with links to each rural region. It supports AOD treatment services through training and consultation, as well as offering direct service provision to clients in specific and serious cases.¹²³¹

13.2 Aboriginal and Torres Strait Islander people

According to the Australian Institute of Health and Welfare's *Alcohol and other drug treatment services in Australia 2015-16*, 1 in 7 (14 per cent) AOD treatment clients were Aboriginal and Torres Strait Islander (ATSI) despite them only comprising 2.6 per cent of the population. This is a rate of 3,400 clients per 100,000 Indigenous Australians,

¹²²⁸ Beyond Blue, *Submission*, no. 175, 17 March 2017.

¹²²⁹ Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 255.

¹²³⁰ Public Health Association Australia, *Submission*, no. 152, 17 March 2017, p. 7.

¹²³¹ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, pp. 46-67.

compared with 540 clients per 100,000 non-Indigenous Australians.¹²³² Issues arising from the harmful use of alcohol, pharmaceutical opioids and amphetamine type stimulants in particular continue to have increasing adverse impacts upon certain ATSI communities.¹²³³ In the Victorian context, Demos Krouskos of NRCH advised the Committee of the Centre's growing number of ATSI clients:

In 2014–15 a study by the Burnet Institute of our client group noted the following: 30 per cent of our clients are from Aboriginal backgrounds. This is quite a new phenomenon for North Richmond. This has got to do with a displacement effect that has occurred in our inner city — again, largely through gentrification to our north — and certain groups in our populations being pushed into our area. It is quite new. In the past Richmond has been known as a multicultural area — an area of recent arrivals, refugees, asylum seekers, migrants and the like. This group is very significant, and 30 per cent is a big number.¹²³⁴

When exploring appropriate treatment options for ATSI clients, it is important to be aware that as with non-ATSI clients, they cannot be simplistically regarded as an undifferentiated whole. Individual characteristics, needs and issues exist within ATSI communities and among individuals who have substance issues. For example, the needs of an urban ATSI person may be quite different to those living in a remote community. Aboriginal and Torres Strait Islander women may also have a different set of issues to address compared to ATSI men. Further, as with non-ATSI people, ATSI people may use drugs in harmful ways for myriad reasons including experimentation, stress, enjoyment and boredom. However, other reasons may relate specifically to Indigenous history and culture, including the legacy of colonisation and dispossession, ongoing racism and the loss of traditional cultural identity.¹²³⁵ In addition and in part because of this history, structural factors such as poverty, unemployment, lack of education, limited access to services and poor health also contribute to harmful drug use.

Given these factors, many ATSI people presenting to either specialist and generalist health facilities will have complex needs. Aside from substance use issues, they may need support for mental health concerns, related or subsidiary physical health issues, grief and trauma, housing, child protection and legal issues.¹²³⁶

13.2.1 Culturally specific and appropriate interventions

The types of treatment delivered to ATSI people are similar to those found in mainstream settings, with many ATSI people receiving treatment in mainstream facilities. However, the way treatment is delivered is crucial to its overall effectiveness. Under the DHHS' *Program guidelines: Alcohol and other drugs*, all publicly funded AOD services are 'expected to provide friendly, welcoming and culturally safe

¹²³² Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Canberra, 2017, p. 7.

¹²³³ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011.

¹²³⁴ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 153.

¹²³⁵ National Indigenous Drug and Alcohol Committee, *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*, Australian National Council on Drugs, Canberra, 2014, p. 5.

¹²³⁶ National Indigenous Drug and Alcohol Committee, *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*, Australian National Council on Drugs, Canberra, 2014, p. 8.

environments for Aboriginal people, and also provide service models that meet the needs of Aboriginal people'.¹²³⁷ The need for cultural competence is also highlighted in the *National Drug Strategy (2017-2026)* (NDS):

It is critical to ensure that any efforts to reduce the disproportionate harms experienced by Aboriginal and Torres Strait Islander people are culturally responsive and appropriately reflect the broader social, cultural and emotional wellbeing needs of Aboriginal and Torres Strait Islander people. Planning and delivery of services should have strong community engagement including joint planning and evaluation of prevention programs and services provided to Aboriginal and Torres Strait Islander communities taking place at the regional level. Wherever possible, interventions should be based on evidence of what works specifically for Indigenous people.¹²³⁸

The following evidenced-based treatment interventions are viewed as appropriate for ATSI clients, when culturally adapted to the needs of ATSI communities and individuals:

- screening and assessment
- referral
- withdrawal management
- Cognitive Behavioural Therapy
- relapse prevention
- therapeutic communities
- maintenance pharmacotherapy
- outreach
- aftercare.¹²³⁹

According to the former National Indigenous Drug and Alcohol Committee (NIDAC) in its report, *Alcohol and Other Drug Treatment for Aboriginal and Torres Strait Islander Peoples – June 2014*, adaptations of evidence-based mainstream interventions 'that integrate culturally specific practices, including traditional values, spirituality and activities have been shown to be more effective than mainstream services'.¹²⁴⁰ Synthesising the literature on the elements that are important in developing culturally appropriate treatment interventions, NIDAC found that:

Workers and services need to be flexible, open and culturally sensitive to the needs of people seeking treatment. For example, Aboriginal and Torres Strait Islander people often find it difficult disclosing information in group settings, so provision of one-to-one counselling options may be more effective. Likewise, aftercare is often best provided face to face with the person rather than over the phone. People should be offered the most effective approach for their circumstances.

- Interventions need to be delivered in culturally meaningful ways.
- Traditional healing practices should be utilised.¹²⁴¹

¹²³⁷ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 42.

¹²³⁸ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 27.

¹²³⁹ National Indigenous Drug and Alcohol Committee, *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*, Australian National Council on Drugs, Canberra, 2014, pp. 14-17.

¹²⁴⁰ National Indigenous Drug and Alcohol Committee, *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*, Australian National Council on Drugs, Canberra, 2014, p. 9.

¹²⁴¹ National Indigenous Drug and Alcohol Committee, *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*, Australian National Council on Drugs, Canberra, 2014, pp. 9-10.

In addition, the involvement of the family and wider community, the use of storytelling and cultural traditions such as ‘returning to country’ may be appropriate in some cases.¹²⁴²

The Committee is aware that while acknowledging such approaches is important, ensuring these are incorporated into treatment services and delivered effectively is essential to ATSI clients achieving their recovery goals. A number of factors will contribute to this, including training non-ATSI staff (including medical specialists, nurses, social workers and ancillary health professionals) who work closely with ATSI people to respond to AOD issues in a culturally appropriate manner. There also needs to be greater numbers of ATSI people trained and employed as AOD workers with nationally recognised AOD qualifications, and specific training in cultural competence. Most importantly, it is necessary for service development to be informed directly by ATSI people who better appreciate what will benefit them and their communities. Demos Krouskos of NRCH spoke of the value of this in his evidence to the Committee:

We have been working closely with VACCHO [Victorian Aboriginal Community Controlled Health Organisation] and the Victorian Aboriginal Health Service to support that group, but that does not necessarily mean that they actually have a relationship either with those services or the communities that those services support. So without an understanding of the history of colonisation and dispossession, the history of the Stolen Generations and all of those very complex factors that come into play, I do not think we will have an effective model...

...and unless mainstream health services learn those lessons, we are going to have inadequate models. At the moment I do not believe there is enough attention. Thirty per cent of our clients are from that sort of background. They are the ones suffering the greatest amount of disadvantage, so unless we hear directly from them, get them to shape the services themselves, I do not think we are going to have much success.¹²⁴³

13.2.2 Young people

As discussed in chapter six, young people may begin to use illicit substances in harmful ways for various reasons. Often this is associated with the presence of too many risk factors and not enough protective factors to either delay the uptake of that use or address any underlying contributing factors. In his evidence to the Committee, Peter Wearne, the Chair of the Yarra Drug and Health Forum and also the Director of Services at the Youth Support and Advocacy Service (YSAS), provided an overview of how some of YSAS’ young clients use substances harmfully:

We have got young people that are injecting drugs. Greg saw them on Saturday. Greg was doing a shift at one of our primary health services on Saturday. The lives of these young people that we treat every day, they are using a cacophony of drugs, but I can tell you this: if heroin becomes cheap again, 99 per cent of all the young people we see at YSAS will be using heroin. The only reason they are not using it at the moment is because of the expense of it, but they are using a truckload of other drugs — up to five or six different substances a week. They are dealing with the real effects of trauma and pain in their lives, and they will do anything to mitigate that.¹²⁴⁴

¹²⁴² National Indigenous Drug and Alcohol Committee, *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*, Australian National Council on Drugs, Canberra, 2014, pp. 9-10.

¹²⁴³ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 157.

¹²⁴⁴ Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 47.

Similarly, in the context of young people from CALD communities, the VMC indicated in its submission, that trauma arising from pre-settlement experiences can lead to substance use issues:

Poor mental health, emanating from pre-settlement experiences, is a pertinent issue and potential trigger in refugee communities for substance abuse. For example, recent research highlights the significant behavioural changes and psychosomatic symptoms in children who have experienced sustained periods of war and conflict. Studies into the mental health of Syrian refugee children have shown staggering levels of trauma and distress. In the worst cases these children are turning to substance abuse, self-harm or even attempting suicide.¹²⁴⁵

In Victoria, publicly-funded youth specific AOD services are available to young people aged 12 to 25 years, in addition to support for their family and friends. In particular, the DHHS advocates a ‘family based approach’ that seeks to integrate alcohol and drug treatment with relevant service provision in the areas of mental health, education, child protection, housing and family support.¹²⁴⁶ Youth specific services include:

- youth outreach services – a mobile service targeting young people who are causing harm to themselves through their substance use. The service can assess, support and provide ongoing coordination to young people in their own space or in a neutral environment.¹²⁴⁷
- youth home-based withdrawal – medical support to young people where the withdrawal from a substance is mild-to-moderate and they can be supported by a family member or friend at home.¹²⁴⁸
- youth residential withdrawal – a residential setting that provides short-term intensive support, time-out and withdrawal services to young people. The average length of stay is approximately ten days, and also comprises pre- and post- support.¹²⁴⁹
- Youth residential rehabilitation – available to young people who have undergone withdrawal or a treatment program, but have not reduced or overcome their substance use issues. They may require more support than what is available in an outpatient program, or their home environment or social circumstances are not supportive of non-residential treatment options.¹²⁵⁰
- youth supported accommodation – a residential setting that aims to assist young people reintegrate back into the community and achieve lasting change.¹²⁵¹
- youth alcohol and drug day program - provides ongoing therapeutic, life skills and recreational programs and support for young people receiving drug treatment.¹²⁵²

¹²⁴⁵ Victorian Multicultural Commission, *Submission*, no. 210, 24 March 2017, p. 2.

¹²⁴⁶ health.vic, ‘Services for young people’, viewed 19 February 2018, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-services-for-young-people>>.

¹²⁴⁷ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 35.

¹²⁴⁸ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, pp. 35-36.

¹²⁴⁹ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 39.

¹²⁵⁰ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, pp. 35-37.

¹²⁵¹ health.vic, ‘Services for young people’, viewed 19 February 2018, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-services-for-young-people>>.

¹²⁵² health.vic, ‘Services for young people’, viewed 19 February 2018, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-services-for-young-people>>.

Young people can also seek advice and assistance through the Youth Drug and Alcohol Advice Service (YoDAA), a seven day, 24 hour telephone and online ‘one stop shop’, providing referrals, information and support.

Another important service provider that addresses AOD issues among young people is YSAS. Recognising that harmful substance use is not only ‘about the drugs’, YSAS also addresses issues pertaining to youth mental health and social disengagement. It provides a wide spectrum of services including day programs, withdrawal programs and residential rehabilitation, such as the Wilum Supported Accommodation Program. It also partners with various youth mentoring and employment programs that seek to give purpose to young people at risk of drug use and dependence, currently in treatment or at a post treatment recovery stage.¹²⁵³

Similar to ATSI adults, the specific needs of young Aboriginal clients requires consideration. On this basis, the Victorian Government funded the *Bunjilwarra Koori Youth Alcohol and Drug Healing Service* based in Hastings, which comprises a purpose built AOD treatment and healing facility for young people aged 16 to 25, including a 12 bed residential rehabilitation program. It is jointly managed by Victorian Aboriginal Health Service (VAHS) and YSAS, with partnerships with the VACCHO, Aboriginal Community Controlled Health Organisations, and the Victorian Government. As with comparable adult services, Bunjilwarra’s approach is guided by a respect for and promotion of the traditional Aboriginal worldview as it applies to youth and ‘[a] holistic approach embedded in culture and inclusive of family and community and connected to country’.¹²⁵⁴

Aside from addressing a young person’s acute substance use issues through the delivery of AOD treatment, the Committee recognises the equal importance of providing continuing support to young people post-treatment. Again, in his evidence to the Committee, Peter Wearne of YSAS spoke of the need to ‘build stimulation, encouragement, support and social and economic viability into young people’s lives’, in addition to assisting them form ‘a significant adult connection in their life’.¹²⁵⁵ This is essential to helping a young person continue to address the underlying causes of their substance use.

13.3 People from culturally and linguistically diverse communities

According to the DHHS’s AOD Program Guidelines, ‘inclusive practice’ is essential to the delivery of health and human services including AOD services in Victoria:

It is critical that services provide culturally safe environments in which individuals are not exposed to bias, discrimination or inappropriate behaviour. Providing a culturally safe and responsive environment empowers clients to make decisions on their own health and wellbeing.

¹²⁵³ Youth Support and Advocacy Service, ‘How We Help’, viewed 19 February 2018, <<http://www.ysas.org.au/how-we-help>>.

¹²⁵⁴ Bunjilwarra Koori Youth Alcohol and Drug Healing Service, ‘Bunjilwarra Service Model’, *Fact Sheet*, viewed 19 February 2018, <http://bunjilwarra.org.au/wp-content/uploads/2014/06/FactSheet_BUNJILWARRA_Service-model.pdf>.

¹²⁵⁵ Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 51.

All Victorian Government-funded AOD services are required to provide a friendly, welcoming and culturally safe environment for all clients, including Aboriginal people, people from culturally and linguistically diverse backgrounds (CALD) and LGBTI people and their families. Inclusive practice is an essential part of the delivery of health and human services.¹²⁵⁶

Despite this, it is widely acknowledged that people from CALD communities are not accessing AOD services as they need to.¹²⁵⁷ According to the Drug and Alcohol Multicultural Education Centre (DAMEC) located in New South Wales (NSW):

People from CALD backgrounds who have substance use issues are underrepresented in AOD treatment, and when in treatment, are less likely to be networked with professional support services. To work better with clients from CALD backgrounds, AOD service providers not only need to acknowledge that Western approaches to AOD treatment in Australia may be unfamiliar to many culturally diverse communities; but we must also take a proactive stance against barriers, such as discrimination.¹²⁵⁸

Further, VAADA outlined in its submission similar issues with providing drug treatment to people from CALD communities in the Victorian context:

CALD communities are underrepresented in AOD treatment. Data shows that only 13 percent of closed treatment episodes for Australians in 2014-15 applied to clients born overseas (Australian Institute of Health and Welfare 2016b). Within the general population, 28% of people living in Australia were born overseas. It is evident that a disproportionately small number of CALD individuals attend AOD treatment services.

While the available research indicates that AOD use is generally lower in CALD communities compared to the general population (Donato-Hunt, Munot and Copeland 2012), it is also clear that the low admission rates of CALD clients into AOD treatment is also due to an under-utilisation of services rather than just a lower need.¹²⁵⁹

In its submission to the inquiry, the VMC advised that often the reasons people from CALD communities, particularly refugees and recent immigrants, use or become dependent on illicit drugs can be attributed to experiences of trauma and deprivation. In the case of refugees from war torn countries, alcohol and illicit substance use becomes a 'coping strategy' for often undiagnosed conditions such as post-traumatic stress disorder. The VMC advised that it is important for health services to be aware of this and respond accordingly:

Migrant populations include some of Victoria's most vulnerable cohorts, particularly asylum seekers and refugees. These communities need specific supports that a public health approach to drug law reform can bring rather than punitive measures that can further exacerbate harm. Victorian health services need to build effective cultural responses to the needs of this multicultural and increasingly young population.¹²⁶⁰

¹²⁵⁶ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 1: overview*, State Government of Victoria, Melbourne, 2017, p. 20.

¹²⁵⁷ Department of Health, *Updated Activity Work Plan 2016-2019: Drug and Alcohol Treatment*, Western Sydney Primary Health Network, Blacktown, 2017.

¹²⁵⁸ Network of Alcohol and Other Drugs Agencies (NADA), *Working with Diversity in Alcohol and Other Drug Settings*, Department of Health, Strawberry Hills, p. 6.

¹²⁵⁹ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 10.

¹²⁶⁰ Victorian Multicultural Commission, *Submission*, no. 210, 24 March 2017, p. 1.

In the context of settlement services, Sonia Vignjevic, Acting Chairperson of the VMC advised the Committee that while these are intensive when people first arrive in Australia, it is often in the second and third year of settlement when young people are inclined to engage in more risky behaviours.¹²⁶¹ The VMC noted in its submission:

Research suggests there is a gap between early intervention and crisis youth services and a gap between mainstream and specialist services, including a lack of funding for longer term interventions. Thus the Victorian health system needs to be resourced to be culturally responsive to tackle the problem early in the settlement process.¹²⁶²

The Committee notes that continued engagement with young people in these circumstances might prove beneficial in reducing their likelihood of moving into more harmful substance use. The Victorian Alcohol and Drug Association suggested in its submission that engaging with at-risk CALD communities may reduce demand for AOD treatment services later on.¹²⁶³

For those people from CALD communities who require treatment, Sonia Vignjevic also indicated that due to language barriers, rehabilitation centres are often not accessible to them:

The other issues that we are hearing in the community are that drug and alcohol rehab centres do not engage interpreters or bilingual, bicultural staff, which means that this part of the community is absent from accessing services. They do not have the capacity to access services because they do not have the language capability to engage. This has been raised to me with the Burmese community in the eastern suburbs of Melbourne. These are some strategies that I think are required in order to have more of a responsive service for this marginalised community.¹²⁶⁴

Aside from issues with language and interpretation, the Committee is aware that it is important for AOD treatment service providers to have an understanding of different cultural perspectives on drug use that exist within CALD communities. Even more so than in mainstream communities, it is arguable that substance use in CALD communities is highly stigmatised. This exists in both newly arrived groups and other groups that have been here for a long time. Because of this judgement and negative attitudes, people do not feel comfortable talking to others in the community about their own drug use, or that of their families.¹²⁶⁵ In addition, some people with substance use issues may be reluctant to access AOD services because they fear bringing shame and disrepute onto their families. The VMC explained:

A major concern for multicultural communities is stigma, which is a barrier to open community dialogue about substance use (particularly across generations) and to the uptake of health services. The experience of stigma can have wide ranging impacts on a person's health and general quality of life, including their ability to participate socially and economically to society and affect willingness to access treatment and other support services.¹²⁶⁶

¹²⁶¹ Sonia Vignjevic, Acting Chairperson, Victorian Multicultural Commission, *Transcript of evidence*, 18 September 2017, p. 379.

¹²⁶² Victorian Multicultural Commission, *Submission*, no. 210, 24 March 2017, p. 2.

¹²⁶³ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 10.

¹²⁶⁴ Sonia Vignjevic, Acting Chairperson, Victorian Multicultural Commission, *Transcript of evidence*, 18 September 2017, p. 380.

¹²⁶⁵ Tina Hosseini, Commissioner, Victorian Multicultural Commission, *Transcript of evidence*, 18 September 2017, p. 381.

¹²⁶⁶ Victorian Multicultural Commission, *Submission*, no. 210, 24 March 2017, pp. 3-4.

Similar to ATSI clients, it is essential that AOD service providers from mainstream or non-CALD backgrounds are sufficiently trained to be culturally competent in addressing the needs and concerns of their CALD clients, such as internalised shame and increased negative labelling. Another way to address the disconnect between AOD service providers and CALD communities is to provide incentives for more people from CALD backgrounds to train as AOD workers, or as suggested by Tina Hosseini, a Commissioner with the VMC, encourage existing multicultural organisations to provide support services in their local communities:

Given that some of these ethnic or multicultural organisations have such a close relationship with members of these communities, they are quite well positioned to be the person they can go to for that support. Making sure that they are better equipped with resources is quite an important thing to consider, because they have got a really important role they can play as well.¹²⁶⁷

The Committee notes that enhanced research into substance use prevalence among CALD communities, as recommended in chapter 6, will assist the Victorian Government, the AOD treatment sector and relevant CALD organisations to better support CALD clients through treatment pathways.

13.4 Support for families of people who use drugs

Harmful drug use, and particularly drug dependence, can take an enormous toll on family members, with family breakdown, depletion of financial reserves, fear of violence or aggression and physical and emotional exhaustion being common experiences. Friends and family members themselves may therefore require advice, information and support to make sense of their loved one's substance use issues, whether or not the person has chosen to seek advice or treatment. Families may also be unaware of how to access support and have difficulty navigating a complex treatment system. This support is particularly important in the context of judgement and negative attitudes felt by people who use drugs and their families as discussed in chapter five. For example, in recounting the story of her son's ten year heroin addiction, Debbie Warner, Volunteer Manager of the organisation Family Drug Support, run by Tony Trimmingham, told the Committee:

So we at first kept it under cover because we didn't want the stigma that was attached to it, you know? If we had police come to our house we would always make up excuses if the neighbours said, "You had the police there." One morning we had about four cars of detectives come all in suits and someone in the street said, "Are you selling your house," because they thought it was all the real estate agents coming through. You know how they come through in a pack? I went, "Yes, thinking about it."

It's a difficult time for families but most families just don't know how to get through it without support.¹²⁶⁸

During the course of this inquiry, some family members reported unhelpful experiences when attempting to seek help such as being ignored, dismissed or having their concerns trivialised by service providers. Brenda Irwin of the Families and Friends for Drug Law Reform (FFDLR) told the Committee of her experience trying to find help to support her daughter, who ultimately died of an overdose in 1996:

¹²⁶⁷ Tina Hosseini, Commissioner, Victorian Multicultural Commission, *Transcript of evidence*, 18 September 2017, p. 380.

¹²⁶⁸ Debbie Warner, Volunteer Manager, Family Drug Support, *Transcript of evidence*, 23 May 2017, p. 103.

When I was struggling in that one month to get help, I walked into more than one leading drug and alcohol agency and said, 'I've found out my daughter's using heroin. Have you got any information and support for families?'. They said, 'No', with no further explanation. That is kind of what drove me into this thing with families. It is not just the person using the drug who is stressed out. It is just shocking. You can imagine how scary it is. They are all scared their child might die, or they are scared of the violence with ice. There is just fear all around.¹²⁶⁹

Similarly, Marion McConnell, Member of the Uniting Church of Australia, Synod of NSW and the ACT told the Committee that 'what I felt was missing then was any support for families' when dealing with her son's addiction, which led to his death in 1992 at age 24.¹²⁷⁰

The Committee learnt throughout the inquiry about the importance of assisting families with practical advice, emotional support and most importantly peer recognition and reinforcement of their worth as family members and friends. In particular, Debbie Warner provided insight to the Committee on the practical ways the support she received from Family Drug Support helped in her son's recovery:

My son ended up in prison because he was in possession of heroin and so during the first couple of years I started to learn from Family Drug Support how important families are to help support the person who's got the issue with drugs. So I had to take my focus off the fact that he was using heroin and just focus on helping to build my relationship with him, the strongest possible I could do. What that did was during his journey, during his 10-year journey using heroin was that he kept his self-esteem intact, and one day when he finally got sick and tired of being sick and tired he came out the other end.¹²⁷¹

The DHHS recognises that families, friends and peers can be crucially important for people with substance use issues as '[t]hey may provide important emotional support, as well as practical assistance. This support can make a significant difference to a person's recovery journey'.¹²⁷² According to the DHHS *Program guidelines: Alcohol and other drugs*, family support programs in Victoria include:

- Family Drug Help – a service providing a 24-hour helpline, and information and referrals to support groups and counselling services, run by the Self Help Addiction Resource Centre (SHARC).
- family drug support services – services can be accessed through certain community health providers. Programs include peer support and group support; and targeted programs for people such as young people with parents affected by drugs, siblings, grandparents, CALD communities and ATSI people.
- family drug education – a consortium of organisations provide family drug education workshops, *Breakthrough: ice education for families*, to recognise and respond to a family member's ice use issues.
- additional support – intake services can provide families with brief interventions and single sessions of therapy, as well as referrals to counselling and other services.¹²⁷³

¹²⁶⁹ Brenda Irwin, Families and Friends for Drug Law Reform, *Transcript of evidence*, 18 September 2017, p. 391.

¹²⁷⁰ Marion McConnell, Member, Uniting Church of Australia, Synod of NSW and the ACT, *Transcript of evidence*, 23 May 2017, p. 130.

¹²⁷¹ Debbie Warner, Volunteer Manager, Family Drug Support, *Transcript of evidence*, 23 May 2017, p. 103.

¹²⁷² health.vic, 'Family and peer support', viewed 19 February 2018, <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/family-and-peer-support-aod-treatment>>.

¹²⁷³ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, pp. 8-9.

The Program Guidelines acknowledge that ‘significant investment’ was made to family support and education under the Victorian Government’s *Ice Action Plan*.¹²⁷⁴

The Committee was interested to hear from Brenda Irwin of FFDLR that her experiences in being unable to access appropriate support contributed to the development of the Family Drug Help support line in Victoria:

...my group in the end linked up with two agencies and started Family Drug Help, which is a state-funded government service in Victoria, which involves a helpline 24 hours a day for family members and groups all around Victoria. People who come to those groups, who go to family drug support groups and who go to Families and Friends for Drug Law Reform groups all say this was so amazingly helpful for them in meeting other parents — all normal people like them.

The family support thing is great. It has to be kept being funded, because it is crucial. If the families get support, it is better for the person in the family who is on drugs.¹²⁷⁵

The effectiveness of such programs has been a subject of comment and evaluation. For example, in 2015 Turning Point conducted an evaluation of four programs run by the Family Drug Help service. It found that:

The Family Drug Help services provided by SHARC fill an important community need, ensuring that the families of those with substance misuse problems have access to professional and peer support. These services are provided by a dedicated pool of paid and volunteer staff who are committed to the values of SHARC and to supporting their community. The four programs under evaluation form a pathway of support for families of those with substance misuse problems, and a vital peer network that enables participants to both gain and provide support at the level that best suits their needs. Dedicated staff and management are committed to ensuring that the programs are tailored to participant need and are delivered in line with best practice. Together this suite of programs provides a valuable service to the community and SHARC is to be commended for the ongoing delivery of these quality programs.¹²⁷⁶

Regarding the *Breakthrough* program described above, Turning Point, in its *Annual Review 2016* stated:

Similarly, our Breakthrough program, which provides families with an insight into what ice is, how it affects people, and how to support family members into treatment, has reached more than 1,500 people across the state since commencing late last year. The program is playing a critical role in addressing the many myths associated with addiction.¹²⁷⁷

The report also highlighted that through the 1800 Ice Help Line set up under the *Ice Action Plan*, 70 per cent of calls were from people concerned about a family member or friend.¹²⁷⁸

The Committee heard from stakeholders within the treatment sector that there is a need for further investment and better understanding of treatment options for families. Australian drug policy expert, Professor Margaret Hamilton advised the Committee:

¹²⁷⁴ Victorian Department of Health and Human Services, *Program guidelines: Alcohol and other drugs: Part 2: program and services specifications*, State Government of Victoria, Melbourne, 2017, p. 8.

¹²⁷⁵ Brenda Irwin, Families and Friends for Drug Law Reform, *Transcript of evidence*, 18 September 2017, p. 391.

¹²⁷⁶ Mackenzie, J, et al., *Evaluating the Effectiveness of Support Programs for Family Members Affected By A Relative’s Substance Use*, Turning Point, Melbourne, 2015, p. 8.

¹²⁷⁷ Turning Point, *Turning Point 2016*, Melbourne, 2016, p. 4.

¹²⁷⁸ Turning Point, *Turning Point 2016*, Melbourne, 2016, p. 13.

When it comes to formal treatment programs, our targets and funding are so tight that there is not much money to engage families in a systematic manner with the treatment process for each person who comes into treatment, and there are not many in our community, notwithstanding the couple of services across Australia, including here in Victoria, that work to support families. There is not much to help families know what to do. So families, not surprisingly, go from support to ‘We’ll be tough’ to ‘No, you can’t come home’ and ‘We’re not going to do that’. Then some catastrophe or some crisis arises, and then they say, ‘Well, we’ve got to keep them alive, so we’ll let them come back home again’, and then all their stuff is pinched or their favourite whatever. Families are in this terrible bind, having no clue about how they can most appropriately respond when they know they have a member of their family who is using something that is causing them grief. I think we just have not sorted out how to respond appropriately to families, and how to incorporate them, including funding for that, into our treatment provisions.¹²⁷⁹

Windana, a drug and alcohol centre in Melbourne, similarly discussed in its submission the need for support for families in the treatment process:

There is an absence of funded activities associated with providing family sensitive practice and family specific treatment, despite the strong rhetoric on these issues during the re-commissioning process. At Windana, we have observed that families play a key role in the recovery process at all stages in during treatment. Complex family dynamics can inadvertently contribute to relapse or equally can provide the necessary support to assist in achieving recovery. To this end, agencies require additional capacity to maximise positive family engagement through the treatment journey.¹²⁸⁰

Further, the joint submission of Harm Reduction Australia and Family Drug Support recommended that there be ‘[g]reater support for families that is ongoing and focused on their needs’.¹²⁸¹

The Committee notes that the Victorian Government’s *Drug Rehabilitation Plan* highlighted the following areas for enhancing family support:

- new family drug support services in the regional and rural areas of the Grampians, the Great South Coast, Barwon, Goulburn Valley, Hume, Gippsland, Loddon Mallee¹²⁸²
- \$3.3 million for ‘a new advice service to provide more practical support and brokerage for families trying to urgently locate treatment services for their loved ones’.¹²⁸³

The Committee acknowledges the positive role that families can play in addressing a person’s substance use issues, which requires ensuring they are also supported effectively through the treatment process. The Committee considers that this area should continue to be a focus for the Victorian Government in enhancing treatment services more generally.

¹²⁷⁹ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 57.

¹²⁸⁰ Windana Drug and Alcohol Recovery, *Submission*, no. 114, 15 March 2017, p. 6.

¹²⁸¹ Harm Reduction Australia / Family Drug Support, *Submission*, no. 112, 15 March 2017.

¹²⁸² Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017, pp. 8-9.

¹²⁸³ Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017, p. 14.

RECOMMENDATION 29: The Victorian Government provide increased support and funding to family support programs to minimise the adverse impact of substance misuse on family and friends, and to contribute to the effective reintegration of people with substance use disorders back into the community.

13.5 Drug treatment in prison

Globally, high proportions of people enter prisons with issues relating to drug use, particularly injecting drug use. There is a strong link between substance misuse and disorders and offending behaviour, as noted in the Victorian *Corrections and Alcohol Drug Strategy 2015*:

By the time offenders become involved in the criminal justice system, they often have long-term habits of drug and alcohol abuse that have played a key role in their criminal behaviour. These patterns pose a threat to the safety and security of prisons as well as to correctional operations in the community. They also undermine individual prospects of rehabilitation.¹²⁸⁴

The high rates of substance use among prisoners also contribute to a range of ongoing health issues within prisons. A 2012 report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Prisons and drugs in Europe: the problem and responses*, stated:

Studies confirm that both drug use and drug use-related health problems are far more common among prisoners than in the general population. Lifetime prevalence of substance use, including illicit drug use, is reported to be very high among prisoners, with levels of up to 80% for tobacco and cannabis use and up to 50% for cocaine, heroin and amphetamines consumption. Although many prisoners stop or reduce their drug use when they enter prison, some continue to use drugs, sometimes switching to different substances or starting an additional drug while incarcerated. There is also evidence that some prisoners, who have never used drugs before, have their debut with illicit drugs while in prison.¹²⁸⁵

The Australian Institute of Health and Welfare (AIHW) noted in its 2015 *Health of Australia's Prisoners* report that 67 per cent of prison entrants reported using drugs in the 12 months prior to their incarceration, with methamphetamine use the most common (50 per cent), followed by cannabis (41 per cent).¹²⁸⁶ The Victorian *Corrections and Alcohol Drug Strategy 2015* described the situation in Victoria:

...a 2011 sample of prisoners found that over 75 per cent of males and at least 83 per cent of females reported illicit drug use...Prisoners also report high levels of injecting drug use prior to entry to prison. In 2013, 35 per cent of Victorian prison entrants reported having ever injected drugs. Amphetamines were the most common drug to be last injected (52 per cent) and heroin was the second most common drug to be last injected (37 per cent) prior to entry into prison.¹²⁸⁷

¹²⁸⁴ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 4.

¹²⁸⁵ European Monitoring Centre for Drugs and Drug Addiction, *Prisons and drugs in Europe: the problem and responses*, Lisbon, 2012, p. 27.

¹²⁸⁶ Australian Institute of Health and Welfare, *The health of Australia's prisoners*, Australian Government, Canberra, 2015, pp. 96-97.

¹²⁸⁷ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 4.

Given these high rates of use before and during periods of incarceration, prison can serve as a unique opportunity to identify and treat health problems, including drug dependency and other issues. As stated in the 2012 EMCDDA report:

In Europe, drug users represent a large proportion of the prison populations and, for some, periods of incarceration may offer an opportunity to reduce their drug use and engage with services. In this respect, imprisonment may be viewed as a chance to make contact with and provide treatment for a particular group of ‘hard to reach’ problem drug users, leading to their better health and also reducing risks to the community on their release.¹²⁸⁸

In a 2015 report, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, the Victorian Ombudsman also considered that addressing AOD issues in prison is a way to reduce recidivism:

There are strong links between problematic substance use and recidivism. AOD problems are highly prevalent in prison populations and are often a direct cause of offending and recidivism, as well as the source of physical and mental health problems. Literature indicates that effective AOD treatment interventions can considerably lower recidivism rates.¹²⁸⁹

13.5.1 Policies on prison drug treatment and broader health services

As discussed in chapter 16, there are a range of international documents and guidelines regarding the treatment of drug use in prisons. This includes the revised United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) issued in September 2015, which states in Rule 24 that prisoners should be given ‘the same standards of health care that are available in the community’¹²⁹⁰, including necessary health care services without cost or discrimination. It further states that these services should ensure ‘continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence’.¹²⁹¹

Regarding governance of Victorian prisons, Corrections Victoria within the Department of Justice and Regulation (DJR) is responsible for the adult correctional system. Justice Health, another business unit within the DJR, is responsible for health services across the prison system including general health, mental health and AOD treatment.¹²⁹² These two units work closely together on these matters and are the most relevant agencies for the purposes of this section.

Building on previous strategies, the *Corrections Alcohol and Drug Strategy 2015* focuses on ensuring ‘an integrated approach to dealing with alcohol and drug use across both adult custodial and community corrections environments’.¹²⁹³ The Strategy comprises a four-pronged approach to drug-related harms across custodial centres and community corrections: supply control, demand reduction, harm

¹²⁸⁸ European Monitoring Centre for Drugs and Drug Addiction, *Prisons and drugs in Europe: the problem and responses*, Lisbon, 2012, p. 27.

¹²⁸⁹ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 56.

¹²⁹⁰ United Nations Office on Drugs and Crime, *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, Vienna, 2015.

¹²⁹¹ United Nations Office on Drugs and Crime, *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, Vienna, 2015.

¹²⁹² Corrections Victoria, *Corrections Victoria Strategic Plan 2015-2018: Delivery Effective Correctional Services for a Safe Community*, State Government of Victoria, Melbourne, 2015, pp. 5,9.

¹²⁹³ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 2.

reduction and monitoring and innovation, and is designed to be complemented by the *Corrections Victoria Strategic Action Plan* and *Evaluation Framework*. Some of the initiatives under the Strategy include:

- supply control – to prevent drugs from entering prisons and deter drug use and trafficking within. Initiatives include enhanced use of intelligence; drug testing prisoners through random and targeted testing, random identified drug user testing, and testing under the drug-free incentive program; and searching prisoners and visitors.
- demand reduction – to respond to drug use issues through programs such as brief psycho-education, group treatment, individual counselling, identified drug user counselling and transitional support. Initiatives include expanding the suite of programs offered, and undertaking reviews of AOD treatment effectiveness.
- harm reduction – to reduce harmful consequences of drug use, in recognition that many people struggle to refrain from AOD use. Initiatives include the prison opioid substitution therapy (OST) program, improving transitional support for ex-prisoners, peer education programs, and blood-borne virus testing and treatment.
- monitoring and innovation – to strengthen the correction system’s capability. Initiatives include a Strategic Governance Committee to provide coordination, staff training, and partnerships.¹²⁹⁴

Further, Justice Health developed the latest version of the *Communicable Diseases Framework 2017*, which aims to reduce the prevalence of communicable diseases, including blood borne viruses, through behaviours such as drug use, body piercing/ tattooing or sexual contact. The 2017 Strategy states:

Prison also provides an opportunity for prisoners to access regular healthcare and to improve the health of priority populations, over-represented in the correctional setting, including Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

Action on communicable disease in correctional settings is an important part of state and national efforts to address the prevalence of these conditions in the community.¹²⁹⁵

Its efforts to prevent, detect and respond to communicable diseases in the prison system are outlined further in Chapter 16.

13.5.2 Drug treatment in Victorian prisons

Across Victoria, there are 14 prisons (11 public and three private) and a transition centre for male prisoners, the Judy Lazarus Transition Centre.¹²⁹⁶ The Committee also understands that the newest prison in Victoria, the Ravenhall Correctional Centre, accommodates 1,000 prisoners and includes the following features: a 75 bed mental health unit and forensic mental health outpatient services for 100 other

¹²⁹⁴ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, pp. 8-19.

¹²⁹⁵ Department of Justice and Regulation, *Justice Health Communicable Diseases Framework 2017: Reducing the disease burden of bloodborne viruses and sexually transmissible infections in Victoria’s prisons*, State Government of Victoria, Melbourne, 2017, p. 3.

¹²⁹⁶ Corrections, Prisons and Parole, ‘Prison’, viewed 19 February 2018, <<http://www.corrections.vic.gov.au/home/prison>>.

patients, a focus on engaging prisoners after release to reduce reoffending, and incentive payments under the contract for reduced reoffending rates across the prison population.¹²⁹⁷

During the Committee's hearing on 4 September 2017, Melissa Westin, Assistant Commissioner of Corrections Victoria advised that there were 7,128 prisoners in custody on that day, with 2,226 on remand and 4,902 as sentenced prisoners.¹²⁹⁸

Minimum requirements for AOD treatment services within prisons are set by Corrections Victoria's *Correctional Management Standards*, with the outcomes stated as to:

- assist in reducing the demand for illicit drug use in prisons
- minimise the harms associated with substance use in prisons and upon release
- reduce relapse upon release
- aim to reduce the risk of re-offending associated with substance use upon return to the community.¹²⁹⁹

Justice Health contracts the private consulting firm, Caraniche, to deliver AOD programs in all Victorian public prisons. In private prisons, G4S has sub-contracted UnitingCare ReGen to deliver AOD services at the Port Phillip Prison, and the GEO Group provides AOD services to Fulham Correctional Centre.¹³⁰⁰

In terms of how a prisoner is referred into AOD treatment, the 2015 Victorian Ombudsman report noted that this can occur through:

- initial prison assessment/intake processes
- screening and assessment for offender behaviour programs
- as part of Case Management Review Committee processes
- where a prisoner tests positive for AOD use
- where a prisoner self-refers to treatment.¹³⁰¹

During entry into prison, all new prisoners are offered an orientation on AOD programs and services, as well as a prison related harm reduction (PRHR) session. According to Jan Noblett, Executive Director of Justice Health, the PRHR:

...provides information about harms associated with substance use in the prisons, it outlines the prison drug strategy, it provides information about pharmacological drug maintenance options in the prison and it provides an overview of the programs available at their location.

¹²⁹⁷ Corrections, Prisons and Parole, 'Ravenhall Prison Project', viewed 19 February 2018, <<http://www.corrections.vic.gov.au/home/prison/ravenhall+prison+project.shtml>>.

¹²⁹⁸ Assistant Commissioner Melissa Westin, Corrections Victoria, *Transcript of evidence*, 4 September 2017, p. 356.

¹²⁹⁹ Corrections Victoria, *Correctional Management Standards for Men's Prisons in Victoria*, State Government of Victoria, Melbourne, 2014, p. 51; Corrections Victoria, *Standards for the Management of Women Prisoners in Victoria*, State Government of Victoria, Melbourne, 2014, p. 57.

¹³⁰⁰ Justice Health and Corrections Victoria, Presentation to Committee: 4 September 2017.

¹³⁰¹ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 57.

In addition to that, 100 per cent of new prisoners receive general health and mental health assessments on reception into the prison, and health service providers are therefore able to make references or referrals to the drug treatment providers within the prison system and detect or discuss any drug and alcohol problems that the prisoner has.¹³⁰²

When a prisoner is transferred between prisons, similar services must be offered by AOD service providers.¹³⁰³

While in prison, there are two types of AOD treatment available:

- health-stream programs - psycho-educational programs to assist identify and manage AOD concerns, varying in duration between six, 12, 14 and 24 hours
- criminogenic-stream programs - these programs target the link between drug use and offending with the aim of reducing the risk of re-offending, varying in duration from 40 to 130 hours.¹³⁰⁴

Jan Noblett of Justice Health provided further information about these programs in her evidence to the Committee. Regarding the health-stream programs, she advised:

They are designed to increase knowledge of the physical, psychological, neurobiological and social impacts of their AOD use, both short and long term, and they include psychological strategies for managing and coping with withdrawal, self-management strategies and relapse prevention strategies. It is designed to increase motivation to change problematic use, and this is available to both remandees and sentenced prisoners at all prisons. It is probably worth saying at this point that in the 2017–18 budget we received additional funding to increase the number of health stream places by 263 places, again in recognition of the increasing remand numbers.¹³⁰⁵

In terms of the criminogenic-stream, Jan Noblett advised the Committee:

The criminogenic programs aim to instil participants with knowledge and encourage them to actively address their substance use and offending behaviour. It goes to thinking patterns, belief systems and behaviours that maintain their offending lifestyle.¹³⁰⁶

Because criminogenic programs involve discussing a prisoner's offending behaviour, Jan Noblett told the Committee that these are not offered to remand prisoners as they have outstanding legal matters which are yet to be dealt with.¹³⁰⁷

Other AOD services offered within prisons include comorbidity stream programs for those with co-occurring AOD misuse and mental health issues; individual counselling for those unable or unsuitable for group programs, for example where high-risk prisoners are unable to mix with other prisoners; peer education programs on issues such as infection control and treatment options; and identified drug user (IDU) reviews for people who have been identified as using drugs within the prison.¹³⁰⁸ Under the IDU program, prisoners identified as using drugs or trafficking drugs are subject to more frequent drug tests as well as loss of contact visits. Further, the

¹³⁰² Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 345.

¹³⁰³ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 345.

¹³⁰⁴ Justice Health and Corrections Victoria, Presentation to Committee: 4 September 2017.

¹³⁰⁵ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 345.

¹³⁰⁶ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 346.

¹³⁰⁷ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 346.

¹³⁰⁸ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, pp. 346-347.

Corrections Alcohol and Drug Strategy 2015 states that '[t]hey are also encouraged to participate in an IDU Review to discuss their participation in drug and alcohol treatment and harm minimisation programs'.¹³⁰⁹ Prisoners with IDU status can also participate in the Drug-Free Incentive Program, which allows them to reduce the loss of their contact visits by agreeing to more frequent drug tests. It also offers incentives when prisoners are drug free.¹³¹⁰

The provision of OST in Victorian prisons is also enabled through the Victorian Prison Opioid Substitution Therapy Program (OSTP), with the accompanying Guidelines most recently updated in 2015.¹³¹¹ According to the *Corrections Alcohol and Drug Strategy 2015*:

The OSTP aims to reduce the harm associated with illicit opioid use among prisoners both during their time in prison and upon their return to the community. It achieves this by reducing the demand for illicit drugs and by addressing risky injecting behaviours, such as the sharing of injecting equipment. In this way, OSTP also impacts on the transmission of blood-borne infectious diseases. In early 2015, approximately 19 per cent of the Victorian prison population was receiving an opioid substitute.¹³¹²

In supplementary evidence to the Committee, Jan Noblett of Justice Health advised the Committee that 1,122 prisoners were on an OST care plan within the prison system as at 3 September 2017.¹³¹³

Finally, prior to release from prison, all prisoners are eligible for a pre-release related harm reduction session (RRHR) to reduce potential harms with AOD use following prison release and to provide information on support options available. As part of the release process, prisoners on the OSTP are also provided with a discharge plan and referral to a community pharmacy to continue OST. Under this policy, Justice Health funds the OST dispensing fees from pharmacies for 30 days post-release.¹³¹⁴ In supplementary evidence to the Committee, Jan Noblett of Justice Health noted that in 2016-17, 708 prisoners accessed the post release OST subsidy.¹³¹⁵

Aboriginal and Torres Strait Islander treatment programs

It is also important to note that there is a particular focus on addressing the overrepresentation of ATSI people in prisons. The *Aboriginal Social and Emotional Wellbeing Plan*, issued by Justice Health and Corrections Victoria in 2015 stated:

Despite significant efforts to close the gap, Aboriginal prisoners continue to be significantly over-represented in the Victorian prison system. Aboriginal people make up 7.8 per cent of the Victorian prison population, despite accounting for only 0.9 per cent of the Victorian population. They are more likely to be on remand and be serving a shorter prison sentence, with many Aboriginal men and women discharged

¹³⁰⁹ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 10.

¹³¹⁰ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 10.

¹³¹¹ Justice Health, *Victorian Prison Opioid Substitution Therapy Program Guidelines*, State Government of Victoria, Melbourne, 2015.

¹³¹² Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 15.

¹³¹³ Jan Noblett, *Supplementary evidence*, Justice Health, 16 October 2017.

¹³¹⁴ Justice Health and Corrections Victoria, Presentation to Committee: 4 September 2017.

¹³¹⁵ Jan Noblett, *Supplementary evidence*, Justice Health, 16 October 2017.

having spent less than one year in prison. Aboriginal prisoners are also more likely to have had a prior period of imprisonment, with males nearly twice as likely to return to prison within the first two years after release.¹³¹⁶

In supplementary evidence to the Committee, Jan Noblett of Justice Health stated that there were 641 ATSI prisoners, representing 9 per cent of the total prison population, and 142 ATSI prisoners on OST care plans, as at 3 September 2017.¹³¹⁷

Jan Noblett outlined to the Committee current pilot programs being run to address AOD use among ATSI prisoners. The first was a criminogenic program:

In 2016 an Aboriginal-focused criminogenic AOD program was piloted in the public prisons, and that program was designed to be delivered by a clinician and an Aboriginal co-facilitator. The program has been reviewed by the Justice Health AOD panel, but the panel recommended that it be reviewed through a cultural lens, and so it has been referred for that further evaluation. We are now looking at rolling out that program more broadly, and the additional funding provided for AOD programs in 2017–18 will enable us to do that.¹³¹⁸

Jan Noblett also provided evidence about a second program, the Aboriginal Continuity of Care pilot for the post release phase:

The pilot is designed to strengthen both health and discharge planning for Aboriginal prisoners in recognition of the significant risks facing ex-prisoners, particularly Aboriginal prisoners, on release. That is being piloted in three sites: in DPFC [Dame Phyllis Frost Centre], through Ngwala Willumbong; Dhurringile; through Rumbalara; and GEGAC [Gippsland and East Gippsland Aboriginal Co-operative] is doing Fulham. What that program does is prerelease planning, and the prerelease planning is designed to attend the usual discharge appointments — they are in there two days a week per site — and then post release, to support them to get to the Aboriginal-controlled organisations for health support.

So the hope is that we will use the ACCHOs [Aboriginal Community Controlled Health Organisations], or the VACCHO [Victorian Aboriginal Community Controlled Health Organisation] network to create a safer and more culturally safe transition from prison to community, because we know that even though we provide discharge summaries and we do discharge planning, some prisoners will bin that on the way out and not take it with them. So then we will be required to provide it post release. We also want to make sure that they get to those appointments.¹³¹⁹

Jan Noblett also described relevant staff training and other capacity building work to enhance their management of ATSI prisoners:

Justice Health provides cultural safety training to all the health service providers. To date we have provided cultural safety training to 129 health provider staff and 196 mental health staff, again in this territory around ensuring that is culturally safe. I talked about the audit work that Justice Health does. That is done through clinical standards and review officers, and we are looking to trial the appointment of an Aboriginal clinical standards review officer for two reasons: one, to kind of establish what might be culturally safe standards of delivery, an audit tool, and then audit against that tool.¹³²⁰

¹³¹⁶ Justice Health and Corrections Victoria, *Aboriginal Social and Emotional Wellbeing Plan*, State Government of Victoria, Melbourne, 2015, p. 4.

¹³¹⁷ Jan Noblett, *Supplementary evidence*, Justice Health, 16 October 2017.

¹³¹⁸ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 355.

¹³¹⁹ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 356.

¹³²⁰ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 356.

The Committee received evidence from stakeholders about some issues in relation to prison drug treatment, as well as broader issues raised in recent research reports, which are briefly outlined below.

13.5.3 Effectiveness and access to prison drug treatment programs

There have been several reports regarding AOD treatment programs within prisons in Victoria. In 2013, the Victorian Auditor-General's Office (VAGO) reported on the *Prevention and Management of Drug Use in Prisons*. It found that while there were a broad range of evidenced-based drug treatment programs in operation, a lack of performance evaluation meant that the programs could not be shown to be effective in reducing the incidence of prison drug use or drug related harms.¹³²¹ In response to VAGO's recommendations, the Department of Justice and Regulation (DJR) advised that the *Corrections Alcohol and Drug Strategy* would include a new performance and monitoring framework, improved governance arrangements, and a new evaluation framework.¹³²²

Jan Noblett of Justice Health described the current arrangements regarding performance and evaluation of AOD service providers:

There is contract management, performance measures; there is monthly and quarterly reporting; and there is an audit program run by Justice Health, which is auditing of the performance of the providers against the Justice Health Quality Framework for alcohol and drug treatment provision. That happens twice per year at every public prison site and quarterly at private prisons. That is on the ground, so that is a review of files and delivery of the programs. There are evaluation obligations under the contract arrangements. The providers are asked to provide evaluations of the programs, and we have recently created an alcohol and drug programs assessment panel and we commission evaluations periodically.

In terms of the accreditation of the AOD programs, Justice Health has established, as I mentioned, an AOD program and assessment panel, which reviews criminogenics AOD treatment programs delivered and intended to be delivered in the Victorian prison system. We established that in November 2016, and it provides expert advice to Justice Health to improve the quality of the programs. Our immediate focus, since its establishment, was reviewing the AOD programs for the new correctional centre at Ravenhall as well as the AOD programs run in the other private prisons. The panel will progressively review the AOD programs across all prisons in Victoria.¹³²³

In response to questions from the Committee about whether programs are evaluated for their impact on reducing recidivism in the community, Jan Noblett described the challenges in being able to measure this effectively:

...there are multiple interventions for prisoners in the system. They may well also go through the offender behaviour program. They may also do alcohol and drug treatment. They may also have individual counselling. So how to segregate the effect of each of those is complicated. For example, has it been attributed to the offender behaviour program, which is about violence or sexual assault; is it about their alcohol and drug treatment; is it about the case management; is it about their parole supervision and how effective that has been on the ground; or have they got a job?¹³²⁴

¹³²¹ Victorian Auditor-General, *Prevention and Management of Drug Use in Prisons*, Melbourne, 2013, p. xi.

¹³²² Victorian Auditor-General, *Prevention and Management of Drug Use in Prisons*, Melbourne, 2013, p. 35.

¹³²³ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 347.

¹³²⁴ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 354.

A common theme identified throughout the inquiry is the need to review the outcomes of programs to determine their impact and cost-effectiveness. Given that prisons represent an opportunity for prisoners to address their underlying substance use issues and offending behaviour, it is important that AOD programs implemented are fit for purpose.

RECOMMENDATION 30: The Victorian Government evaluate prison alcohol and other drug programs based on their effectiveness in reducing recidivism, particularly where offending is directly related to substance use issues.

The Victorian Ombudsman's 2015 report referred to earlier highlighted issues regarding the inaccessibility of prison AOD treatment programs, including 'the large volume of complaints received by my office from prisoners about delays in accessing AOD programs, which are often required for parole eligibility'.¹³²⁵ On this, the report stated:

While a range of programs are provided to address these problems – including new programs on specific drugs like ice – my investigation found that the steep population growth in prisons has led to high demand and long waiting lists. As a result, an effective response has been difficult, however I understand funding in this area has recently increased considerably.¹³²⁶

The report recommended that the DJR '[e]nsure that alcohol and drug treatment programs are available in all Victorian prisons, including minimum security prisons'.¹³²⁷ A follow up report by the Victorian Ombudsman in 2017, *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system*, noted that the DJR reported completing this recommendation in February 2016.¹³²⁸

The Committee did not receive evidence from stakeholders regarding limited accessibility to AOD programs within prisons, although it received evidence about the need for various treatment options to be available in prison settings. In particular, Sam Biondo, Executive Officer of the VAADA considered that:

...within prisons, while we do have alcohol and drug programs and a preponderance of group sessions, I think what might really be required is a look at a more efficacious one-on-one counselling approach rather than the things that may not necessarily work where you need to expose your issues in front of other prisoners, which can make you more vulnerable.¹³²⁹

Similarly, Dr Stefan Gruenert, CEO of Odyssey House Victoria (OHV) provided further information to the Committee about the difficulties associated with prison drug treatment programs:

¹³²⁵ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 59.

¹³²⁶ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 149.

¹³²⁷ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 155.

¹³²⁸ Victorian Ombudsman, *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system* Melbourne, 2017, p. 5.

¹³²⁹ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 300.

In prison in a general population it is very difficult for people to get real and honest and vulnerable, in a sense, to actually develop the emotional regulation skills, to develop the relationship skills and to be surrounded by a good peer network that is positively working towards that.

So I think any prison program is always a challenge. I think examples where they work best are where there is a precinct of people who have made a commitment to working on their drug use. So there have been some therapeutic communities where the prison officers, the staff, everyone is on board with a treatment program and people are actually able to get real, honest and vulnerable and do that hard work to make the real changes in their relationships, but in a generalist population it is very difficult to do much more than give people some education. They will comply with those courses but we do not see much evidence of behaviour change as a result.¹³³⁰

In its submission, OHV suggested that:

Prisoners should also have access to, and be able to choose, their own AOD treatment including group counselling, individual counselling, pharmacotherapies, AA [Alcoholics Anonymous], NA [Narcotics Anonymous], and more intensive rehabilitation. OHV believes that current drug treatment in most Victorian prisons is outdated and tokenistic. We support the trial of a Therapeutic Community approach to drug and alcohol treatment within prisons, with additional rewards and responsibilities, and the capacity to move prisoners back into mainstream prison as needed.¹³³¹

In the context of programs to address drug-related harms within prisons, a number of stakeholders discussed a prison-based needle and syringe program (NSP), discussed in detail in chapter 16.

13.5.4 Reintegration of prisoners into the community

A common issue within prison systems is the transition of prisoners with AOD use issues back into the community following their release from prison. As noted earlier, a pre-release related harm reduction session is offered to this cohort, as well as continuing OST for eligible prisoners for 30 days upon release from prison.

Again, this issue was recently considered by the Victorian Ombudsman in her 2015 and 2017 reports. In 2015, the Victorian Ombudsman found that:

The effectiveness of alcohol and other drug programs in prison is not tested until a prisoner is released back into the community. My investigation found inadequate transitional support services for prisoners with substance abuse issues and limited community based support services for prisoners once they are released. Recently released prisoners have a much higher risk of death and overdose than the general population, underscoring the need for sufficient, coordinated support when they transition back into the community.¹³³²

¹³³⁰ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 166.

¹³³¹ Odyssey House Victoria, *Submission*, no. 179, 17 March 2017, p. 6.

¹³³² Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 149.

It recommended a range of changes such as the development of a ‘throughcare’ model of care ‘from prison to community health services, to address the health needs, in particular mental health, alcohol and drug, and disability, of prisoners being released into the community’.¹³³³ Underscoring the importance of ensuring appropriate support for people exiting prisons, the Victorian Ombudsman also reported IN 2017:

With such prevalence, it is not surprising that substance abuse has become recognised as a significant challenge to rehabilitation. At its most acute, this is manifest in the tragically high rate of death and overdose amongst prisoners upon release into the community: Coroners Court data shows that between 2000 and 2010, 120 former prisoners died from drug overdose, an average of one death each month.¹³³⁴

In the current inquiry, one of the key strategies supported by stakeholders to improve post-release support was to provide naloxone to exiting prisoners to address the high rates of overdose, discussed in detail in chapter 17. Other than this, the Abolitionist and Transformative Justice Centre (ATJC) stated in its submission:

We note that given the interruption to connection with community faced by prisoners, we recommend better coordination in relation to all medical treatment, but for the purposes of this Submission, particularly treatment for drug and alcohol dependence and withdrawal to ensure seamless transition from community-to-prison, transition from prison-to-prison and from prison-to-community.¹³³⁵

Cohealth indicated in its submission a need to ‘improve the pre-release planning and post-release referral for inmates with a history of drug and alcohol problems’.¹³³⁶ It recommended the development of programs ‘for community health services to deliver bundled care and support to people with a history of drug use who have recently exited prison’.¹³³⁷

The Committee acknowledges the importance of ensuring appropriate social supports are in place for released prisoners, such as housing and employment, to reduce the likelihood of reoffending. Similarly, such supports are widely recognised as essential to reducing recidivism rates among people subject to drug treatment orders of the Drug Court of Victoria, as discussed in chapter 8.

The 2017 report by the Victorian Ombudsman specifically dealt with these issues, focusing on access to services following contact with the criminal justice system (including after serving a prison term). The report noted concerns such as the lack of residential rehabilitation beds, shortages in pharmacotherapy services, and inadequate access to secure housing following release.¹³³⁸ It also outlined developments in these areas including:

- funding for at least 30 new residential rehabilitation beds as part of the budget, as well as three new residential facilities, which the DHHS reported will improve capacity by 68 per cent

¹³³³ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 156.

¹³³⁴ Victorian Ombudsman, *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system* Melbourne, 2017, p. 5.

¹³³⁵ Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017.

¹³³⁶ cohealth, *Submission*, no. 140, 16 March 2017.

¹³³⁷ cohealth, *Submission*, no. 140, 16 March 2017.

¹³³⁸ Victorian Ombudsman, *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system* Melbourne, 2017, pp. 8-12.

- funding for homelessness assessment and planning across the prison system.¹³³⁹

Of particular importance is that funding has been allocated towards a Reintegration Pathway. The report quoted a letter from the DJR in August 2017 which stated:

In 2017–18, the Government invested a further \$41.1 million in programs and services to reduce reoffending – including a three-fold increase in the number of prisoners able to access post-release support services.

The Reintegration Pathway for prisoners provides an integrated approach to transitional planning and support that directly targets the seven critical intervention areas which commence on entry to the prison system and continue post release, for eligible prisoners. This has included the introduction of a new pre-release service and post-release service.

The Reintegration Pathway has been specifically designed to target seven critical areas demonstrated by the evidence to be key in effective and successful reintegration of prisoners.

These critical areas are:

- Education and training
- Community and family connectedness
- Mental health
- Alcohol and other drugs
- Employment
- Independent living skills
- Housing

The service operates as a hybrid model combining DOJR staff with contracted services delivered by Community Service Organisations. The pre-release service is delivered by the Victorian Association for the Care and Resettlement of Offenders (VACRO) and is known as the ReLink program, with the post release service delivered by four providers to ensure a state-wide service inclusive of an Aboriginal specific response.¹³⁴⁰

In supplementary evidence to the Committee, Jan Noblett of Justice Health provided the following information on the three reintegration programs:

- ReGroup: a pre-release program that involves information sessions, provision of targeted support and referrals to external agencies to all prisoners on reception into custody and all sentenced prisoners on discharge from custody.
- ReLink: a more intensive pre-release transitional support program that services up to 2,500 prisoners per annum through Level 1 (an 8 hour group program) and up to 400 prisoners per annum and Level 2 (a 4 hour individual program). Prisoners who are serious violent offenders, sex offenders, Aboriginal and Torres Strait Islander, women, parolees, offenders or serving sentences greater than 12 months are prioritised for this program.

¹³³⁹ Victorian Ombudsman, *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system* Melbourne, 2017, pp. 13-14.

¹³⁴⁰ Victorian Ombudsman, *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system* Melbourne, 2017, p. 13.

- ReConnect: a post release program that provides assertive outreach and practical assistance to reintegrate prisoners returning to the community. ReConnect supports up to 1,309 prisoners per annum and prioritises prisoners who are serious violence offenders, sex offenders, Aboriginal and Torres Strait Islander, women or those who come through the ReLink Level 2 Program.¹³⁴¹

During the Committee hearing, Jan Noblett particularly spoke to the ReConnect program:

This is for those who require highly individualised transition planning to address very complex needs. The workers provide inreach support six weeks prior to release. They are trying to engage with the person. That can involve case conferencing with community correctional services; it can involve connecting them to other services. The targeted reintegration stream can provide up to four weeks of assertive outreach post release, and the extended reintegration program can provide up to 12 months of assertive outreach and practical support. So this is very much the hand-holding.

We know that they have picked up prisoners at the gate and have transitioned them to their accommodation. They will actively work on what the first set of priorities are post release that they need to do. It is not available to everybody at this stage, but it does try to target those who need it.¹³⁴²

In supplementary evidence, Jan Noblett further advised that in 2016/2017, 96 per cent of prisoners took part in ReGroup on entry into prison, and 82 per cent on leaving prison. Further, additional funding for post release services means that a total of 3,000 prisoners per year will be supported under these programs by 2020-2021.¹³⁴³

The Committee considers the issues raised by stakeholders and broader literature should continue to be a priority focus for the DJR, particularly through Corrections Victoria and Justice Health, to improve how people with substance use issues are assisted to identify and respond to these matters in prison environments. This is particularly in the context of high rates of drug use before incarceration (67 per cent of prison entrants reported drug use 12 months prior), compared to the broader community. While a range of actions are currently being taken, it will require sustained efforts over a long period of time for changes to translate into improved AOD treatment delivery in prisons. Enhanced reintegration to help exiting prisoners to seamlessly transition into community supports will also be needed.

13.6 Compulsory drug treatment

This section highlights debates on the controversial issue of compulsory, or involuntary, drug treatment for people identified as having substance use disorders. The Committee heard some evidence on these issues, but notes that careful consideration of this requires detailed analysis, substantial research evidence, and an examination of human rights implications and ethical concerns. This has not been possible in this inquiry given the broad range of other matters that were examined. Despite this, the Committee believes it is important to briefly outline some of the models of compulsory drug treatment as discussed by inquiry stakeholders.

At the outset, it is useful to note that drug treatment can be mandated when there is offending behaviour involved with substance use disorders (through the criminal justice system), and when there is no related offending behaviour but people appear

¹³⁴¹ Jan Noblett, *Supplementary evidence*, Justice Health, 16 October 2017.

¹³⁴² Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 358.

¹³⁴³ Jan Noblett, *Supplementary evidence*, Justice Health, 16 October 2017.

to be at risk of serious harm to themselves or others through their substance use (through civil schemes). It is also useful to note that compulsory treatment differs to forms of coerced treatment, for example through the Drug Court model. As stated in a November 2016 report by the Queensland Courts, *Queensland Drug and Specialist Courts Review Final Report*:

It is important to distinguish between compulsory drug treatment and coerced drug treatment, the latter including drug courts. Compulsory treatment refers to drug treatment program[s] in which clients are mandated to enrol. It typically involves forced inpatient treatment, but can also involve outpatient treatment. Coerced treatment is different in that it provides individuals with a choice to avoid treatment (such as, in the case of drug courts, not consenting to participate in the program).¹³⁴⁴

Globally, compulsory drug treatment models are typically found in Southeast Asia, Latin America and Australia.¹³⁴⁵ A discussion paper by the United Nations Office on Drugs and Crime (UNODC) in 2009, *From coercion to cohesion: Treating drug dependence through health care, not punishment*, stated:

For a minority of drug dependent persons, short-term compulsory treatment may be justifiable only in emergency situations for the protection of the person using drugs or the protection of the community. Even in these circumstances, the ethics of treatment without consent is debated and may breach some United Nations conventions, such as the Convention of the Rights of Persons with Disabilities. In any case, this intervention should not exceed a maximum of some days and should be applied under strict legal supervision only.¹³⁴⁶

Given particularly concerning models of compulsory drug treatment in East and South East Asia, in 2012 the United Nations called for the closure of such 'detention and rehabilitation centres' in those regions. This was on the basis that they do not have legal oversight and detain people for prolonged periods for suspected or actual drug use, without a valid court process.¹³⁴⁷

The Committee notes that evidence of the effectiveness of compulsory drug treatment, as opposed to people voluntarily accessing treatment, is limited and mixed. For example, a 2008 study on quasi-compulsory treatment by the Queensland Crime and Misconduct Commission, *Mandatory treatment and perceptions of treatment effectiveness: a Queensland study of non-custodial offenders with drug and/or alcohol abuse problems*, found that there were good outcomes for participants in both mandatory and voluntary treatment:

On average, 65 per cent (range: 54%–68%) of respondents who had undergone either mandatory or voluntary treatment reported that their treatment had helped them use less drugs/alcohol, stop using drugs and/or alcohol for a while, or use drugs and

¹³⁴⁴ Freiberg, A, et al., *Queensland Drug and Specialist Courts Review: Final Report*, Queensland Courts, Brisbane, 2016, p. 132.

¹³⁴⁵ Werb, D, et al., 'The effectiveness of compulsory drug treatment: A systematic review', *International Journal of Drug Policy*, vol. 28, 2016, p. 2.

¹³⁴⁶ United Nations Office on Drugs and Crime, *From coercion to cohesion: Treating drug dependence through health care, not punishment: Discussion Paper*, Vienna, 2010, p. 7.

¹³⁴⁷ International Labour Organisation / Office of the High Commissioner for Human Rights / United Nations Development Programme / United Nations Educational, Scientific and Cultural Organisation / United Nations Population Fund / United Nations High Commissioner for Refugees / United Nations Children's Fund / United Nations Office on Drugs and Crime / United Nations Entity for Gender Equality and the Empowerment of Women / World Food Programme / World Health Organisation / Joint United Nations Programme on HIV/AIDS *Joint Statement: Compulsory drug detention and rehabilitation centres*, 2012.

alcohol safely. About 52 per cent (range: 34.7%–66.9%), on average, also reported that treatment had improved their mental and physical health as well as their relationships with family, partners and friends.¹³⁴⁸

Other studies have been less positive about the outcomes. A recent study from Malaysia published in *The Lancet*, *Relapse to opioid use in opioid-dependent individuals released from compulsory drug detention centres compared with those from voluntary methadone treatment centres in Malaysia: a two-arm, prospective observational study*, found that:

Opioid-dependent individuals in CDDCs [compulsory drug detention centres] are significantly more likely to relapse to opioid use after release, and sooner, than those treated with evidence-based treatments such as methadone, suggesting that CDDCs have no role in the treatment of opioid-use disorders.¹³⁴⁹

The study focused on countries in East and South East Asia that quite commonly detain people who use drugs without due process for compulsory treatment. In reviewing the evidence, the authors of the study stated:

The findings here strongly support international calls for all countries that support CDDCs to cease operations in light of the ineffectiveness of these centres in treating drug dependence. Simultaneously, these countries should scale-up evidence-based opioid agonist therapies such as methadone or buprenorphine maintenance in communities, which should be encouraged and voluntary.¹³⁵⁰

In 2016, Werb et al conducted a systematic review on the evidence regarding compulsory treatment programs globally, noting that such studies are limited. It found that:

While a limited literature exists, the majority of studies (78%) evaluating compulsory treatment failed to detect any significant positive impacts on drug use or criminal recidivism over other approaches, with two studies (22%) detecting negative impacts of compulsory treatment on criminal recidivism compared with control arms. Further, only two studies (22%) observed a significant impact of long-term compulsory inpatient treatment on criminal recidivism: one reported a small effect size on recidivism after two years, and one found a lower risk of drug use within one week of release from compulsory treatment (Strauss & Falkin, 2001). As such, and in light of evidence regarding the potential for human rights violations within compulsory treatment settings, the results of this systematic review do not, on the whole, suggest improved outcomes in reducing drug use and criminal recidivism among drug-dependent individuals enrolled in compulsory treatment approaches, with some studies suggesting potential harms.¹³⁵¹

¹³⁴⁸ Ip, R, 'Mandatory treatment and perceptions of treatment effectiveness: A Queensland study of non-custodial offenders with drug and/or alcohol abuse problems', *Research & Issues Paper Series*, no. 7, Crime and Misconduct Commission, 2008, viewed 19 February 2018, <<http://www.ccc.qld.gov.au/research-and-publications/publications/research/research-and-issues-papers/mandatory-treatment-and-perceptions-of-treatment-effectiveness-a-queensland-study-of-non-custodial-offenders-with-drug-and-or-alcohol-abuse-problems-research-issues-paper-no.7.pdf>>, p. 2.

¹³⁴⁹ Wegman, M, et al., 'Relapse to opioid use in opioid-dependent individuals released from compulsory drug detention centres compared with those from voluntary methadone treatment centres in Malaysia: a two-arm, prospective observational study', *The Lancet: Global Health*, vol. 5, no. 2, 2017, p. e198.

¹³⁵⁰ Wegman, M, et al., 'Relapse to opioid use in opioid-dependent individuals released from compulsory drug detention centres compared with those from voluntary methadone treatment centres in Malaysia: a two-arm, prospective observational study', *The Lancet: Global Health*, vol. 5, no. 2, 2017, p. e204.

¹³⁵¹ Werb, D, et al., 'The effectiveness of compulsory drug treatment: A systematic review', *International Journal of Drug Policy*, vol. 28, 2016, p. 7.

13.6.1 Compulsory drug treatment under civil commitment

In the Victorian context, a 2015 literature review conducted as part of a broader review of Victoria's *Severe Substance Dependence Treatment Act 2010*, commissioned by the DHHS, noted different ways to conceive of compulsory (or involuntary) treatment:

There are different definitions of involuntary treatment in the literature. The following definition of involuntary treatment, and the related concepts of civil commitment and coercive treatment, is described here to assist in the interpretation of literature pertaining to involuntary treatment:

Involuntary treatment refers to commitment to treatment where the individual (offender or non-offender) has no choice. This includes treatment for substance dependence with a mandate based in legislation and/or government implemented programs, such as court-mandated treatment of offenders and the civil commitment of non-offenders.

Civil commitment is a process undertaken outside the criminal justice system and refers to the “legally sanctioned, involuntary commitment of a non-offender into treatment [for drug or alcohol dependence]”. In Australia, civil commitment legislation for substance dependence exists in New South Wales, Victoria and Tasmania, while the Northern Territory has involuntary treatment orders for alcohol and volatile substance dependence. Sweden and New Zealand also have civil commitment legislation...

Coercive treatment is considered to be a form of involuntary treatment. Coercive treatment occurs when an individual “is given the choice to choose between an opportunity to comply with addiction treatment or receive the ‘alternative consequences’ prescribed by the enforcement of the law, policy or agency” (e.g. prison or probation, loss of child custody, loss of employment or benefits). This includes court diversion programs.¹³⁵²

In Victoria, the civil commitment regime is found in the *Severe Substance Dependence Treatment Act 2010* (the Act). It applies to adults and its objectives are:

- (a) to provide the detention and treatment of persons with a severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and
- (b) to enhance the capacity of those persons to make decisions about their substance use and personal health, welfare and safety.¹³⁵³

Under section 8 of the Act, conditions for the relevant court order to be made include that immediate, necessary treatment can only be provided through detaining them in a centre, with no less restrictive means reasonably available to ensure the person receives treatment.¹³⁵⁴ The 2015 final report of the Act's review noted that there are currently two declared treatment centres, and further summarised that:

...the person must be incapable of making decisions about their substance use and personal health, welfare and safety due primarily to their substance dependence. The purpose is to give the person access to medically-assisted withdrawal, time to recover, capacity to make decisions about their substance use and the opportunity to engage in voluntary treatment.

¹³⁵² DLA Piper Australia, *Review of the Severe Substance Dependence Treatment Act 2014 (Vic): Volume 2: Literature Review*, State Government of Victoria, Melbourne, 2015, pp. 2-3.

¹³⁵³ *Severe Substance Dependence Treatment Act 2010 (Vic)*, 43., s3

¹³⁵⁴ *Severe Substance Dependence Treatment Act 2010 (Vic)*, 43., s8

Detention and treatment must be a consideration of last resort. Treatment is limited to ‘anything done in the course of the exercise of professional skills to provide medically assisted withdrawal from a severe substance dependence or to lessen the ill effects, or the pain and suffering, of the withdrawal’ and the period of detention is limited to a maximum of 14 days.¹³⁵⁵

An overlap also exists with treatment orders issued under the Victorian *Mental Health Act 2014*, in particular where there are mental health issues that are caused by substance use.¹³⁵⁶

The review found that between March 2011 and February 2015, 28 admissions were made under the Act in relation to 23 clients. The review report stated:

It terms of achievement of the Act’s objectives, it is clear that:

- provision has been made for detention and treatment of a small number of people with severe substance dependence; and
- the period of involuntary treatment improved the capacity of most clients detained under the Act to make decisions about whether they would continue with voluntary treatment.

For this very complex and ill group of clients, an abstinence/reduced use rate of almost 30% is encouraging.¹³⁵⁷

The report also outlined various stakeholder views in relation to the operation of the Act, and made some suggestions for improvement. The Victorian Government, in responding to the review, noted that:

The Government is strongly committed to the principles of human rights, and to safeguarding the health and welfare of individuals severely affected by their alcohol and other drug use. The Government notes the review’s finding that the vast majority of stakeholders, whilst recognising the infringement on human rights associated with involuntary detention and treatment, believe that the Act remains appropriate as a last resort for a small group of people. To date, the people detained under the Act have reflected the targeted client group of highly complex substance dependent people at serious risk of death or harm.¹³⁵⁸

While noting that the Victorian Government does not intend to extend or change the reach of the scheme, the response provided information on some policy and administrative changes, including:

- enhancing pathways for clients to community treatment following discharge from involuntary treatment
- education and communication to clinicians and service providers to support applications for orders to be made where appropriate

¹³⁵⁵ DLA Piper Australia, *Review of the Severe Substance Dependence Treatment Act 2014 (Vic): Volume 1: Report of the Review*, State Government of Victoria, Melbourne, 2015, p. 7.

¹³⁵⁶ DLA Piper Australia, *Review of the Severe Substance Dependence Treatment Act 2014 (Vic): Volume 1: Report of the Review*, State Government of Victoria, Melbourne, 2015, p. 9.

¹³⁵⁷ DLA Piper Australia, *Review of the Severe Substance Dependence Treatment Act 2014 (Vic): Volume 1: Report of the Review*, State Government of Victoria, Melbourne, 2015, pp. 1-2.

¹³⁵⁸ Victorian Department of Health and Human Services, *Review of the Severe Substance Dependence Treatment Act 2010: Victorian Government Report and Response 2015*, State Government of Victoria, Melbourne, 2015, p. 8.

- enhancing monitoring and accountability mechanisms for designated treatment centres under the Act.¹³⁵⁹

This form of civil commitment was only raised by two stakeholders to the Committee. Dr Stefan Gruenert of OHV advised:

We know that the current substances misuse act gets rarely used, and it is really only used on very rare occasions where someone is at risk of causing substantial harm to themselves and others. It is not necessarily well understood. There are very few beds and, as you point out, the way it has been set up is a very short passage of treatment. So for many people it does not even come on their radar, or where people have used that service it is a very short-term relief — sometimes just helping someone get through the withdrawal, reducing their tolerance to a drug and then they will be back out on that drug.¹³⁶⁰

In New South Wales (NSW), there is a similar Involuntary Drug and Alcohol Treatment (IDAT) Program under the *Drug and Alcohol Treatment Act 2007* to provide for short term, involuntary care of people with severe substance dependence, where there is risk of serious harm and compromised decision making capacity.¹³⁶¹ Professor Alison Ritter, Director of the Drug Policy Modelling Program (DPMP) at the National Drug and Alcohol Research Centre (NDARC) told the Committee:

...one must then consider the potential options for involuntary treatment. I know this is controversial and difficult. I am currently involved in evaluating the involuntary treatment program here in New South Wales, and I know that you also have an involuntary treatment program in Victoria. Clearly the loss of liberty is a substantial step to take, but where someone is at serious risk of harming themselves or harming another person — an immediate, serious risk — then there are grounds for the potential for involuntary detention with appropriate health care, medical support, medication and so on. It is not a step that one would take lightly, but the availability of a small number of these treatment places, I think, forms an important part of the overall response.¹³⁶²

Sweden is also a jurisdiction that employs a civil commitment scheme for involuntary drug treatment, and is commonly discussed in these debates. A 2016 document from the Swedish Ministry of Health and Social Affairs outlined that its drug policy is based on achieving a drug free society, and that treatment interventions, often based on abstinence, can include compulsory treatment in particular cases:

If the opportunities for voluntary measures are exhausted, the Care of Persons with Substance Use Disorders in Certain Cases Act states that if anyone as a consequence of continuing abuse is placing their physical or mental health in serious danger, is running a clear risk of destroying their life, or if there is a fear that they may seriously harm themselves or a person close to them, a court may decide on compulsory care provided that the care cannot be provided in any other way. This opportunity exists in the majority of countries, but tends to be incorporated under the framework of national psychiatric legislation. It is important that the decision is made in a manner that complies with the rule of law and the human rights conventions. The purpose is to, for a limited time (maximum six months), motivate the person to seek voluntary

¹³⁵⁹ Victorian Department of Health and Human Services, *Review of the Severe Substance Dependence Treatment Act 2010: Victorian Government Report and Response 2015*, State Government of Victoria, Melbourne, 2015, pp. 8-9.

¹³⁶⁰ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 164.

¹³⁶¹ NSW Health, 'The Involuntary Drug and Alcohol Treatment Program', viewed 19 February 2018, <<http://www.health.nsw.gov.au/aod/programs/Pages/idad-gi.aspx>>. Webpage:

¹³⁶² Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, *Transcript of evidence*, 19 June 2017, pp. 252-253.

treatment. The vast majority of people who undergo compulsory care, 75 per cent, choose, and are given the opportunity during the period the decision is valid, to transfer to voluntary treatment.¹³⁶³

13.6.2 Compulsory drug treatment related to criminal justice

What Can Be Done? Steering Committee

The issue of compulsory drug treatment was raised in the inquiry specifically in relation to young people by Her Honour Jennifer Bowles, a magistrate with the Children's Court of Victoria. Magistrate Bowles undertook a Churchill Fellowship to visit mandated drug treatment centres for young people in numerous overseas jurisdictions, largely as a result of the 'revolving door problems' associated with the drug use of children and young people who come before her court in both the criminal and welfare divisions.

Magistrate Bowles considered that in certain circumstances, where less coercive options had not worked, secure, intensive and often long term treatment may be necessary to address the often complex histories of trauma, abuse, neglect and mental illness that some of these young people have experienced. In her Churchill Report, Magistrate Bowles advocated for a mandated therapeutic residential service for young people subject to the Children's Court jurisdiction. She stated:

The advice I received from numerous experts and practitioners in all countries was that, for some young people, compulsory orders to attend therapeutic residential facilities are necessary in order to ensure these young people are safe and secure, to deal with the addiction, to commence the process of improving their physical and mental health and wellbeing and to reconnect them with education and training. I spoke with some young people who admitted they did not wish to attend such a facility, but having been there, they believed that it was essential for them.¹³⁶⁴

Under the proposed model, a young person would be sent to a facility by way of a Youth Therapeutic Order (YTO), with priority provided to young people before the Criminal Division of the Children's Court. The *What Can Be Done* Steering Committee was established to undertake further development of the model, and to address matters relating to the entry points for compulsory treatment, costs, and human rights issues.¹³⁶⁵

In outlining her report to the Committee, Magistrate Bowles stressed that the model was only as good as the accompanying therapeutic and supportive services, and that unfortunately service provision for young people was lacking in Victoria:

When I wrote the report there were only 33 detox beds for young people in the whole of Victoria. There are very few residential programs for young people. There is a lot of emphasis, for whatever reason, on adults and adult services, and I am not sure if that is because adults are more effective at lobbying for themselves than children, but there is a real lack of provision of services. If you speak to any of the service providers, they will say, 'We are desperate to have more beds, more funding, in order to try to

¹³⁶³ Ministry of Health and Social Affairs, *Swedish drug policy - a balanced policy based on health and human rights*, Swedish Government, Stockholm, 2016, p. 8.

¹³⁶⁴ *What Can Be Done* Steering Committee, *Submission*, no. 149 - attachment 1, 17 March 2017, p. 6.

¹³⁶⁵ *What Can Be Done* Steering Committee, *Submission*, no. 149, 17 March 2017, p. 2.

provide services for young people'. So yes, there are current gaps in the voluntary sector, and obviously with what I am talking about at the moment there is not any equivalent service to what I am recommending.¹³⁶⁶

The Committee also heard from some stakeholders on such a proposal. Magistrate Tony Parsons of the Drug Court of Victoria stated:

I think there is a very powerful case that Ms Bowles articulates very well that says we should be considering the establishment of a similar facility in Victoria, particularly for youthful offenders, particularly for young people who are completely out of control. Even exercising the authority of that legislation you quoted, as I understand it, it is a 10 to 14-day period of incarceration — and that is all the powers that the system has under that legislation. I think there are very powerful grounds for arguing the application of compulsory treatment in the very worst cases.¹³⁶⁷

Dr Stefan Gruenert of OHV told the Committee:

So a mandated form of treatment, I believe, absolutely has some place in a spectrum, particularly, as Tony Parsons mentioned, where many young people are referred to a voluntary service and they may access it for a few days and simply leave without any sort of accountability or consequences of that. So when voluntary treatment fails for someone who is really out of control and causing harm to themselves, I think the models that she has looked at overseas can form a basis for treatment where at least the front end is secure — where people need to go in and comply — and over time as they step through they can move to a less secure part of that facility where the boundaries are really set by themselves and their desire to get better and get well.¹³⁶⁸

New South Wales Compulsory Drug Treatment Program

While most mandated drug treatment associated with the criminal justice system is coercive (requiring consent of the offender) rather than compulsory, the exception in Australia is the NSW prison-based Compulsory Drug Treatment Program under the *Drug Court Act 1988*. Under this program, courts must refer to the Drug Court certain eligible offenders for consideration of imposing a compulsory drug treatment order following their convictions. Eligibility is restricted in many ways, for example it only applies to: males aged 18 years old and over living in certain areas of NSW; convictions not relating to serious offences such as murder, attracting an imprisonment sentence with a non-parole period of at least 18 months and sentence no more than six years; long term dependency; and consideration of factors such as the offence and person's history. It cannot be applied to people with mental health conditions which could lead to the person being violent or affect their participation in treatment.¹³⁶⁹

If the NSW Drug Court makes a compulsory drug treatment order (which cannot be appealed), the person is moved to the Compulsory Drug Treatment Correctional Centre (CDTCC), a small prison built specifically to house people on these orders. There are three stages of the order: full-time detention at the CDTCC for at least six

¹³⁶⁶ Magistrate Jennifer Bowles, 2017 Churchill Fellow, *What Can Be Done Steering Committee, Transcript of evidence*, 18 September 2017, p. 415.

¹³⁶⁷ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, pp. 148-149.

¹³⁶⁸ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 164.

¹³⁶⁹ Sentencing Advisory Council, *Mandatory Treatment for Alcohol and Drug Affected Offenders: Research Paper No. 2*, State Government of Tasmania, Hobart, 2017, pp. 17-18.

months to undergo treatment, semi-open detention for at least six months where the person remains in the CDTCC but is also allowed to access community programs, and community custody under intensive supervision.¹³⁷⁰

A September 2017 research paper by the Tasmanian Sentencing Advisory Council, *Mandatory treatment for alcohol and drug affected offenders*, considered various options for mandatory treatment. In relation to the NSW model, it noted that, while it is compulsory there is still some level of choice for the offender involved:

If the order is revoked, the consequence for the offender ‘simply means that they return to the conditions of ordinary imprisonment’. In reality, then, the offender has a choice (albeit constrained) about whether to take part in treatment because the compulsory nature of the order only means that the offender will be housed in the Compulsory Drug Treatment Correctional Centre...while an offender can be actively encouraged to participate in treatment, he or she cannot be compelled against their will to actually take part or to satisfactorily take part in treatment.¹³⁷¹

In terms of the evidence regarding the NSW model, the Sentencing Advisory Council indicated:

...this model was carefully designed to counter anti-therapeutic effects arising from its compulsory nature and evaluations have found positive results in terms of offender health and attitudes towards the program. However, there are no published evaluations of its effectiveness in terms of reducing recidivism and long-term drug use. It is also noted that this is a costly intervention and that, despite its mandatory nature, the order cannot compel an offender to participate and the order may be revoked and the offender returned to mainstream prison.¹³⁷²

More generally in terms of various options for mandatory treatment in the criminal justice system it suggested:

...while there is evidence that coerced treatment (ie where there is legal coercion to participate in treatment but an offender has a choice as to whether to take part) can be effective, there is no research base to support mandatory treatment (ie where there is legal coercion and the offender is not given a choice as to whether to take part). Mandatory treatment is also considered to raise significant ethical and human rights concerns. Other concerns exist in Tasmania in relation to the appropriateness of expanding mandatory treatment in light of the current availability of treatment for offenders who wish to engage in treatment.¹³⁷³

The Committee notes recent developments regarding compulsory treatment options in Victoria. The Victorian Government’s *Drug Rehabilitation Plan* states that it will consult on options for compulsory treatment for those aged 18 years and over with ‘complex needs such as addiction and mental illness and who pose a violence risk to others’, as well as considering a spectrum of treatment options for young offenders.¹³⁷⁴ The Parliamentary Legal and Social Issues Committee also recently recommended a trial program of Youth Therapeutic Orders based on the *What Can Be*

¹³⁷⁰ Corrective Services NSW, ‘Compulsory Drug Treatment Correction Centre’, viewed 19 February 2018, <<http://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/custodial-corrections/table-of-correctional-centres/compulsory-drug-treatment-centre.aspx>>.

¹³⁷¹ Sentencing Advisory Council, *Mandatory Treatment for Alcohol and Drug Affected Offenders: Research Paper No. 2*, State Government of Tasmania, Hobart, 2017, p. 19.

¹³⁷² Sentencing Advisory Council, *Mandatory Treatment for Alcohol and Drug Affected Offenders: Research Paper No. 2*, State Government of Tasmania, Hobart, 2017, p. 41.

¹³⁷³ Sentencing Advisory Council, *Mandatory Treatment for Alcohol and Drug Affected Offenders: Research Paper No. 2*, State Government of Tasmania, Hobart, 2017, p. 42.

¹³⁷⁴ Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017, p. 6.

Done model proposed by Magistrate Jennifer Bowles in its *Inquiry into Youth Justice Centres in Victoria* final report.¹³⁷⁵ As it will continue to be a policy topic of ongoing discussion and debate, it is essential that these discussions be informed by research as it emerges, particularly regarding best practice, and international and domestic dialogue around human rights implications.

¹³⁷⁵ Legal and Social Issues Committee, *Inquiry into youth justice centres in Victoria: Final Report*, Parliament of Victoria, Melbourne, 2018, p. 102.

14 Medication assisted treatment for opioid dependence

In Australia, heroin has traditionally been the main type of opioid that people seek treatment for, usually as a result of injecting drug use. In more recent times, the harmful use of pharmaceutical opioids such as codeine and oxycodone has become more prevalent, requiring similar treatment used for heroin dependency.¹³⁷⁶

This chapter discusses the nature of opioid dependency and its related harms, with a focus on treatment types that involve the prescription of substitution medication to help a person treat their opioid dependency. In treating opioid addiction, pharmacotherapy has been proven to improve clients' stability, reduce involvement in criminal activity and reduce blood-borne virus transmission. While the use of opioids to treat opioid dependency may seem 'counterintuitive' or 'confusing', it is no different than the use of, for example, nicotine replacement strategies that may assist with the eventual cessation of smoking. As discussed by renowned addiction researcher, Professor Sir John Strang, whose work is referred to throughout this chapter:

...our concern is not only about the physiological or psychological dependence, but is also importantly about the associated health and societal consequences of the heroin use. Thus, it is the reduction of risk of heart disease or stroke or of lung cancer, etc. in the former cigarette smoker which constitutes an important health gain, even while the replacement nicotine supply is maintained. And similarly with the injecting heroin user, it is the quitting of involvement with use of 'street' heroin, disengagement from criminal activities and improvements in health and social well-being which are some of the important gains sought.¹³⁷⁷

The main form of treatment for opioid dependency in Australia, opioid substitution therapy (OST), remains a safe and effective option for most opioid dependent users. A number of barriers currently exist which obstructs improved utilisation of this treatment, particularly relating to governance of the OST program, costs of the treatment, and the limited number of health professionals that deliver these services in Victorian communities. This chapter explores how each of these issues can be addressed to enhance effectiveness of Victoria's OST program. The chapter also explores the potential of heroin-assisted treatment, in very limited circumstances, where other forms of treatment have not worked to help a person overcome their opioid dependency.

¹³⁷⁶ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 6.

¹³⁷⁷ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 159.

14.1 Opioid dependence

Opioid dependence broadly relates to a person's condition of physical and mental reliance on opioids such as heroin and pharmaceutical opioids. The central feature of opioid dependence is that a person experiences 'a loss of control over use, which is seen as continued use despite drug-related legal, interpersonal and health problems as well as drug use taking priority over other activities and obligations'.¹³⁷⁸ It is difficult to estimate the exact prevalence of opioid dependence in Australia, noting that overall use of opioids remains low with reports of recent use of heroin at 0.2 per cent.¹³⁷⁹ Further, not everyone that uses opioids would necessarily become dependent on them. However, the effects and harms of opioid dependence to the individual and community are far greater than prevalence of use, requiring a concerted effort to treat this condition.¹³⁸⁰

The range of harms associated with opioid dependence relate to health, financial and social issues. For example, there is a greater risk of transmission of blood borne viruses such as HIV and hepatitis C, and risk of overdose including death. Significant financial harms can be incurred, including through the costs of the drug to the individual user, loss of employment and increased burden on the healthcare system. Social issues to consider include stress on relationships, loss of quality of life, homelessness, and increased crime and burden on the justice system.¹³⁸¹ Mortality rates associated with opioids are particularly disturbing as it is the drug group related to the highest number of illicit drug-related deaths, largely due to causes such as overdose, disease including AIDS, suicide and trauma. Deaths from opioids typically occur at a younger age than alcohol or tobacco-related deaths, with a 2011 cohort study showing the median age of death among opioid users in Australia was 34.5 years old.¹³⁸²

Opioid dependence is recognised in Australia as a chronic relapsing condition, and is comparable with other conditions such as diabetes and asthma. Similarities between opioid dependence and other chronic relapsing conditions include: they are the result of genetic, personal choice and environmental factors; relapse and medication compliance rates are similar; there is no cure for these conditions but complying with treatment regimens results in more positive outcomes; people who are older, employed and in stable relationships are more likely to comply and have better outcomes than people who are younger, unemployed and lacking in stable relationships; and the most effective treatment combines medication and behavioural interventions.¹³⁸³ 360Edge's submission highlighted that, despite the similarities between opioid dependence and other chronic relapsing conditions, 'a different yardstick' is used to determine the success of alcohol and other drugs (AOD) treatment:

¹³⁷⁸ Gowling, L, et al., *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth Department of Health, Canberra, 2014, p. 1.

¹³⁷⁹ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 33.

¹³⁸⁰ Gowling, L, et al., *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth Department of Health, Canberra, 2014, p. 1.

¹³⁸¹ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 7.

¹³⁸² Gowling, L, et al., *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth Department of Health, Canberra, 2014, p. 65.

¹³⁸³ Gowling, L, et al., *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth Department of Health, Canberra, 2014, p. 2.

Treatment in other areas is considered effective if it reduced symptoms, increases function and prevents relapse to pre treatment levels. The belief that treatment is a failure if a person is not completely abstinent from drugs is unhelpful and a legacy from the war on drugs. When compared to other chronic health conditions, AOD treatment shows similar recovery and relapse rates.¹³⁸⁴

It is recognised that for opioid dependence, ‘abstinence is not easily achieved or maintained’ given it is a relapsing condition.¹³⁸⁵ Abstinence requires a person to manage a range of difficult tasks, including their compulsion to use drugs; dealing with physical changes as a result of dependence; and importantly dealing with psychological and social issues that accompany and drive dependence. Given these factors, abstinence generally takes a long period of time (typically over a number of years) and, despite all efforts, may not necessarily occur. Effective treatment for opioid dependence therefore combines medication and psychosocial support to achieve sustainable behavioural changes for individuals. It also recognises that abstinence may not necessarily be the goal of treatment, and lapses may occur, but could possibly be achieved in the long term.¹³⁸⁶

Instead, treatment goals may focus on reducing the harms of substance use to stabilise a person’s life, achieve social reintegration, and retain a person in treatment for as long as required.¹³⁸⁷ The Committee believes that keeping people alive and improving their health and wellbeing, including through reduced criminal activity associated with drug use and reducing risk of transmission of hepatitis C and HIV, are clearly some of the most important aspects.

14.2 Opioid substitution therapy

Opioid substitution therapy is a type of treatment for opioid dependence where the drugs of dependence at issue, particularly heroin or misused pharmaceuticals, are substituted with controlled opioid medication with lower risks to assist people ‘to successfully manage physical dependence, drug craving and compulsive drug use’.¹³⁸⁸ It is referred to in a variety of ways such as opioid replacement therapy (ORT), substitution maintenance treatment, pharmacotherapy for opioid dependence, and methadone treatment (methadone being the main form of OST drug).

Opioid substitution therapy is identified as one of the most effective treatment options for opioid dependence, and is well established across Australia and internationally. International bodies such as the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recognise it as an effective treatment. It is also compliant with international drug control conventions in the framework of approved medical practice.¹³⁸⁹ There are, of course, a number of risks involved with OST if the opioid medication is used inappropriately. In Australia, each jurisdiction has its own

¹³⁸⁴ 360Edge, *Submission*, no. 229, 4 September 2017.

¹³⁸⁵ Gowling, L, et al., *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth Department of Health, Canberra, 2014, p. 3.

¹³⁸⁶ Gowling, L, et al., *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth Department of Health, Canberra, 2014, pp. 2-4.

¹³⁸⁷ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 13.

¹³⁸⁸ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 8.

¹³⁸⁹ World Health Organization, United Nations Office on Drugs and Crime, UNAIDS, *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: position paper* Geneva, 2004, p. 13.

rules regarding the safe and effective administration of OST, as well as guidelines to assist with clinical care and avoidance of such risks. Victoria's OST program is discussed below.

A commonly identified theme among stakeholders was the positive outcomes for individuals and the community arising from OST, such as reduced illicit drug use, reduced criminal activity associated with illicit drug use, reduced mortality rates, improved health and wellbeing outcomes, and cost effectiveness.¹³⁹⁰ For example, according to the Pennington Institute:

ORT is a highly effective treatment for opioid dependence – often described as the most effective, as well as the most preferred by people who use opioids themselves. It is associated with reductions in heroin use, criminal activity, deaths due to overdose, and behaviours associated with a high risk of HIV transmission. It has also been demonstrated to improve health and social functioning. These benefits apply broadly to both methadone and buprenorphine. ORT is also highly cost effective.¹³⁹¹

Similarly, Judge Sarah Hinchey, State Coroner of Victoria, stated:

As Victorian coroners have repeatedly emphasised in their roles, methadone maintenance therapy plays a vital role in assisting opioid-dependent people to come to grips with their dependence in order to reduce their addiction and move on with their lives.¹³⁹²

Greg Chipp, Chief Executive Officer (CEO) and Director of Drug Policy Australia (DPA) discussed with the Committee his personal experience of being on OST and the positive impacts that flowed:

It allows hapless individuals, which I was as an addict or as any addict is, to stabilise a lifestyle and to seek treatment, to withdraw from the need to associate with criminals and the black market and to find money for a daily hit. The benefits to society are enormous in terms of reducing the total use of heroin and the money and the crime required to finance it.¹³⁹³

On the other hand, Drug Free Australia (DFA) commented that evidence provided by other stakeholders on OST effectiveness is inaccurate. According to Gary Christian, Research Director:

When it comes to methadone, unfortunately so many of the submissions seemed to think that it was a success in terms of reducing mortality and criminal behaviour. The gold standard in reviews, back in 2009, was the Cochrane review — it was done by an Australian, Richard Mattick from NDARC — and when he looked at the random controlled trials on methadone, they showed no such successes cited by so many of the submissions. It did not reduce opiate mortality or criminal behaviour beyond those people who were in no treatment at all. So it is not the success that it is painted to be.¹³⁹⁴

The Committee notes that the Cochrane review discussed by Gary Christian did not find statistically significant reductions in mortality or criminal activity for methadone treatment compared to treatment that did not involve the use of drugs. However,

¹³⁹⁰ John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, p. 4; 360Edge, *Submission*, no. 229, 4 September 2017; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 28.

¹³⁹¹ Pennington Institute, *Submission*, no. 209, 24 March 2017, p. 44.

¹³⁹² Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 14.

¹³⁹³ Greg Chipp, CEO and Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 292.

¹³⁹⁴ Gary Christian, Research Director, Drug Free Australia, *Transcript of evidence*, 21 August 2017, p. 285.

the review concluded that methadone is effective because it has better treatment retention rates as well as better rates of reduced heroin use. Further, the review suggested that there is other evidence demonstrating reductions in mortality and criminal activity associated with methadone treatment.¹³⁹⁵

Dr John Sherman, a medical practitioner who has 35 years' experience in treating drug dependence, including nine years focusing on opioid dependence, also responded to such concerns by advising the Committee that:

...the research since 1965 suggests strongly that there are five things about methadone programs. There are less deaths from overdose; there is less intravenous drug use, but it is not cessation-less; there is less HIV; there is less criminality; and there is a greater chance of work. That is repeated time and time again in the research, particularly if it is a well-run program and the dose is adequate enough.¹³⁹⁶

Overall, despite one stakeholder questioning the effectiveness of OST, the Committee considers there is a substantial body of evidence demonstrating OST as the gold standard treatment for opioid dependence. However, the Committee is concerned that despite the success of OST and its ability to positively impact a person's health and wellbeing, it is estimated that less than half of people who are opioid dependent in Australia access this treatment on any given day.¹³⁹⁷ There may be a number of reasons for this (including a person's willingness to enter treatment), some of which are identified in this chapter accompanied with strategies to improve the utilisation of OST.

14.2.1 Victoria's opioid substitution therapy program

Victoria's OST program is governed by a range of rules and policy guidelines at both federal and state levels. Strong regulation and governance in this area reflects the potential risks involved with the prescription of potent and possibly dangerous opioid medication, while also recognising the long-term benefits for individuals and the community in successfully managing opioid dependence.

The Department of Health and Human Services (DHHS) oversees Victoria's *Policy for maintenance pharmacotherapy for opioid dependence* (the Victorian OST policy). This policy is used in conjunction with the *Australian National Guidelines for Medication-Assisted Treatment of Opioid Dependence* (the Australian MATOD policy). The main legislative instruments governing OST provision in Victoria are the *Drugs, Poisons and Controlled Substances Act 1981* (DPCSA) and the *Drugs, Poisons and Controlled Substances Regulations 2017* which commenced in May 2017 (replacing previous 2006 Regulations). While it is not possible for this report to consider all areas covered by the relevant policies and legislative instruments, they briefly include:

- requirements for doctors and pharmacists to apply to become authorised by the DHHS to deliver OST services, and the issuing of individual permits for each patient on OST
- clinical guidance on issues such as assessing suitability of a person for OST, prescribing practices, appropriate dosing levels and regular review of a patient's progress

¹³⁹⁵ Mattick, R, et al., 'Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence', *Cochrane Database of Systematic Reviews*, 2009, pp. 10-11.

¹³⁹⁶ Dr John Sherman, Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 292.

¹³⁹⁷ Lord, S, et al., 'Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention', *Policy Brief No. 8*, Centre for Research Excellence into Injecting Drug Use, 2014, viewed 9 January 2018, <http://www.atoda.org.au/wp-content/uploads/Policy_Brief_Lord_Kelsall.pdf>.

- appropriate coordination of care between various professionals involved with a patient's treatment
- clinical guidance to avoid adverse events such as overdose or mortality, including high risks of overdose during the initial stages of treatment and high risk of mortality when OST drugs are used with other drugs such as alcohol and benzodiazepines
- ensuring OST drugs are not diverted to the illicit market or used in unsanctioned ways
- a strict policy for patients to take away a limited number of doses for use outside of clinical settings
- other legislative requirements such as prescribing and supplying Schedule 8 drugs, the storage of OST drugs, record keeping, and patient confidentiality.¹³⁹⁸

The Victorian OST program is often described as a 'community-based' model, which is significantly different to other Australian jurisdictions. In the 1990s, the Victorian Government deliberately moved OST provision away from dedicated public clinics and into the community, to be prescribed by general practitioners (GPs) in primary health care settings and dispensed through community pharmacies. The Victorian OST Policy highlights that the benefits of the community-based model include decreasing the stigmatisation of opioid dependence, integrating treatment of opioid dependence with treatment of other conditions, and enabling relationships between patients and their usual GPs to be maintained. This model is complemented by several initiatives including:

- five Specialist Pharmacotherapy Services throughout Victoria to assist with patients with more complex or difficult conditions, such as psychiatric, social or medical problems. The Services can provide expert advice to prescribers or can receive referrals of such patients
- the Drug and Alcohol Clinical Advisory Service (DACAS) that provides telephone clinical advice on alcohol and other drug (AOD) treatment to health professionals such as doctors, nurses, pharmacists and others, operated by Turning Point
- training for prescribers and pharmacists
- the Pharmacotherapy, Advocacy, Mediation and Support (PAMS) Service for clients and health professionals to resolve problems of access or delivery of treatment, and to encourage more health professionals to participate in the OST program, operated by Harm Reduction Victoria (HRV).¹³⁹⁹

An evaluation of the Victorian OST program in 2010 by the National Drug and Alcohol Research Centre (NDARC) and Turning Point reported that the fundamentals of the community-based model are 'sound', but the rapid growth of the program required changes such as addressing a shortage of treatment places, improving referral pathways between specialist and primary care, and addressing affordability of the treatment (discussed in more detail below).¹⁴⁰⁰

The two OST drugs available in Victoria are methadone and buprenorphine. Methadone is prepared in an oral liquid form, and buprenorphine is available on its own or as a combination of buprenorphine/naloxone (the combination is associated

¹³⁹⁸ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017.

¹³⁹⁹ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 9.

¹⁴⁰⁰ King, T, et al., *Victorian Pharmacotherapy Review*, National Drug and Alcohol Research Centre, Sydney, 2010, p. 5.

with greater safety than buprenorphine alone).¹⁴⁰¹ Generally methadone is the most common form of OST medication used – for example, in 2016, the majority of patients were prescribed methadone (9,002 patients), followed by buprenorphine/naloxone (4,445 patients), and buprenorphine only (433 patients).¹⁴⁰² The medication is required to be taken daily and is largely consumed in supervised settings, although there is some provision for prescribers to permit a limited number of takeaway doses to be provided to a suitable patient (discussed in further detail below).

The process for OST involves medical practitioners (doctors and nurse practitioners) as prescribers, and pharmacists as the dispensers of each dose of OST medication. Following completion of free training, medical practitioners obtain permission from the DHHS to become authorised prescribers, and pharmacies are also required to apply to become dispensers. Since 2013, the Victorian OST policy also allows medical practitioners and nurse practitioners with a specific notation to prescribe buprenorphine/naloxone for up to five patients without undertaking the training. This reflected improved safety of the OST combination drug, buprenorphine/naloxone, as well as recognising the benefits in people receiving OST in conjunction with other medical treatment from their usual medical practitioner.¹⁴⁰³

Prescribers are expected to assess the patient's history, nature of opioid dependency, physical and mental condition and any other issues. Following a diagnosis of opioid dependency and a consideration of all treatment types (including counselling, detoxification or residential treatment), a decision may be made for a patient to be treated with OST.¹⁴⁰⁴ The prescriber must obtain a permit from the DHHS to prescribe OST medication to any individual patient, and the Department oversees these records to guard against multiple prescriptions being provided to the same person.¹⁴⁰⁵ Following this, the prescriber can begin to prescribe OST medication doses that are then dispensed through community pharmacies. The Victorian OST policy suggests that pharmacists should interview potential patients 'to ensure potential patients are fully aware of the structure and requirements' of OST, and that written agreements with patients can also be considered.¹⁴⁰⁶

As noted above, a key component of treatment for opioid dependence is psychosocial support to address a range of complex issues, such as mental health, homelessness, and unemployment, which are often experienced by this cohort of people. The Australian MATOD policy highlights the importance of such support, couple with the physiological changes brought about by the medication:

The medications eliminate withdrawal, control or eliminate cravings or block the euphoric effect of further opioid use, while psychosocial support refers to the many ways in which the psychological health and the social environment of the opioid user can be addressed, to help improve both the quality and duration of

¹⁴⁰¹ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 14.

¹⁴⁰² Australian Institute of Health and Welfare, 'National opioid pharmacotherapy statistics (NOPSAD) 2016: Data tables: Tables S1-S31 (re-release November 2017)', viewed 9 January 2018, <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-nopsad-2016/data>>, p. Table S4.

¹⁴⁰³ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 21.

¹⁴⁰⁴ Gowling, L, et al., *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth Department of Health, Canberra, 2014, pp. 10-14.

¹⁴⁰⁵ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 20.

¹⁴⁰⁶ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 50.

life. Assistance can range from the simple (e.g. provision of food and shelter) to the complex (e.g. structured psychotherapy). Psychosocial support provided as a component of MATOD should be phased and layered to reflect changing patient needs over time, with the style and content adapted to fit preparedness for change and cognitive capacity.¹⁴⁰⁷

As OST involves a number of different healthcare stakeholders, it is typically devised as a long term treatment. As it has inherent risks for patient safety, the Victorian OST policy highlights the importance of collaboration among all professionals involved with an individual's treatment:

Prescribers, pharmacists and other allied healthcare professionals each have important roles in a patient's treatment with pharmacotherapy. Good communication between all parties is essential to maximise the benefits of pharmacotherapy. Treatment goals and decisions should be discussed and agreed upon by all health professionals and with the patient. Responsibility of providing safe clinical care is shared equally among all healthcare professionals involved in the care of a patient.¹⁴⁰⁸

The Australian Institute of Health and Welfare's National opioid pharmacotherapy statistics (NOPSAD) dataset provides information about OST clients, prescribers and pharmacies on a snapshot day. While data for Victoria and the Australian Capital Territory (ACT) were not available at the time of the latest report, it indicated that numbers of people on OST across Australia remained stable with small increases. A further release of Victorian data tables (without an update to the report) showed that the number of OST clients in Victoria on the snapshot day increased between 1998 to 2015 from 5,334 clients to 14,122, and in 2016 there was a small decline to 13,880 clients.¹⁴⁰⁹ The median age of clients in 2016 across Australia was 42, which represented an increase from 38 years old in 2011. The report suggested that this increase demonstrates an ageing cohort of those on OST:

This continues the trend of an ageing cohort in opioid pharmacotherapy treatment and is consistent with the pattern observed in other drug treatment services. This may be due to:

- methadone treatment having been available for more than 40 years
- pharmacotherapy treatment reducing the risk of premature death, resulting in some clients remaining in treatment for decades
- clients seeking treatment for the first time at an older age
- an ageing cohort of injecting drug users which is strongly influenced by heroin use (people who had injected a drug in 2013 were 10 years older than they were in 2001 (their age rose from 26 to 36)).¹⁴¹⁰

¹⁴⁰⁷ Gowling, L, et al., *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth Department of Health, Canberra, 2014, p. 3.

¹⁴⁰⁸ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 21.

¹⁴⁰⁹ Australian Institute of Health and Welfare, 'National opioid pharmacotherapy statistics (NOPSAD) 2016: Data tables: Tables S1-S31 (re-release November 2017)', viewed 9 January 2018, <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-nopsad-2016/data>>, p. Table S1.

¹⁴¹⁰ Australian Institute of Health and Welfare, 'National opioid pharmacotherapy statistics (NOPSAD) 2016: Opioid pharmacotherapy clients', viewed 9 January 2018, <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-nopsad-2016/contents/opioid-pharmacotherapy-clients>>.

According to NOPSAD, the number of prescribers in Victoria increased from 803 in 2013 to 1,245 in 2016.¹⁴¹¹ In contrast to other jurisdictions, Victoria was the only jurisdiction that did not have any public prescribers, consistent with the model that places the OST program firmly within community settings through private primary care. The number of community pharmacies involved also increased from 385 in 2005-06 to 572 in 2015-16.¹⁴¹² While these figures encouragingly show increased involvement of health professionals in the OST program, the Penington Institute suggested that this does not accurately reflect the situation of accessibility of OST, particularly in regional areas:

...these headlines figures mask significant access problems, especially for people living in regional areas. On a snapshot day in 2015, 550 of Victoria's registered prescribers did not have any pharmacotherapy clients. Victoria has long had the highest average number of clients per dosing point, but a relatively low average number of clients for prescriber, suggesting difficulties in recruiting and maintaining participating pharmacies.¹⁴¹³

The latest NOPSAD 2016 data similarly reflected that 716 of the 1,445 private prescribers in Victoria did not have any clients on the snapshot day.¹⁴¹⁴

14.2.2 Improving management of the opioid substitution therapy program

A particular concern highlighted by Turning Point is that there is a lack of governance of some aspects of the OST program in Victoria, describing the current situation as a 'looming crisis.' In terms of permits granted by the DHHS, Turning Point stated in its submission that:

Permits last in perpetuity unless actively cancelled by the prescriber - at the moment there are more permits than active patients (i.e., about 20,000 permits and about 13,500 active). There is currently no active oversight of these permits, and review of their continued relevance.¹⁴¹⁵

John Ryan, CEO of the Penington Institute also indicated that current data does not readily explain the gap between the number of issued permits and those that are active:

...there is a big gap between those that are currently being dosed — being medicated — and those that are entitled to be medicated. Some of those entitled might have become abstinent and ceased treatment for that reason, but we do not know because the data is too soft. It is likely that the churn in the system is that they have dropped out of drug treatment and back into illegal drug use. That pharmacotherapy system is

¹⁴¹¹ Australian Institute of Health and Welfare, 'National opioid pharmacotherapy statistics (NOPSAD) 2016: Data tables: Tables S1-S31 (re-release November 2017)', viewed 9 January 2018, <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-nopsad-2016/data>>, p. Table S15.

¹⁴¹² Australian Institute of Health and Welfare, 'National opioid pharmacotherapy statistics (NOPSAD) 2016: Data tables: Tables S1-S31 (re-release November 2017)', viewed 9 January 2018, <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-nopsad-2016/data>>, p. Table S17.

¹⁴¹³ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 44.

¹⁴¹⁴ Australian Institute of Health and Welfare, 'National opioid pharmacotherapy statistics (NOPSAD) 2016: Data tables: Tables S1-S31 (re-release November 2017)', viewed 9 January 2018, <<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-nopsad-2016/data>>, p. Table S19.

¹⁴¹⁵ Turning Point, *Submission*, no. 116, 15 March 2017.

an enormous opportunity for much more rigorous data, because we just do not know where that 7000-odd are. But that is the scale of the problem, and I think that is a very big problem.¹⁴¹⁶

There are also a disproportionate number of permits being managed by a small number of prescribers, which itself creates risks for patient safety and demonstrates a need for more health professionals' involvement. The review of OST in 2010 noted that a small number of prescribers (13 per cent) were responsible for 73 per cent of the entire number of people on OST,¹⁴¹⁷ a point also discussed further by Turning Point in its submission:

There are no limits on doses or number of patients allowed in a single prescriber's caseload, meaning that there are a small number of prescribers who hold hundreds of permits, and others that prescribe well above current clinical guidelines. There is currently no active oversight of these practices, which potentially leaves the community at risk of iatrogenic harm, and is counter to existing evidence on best practice.¹⁴¹⁸

To address these issues, Turning Point advised the Committee that a specific unit within the Victorian Government is required to oversee and actively manage the OST program in Victoria including the handling of permits, dosing, clinical issues and reform matters. This would be similar to the approach taken in some other jurisdictions:

There is currently no statutory body overseeing pharmacotherapy in Victoria other than the Department of Health and Human Services (DHHS) Drugs and Poisons division. Unlike some States which have a dedicated alcohol and drug section of government (e.g., NSW, SA, Tas) there is no clear governance. Victoria has rested on a tired assumption that its system is superior by pointing out that states like NSW have long waiting lists for opioid maintenance treatment and that Victoria's system is cost effective and normalises treatment of opioid addiction. The reality is that Victoria does not adequately fund pharmacotherapy support services, meaning that Victoria has few GPs and pharmacists who are able to manage the number of Victorians needing opiate pharmacotherapy...¹⁴¹⁹

The Committee also heard that there is a need for the Victorian Government to improve information sharing between medical practitioners and pharmacists. The Victorian OST policy highlights the importance of strong collaboration at all stages of treatment, including at the initial stages to determine the treatment arrangements. For example, a prescriber is meant to arrange for supervised dosing of OST by contacting the relevant pharmacy and discussing the patient's needs.¹⁴²⁰ Despite these assertions and the clear need for communication about the available prescribers and dispensers to deliver OST services, the Australian Medical Association (AMA) (Victoria) discussed that coordination does not often occur in practice, and improved information sharing in a confidential manner is required. According to Dr Lorraine Baker, President:

There is poor coordination between opioid replacement therapy prescribers and pharmacists who dispense, and that would be a really good place for, if you like, confidential — within the bounds possible — disclosure to doctors who are

¹⁴¹⁶ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 9.

¹⁴¹⁷ King, T, et al., *Victorian Pharmacotherapy Review*, National Drug and Alcohol Research Centre, Sydney, 2010, p. 6.

¹⁴¹⁸ Turning Point, *Submission*, no. 116, 15 March 2017.

¹⁴¹⁹ Turning Point, *Submission*, no. 116, 15 March 2017.

¹⁴²⁰ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 22.

prescribing about the pharmacists who are dispensing and feel ready to dispense, and also for pharmacists to be aware of which GPs in their community are willing to accept patients who require opioid replacement therapy.¹⁴²¹

Dr Lorraine Baker also told the Committee that this poor coordination limits the number of doctors willing to participate in the program:

...we are aware of the number of doctors who have done opioid replacement therapy training — I have not got the statistics with me — and would be willing to do it, but it is that liaison with a pharmacist and a confidence, that exchange of information, would be very, very important. My understanding is that there is no carefully managed register that a pharmacist can contact and the doctor can. So there might be a pharmacist who would want to know which doctors in Shepparton, for instance, have done training in opioid replacement therapy, so that they could contact that doctor and say, ‘We have someone here. He or she needs ongoing prescriptions. Are you in a position to address this particular person’s need?’¹⁴²²

Dr Lorraine Baker and Frances Mirabelli, CEO of the AMA Victoria, identified that the reason for confidentiality would be to ensure coordination between the pharmacist, patient and the GP, balanced against a potential risk that being known as a prescriber in the community may result in the loss of full-paying patients.¹⁴²³ While the Committee emphasises the need not to negatively label patients who are on OST, the Committee considers it reasonable for such a register to be confidential if this would attract more health professionals to engage with the program.

Overall, the Committee agrees that governance of the OST program should be strengthened, particularly as its success lies in the ability to coordinate a system that is largely managed in private community-based settings. There is a need to increase access to OST for opioid dependent Victorians, balanced with appropriate oversight due to the nature of OST drugs as potentially harmful. To this end, establishing a dedicated unit of the Victorian Government would assist to actively manage its OST policy, including addressing the management of permits, overseeing clinical practices and dealing with any other reform areas within the OST program. As part of this, the dedicated unit should explore ways to enhance data collection in various areas, including examining the level of unmet need for OST in Victoria and establishing longitudinal data on compliance rates with treatment regimes. Given the effectiveness of OST in treating opioid dependence, such information would strengthen and complement initiatives to improve access where possible. A further key task would be to explore ways to improve collaboration and communication between participating prescribers and pharmacists, for example through the development of a confidential registry that could be accessed by local health professionals in various areas of Victoria. A dedicated unit on OST policy matters will also be important in the context of a Victorian real-time prescription monitoring system, which will require enhanced coordination and communication regarding OST matters to support people identified as requiring treatment. The real-time prescription monitoring system is discussed further in chapter 15.

¹⁴²¹ Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 257.

¹⁴²² Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 258.

¹⁴²³ Frances Mirabelli, Chief Executive Officer, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 259; Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 259.

RECOMMENDATION 31: The Victorian Government establish a dedicated arm of government to actively manage opioid substitution therapy (OST) policy in Victoria. The dedicated unit should explore options for enhanced data collection on OST, including current take-up, compliance rates, people who have ceased treatment and why. It should also explore an OST registry for general practitioners and pharmacies where they can seek information on current prescribers/dispensers in specified areas.

14.2.3 Addressing the costs of opioid substitution therapy

A key issue raised by stakeholders is the current cost for people to enter and remain on OST. Drugs used as part of OST are listed on the Pharmaceutical Benefits Scheme (PBS), with the costs of the drugs paid for by the Commonwealth Government under section 100 of the *National Health Act 1953*. However, under these arrangements, any costs incurred by community pharmacies for dispensing these drugs are not covered. People on OST are therefore charged a dispensing fee by community pharmacies each time they are provided with an OST dose.¹⁴²⁴

There are certain situations in which these fees are paid for by the Victorian Government, namely the DHHS paying for clients under 19 years of age and those on Youth Justice community orders; and the Department of Justice and Regulation paying for clients for up to 30 days post-release from prison.¹⁴²⁵ Other than these specified circumstances, clients are required to pay for any dispensing fees. The Penington Institute and Harm Reduction Victoria (HRV) advised that these fees vary between community pharmacies and can amount to between \$1800 and \$3650 per year for each patient.¹⁴²⁶ Harm Reduction Victoria further indicated such fees would represent 10 to 15 per cent of the weekly income of a client who was on government benefits.¹⁴²⁷

While not suggesting that dispensing fees are inherently unfair, the Committee notes that some stakeholders advised that these fees represent a substantial barrier for people to enter and maintain OST treatment. The Penington Institute and HRV pointed to research conducted in Victoria in 2008 which found that such fees are one of the main reasons why people discontinue treatment, and also described the fees as the ‘single greatest obstacle to retention’ in OST.¹⁴²⁸ According to the Penington Institute, this situation creates an inherent difference in the way that opioid dependence is treated compared to other medical conditions:

It is broadly accepted in Australia that ability to pay should not be a barrier to treatment in our health care system. In terms of its PBS arrangement, treatment for opioid dependence is treated differently from essentially every other health condition, raising equity issues.¹⁴²⁹

Further, John Ryan from the Penington Institute highlighted in his evidence to the Committee that there is a disturbing anomaly where it may be cheaper for people to illicitly source medication than to access OST:

¹⁴²⁴ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 28.

¹⁴²⁵ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 22.

¹⁴²⁶ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 28; Penington Institute, *Submission*, no. 209, 24 March 2017, p. 45.

¹⁴²⁷ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 28.

¹⁴²⁸ Rowe, J, *A raw deal?: impact on the health of consumers relative to the cost of pharmacotherapy*, Salvation Army, Melbourne, 2008, p. 1.

¹⁴²⁹ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 46.

It is cheaper to be on illegally prescribed pharmaceuticals than it is to be on medically assisted treatment. People who access methadone or buprenorphine, protective of their health, preventative of blood-borne viruses and preventative of overdose, are expected to pay \$5, \$7 or \$10 a day in dispensing fees to pharmacists. That is a cost barrier on people who are socio-economically disadvantaged to begin with. That generates an enormous amount of grief for those people who are trying to get on top of their drug addiction. It also generates an enormous amount of churn in and out of the treatment system. So we see people dropping out of treatment because they cannot afford their dispensing fees, going back to the illicit consumption of drugs because it is actually cheaper to hoodwink GPs and others into accessing those pharmaceuticals than it is to be on medically supervised treatment.¹⁴³⁰

Magistrate Tony Parsons of the Drug Court of Victoria further commented on the substantial costs that these fees can represent for individuals and the increased risk of crime that may result. Estimating that the dispensing fee is roughly \$35 a week, Magistrate Parsons stated:

...if people are on Newstart, which is slightly less than \$270 a week, that represents 13 per cent of their disposable income. It is too much, particularly towards the end of the two-week social security benefits cycle. Often people do not have a bean, and then if they miss their methadone, they are going into withdrawal almost straightaway, and that is really serious. That is when they will try and shoplift some expensive perfume from David Jones to flog off for \$20 so they can just get a hit to stop the withdrawal. It would be fantastic if we could find a way to provide methadone to people who need it free of charge.

It is a very, very fine treatment for heroin dependence. It is the gold standard. When people have the right dose of methadone, it not only stops them enjoying the heroin, it actually diminishes the cravings substantially. It is just a question of finding the right dose. But for people to have to pay for it and find themselves in that position on what is really scant money — if you are living on the dole, you have got to put food in the fridge, you have got to pay rent, you have got to have a myki card — it is a significant whack out of their pay. It is 13 per cent — more than one-eighth.¹⁴³¹

In terms of mechanisms to remove these cost barriers, stakeholders considered that this issue should be addressed by publicly subsidising the dispensing fees charged by community pharmacists. The Penington Institute indicated that:

Overall, there is compelling statistical, cost-benefit and empirical evidence to support a fee subsidy scheme for ORT in Victoria. Barriers to access that can be easily dismantled, and for which there is a favourable cost-benefit analysis, surely ought to be.

At present, the lack of a fee subsidy contributes more than any other factor to churn and service gaps in the system, and makes relations between clients and pharmacies unnecessarily strained, inhibiting the recruitment of additional dosing points.¹⁴³²

Given the effectiveness of OST in assisting people to deal with their opioid dependency and lead productive lives, the Committee supports enhancing as much access to this treatment as possible. The Committee agrees that the cost barriers should be removed through the introduction of a subsidy scheme to cover the dispensing fees charged by community pharmacists. Subsidising these fees will ensure that people who are ready to undertake treatment are able to do so, and also acknowledges the role played by community pharmacists and may encourage

¹⁴³⁰ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 4.

¹⁴³¹ Tony Parsons, Magistrate, Drug Court of Victoria, *Transcript of evidence*, 5 June 2017, p. 143.

¹⁴³² Penington Institute, *Submission*, no. 209, 24 March 2017, p. 46.

their wider participation. Dr John Sherman advised the Committee that a rough estimate of the cost of covering dispensing fees for 15,000 people at \$30 a week would be \$22 million per year.¹⁴³³ The Committee considers that, relative to the positive outcomes that would be achieved by attracting and retaining more people on OST, addressing this cost through a subsidised scheme would produce a broad range of net benefits for the community.

A threshold issue is whether the subsidy should be developed as a state-based scheme, funded by the Victorian Government, or funded nationally through the Commonwealth Government. If it were to be a national scheme, the Penington Institute and HRV advised that OST drugs would need to be moved from section 100 to section 85 of the *National Health Act 1953*. Under section 85, the dispensing fee would be covered and patients would be required to make a co-payment up to a threshold - lower than the estimated cost of current dispensing fees.¹⁴³⁴ While the ideal solution would be for a national scheme to be developed, the Penington Institute indicated that there has been ‘perennial inaction’ on this issue at the national level over a long period of time:

...given ORT dispensing fees are such a long-ignored issue – despite almost all stakeholders supporting a move to section 85 – the prospect of change may be low. Victoria should therefore strongly consider introducing its own system.¹⁴³⁵

Judith Abbott, Director of Community-based Health Policy and Programs and Kym Peake, Secretary at the DHHS, acknowledged that cost issues need to be addressed, noting that discussions with the Commonwealth Government are ongoing:

Ms PEAKE — Then we are continuing to work with our commonwealth colleagues, and they have taken this on board just to look at what are some of the barriers, including cost, to the prescription of this.

...

Ms ABBOTT — The commonwealth — we checked with them again a couple of weeks ago. Any time we have a face-to-face meeting we do indeed check. They were still considering it, because this is the issue of who meets the cost of the dispensing of the drugs.¹⁴³⁶

Given the importance and effectiveness of OST, the Committee believes the Victorian Government should act to address these cost barriers in the absence of any other clear pathways at this time. This could be achieved through various avenues. For example, the Penington Institute suggested that a Victorian scheme be means tested based on the possession of a Health Care Card.¹⁴³⁷ Harm Reduction Victoria suggested that, similar to New South Wales (NSW), Victoria could consider establishing public OST clinics where dispensing could occur without fee (however this would move away from the current Victorian community-based model which relies on community settings for the delivery of OST). Harm Reduction Victoria alternatively pointed to a subsidy scheme operating in the ACT where the state government partially subsidises the dispensing fee, with patients responsible for a co-payment:

¹⁴³³ Dr John Sherman, Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 289.

¹⁴³⁴ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 28; Penington Institute, *Submission*, no. 209, 24 March 2017, p. 46.

¹⁴³⁵ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 46.

¹⁴³⁶ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 324; Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 325.

¹⁴³⁷ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 46.

The ACT Government provides a subsidy of \$20 per week, paid directly to the ORT community pharmacies, and ORT consumers make an additional weekly co-payment to the pharmacist of \$15 per week, per ORT consumer, regardless of income level. This allows community pharmacies to receive remuneration of \$35 per week per ORT consumer. It has been argued that the ACT Government is able to offer such an arrangement due to the relatively small numbers of ORT consumers. Whether such a subsidised approach could work in a much larger jurisdiction such as Victoria with approximately 14,000 ORT consumers remains open to debate.¹⁴³⁸

The Committee considers that the introduction of a subsidy scheme is worthy of implementation. Based on the evidence received by the Committee, at most a full subsidy scheme would cost the Victorian Government approximately \$25 million per year, and a partial scheme (for example, through a means test or partial payment) would be less. Simultaneously to providing this subsidy, the Victorian Government should continue to advocate to the Commonwealth for the necessary legislative changes to the *National Health Act 1953* that would secure the permanent removal of cost barriers for patients, and ensure that opioid dependency is treated equally to other medical conditions.

RECOMMENDATION 32: The Victorian Government fund opioid substitution therapy (OST) dispensing fees to enhance access and remove barriers to a person entering and remaining on OST.

14.2.4 Enhancing health professionals' engagement across Victoria

Another key theme highlighted by stakeholders in relation to OST is the concern about maintaining and increasing the number of medical practitioners and community pharmacies involved with the OST program. The review of the Victorian OST program in 2010 noted the small proportion of the overall health profession that provided OST services, as less than 10 per cent of all GPs were involved in the program, and GPs involved had declined by about 15 per cent in the previous four years while OST patient numbers had increased by the same amount. Further, only 40 per cent of pharmacies were involved in OST (90 per cent of patients received their doses at pharmacies), although that number had increased by five per cent in the four years previous.¹⁴³⁹

Frances Mirabelli from the AMA Victoria outlined some of the reasons that prevent medical practitioners from participating in the OST program:

Some of our research has shown us that a lot of doctors do the training for opioid replacement but then they do not actually practise in that area. There is a whole reason for that, and that is because it is expensive to practise in that area, because people who attend drive away your fee-paying customers generally; your staff need special training on how to deal with the behaviours as they come into the door, so your receptionist needs to be a special person who can handle those behaviours as they come in; and you need extra security measures.¹⁴⁴⁰

There have been a range of efforts to improve this situation and encourage more practitioners to deliver these services in their local communities. As noted earlier, since 2013 all medical practitioners as well as nurse practitioners with a specific

¹⁴³⁸ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 32.

¹⁴³⁹ King, T, et al., *Victorian Pharmacotherapy Review*, National Drug and Alcohol Research Centre, Sydney, 2010, p. 4.

¹⁴⁴⁰ Frances Mirabelli, Chief Executive Officer, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 257.

notation have been allowed to prescribe buprenorphine/naloxone for up to five patients without completing the required training. Further, in 2014 the Victorian Government established five pharmacotherapy area-based networks (PABNs) ‘to facilitate localised approaches in connecting care, driving best practice and improving health and wellbeing outcomes for opioid dependent patients’.¹⁴⁴¹ These PABNs support health professionals to handle opioid dependency issues. cohealth outlined in its submission its role as one of the PABN operators, which focuses on increasing the number of participating medical practitioners and pharmacies:

cohealth also operates the North West Melbourne Pharmacotherapy Network (NWMPN) to support the community based Opioid Replacement Therapy (ORT) system and increase the number of GPs and pharmacists prescribing or dispensing ORT. Through the network, GPs and pharmacists currently prescribing or dispensing ORT can access individual support and advice, participate in community of practice and attend training, thereby increasing the skill and confidence for these health professional to effectively work with people who use drugs and help reduce harm. Additionally GPs and pharmacists who may be interested in prescribing and dispensing ORT can also attend the Network’s training events or access support and/or secondary consults with Addiction Medicine Specialist and Mentor GPs, thereby increasing the number of health professional in the region who are willing and able to work with PWUD [people who use drugs].¹⁴⁴²

Judith Abbott from the DHHS noted that, contrary to previous concerns about reduced numbers of participating medical practitioners, the PABNs have contributed to some increases:

We are actually not seeing a decline at the moment. So through the networks we have seen some increase in numbers, because they are out there actively dealing with — if there is a problem locally and we become aware of a problem, one of their tasks is to look at who else could prescribe or dispense, engage with those practitioners, encourage them to consider doing the training and doing that, so we are not seeing a decline.¹⁴⁴³

The Committee supports the Victorian Government’s investment in establishing the PABNs, and encourages such networks to continue to affect cultural change within the medical profession. Coupled with efforts to ensure adequate numbers and representation of prescribers across Victoria is the serious concern about the current cohort of prescribers ageing. This will result in a further shortage of prescribers once they retire, if they are not replaced. These concerns were acknowledged by Kym Peake, Secretary of the DHHS, and raised by stakeholders.¹⁴⁴⁴ According to HRV’s submission:

A growing problem for the ORT program in Victoria is the decreasing number of new prescribers entering the program, particularly as some of Victoria’s most established and experienced GP prescribers, many with very large client loads, reach retirement age and leave the system.¹⁴⁴⁵

¹⁴⁴¹ Department of Health and Human Services, *Victorian Pharmacotherapy Area-Based Networks*, Melbourne, 2017.

¹⁴⁴² cohealth, *Submission*, no. 140, 16 March 2017.

¹⁴⁴³ Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 325.

¹⁴⁴⁴ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, pp. 324-325.

¹⁴⁴⁵ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 30.

The Committee is cognisant that the implementation of the Victorian real-time prescription monitoring system (RTPM) in 2018 is also likely to have an impact on the number of people requiring OST, meaning that a continued focus on increasing the numbers of participating medical practitioners across all parts of the State will be important (see chapter 15 for further details regarding the RTPM system).

Given these complex and compounding issues, the Committee considers that a number of strategies suggested by stakeholders should be explored to enhance access to OST in Victoria.

According to Associate Professor Dr Nadine Ezard, there is a need to enhance the capacity of GPs to deal with opioid dependency through training and strong referral networks:

The mortality rate in an opioid-using population is far higher than a non-opioid-using population.

So rightfully, doctors are afraid to work in that setting if they don't feel adequately skilled, so we do need to provide the referral networks, we need to provide the training support and we need to expand access in a primary level to some of the other medications that are not methadone but other opioid treatments.¹⁴⁴⁶

Stakeholders also commented on the need to address the high level of negative labelling associated with opioid dependency within the medical profession, as described in chapter five of this report. Dr Lorraine Baker of the AMA Victoria acknowledged this issue, while noting the difficult circumstances that often accompany patients requiring OST, and the need for further resources:

I simply also want to be on the record to say that a lot of what we are saying sounds like we are stigmatising a group of people. I want to acknowledge that much of this behaviour comes from a background of significant social disadvantage, poor education, and social alienation, and we are conscious of that. So these people, if we want to deliver that absolute best possible care to them, as the leader, if you like, of a treatment team, as doctors, we are aware of the resources that are required and very frustrated that we cannot obtain for them the best possible help, which cannot be all medically based.¹⁴⁴⁷

Judith Abbott highlighted that one of the key roles of the PABNs is to reduce negative labelling:

One of the biggest challenges we have got is actually that what we hear is that the biggest barrier to people doing pharmacotherapy, the practitioners, is often the stigma of having people in their consulting room or in their pharmacy who are on methadone. It is a very good example of where the stigma associated with illicit drug use is very high. A lot of the work the networks do is connecting with people about how you can do that as a practitioner safely and comfortably without a downside for your clients. We are not hearing supply of GPs as much of an issue. Surely for small rural it is a challenge for everybody, but that piece we hear more commonly is about how you get practitioners comfortable with the idea of it.¹⁴⁴⁸

¹⁴⁴⁶ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 124.

¹⁴⁴⁷ Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 259.

¹⁴⁴⁸ Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 325.

On this issue, the Committee notes that HRV indicated that training should also be provided to assist improve attitudes among health professionals towards people with opioid dependency issues.¹⁴⁴⁹ As recommended in chapter five, Victorian Government guidelines on the use of appropriate, objective and non-judgmental language regarding substance use issues would be a useful starting point for such training.

Another strategy put forward is to incentivise the provision of OST services by medical practitioners and pharmacies.¹⁴⁵⁰ In relation to GPs, Frances Mirabelli from the AMA Victoria suggested that prescribers should be funded and supported to provide OST as a service to the community.¹⁴⁵¹ Dr John Sherman similarly considered that doctors should be adequately remunerated for providing treatment, and that there should be a review of fees to introduce a Medicare Item Number for the treatment of addiction.¹⁴⁵² Regarding pharmacies, the NSW Ministry of Health funds a Pharmacy Incentive Scheme to support community pharmacies involved with the OST program. Under the Scheme, registered pharmacies receive an introductory payment as well as \$110 per capita twice a year for patients being managed continuously for two months (a cap of 20 patients).¹⁴⁵³ The Committee considers that the Victorian Government should support similar incentives for both prescribers and pharmacies to maintain and enhance participation rates.

While not discussed in detail by stakeholders, expanding the role of nurse practitioners in OST provision is also a key area for further exploration. The Department of Health and Human Services briefly noted that such issues are currently being considered.¹⁴⁵⁴

The Committee believes that the role of emergency departments as a potential setting for the provision of OST should also be explored. Alfred Health indicated in its submission that there is a 'lost opportunity' currently where hospitals have limited options for assisting patients to deal with drug-related harms. It suggested that there is a possible role for emergency departments to supply the OST drug buprenorphine, where appropriate, as part of a person's emergency department treatment.¹⁴⁵⁵ The submission also highlighted a 2015 study in the United States (US), which found that, compared to providing only brief interventions and referrals to treatment, emergency department-initiated buprenorphine resulted in significant increases in a patient's involvement in formal treatment, reductions in self-reported use of heroin, and reductions in the use of inpatient treatment services. However, it did not find decreases in positive urine tests or risk of HIV, and recommended further research be undertaken.¹⁴⁵⁶

The Victorian OST policy discusses the provision of OST in hospitals only in terms of continuing OST treatment that has already been initiated.¹⁴⁵⁷ However, based on the above evidence, research in this area is required in an Australian context.

¹⁴⁴⁹ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 30.

¹⁴⁵⁰ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 32.

¹⁴⁵¹ Frances Mirabelli, Chief Executive Officer, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 259.

¹⁴⁵² Dr John Sherman, *Submission*, no. 145, 17 March 2017.

¹⁴⁵³ The Pharmacy Guild of Australia, 'Program Incentives', viewed 9 January 2018, <<https://www.guild.org.au/guild-branches/nsw/professional-services/pharmacy-incentive-scheme/information-program-incentives>>.

¹⁴⁵⁴ Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 331.

¹⁴⁵⁵ Alfred Health, *Submission*, no. 173, 17 March 2017, p. 21.

¹⁴⁵⁶ D'Onofrio, G, et al., 'Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial', *AMA Journal of Ethics*, vol. 313, no. 16, 2015.

¹⁴⁵⁷ Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, p. 25.

In particular, the potential for emergency departments to initiate treatment and provide ongoing referrals could be a further source to expand the provision of OST in appropriate cases.

During the Committee's overseas study tour, it also heard of efforts in Portugal to lower the thresholds for access to OST. For example, the Portuguese NGO, Piaget Agency for Development (APDES), manages an outreach bus service that provides methadone to typically 80 people per day. Registration with the service is not required to start receiving methadone, although people are often more willing to share their personal information once they have established a relationship with the outreach workers.¹⁴⁵⁸

As previously outlined, there are two specialist support services for health professionals in this area – the Drug and Alcohol Clinical Advisory Service (DACAS) and the Pharmacotherapy, Advocacy, Mediation and Support (PAMS) service. Turning Point, which operates DACAS, highlighted in its submission that it is currently unable to meet the demand for this highly valued service, and outlined its expectation that demand will grow with the implementation of the RTPM system:

This service is widely utilised given the significant shortage of addiction medicine positions across the state, but is limited in its capacity to offer clinical consultations to patients in need of specialist assessment. With the introduction of real time prescribing, calls to this service are likely to grow substantially, and there is an urgent need to consider the capacity of the service to meet the expanded volume of calls.¹⁴⁵⁹

Similarly, HRV advised the Committee that its PAMS service is essential in increasing professional participation in the OST program, but operates with little funding:

PAMS is a state-wide, telephone service which addresses any Victorian ORT related issue or concern. Over the last 16 years, PAMS has grown from a complaints-resolution service into its current form, which focuses on increasing access to and retaining current consumers in ORT treatment. PAMS also supports service providers to continue prescribing and dispensing ORT, especially with complex clients or when complex client related problems arise. The results achieved by PAMS' intervention constitute win/win outcomes which benefit all parties.

Despite its unique and vital role, PAMS is extremely under-resourced with only 1.5 funded workers. Currently, the service is funded to manage a client case-load of 35 cases per month. In the 2015/16 financial year, PAMS managed a total of 964 cases at an average of 81.3 cases per month. To date, in 2016/17, PAMS has already managed a total of 663 cases at an average of 55.2 cases per month. The need for greater resourcing for PAMS is urgent and will not only improve the responsiveness of PAMS itself, but will also encourage GPs and pharmacies to the participate in the program due to the assistance it provides in managing complex client issues.¹⁴⁶⁰

The Committee considers that these services should be enhanced to ensure there are strong support systems in place, which will encourage health professionals to participate in the OST program.

The Australian Medical Association Victoria suggested that the Victorian Government consider establishing public OST clinics, particularly in regional areas, to provide a range of related services to patients such as OST prescription and dispensing,

¹⁴⁵⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 18-19.

¹⁴⁵⁹ Turning Point, *Submission*, no. 116, 15 March 2017.

¹⁴⁶⁰ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 31.

addiction specialist services, mental health services and other supports.¹⁴⁶¹ This proposal was discussed further in chapter 12 and incorporated into recommendation 27. The Committee also notes that consideration of this issue would also need to be balanced against the Victorian Government's emphasis on community-based OST services.

All of these strategies should be considered by the Victorian Government as part of a concerted effort to enhance uptake of OST in Victoria. These strategies would also be particularly important in the context of an opioid overdose prevention strategy in the event of an opioid crisis, as discussed in chapter 17. In such an event, the immediate removal of the cost barriers for accessing OST should be a strong priority.

RECOMMENDATION 33: The Victorian Government expand access to opioid substitution therapy (OST) through a range of measures including:

- the provision of financial incentives to medical practitioners and pharmacists to prescribe OST, particularly as the current cohort of prescribing doctors is ageing and a shortage is expected
- enhancing the role of nurse practitioners to prescribe OST
- exploring models for hospitals to provide OST to suitable patients as part of emergency department treatment.

Takeaway doses

A related issue that deserves mention is the recent change to the Victorian OST policy regarding takeaway doses of OST drugs. Under the policy, prescribers can assess whether some people might be suitable to receive takeaway doses, to be used outside of supervised settings, based on criteria such as whether a patient has demonstrated consistent adherence to the treatment regime; has not continued with illicit drug use or use of other drugs; is unlikely to sell their doses; and is unlikely to place others at risk of accidental poisoning (such as children). The client must also demonstrate a reasonable need to access takeaway doses, such as work, study or travel commitments, and the pharmacist involved in the patient's treatment should also be consulted.¹⁴⁶²

Judge Sarah Hinchey, State Coroner of Victoria, advised the Committee that, while the Coroners Court supports OST, a number of overdoses have resulted from takeaway doses, including of children through accidental poisoning:

...methadone is a very dangerous drug and coroners see many overdose deaths involving misuse of takeaway methadone. Tragically since 2010 these have included the deaths of seven children aged under 18, who overdosed on methadone that was not prescribed to them. The question which Victorian coroners have therefore been grappling with for the past decade is: how can the benefits of methadone maintenance therapy be maximised while its risks are minimised?¹⁴⁶³

Following such concerns, in 2016 the DHHS reduced the number of takeaway doses allowed from five per week to four per week. While this change was supported by the Coroners Court, some stakeholders indicated that it has had a negative impact

¹⁴⁶¹ Australian Medical Association, *Submission*, no. 203, 20 March 2017, p. 3.

¹⁴⁶² Department of Health and Human Services, *Policy for maintenance pharmacotherapy for opioid dependence*, State Government of Victoria, Melbourne, 2017, pp. 28-39.

¹⁴⁶³ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 14.

on OST patients. In particular, Paul Dietze, Director of Behaviours and Health Risks Program at the Burnet Institute, advised it limits people's capacity to stay on OST, and suggested instead that this concern would be better addressed by educating clients about how to safely secure and store their doses to ensure there is no misuse.¹⁴⁶⁴ Sarah Lord, Program Manager of PAMS at HRV indicated that reducing the number of allowed takeaway doses has had practical implications for clients:

...having to get into a pharmacy three days a week, particularly for people who are working full time, is really difficult, and if you are having to travel considerable distances, which a lot of people in the rural and regional areas are, then you have got that additional cost of the petrol and transport.¹⁴⁶⁵

As indicated, the Committee is supportive of measures to attract and retain as many people as possible on the OST program. However, there is also a need to balance this against the risks involved with opioid medication. In this context, the Committee considers there is a need to closely monitor the impact of this policy change, particularly regarding whether it results in decreased methadone overdose deaths, and whether it affects the retention rates of people on OST.

14.3 Expanding opioid substitution therapy options

Heroin-assisted treatment (HAT), also referred to as supervised injectable heroin (SIH), is another form of medication assisted treatment for heroin dependency, albeit a more controversial one, that is used in some overseas jurisdictions. It involves the prescription and strict clinically-supervised consumption of pharmaceutical-grade heroin (diacetylmorphine or diamorphine) by people with opioid dependency. The topic of HAT has long been politically sensitive in Australia, with numerous recommendations for a trial of HAT over 30 years having been rejected or ignored (see section 14.3.2). Despite these obstacles, the Committee considers there is now a strong evidence base supporting the use of HAT in very limited circumstances, largely developed through trials conducted in European countries.

While the aims of HAT are similar to that of OST – namely to reduce the use of illicit 'street' heroin and criminal activity, improve peoples' health and wellbeing, and encourage social integration – HAT is aimed solely at a small cohort of people with chronic opioid dependency issues who have failed to respond to OST and other types of treatment, thus requiring a more intensive service:

Thus, the typical patient population considered for SIH will be those with a long-standing history of injectable heroin use and an entrenched addiction, with major physical and social complications and who are treatment refractory. In many instances, these patients may have been considered as 'heartsink patients' and will often have had previous extensive involvement with the criminal justice system and prison, as well as diverse treatment and rehabilitation agencies.¹⁴⁶⁶

As Dr Alex Wodak AM, Director of Australia21 and President of the Australian Drug Law Reform Foundation (ADLRF) told the Committee:

¹⁴⁶⁴ Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 37.

¹⁴⁶⁵ Sarah Lord, Program Manager, Pharmacotherapy Advice and Mediation Service, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 70.

¹⁴⁶⁶ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 161.

They have to have severe dependence and they have to have tried and not benefited from all the other treatments available - so-called treatment refractory people. Those people are particularly important. They're a small minority but they're using prodigious quantities of heroin.

They're accounting for a disproportionate share of the crime committed in the community and presumably also doing a disproportionate share of the recruitment of novice users, so taking those people out of the market and putting them into some kind of treatment is good for them, very good for the community.¹⁴⁶⁷

The prescription of pharmaceutical-grade heroin has been historically used in the treatment of opioid dependency at various points during the 1900s in some jurisdictions (namely the US and the United Kingdom). However, the current model of HAT has been developed and trialled in a range of European countries since the 1990s, particularly in Switzerland.

Regarding the status of HAT in the context of international drug control conventions, it is noted that:

At the international level, the 1961 and 1971 UN conventions contain no explicit regulations concerning the prescribing of diamorphine (heroin) in the context of substitution treatment provision, leaving it to the competence of national governments to regulate in this area.¹⁴⁶⁸

While the International Narcotics Control Board (INCB) has been opposed to the development of HAT approaches in the past, particularly in Switzerland, other international bodies have been less critical. The World Health Organization, when analysing the results of the Swiss trial of HAT in 1999, 'confirmed the positive findings' while taking issue with some of the trial's design features.¹⁴⁶⁹ More recently, UNAIDS suggested that approaches such as HAT 'may deliver important benefits to the most marginalized and severely dependent people who inject drugs' and recommended further exploration of this.¹⁴⁷⁰

There are two key features of the current HAT approach. First, HAT is used only as a second-line treatment where patients have not responded to other forms of treatment, reflected in the fact that in 2011 only 0.5 per cent of patients in substitution treatments across Europe were on HAT (2,500 patients), and in countries where HAT had been well-established (such as Switzerland), the rates were stable at about five to eight per cent of all patients in substitution treatments.¹⁴⁷¹ Secondly, all injectable doses are taken by patients under direct medical supervision in clinical settings (i.e. - no takeaway doses are allowed, unlike in OST programs) to ensure appropriate patient safety and monitoring, and to prevent adverse outcomes such as the possible diversion of prescribed heroin into the illicit market.¹⁴⁷² It is also important to note

¹⁴⁶⁷ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 89.

¹⁴⁶⁸ Strang, J, et al., 'Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction', *The British Journal of Psychiatry*, vol. 207, no. 1, 2015, p. 10.

¹⁴⁶⁹ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 29.

¹⁴⁷⁰ UNAIDS, *Do No Harm: Health, Human Rights and People Who Use Drugs*, Geneva, 2016, p. 3.

¹⁴⁷¹ Strang, J, et al., *EMCDDA Insights: New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 162.

¹⁴⁷² Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, pp. 11-12.

that the prescription of pharmaceutical-grade heroin is seen as only one aspect of the treatment that equally encompasses broader support for patients in areas such as family relationships, criminal matters, debt, addressing other health issues, and rehabilitation.¹⁴⁷³

A 2012 report by Strang et al, *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, published by the European Monitoring Centre for Drugs and Drug Addiction (2012 EMCDDA report), compiled evidence from robust randomised controlled HAT trials conducted in six countries (Switzerland, the Netherlands, Spain, Germany, Canada and England) over 15 years and involved more than 1,500 patients.¹⁴⁷⁴ Each country developed its own rules regarding entry onto HAT, such as minimum age requirements, the minimum duration of heroin dependency, demonstration of previous attempts with other treatment and agreeing to comply with regulations of the service. The primary aim of the trials was to consider whether HAT offered a superior form of treatment than standard OST (for example, methadone) for this particular cohort of long-term, severely dependent opioid users.

The trials generally found that HAT resulted in substantial improvements for patients' health and wellbeing in comparison with oral methadone treatment, including significant reductions in use of illicit heroin, and improved general health, psychological and social outcomes. It also significantly reduced patients' involvement in criminal activity, and had good rates of retention in treatment. The risks involved with HAT, such as mortality, were higher than for methadone and thus required a greater level of precautions to be taken and a focus on security measures. Therefore, the cost of HAT was significantly higher than the cost of methadone treatment (€12,700–20,400 per patient per year compared with €1,600–3,500). However, HAT was still considered to be effective when considering the cost savings associated with reduced criminal activity (for example, the UK HAT cost of €18,300 per year was much lower than imprisonment costs of €50,400 per year). The report concluded that HAT was a 'useful addition' to treatment, however, noted it alone would not address concerns generally associated with chronic heroin use.¹⁴⁷⁵

A 2015 article by Strang et al reported on a systemic review and meta-analysis of HAT trials and similarly concluded that:

SIH is found to be an effective way of treating heroin dependence refractory to standard treatment. SIH may be less safe than MMT [methadone maintenance treatment] and therefore requires more clinical attention to manage greater safety issues. This intensive intervention is for a patient population previously considered unresponsive to treatment. Inclusion of this low-volume, high-intensity treatment can now improve the impact of comprehensive healthcare provision.¹⁴⁷⁶

¹⁴⁷³ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 162.

¹⁴⁷⁴ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 12.

¹⁴⁷⁵ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, pp. 161-162.

¹⁴⁷⁶ Strang, J, et al., 'Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction', *The British Journal of Psychiatry*, vol. 207, no. 1, 2015, p. 5.

Various stakeholders referred to the overseas evidence as providing a strong scientific and medical evidence base for HAT.¹⁴⁷⁷ Harm Reduction Victoria's submission referred to the 'consistently impressive results' of HAT compared to methadone for this group of people, and highlighted that positive outcomes included:

- access to heroin in controlled clinical settings;
- reduction in heroin related harms eg overdose and virus transmission;
- substantial reduction in use of street heroin;
- substantial reduction and/or cessation in (property) crime;
- higher treatment retention rate;
- reduced need to sell to other users to support habit;
- improvements in health and social functioning;
- no indication heroin has leaked from the facilities onto the black market; and
- treatment has not led to an increase in the number of persons experimenting with heroin.¹⁴⁷⁸

14.3.1 Insights from the Committee's overseas study tour

During its overseas study tour, the Committee travelled to Switzerland, the UK and Canada and gained insights regarding the use of HAT in those countries. They had all developed well-functioning and strongly regulated HAT programs that prioritised safety and ensured that the program applied only to a targeted cohort of people with severe opioid dependency issues. None of the programs, operating in controlled medical environments, reported any significant negative outcomes that would provoke cause for concern. In fact, it was clear that the programs resulted in a range of positive benefits for individual patients and the broader community.

Switzerland

Switzerland is a pioneer in developing the current HAT model globally, and is likely the most well-known example of a successful HAT model.

In response to the rise of injecting heroin use in Switzerland in the 1990s, the first HAT clinics opened for a three-year trial beginning in 1994 under the approval of federal authorities. The trial was extended in 1997 to allow it to capture 15 per cent of heroin users in Switzerland (estimated to be approximately 30,000 heroin users). Key outcomes from the trials included: improved health and wellbeing for patients; demonstrated ability for doses to be stabilised within two or three months rather than needing to be continually increased; reductions in illicit heroin and cocaine use; reductions in criminal activity, amounting to more than the costs of HAT; no diversion of pharmaceutical-grade heroin to illicit markets; and increases in the rates of people undertaking other treatments such as methadone.¹⁴⁷⁹ A study on cost effectiveness confirmed that, while HAT is an expensive treatment, it resulted in

¹⁴⁷⁷ 360Edge, *Submission*, no. 229, 4 September 2017; Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017; cohealth, *Submission*, no. 140, 16 March 2017; Penington Institute, *Submission*, no. 209, 24 March 2017, pp. 33-34; Unharm, *Submission*, no. 182, 17 March 2017, pp. 25-26; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 14; Yarra Drug and Health Forum, *Submission*, no. 107, 14 March 2017, p. 8.

¹⁴⁷⁸ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 26.

¹⁴⁷⁹ Transform, *Heroin-assisted treatment in Switzerland: successfully regulating the supply and use of a high-risk injectable drug*, Bristol, 2017, p. 3.

an annual socio-economic benefit of €13,096 when considering societal benefits of reduced housing and criminal justice system costs, and increased productivity and health.¹⁴⁸⁰

A longer-term study of HAT in Switzerland in 2001 found high retention rates of patients in treatment (86 per cent for at least three months, 70 per cent for at least one year, 50 per cent for at least two and a half years, and 34 per cent for five years or longer), as well as reductions in heroin, cocaine and benzodiazepine use. Patients also continued to experience a range of health and social benefits such as reductions in health conditions, homelessness, unemployment, debts and illicit income. It also found that 29 per cent of those discharged from HAT switched to an abstinence-based program after three years of treatment. A six-year follow up study found that those still on HAT had reduced rates of daily heroin use compared with those that had dropped out.¹⁴⁸¹

Following a successful national referendum in 2008, HAT was approved as a permanent service in Swiss drug treatment, and is now available throughout the country.¹⁴⁸² HAT as an established treatment mode is supported by all the appropriate formal supports, namely ‘a definite legal basis, funding by health insurance and additional local sources, a well-established clinical practice and a monitoring system’.¹⁴⁸³

The Committee met with Professor Dr Daniele Zullino, Head of Division of the University Hospital of Geneva (HUG) Addictology Services, which provides the only HAT service in Geneva. The Committee observed a well-organised operation that focused on medically treating patients’ severe opioid dependency in the most secure and appropriate way possible. Patients visit the clinic once or twice a day to take their supervised doses, and are connected to a wide range of other support services to assist them improve their lives. The Committee was made aware of the strict entry criteria to the HAT program including a minimum age of 18 years, a minimum opioid dependency duration of two years, a minimum of two previous failed treatment attempts and a requirement to hand over driving licences while on the program. These criteria demonstrated that HAT is restricted to only the most severe cases of opioid dependency, while the bulk of people are directed to standard OST programs. The Committee was told of a range of personal benefits experienced by patients on HAT, including that 30 per cent of patients are employed and 100 per cent are no longer involved in the criminal justice system. Such programs have also contributed to a decrease in injecting drug use in Switzerland.¹⁴⁸⁴

The Committee also received evidence from stakeholders about the benefits of the Swiss HAT approach. According to Dr Alex Wodak AM of the ADLRF:

¹⁴⁸⁰ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, pp. 84-85.

¹⁴⁸¹ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, pp. 66-67.

¹⁴⁸² Transform, *Heroin-assisted treatment in Switzerland: successfully regulating the supply and use of a high-risk injectable drug*, Bristol, 2017, p. 4.

¹⁴⁸³ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 109.

¹⁴⁸⁴ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 10.

Switzerland went ahead with their trial and they now have this treatment for about 1,000 Swiss people, spread throughout the country, and we can see that the Swiss epidemic of heroin use declined significantly during the 1990s and early 2000s after prescription heroin was introduced.¹⁴⁸⁵

Greg Denham, Executive Officer of the Yarra Drug and Health Forum (YDHF) noted the role of HAT as part of a wider strategy in Switzerland to treat heroin issues through a health-based framework:

...if you look at Switzerland and the holistic approach towards heroin use, they have taken heroin and completely changed the culture and the way in which they see heroin, particularly in terms of the number of different programs they have got that really push it very much into a medical issue, very much into, 'Okay, if you're heroin dependent, we'll look at heroin prescribing, we'll look at comprehensive programs about opiate substitution, we'll look at injecting facilities to get you into those programs'. So it really has had a significant impact, and my understanding is that heroin use in Switzerland has declined significantly over a number of years.¹⁴⁸⁶

William Bush, President of Families and Friends for Drug Law Reform (FFDLR) also cited a range of evidence in support of Switzerland's model, such as reductions in the commission of serious property offences, increases in employment, improved stable living conditions and cost savings to the community.¹⁴⁸⁷

United Kingdom

According to the 2012 EMCDDA report, the prescription of heroin has been available as a treatment option in the UK for the past 80 years. Historically, the right of doctors to prescribe opioids (including heroin) for dependency issues was established in a 1926 report, allowing doctors to legally prescribe heroin for unsupervised use outside of clinical settings. However, restrictions in the late 1960s requiring doctors to obtain licences meant that in practice this treatment option became rarely used (even though it remained legal).¹⁴⁸⁸

Following positive results from HAT trials in other European countries (such as Switzerland) in the 2000s, the UK Government supported a local trial of HAT with two key differences from the previous use of HAT to align with developing European approaches – it would be delivered in clinical settings (rather than unsupervised takeaway doses) and would be used only for patients that had not responded to other treatment modes.¹⁴⁸⁹ Under the trial, three supervised injecting clinics were established, and entry criteria for the trial included age limits between 18 and 65, a minimum duration of opioid dependency of three years, regular injecting heroin use, no other active significant medical or psychiatric conditions, and no alcohol or benzodiazepine misuse concerns.¹⁴⁹⁰

¹⁴⁸⁵ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 89.

¹⁴⁸⁶ Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 46.

¹⁴⁸⁷ William Bush, President, Families and Friends for Drug Law Reform, *Transcript of evidence*, 18 September 2017, p. 387.

¹⁴⁸⁸ Strang, J, et al., *EMCDDA Insights: New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 137.

¹⁴⁸⁹ Strang, J, et al., *EMCDDA Insights: New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, pp. 135-136.

¹⁴⁹⁰ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, pp. 141-142.

The trial showed HAT produced similar results to methadone in terms of retention in treatment, but significantly lower rates of illicit heroin use compared to those on methadone. The 2012 EMCDDA report stated that the HAT clinics were shown to 'be feasible and effective', and suggested expanding them to increase utilisation of HAT among this cohort.¹⁴⁹¹ A further study, while finding that there were no major differences in secondary outcomes such as other drug use, crime, health or social outcomes compared to methadone treatment, showed that those on HAT spent less money on illicit drugs compared to those on methadone treatment.¹⁴⁹²

In 2016, the UK's Advisory Council on the Misuse of Drugs issued a report, *Reducing Opioid-Related Deaths in the UK*, which highlighted HAT's positive outcomes such as reducing the use of illicit heroin, reduced rates of opioid-related deaths and cost-effectiveness. However, it also reported that central funding for the HAT clinics ended in 2015, and recommended that such funding be re-established.¹⁴⁹³ As part of the overseas study tour, the Committee met with representatives of the Drug and Alcohol Unit of the UK's Home Office and discussed these funding issues. The representatives informed the Committee that decentralisation of all alcohol and drug services meant that local areas are now responsible for determining local community priorities and responses. The local clinics offering HAT ended the programs as they could no longer justify the cost in their existing restrained budgets. The Committee is aware, however, that while funding is no longer centrally available, clinical guidelines published by the Department of Health in July 2017 continue to refer to the benefits of HAT.¹⁴⁹⁴ The guidelines particularly noted the range of reviews that found it a valuable and cost-effective treatment, with improved outcomes that cannot be achieved with OST for this group of people.¹⁴⁹⁵

Canada

Canada has undertaken the only trials of HAT in North America, which has been accompanied with fluctuating support from federal authorities.

Following successful trials of HAT in Switzerland, Canada carried out the North American Opiate Medication Initiative (NAOMI) from 2005-2008 to study the benefits of HAT over OST for long-term chronic opioid dependent people. The trial registered a range of positive outcomes including:

- improved physical and mental health for patients
- higher rates of patients remaining in HAT than methadone treatment (88 per cent compared to 54 per cent)
- patients in HAT were 40 per cent less likely to use illicit heroin and engage in criminal activities to support their illicit heroin purchases than patients in methadone treatment

¹⁴⁹¹ Strang, J, et al., *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, European Monitoring Centre for Drugs and Drug Addiction, Luxembourg, 2012, p. 144.

¹⁴⁹² Metrebian, N, et al., 'Drug use, health and social outcomes of hard-to-treat heroin addicts receiving supervised injectable opiate treatment: secondary outcomes from the Randomized Injectable Opioid Treatment Trial (RIOTT)', *Addiction*, vol. 110, no. 3, 2015.

¹⁴⁹³ *Reducing Opioid-Related Deaths in the UK*, Advisory Council on the Misuse of Drugs, London, 2016, pp. 33-34.

¹⁴⁹⁴ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 30.

¹⁴⁹⁵ Home Office, *Drug misuse and dependence: UK guidelines on clinical management*, UK Government, London, 2017, pp. 113-114.

- patients on HAT also moved into other treatment programs including OST and abstinence-based treatment.¹⁴⁹⁶

At the end of NAOMI trial, a new Canadian government did not support the program and trial doctors were unable to gain approval to continue to treat patients with pharmaceutical-grade heroin.

In order to continue work in this area, the Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) was conducted from 2011-2015, and focused on comparing the effectiveness of pharmaceutical-grade heroin with a legal pain medication called hydromorphone (HDM). The researchers suggested that, if HDM was as effective as pharmaceutical-grade heroin, it could be used in situations where there are legal barriers and stigma associated with medical heroin. The study found that HDM was equivalent to pharmaceutical-grade heroin, and could be used as another treatment option for this patient group.¹⁴⁹⁷

As patients were exiting the SALOME study in 2013, applications to federal authorities to continue access to HAT under a special access program (SAP) were approved by Health Canada in September. However, in October, the federal government announced regulatory changes to make heroin a drug that could not be approved under the SAP, with a message from the Minister of Health to ‘stop giving heroin to addicts’.¹⁴⁹⁸ A Supreme Court challenge was launched against these regulatory changes on the basis that they infringed the Canadian Charter of Rights and Freedoms. A temporary injunction was granted in 2014 while the matter was proceeding.

A new federal government elected in 2015 again changed the landscape of HAT, particularly recognising the value of HAT as a response to the opioid crisis in Canada. In September 2016, the SAP regulations were restored so that HAT was available again, thus removing the need for the Supreme Court matter. Further, the government announced changes to allow for the bulk importation of pharmaceutical-grade heroin where needed for public health reasons, as well as to remove barriers for access to HAT in appropriately controlled circumstances.¹⁴⁹⁹ In October 2017, the British Columbia Centre on Substance Use published guidelines, *Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder*, to establish clinical practices for prescribing HAT (whether through pharmaceutical-grade heroin or HDM). The guidelines focus on ensuring patient safety and reducing risks of any adverse events during treatment such as overdose, as well as assisting patients to engage in achieving therapeutic goals of treatment.¹⁵⁰⁰ Further, the guidelines focus primarily on the use of hydromorphone as a treatment for opioid dependence, noting the studies that found it produces similar results to pharmaceutical-grade heroin, and also because ‘hydromorphone does not face the same regulatory challenges as diacetylmorphine and faces few barriers to rapidly scaling up treatment’.¹⁵⁰¹

¹⁴⁹⁶ Providence Health Care, ‘SALOME Clinical Trial Questions and Answers’, viewed 9 January 2018, <<http://www.providencehealthcare.org/salome/faqs.html>>.

¹⁴⁹⁷ Providence Health Care, ‘SALOME Clinical Trial Questions and Answers’, viewed 9 January 2018, <<http://www.providencehealthcare.org/salome/faqs.html>>; Providence Health Care, ‘About SALOME’, viewed 29 January 2018, <<http://www.providencehealthcare.org/salome/about-us.html>>.

¹⁴⁹⁸ Boyd, S, et al., ‘Telling our stories: heroin-assisted treatment and SNAP activism in the Downtown Eastside of Vancouver’, *Harm Reduction Journal*, vol. 14, no. 27, 2017.

¹⁴⁹⁹ Boyd, S, et al., ‘Telling our stories: heroin-assisted treatment and SNAP activism in the Downtown Eastside of Vancouver’, *Harm Reduction Journal*, vol. 14, no. 27, 2017.

¹⁵⁰⁰ British Columbia Centre on Substance Use, ‘Provincial guidelines for injectable opioid treatments released’, viewed 9 January 2018, <<http://www.bccsu.ca/news-release/provincial-guidelines-for-injectable-opioid-treatments-released/>>.

¹⁵⁰¹ British Columbia Centre on Substance Use and Ministry of Health, *Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder*, Vancouver, 2017, p. 13.

While in Vancouver, the Committee was told by many stakeholders of the need to expand HAT as widely as possible to target this group of chronic opioid users, particularly as a key strategy to tackle the unprecedented opioid crisis taking hold across the country. The Committee also had the opportunity to visit the Crosstown clinic in Downtown Eastside Vancouver and meet with Dr Scott McDonald, who had been involved with two HAT trials. He advised the Committee that the program currently comprises 120 clients but this number should increase once the clinic had been expanded. The most striking factor was the support of the Vancouver Police Department to expand access to HAT as a mechanism to reduce crime levels associated with the illicit heroin market, and to save peoples' lives. Staff Sergeant Mark Horlsey highlighted in particular that there are never any police call outs to the clinic, and the cost savings of individuals no longer having involvement in criminal activities while on HAT was significant.¹⁵⁰²

Having observed firsthand the crisis unfolding in Vancouver, the Committee gained a greater understanding of the benefits of a HAT program, both for individuals and the broader community. In particular, it enables provision of a safe product in controlled medical environments where there are no other viable options available. Heroin-assisted treatment is one of the most important strategies in Vancouver because the majority of people dying from illicit drug overdoses do so alone in private homes and residences. Whereas HAT allows people to be effectively guarded against such overdoses, rather than accessing fentanyl-laced heroin from the illicit market.

14.3.2 Proposal for a Victorian trial

Given the strong evidence base to support the effectiveness of HAT, as well as the Committee's experiences firsthand in observing these programs overseas, the Committee is supportive of the Victorian Government to conduct a trial to ascertain whether these same benefits can be replicated in Victoria for the small cohort of long-term opioid dependent users who have not responded to other treatment types. The Committee particularly considers that hydromorphone (HDM), given its increased use in Canada to treat opioid dependence, should be the focus of such a trial. The Committee agrees with the range of compelling reasons put forward by stakeholders for such a trial to occur. For example, cohealth noted that HAT could assist in significantly reducing overdose deaths by regulating the strength and supply of heroin to this group of at-risk people, as well as provide supervision of drug taking; link this group to a range of important health and social services; and potentially reduce the number of new heroin users.¹⁵⁰³ Speaking from the perspective of a mother whose son was dependent on heroin for ten years, Debbie Warner from Family Drug Support told the Committee that during this time HAT would have been 'the best thing' for him, as it would have allowed him to remain in employment and be productive. She suggested this was the most logical solution that would have facilitated her son's contact with health professionals rather than individuals operating in the illicit drug market.¹⁵⁰⁴

Successful treatment of opioid dependence requires a range of different responses tailored to the needs of particular groups. To this end, expanding opioid-based treatments should be viewed as extending the continuum of care for opioid dependence, reserved as a last resort treatment for a small minority of patients. As explained by Dr Stefan Gruenert, CEO of Odyssey House Victoria:

¹⁵⁰² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 50.

¹⁵⁰³ cohealth, *Submission*, no. 140, 16 March 2017.

¹⁵⁰⁴ Debbie Warner, Volunteer Manager, Family Drug Support, *Transcript of evidence*, 23 May 2017, p. 103.

What we have learned over many years is that there is no one size that fits all and we need a really nuanced approach to different cohorts and different populations. There may be a longstanding group of people resistant to all sorts of other forms of treatment who will require ongoing support where prescribed heroin may be the safest and most effective way of supporting them and helping them perhaps move to better health or even maintain health over time.¹⁵⁰⁵

This sentiment was echoed by Associate Professor Nadine Ezard who suggested that ‘as a clinician, to have that other additional treatment option, that would be very useful’.¹⁵⁰⁶ William Bush of FFDLR indicated that HAT is one of the safest options for reform because it means ‘medicalising’ the issue while not otherwise changing the status of heroin.¹⁵⁰⁷ Crucial to this is the understanding that a trial should accompany a concerted effort to expand access to OST, noting that it would only ever apply to a small number of people whereas OST is a proven method of treatment for the vast majority of opioid dependent users.

The Committee was also interested to learn how such treatments could potentially contribute to addressing the illicit heroin market. According to Transform, a UK-based drug policy organisation, it has been estimated that 10 per cent of the heaviest opioid dependent users in Switzerland consumed approximately 50 per cent of all the heroin in the country. Such figures suggest that HAT programs, designed to specifically target this 10 per cent, could reduce demand for illicit heroin, thereby reducing the overall size of the illicit market.¹⁵⁰⁸ This was similarly highlighted by Dr Alex Wodak AM of the ADLRF who noted that, rather than the problem being about heroin itself, the problem ‘is the dispensing, the distribution system, so what we need to change is the distribution system’.¹⁵⁰⁹

The Committee underscores that central to a trial in Victoria would be the development of a robust model focused on ensuring safety for both patients and the broader community, as well as the provision of psychosocial support for individuals. Consistent with the HAT models observed overseas, the trial must occur within strict medical settings where patients are clinically supervised to consume their lawfully prescribed doses. The mode of consumption could be either injecting or in tablet form. Clear criteria on a patient’s eligibility for the trial would also be crucial to the program. This would focus on issues such as age requirements, the length of opioid dependency and demonstrating a number of previous failed attempts in treatment. The model would also include rules regulating patient behaviour while on the trial, such as requirements not to drive, rules of conduct in treatment settings, and security measures to protect against diversion of pharmaceutical-grade heroin onto the illicit market. These criteria should not be so strict that it would unnecessarily exclude people that could benefit from the treatment (for example, having a minimum duration of dependency that was too long). The trial must also be accompanied by a strong evaluation component, to determine its effectiveness over other forms of standard OST treatment in Victoria. Of course, consideration of costs would also be an important issue to deal with. While the trial will be a costly endeavour, the Committee is confident that, based on experiences of other jurisdictions such as Switzerland and Canada, this investment will prove to be worthwhile.

¹⁵⁰⁵ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 161.

¹⁵⁰⁶ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 122.

¹⁵⁰⁷ William Bush, President, Families and Friends for Drug Law Reform, *Transcript of evidence*, 18 September 2017, p. 392.

¹⁵⁰⁸ Transform, *Heroin-assisted treatment in Switzerland: successfully regulating the supply and use of a high-risk injectable drug*, Bristol, 2017, p. 4.

¹⁵⁰⁹ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 88.

The Committee further stresses the importance of expanding opioid-based treatments in the event that Victoria experiences an opioid overdose crisis similar to that seen in other overseas jurisdictions (see chapter 17 for further details). Further, the Committee acknowledges that drug addiction, as a chronic medical condition, requires a range of tools, in order to assist as many people as possible to effect positive and health changes in their lives.

RECOMMENDATION 34: The Victorian Government trial the expansion of the opioid substitution therapy program to include other controlled and pharmaceutical grade opioids (such as hydromorphone), for a small group of people for whom other treatment types have not been successful. This should be accompanied with robust evaluation.

Barriers to implementation

As mentioned, this is not the first time that consideration of HAT has occurred in Australia. In fact, there have been a number of recommendations over three decades for a trial to be conducted, only for inaction or rejection to subsequently play out. A particularly important HAT recommendation was made in the 1990s when a proposal for a HAT trial to be established in the ACT was made, following a parliamentary inquiry and an extensive research program conducted by the Australian National University. The following events then occurred at the federal level:

In June 1997, the results of similar trials being conducted in Switzerland were released, reporting what appeared to be conclusive evidence in favour of the practice of prescribing heroin to long-term, problematic heroin users (Uchtenhagen, 1997). A meeting between State Health and Police Ministers held on 31 July, 1997 approved the first stage of such trials. Prior to this meeting, the Australian Prime Minister, John Howard, stated that if the proposal was approved by this forum, then he would support it. This meeting was followed by three weeks of intense lobbying by religious groups, political speculation and a sensational and intense media campaign. On 19 August, Prime Minister Howard reversed his publicly stated position, withdrawing Federal support for the trials because he said that such trials would ‘send the wrong message’ (The Age, 20 August, 1997:1).¹⁵¹⁰

At the same time, discussions took place in Victoria regarding support for the HAT trial in the ACT, as well as the potential for Victoria to become involved with it. As part of then Premier Jeff Kennett’s Drug Advisory Council landmark report entitled *Drugs and Our Community* in 1996, the Council recommended that Victoria encourage the Commonwealth to support the proposed HAT trial and become involved at some stage. Following the trial’s rejection, the interim report of the former Victorian Parliamentary Drugs and Crime Prevention Committee in December 1997 into the Victorian Government’s *Turning the Tide* drug strategy set out the merits of HAT and expressed disappointment with then Prime Minister Howard’s decision to prevent the ACT trial. The report particularly stated that ‘the committee considers it important that the idea of controlled prescription of heroin be kept on the agenda as a therapeutic possibility with a certain role to play’.¹⁵¹¹

More than 20 years later, Victoria is yet to act on these recommendations and commission a trial of HAT, even though since that time the evidence in its favour has only grown stronger. In August 2017, more than 40 prominent Australian experts,

¹⁵¹⁰ Miller, P, ‘Reporting of the ACT heroin trials’, *Journal of media and communication studies*, vol. 2, no. 1, 2010, p. 1.

¹⁵¹¹ Drugs and Crime Prevention Committee, *Interim Report: Inquiry into the Victorian Government’s Drug Reform Strategy: Turning the Tide*, Parliament of Victoria, East Melbourne, 1997, pp. 155-158.

including a number that appeared at public hearings for this inquiry¹⁵¹², called for the provision of HAT in Australia to commemorate the 20 years since the Howard decision:

It is now clear from all the international evidence available that the 1997 Federal Cabinet made the wrong decision regarding a trial of Heroin Assisted Treatment. As a result, far too many lives have been lost, far too many families have been left devastated and far too much harm has befallen our communities.¹⁵¹³

Despite the evidence, the Committee recognises that undoubtedly there will be similar political and community hesitation for a trial to occur now. Gino Vumbaca, President of Harm Reduction Australia highlighted in a recent blog post that '[t]here are times in health policy debates when you can have the scientific evidence, the health experts and even law enforcement in your corner but still face an irrational resistance to change'.¹⁵¹⁴

In recognition of the potential barriers, the Committee urges the Victorian Government to promote or seek support for this recommendation on the basis that it would only be implemented as part of a strictly controlled trial to determine its effects, and that hydromorphone be trialled rather than pharmaceutical grade heroin. Significant negative impacts on individuals or the community would rightly be followed by a determination not to extend the trial. In addition, the Committee stresses that the range of adverse outcomes feared for HAT trials in other jurisdictions, such as increased heroin use among the broader population, diversion of pharmaceutical-grade heroin onto the illicit market, and a community message to young people condoning heroin use, did not eventuate. This scientific evidence base, and the facts about how HAT programs operate in a tightly controlled medical environment, must be front and centre of community discussions around the recommended trial. The following responses to community concerns about HAT are important to note, adapted for this context from a report by Strang et al, who were involved in the European systematic reviews:

- a lack of scientific evidence – there is now ample evidence supporting the effectiveness of HAT, while recognising that further research is of course required, as is the case with most complex policy issues. The benefit of a Victorian trial of expanded opioid-based treatment is that it will enable such research and evaluation to be conducted.
- the potential for diversion and public safety concerns – findings from trials in the Netherlands, Canada and the United Kingdom did not find any of these negative effects, and instead found that there may be some local support.

¹⁵¹² Signatories included many stakeholders that presented evidence at Committee hearings including: Sam Biondo of the Victorian Alcohol and Drug Association, William Bush of Families and Friends for Drug Law Reform, Dr David Caldicott, a consultant emergency physician, Greg Denham of the Yarra Drug and Health Forum, Meghan Fitzgerald of Fitzroy Legal Service, Professor Margaret Hamilton AO, Charles Henderson of Harm Reduction Victoria, Penny Hill of Students for Sensible Drug Policy Australia, Marion McConnell OAM of Families and Friends for Drug Law Reform, Mick Palmer, Former Commissioner of the Australian Federal Police, Professor Alison Ritter of the National Drug and Alcohol Research Centre, John Rogerson of the Alcohol and Drug Foundation, Gino Vumbaca of Harm Reduction Australia, and Dr Alex Wodam AM of the Australian Drug Law Reform Foundation.

¹⁵¹³ Harm Reduction Australia and Australian Drug Law Reform Foundation, 'Australia should start providing Heroin Assisted Treatment', viewed 9 January 2018, <<http://www.harmreductionaustralia.org.au/wp-content/uploads/2017/08/Heroin-Assisted-Treatment-Statement.pdf>>.

¹⁵¹⁴ Vumbaca, G, 'If Heroin Assisted Treatment Works, Why Isn't Australia Providing It To Those In Need?', *Huffpost*, 24 August 2017, viewed 9 January 2018, <http://www.huffingtonpost.com.au/gino-vumbaca/if-heroin-assisted-treatment-works-why-isnt-australia-providing-it-to-those-in-need_a_23158072/>.

- other treatments such as OST and rehabilitation will not be used as much as HAT – contrary to these concerns, most trials experienced difficulty in finding participants, demonstrating the intensity of the program and its applicability to only a small cohort of people. Further, many people transition from HAT to OST or abstinence-based treatments after a period of time.
- significant costs of HAT – trials have shown the significant cost benefits of HAT relating to reductions in criminal activity, imprisonment and healthcare. The Committee also notes that using HDM as an alternative to pharmaceutical grade heroin is likely to be a more cost-effective form of treatment.
- Diamorphophobia – this is described as a community and political fear of viewing heroin as a medical product due to it being seen as inherently dangerous and illicit. Such fears contributed to decisions in Australia to reject a HAT trial. Again, the use of HDM may alleviate community fears.¹⁵¹⁵

1515 Strang, J, et al., 'Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction', *The British Journal of Psychiatry*, vol. 207, no. 1, 2015, pp. 11-12.

15 Pharmaceutical drugs

Pharmaceutical drugs play an important role in society, improving the health of our communities and enhancing Australians' quality of life. However, since the 1990s, Australia has experienced rapid growth in the availability, prescription and use of pharmaceutical drugs. This is not a problem on its own and to some degree is expected with an ageing population, although there has been a significant increase in the misuse of pharmaceuticals, particularly opioids. This has resulted in harms such as pharmaceutical-related deaths and increased hospitalisations, and an illicit trade in these medications.¹⁵¹⁶

The reasons for this misuse are diverse and complex, particularly in regard to opioid use. A 2016 analysis by Karanges et al, *Twenty-five years of prescription opioid use in Australia: a whole-of-population analysis using pharmaceutical claims*, noted that these drugs were originally developed for treating cancer pain, however, a range of policy changes allowed for their use in the treatment of chronic non cancer pain. This and the decision to subsidise opioid analgesics through the Pharmaceutical Benefits Scheme (PBS) resulted in an almost four-fold increase in opioid use from 1990 to 2014, particularly those with strong and long-acting formulations.¹⁵¹⁷ This also needs to be understood in the context of rising experiences of pain among Australians (for example, rates of self-reported pain increased from 57 per cent in 1995 to 68 per cent in 2008),¹⁵¹⁸ in addition to corresponding increases in misuse and diversion of these drugs to the illicit market. Interestingly, the overuse of opioids occurred despite evidence of their long-term effectiveness being weak.¹⁵¹⁹

It has also been suggested that at a similar time, Australia's heroin drought in 2001 may have shifted the cohort of people who used heroin into a trend of misusing pharmaceuticals. For example, a 2006 report on injecting drug users in Melbourne noted that:

The main consequence of the heroin shortage then appears to have been the change in the patterns of drug use reported by IDU [injecting drug users]. While many of these changes appear to have been established prior to the onset of the heroin shortage, the heroin shortage appears to have exacerbated and entrenched them among IDU...This suggests the emergence of a fluid market in pharmaceutical drugs that has emerged in response to the heroin shortage.¹⁵²⁰

¹⁵¹⁶ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, pp. 1-3.

¹⁵¹⁷ Karanges, E, et al., 'Twenty-five years of prescription opioid use in Australia: a whole-of-population analysis using pharmaceutical claims', *British Journal of Clinical Pharmacology*, vol. 82, no. 1, 2016, p. 256.

¹⁵¹⁸ Karanges, E, et al., 'Twenty-five years of prescription opioid use in Australia: a whole-of-population analysis using pharmaceutical claims', *British Journal of Clinical Pharmacology*, vol. 82, no. 1, 2016, p. 263.

¹⁵¹⁹ Karanges, E, et al., 'Twenty-five years of prescription opioid use in Australia: a whole-of-population analysis using pharmaceutical claims', *British Journal of Clinical Pharmacology*, vol. 82, no. 1, 2016, p. 264.

¹⁵²⁰ Dietze, P, et al., NDLERF: The course and consequences of the heroin shortage in Victoria: Monograph Series No. 6, Turning Point Alcohol and Drug Centre / National Drug and Alcohol Research Centre, Sydney, 2004, p. 34.

Like many other areas of drug policy considered in this report, the shift from heroin to pharmaceutical drugs demonstrates the resilience and flexibility of the drug market. It also demonstrates the need to carefully monitor unintended consequences arising from policy changes and for policies to be subsequently adapted to address such consequences.

15.1 Setting the scene – the problem of the misuse of pharmaceutical drugs

The term ‘misuse’ in this context broadly relates to the non-medical use of pharmaceutical drugs, which refers to using prescription or over-the-counter drugs for non-therapeutic purposes, as well as the use of such drugs for genuine medical reasons without proper prescription or in disproportionate quantities or frequencies.¹⁵²¹ In some instances, this use can be caused by drug dependency that is a direct result of medical treatment itself, as many of these drugs are particularly addictive.

Among the general community, there are significantly high levels of misuse of pharmaceutical drugs. The 2016 *National Drug Strategy Household Survey* (NDSHS) found that approximately 1 million people aged 14 years or over, roughly 1 in 20 Australians or 4.8 per cent of the population, reported misusing a pharmaceutical in the previous 12 months. This represented an increase from 4.7 per cent in 2013 and 3.7 per cent in 2007. The misuse of painkillers and opioids in particular, the most common pharmaceuticals subject to misuse, was second only to cannabis. In terms of frequency of use, pharmaceuticals were misused daily or weekly at a rate of 28 per cent, second only to the frequency of cannabis use which was 36 per cent. Poly-drug use was also reported, with 39 per cent of people who reported misusing a pharmaceutical in the previous 12 months also reporting using an illicit drug.¹⁵²²

The Committee heard of the ease at which these drugs can be obtained, given their wide availability and common use among the general population. For example, when asked about the types of drugs available in the City of Yarra, Demos Krousos, Chief Executive Officer (CEO) of North Richmond Community Health (NRCH) stated:

Obviously heroin is the most prominent illicit drug that is used in Richmond...but also virtually every other drug is available, particularly prescription drugs. They are very easy to purchase in the City of Yarra.¹⁵²³

Alarmingly, the misuse of pharmaceuticals is the greatest contributor to drug-induced deaths in Australia, with a disturbing rise in such deaths across Victoria and the country. In its annual report, *Causes of Death*, the Australian Bureau of Statistics (ABS) stated that in 2016 there were 1,808 drug deaths, the highest number of such deaths in 20 years. The ABS reported that the profile of deaths has changed in two decades, with increased involvement of pharmaceuticals rather than heroin:

¹⁵²¹ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 2.

¹⁵²² Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, pp. 77-83

¹⁵²³ Demos Krousos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 157.

In 2016, an individual dying from a drug induced death in Australia was most likely to be a middle aged male, living outside of a capital city who is misusing prescription drugs such as benzodiazepines or oxycodone in a polypharmacy (the use of multiple drugs) setting. The death was most likely to be an accident. This profile is quite different from that in 1999, where a person who died from a drug induced death was most likely to be younger (early 30s) with morphine, heroin or benzodiazepines detected on toxicology at death.¹⁵²⁴

Further, a report by the Australian Institute of Health and Welfare (AIHW) in December 2017, *Non-medical use of pharmaceuticals, Trends, harms, and treatment 2006–07 to 2015–16*, stated that '[o]ver the past decade, drug-induced deaths were more likely to be due to prescription drugs than illegal drugs, and there has been a substantial rise in the number of deaths with a prescription drug present'.¹⁵²⁵

Such trends have been similarly replicated within Victoria, as reported by the Coroners Court of Victoria. Judge Sara Hinchey, State Coroner of Victoria, told the Committee that pharmaceuticals contributed to approximately 80 per cent of all overdose deaths each year between 2009 and 2016, and that:

A study of 838 overdose deaths involving pharmaceutical drugs found that the vast majority of these drugs were prescribed to the deceased rather than diverted or purchased over the counter or imported via the internet; that is, most of these drugs were obtained legitimately through the existing health system by the person who died from their toxic effects.¹⁵²⁶

The Coroners Court's submission provided further details regarding the contribution of pharmaceuticals to overdose deaths, with benzodiazepines the most frequent contributor followed by opioids and antidepressants.¹⁵²⁷ While most deaths were the result of poly-drug use, pharmaceuticals contributed in greater proportion (and increasing numbers) than either illicit drugs or alcohol.

Both the ABS and the AIHW discussed in their reports the similarities of such trends with overseas jurisdictions. Of particular concern is the situation in the United States (US), where deaths as a result of prescription opioids such as oxycodone and fentanyl 'are now considered an epidemic'.¹⁵²⁸ Drug induced deaths are the leading cause of injury death in the country, with opioids present in over 60 per cent of cases. The report from the AIHW highlighted:

Research in the USA suggests that the rise in the harms from the non-medical use of pharmaceuticals is driven by a combination of a culture of unrealistic expectations about pain management, financial incentives for doctors to offer prescriptions, and less regulation of the pharmaceutical industry advertising products compared with other high-income countries (Humphreys 2017).¹⁵²⁹

¹⁵²⁴ Australian Bureau of Statistics, 'Drug Induced Deaths in Australia: A changing story', 3303.0 - *Causes of Death, Australia, 2016*, 2017, viewed 29 January 2018, <<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0-2016-Main%20Features-Drug%20Induced%20Deaths%20in%20Australia-6>>.

¹⁵²⁵ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 22.

¹⁵²⁶ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 13.

¹⁵²⁷ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 28.

¹⁵²⁸ Australian Bureau of Statistics, 'Drug Induced Deaths in Australia: A changing story', 3303.0 - *Causes of Death, Australia, 2016*, 2017, viewed 29 January 2018, <<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0-2016-Main%20Features-Drug%20Induced%20Deaths%20in%20Australia-6>>.

¹⁵²⁹ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 1.

The Penington Institute recently noted rising rates of overdose deaths due to fentanyl in its report, *Australia's Annual Overdose Report 2017* which stated that 'deaths from fentanyl across Australia has risen nearly 800 per cent (an eight-fold increase) over the ten-year period from 2001-2005 to 2011-2015'.¹⁵³⁰ A media release accompanying the release of the report stated:

Fentanyl, a dangerous drug 100 times more potent than pure morphine is at the forefront of Australia's drug overdose crisis. Australia's Annual Overdose Report 2017 has revealed that diverted fentanyl, a synthetic opioid, is killing hundreds of Australians amid the country's escalating overdose problem.

The report, produced annually by Penington Institute, says Australia is on track to experience a US-style drug overdose crisis with fentanyl-related deaths, among several other drug categories, soaring in recent years.¹⁵³¹

Dr Alex Wodak AM, Director of Australia 21 and President of the Australian Drug Law Reform Foundation (ADLRF), told the Committee of the seriousness of these similarities:

We only have to look across the Pacific at what's happened in the United States to realise that we are following the United States. We started after the United States and our problems haven't increased as rapidly as the problems have in the United States but it's still a very significant problem in Australia. In other words, drug overdose deaths from prescription drugs are rising rapidly in Australia and I think we should be very concerned about this.¹⁵³²

The situation in North America is discussed in detail in chapter 17.

Along with increased rates of deaths and overdoses, a range of other harms are caused by high rates of pharmaceutical misuse in the community. Ambulance Victoria told the Committee that ambulance attendance rates as a result of such substances were similar to the rates for illicit drugs in 2015/16, as each represented 1.8 per cent of its total emergency case load (although the growth of attendances for illicit drugs rose at higher rates than for pharmaceutical drug attendances).¹⁵³³

There are also increased hospitalisations as a result of pharmaceutical misuse, including that 'pharmaceutical opioid-related poisoning hospitalisations now exceed those associated with heroin use'.¹⁵³⁴ In its submission, the Australasian College for Emergency Medicine (ACEM) provided raw data from the Victorian Poisons Information Centre (VPIC), an expert telephone advice service for the public and health professionals located at the Austin Hospital Emergency Department. The VPIC data showed calls from health professionals rose significantly over the ten-year period from 2006 to 2016 for pharmaceuticals. For example, there was a 47.8 per cent increase in calls about benzodiazepines, and a 1021.1 per cent increase in calls about oxycodone. The ACEM also noted that in 2012/13, emergency department presentations relating to pharmaceutical drugs was 12.6 per 100,000 population, compared to 2.1 for illicit drug presentations.¹⁵³⁵

¹⁵³⁰ Penington Institute, *Australia's Annual Overdose Report 2017*, Carlton, 2017, p. 19.

¹⁵³¹ Penington Institute, 'Australia's continuing overdose tragedy', viewed 1 February 2018, <<http://www.penington.org.au/australias-continuing-overdose-tragedy>>.

¹⁵³² Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 87.

¹⁵³³ Ambulance Victoria, *Submission*, no. 208, 24 March 2017.

¹⁵³⁴ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, p. 3.

¹⁵³⁵ Australasian College for Emergency Medicine, *Submission*, no. 223, 21 April 2017, pp. 1-2.

In response to these increasing harms, a national strategy was established, the *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)* (the Australian Framework), adopted under the previous *National Drug Strategy (NDS) 2010-2015*. The Australian Framework's goals aimed to reduce pharmaceutical misuse and harms, as well as enhance the quality use of such drugs 'without stigmatisation or limiting their accessibility for therapeutic use'.¹⁵³⁶ The current NDS 2017-2026 noted that, while the Australian Framework expired in 2015, it should continue to be considered by governments.¹⁵³⁷ The non-medical use of pharmaceuticals was also included as a priority substance area in the current NDS, noting the harms of overdose, infection, blood vessel issues, memory lapses and aggression.¹⁵³⁸

15.2 Key factors involved in the misuse of pharmaceutical drugs

15.2.1 Types of pharmaceuticals

The most widely misused pharmaceutical drug groups are opioid analgesics and benzodiazepines. Benzodiazepines are depressants of the central nervous system commonly prescribed for sleep issues and to treat stress and anxiety. Opioid analgesics are included as Schedule 8 drugs under the Victorian *Drugs, Poisons and Controlled Substances Act 1981*, meaning they are subject to controls given their high propensity for misuse and dependence. These include requiring a prescriber to obtain a permit from the Department of Health and Human Services (DHHS) in some circumstances, for example when prescribing certain medications continuously for more than eight weeks.¹⁵³⁹ Benzodiazepines, on the other hand, are generally Schedule 4 medicines that do not have the same level of control.

As discussed earlier, opioid analgesics are typically prescribed for pain management. According to the AIHW report, the number of opioids prescribed in 2014/15 rose by 24 per cent from 2010/11, reaching a rate of 45,600 prescriptions per 100,000 population (an overall figure of 11.12 million prescriptions on the PBS). The most commonly prescribed opioid is oxycodone, which represented approximately one third of all opioid prescriptions dispensed (an increase from 27 per cent of prescriptions in 2010/11 to 34 per cent in 2014/15). In terms of the population, oxycodone prescriptions increased 60 per cent from 2010/11 to 2014/15, from 9,800 to 15,500 per 100,000 population. Noting similar increases across a range of other opioids such as fentanyl and tramadol (while codeine rates remained stable), the AIHW report stated that 'substantially more opioid analgesics are being prescribed and dispensed than previously'.¹⁵⁴⁰ It suggested that these increases could be attributed to the following factors:

- longer survival periods for cancer sufferers
- ageing population, and a growing number of people with chronic pain (ABS 2015)
- community expectations of coping with chronic pain (Monheit et al. 2016).¹⁵⁴¹

¹⁵³⁶ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, p. i.

¹⁵³⁷ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 38.

¹⁵³⁸ Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 33.

¹⁵³⁹ health.vic, 'Schedule 8 permits and notifications', viewed 29 January 2018, <<https://www2.health.vic.gov.au/public-health/drugs-and-poisons/treatment-approvals/schedule-8-permits-and-notifications>>.

¹⁵⁴⁰ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, pp. 7-9.

¹⁵⁴¹ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 9.

A report from the National Drug and Alcohol Research Centre (NDARC) on trends in accidental overdose deaths due to opioids suggested that 68 per cent were due to pharmaceutical opioids (408 of 597 accidental opioid overdose deaths) in 2013, a consistent finding over a number of years.¹⁵⁴² The Coroners Court stated in its submission that opioids were the second most frequent pharmaceutical drug group contributor to Victorian deaths, with an average involvement in 46.9 per cent of overdose deaths between 2009 and 2016.¹⁵⁴³

Benzodiazepines are the second most commonly misused pharmaceutical drug group. According to the AIHW report, prescriptions of benzodiazepines remained largely stable (4.86 million prescriptions in 2014/15), and the population rate fell from 21,800 per 100,000 population in 2010/11 to 19,911 in 2014/15. Diazepam was the only type of benzodiazepine where the rate of prescription increased significantly in this time period, from 6,950 to 7,440 per 100,000 population.¹⁵⁴⁴ Despite relatively stable rates of prescriptions among the community and prescription numbers being fewer than opioid analgesics, benzodiazepines were the largest pharmaceutical group contributor to Victorian overdose deaths from 2009 to 2016, at an average rate of 51.8 per cent of overdoses each year.¹⁵⁴⁵

15.2.2 Reasons for misuse

The Committee understands that there are broad-ranging reasons for the misuse of pharmaceutical drugs, such as: the non-medical use for non-therapeutic purposes, or in contravention of directions from health professionals; for recreational use or mood enhancing; to enhance the effects of illicit drugs or alcohol; for self-medication for illness, injury or drug dependence; to manage withdrawal from illicit drugs or alcohol; or to improve performance.¹⁵⁴⁶

The Committee is also aware that particularly for opioid analgesics, some patients prescribed these drugs for genuine medical purposes (e.g. for chronic non cancer pain) over a long period of time can develop a dependency, given the drug's addictive properties. This is called iatrogenic dependence, where a person becomes dependent on a pharmaceutical following its use for legitimate medical treatment. Opioids such as oxycodone and fentanyl have particularly 'high potential for abuse and addiction, and are often the most susceptible to producing iatrogenic dependence'.¹⁵⁴⁷ This form of misuse is significantly different to other forms, as dependence is inadvertent and continued use of these substances is not for recreational reasons but as a result of loss of control over use and cravings. The factors that may increase risk of iatrogenic dependence include 'inappropriate prescribing, limited health literacy, poorly worded medical instructions or poor communication by health care providers'.¹⁵⁴⁸ As described by Associate Professor Nadine Ezard:

¹⁵⁴² Roxburgh, A and Burns, L, *Accidental drug-induced deaths due to opioids in Australia, 2013*, National Drug and Alcohol Research Centre, Sydney, 2017, p. 1.

¹⁵⁴³ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 34.

¹⁵⁴⁴ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, pp. 9-11.

¹⁵⁴⁵ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 34.

¹⁵⁴⁶ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 12.

¹⁵⁴⁷ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 17.

¹⁵⁴⁸ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. 3.

The role of opioids in the management of chronic pain needs to be really addressed with our prescribers. What we see in the addiction sector is that people sometimes have had chronic pain, have a long-time opioid prescription and then they get referred to us after several years of being prescribed opioids and the doctor actually then realises there's an issue and so does the patient, so then they come to the addiction sector.¹⁵⁴⁹

There is 'a wide spectrum' of people that misuse pharmaceuticals, described in a report published by the National Centre for Education and Training on Addiction (NCETA) as part of the process for developing the Australian Framework, *Pharmaceutical drug misuse in Australia: complex problems, balanced responses* (Nicholas et al).¹⁵⁵⁰ It reproduced the following table to describe three main patient groups:

Table 15.1 Patient groups

The dependent patient	This group may have genuine pain problems. Some patients have come to rely on drugs to improve their mood and how they feel. Others have general difficulties coping with life's problems. In general, they have become more interested in continuing and increasing their supply of drugs, rather than in the resolution of their medical and other problems.
The drug misuser	This group may have a history of drug abuse but also may have some evidence of pain. They may also have social or drug trading connections with others who abuse drugs. They are likely to be injecting prescribed and other drugs. Since prescription drugs have a high value on the black market, these patients work hard at developing their presentations to doctors and obtaining drugs for personal use or trading, and this is a high priority in their lives.
The drug seller	This group attend doctors with the primary aim of obtaining drugs to sell or trade. They may include some from the second subgroup. They may also be scammers who use stolen or forged ID documents. Some may be ordinary patients who have come to rely on the income that can be made from selling a proportion of their medication (some of these patients may be elderly or have cancer). They may also be patients who intimidate or threaten doctors and some may have evidence of a pain condition.

Source: Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. 3.

There are also various ways that people obtain pharmaceuticals including: from family or friends who have legitimate prescriptions, stealing prescriptions, stealing pharmaceuticals directly from medical facilities and pharmacies, buying them from illicit drug markets or dealers, and the internet. The AIHW noted that 52 per cent of those who recently misused pharmaceutical opioids purchased them over-the-counter at a pharmacy, and 18.2 per cent had prescriptions. For benzodiazepines, these were more commonly obtained through a medical prescription (36 per cent). In terms of family or friends, 41 per cent of those using benzodiazepines reported this as their source, and 20 per cent using opioids reported this as the source.¹⁵⁵¹

A particular focus of drug policy in this space is that some people obtain pharmaceuticals by seeing several doctors and pharmacists to obtain the same medication, termed colloquially as 'doctor shopping' or 'medication shopping'.¹⁵⁵² One policy response, developed internationally and soon to be implemented in Victoria, is a real-time prescription monitoring system, which is discussed in detail in section 15.4.

¹⁵⁴⁹ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 119.

¹⁵⁵⁰ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. 3.

¹⁵⁵¹ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 14.

¹⁵⁵² Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 14.

15.2.3 Particular at-risk groups and common characteristics

The AIHW report outlined certain groups of people that are particularly at-risk and have higher levels of misuse of pharmaceuticals than the general population. People living in remote and disadvantaged areas have been shown to misuse pharmaceuticals at higher rates than in metropolitan areas, for example the NDSHS 2016 found people in remote or very remote areas were 1.7 times as likely than people in major cities to have recently misused a pharmaceutical.¹⁵⁵³ Such findings were echoed by some inquiry stakeholders, particularly Professor Dan Lubman, Director of Turning Point, which runs Victoria's Ambo Project. He stated:

We are also seeing dramatic increases in prescription drug presentations, particularly in regional areas where illicit drugs traditionally have been much more difficult to access but where prescription drugs are widely available and there is significant harm in that space.¹⁵⁵⁴

In terms of socioeconomically disadvantaged areas, the AIHW reported:

In 2016, Australians living in the most disadvantaged socioeconomic areas (that is, areas with the highest levels of unemployment, lowest incomes, and overcrowding according to the Index of Relative Socio-Economic Advantage and Disadvantage) were 1.4 times as likely as people in the most advantaged areas to have used a pharmaceutical for non-medical purposes (6.0% compared with 4.2%).¹⁵⁵⁵

Similarly, people who are unable to work are at greater risk of recent misuse of pharmaceuticals - 7.8 per cent compared to 5 per cent of people currently employed and 5.9 per cent currently unemployed.¹⁵⁵⁶

Aboriginal and Torres Strait Islander (ATSI) people aged 14 and over were also more likely to have recently misused a pharmaceutical than non-ATSI people as reported in the 2016 NDSHS (10.6 per cent compared to 4.6 per cent). It is important to note, however, that the small sample size of ATSI people surveyed as part of the NDSHS means these results should be interpreted cautiously.¹⁵⁵⁷

People in the criminal justice system are another high risk group compared to the general population, for example recent data from the 2015/16 Drug Use Monitoring in Australia (DUMA) program showed that 24 per cent of police detainees tested positive for benzodiazepines and 11 per cent tested positive for at least one opioid.¹⁵⁵⁸

There are also particular age groups that are more likely to misuse pharmaceuticals, with the ABS noting that drug deaths from pharmaceuticals largely impact older age groups. The AIHW report also discussed that the average age of those misusing pharmaceuticals was 45 in 2016, compared with an average age of 34 for

¹⁵⁵³ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 18.

¹⁵⁵⁴ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 24.

¹⁵⁵⁵ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 18.

¹⁵⁵⁶ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 18.

¹⁵⁵⁷ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, pp. 18-19.

¹⁵⁵⁸ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 19.

those using illicit substances. It also highlighted that '[o]ver time, people who use pharmaceuticals for non-medical purposes have been steadily getting older, with the average age rising from 39 in 2001 to 45 in 2016'.¹⁵⁵⁹

Association with mental health, drug dependency and pain issues

A particularly concerning issue among people who misuse pharmaceuticals is the high rates of comorbidity of mental health illness and substance use issues. As part of the Coroners Court of Victoria's submission, it provided results of a recent study of 838 overdose deaths that occurred between 2011 and 2013 where at least one pharmaceutical drug was involved. It found that, of these deaths, 49.6 per cent (416 deaths) of this cohort had diagnosed mental illness issues as well as a documented drug dependency. This is compounded by the fact that the mental illness and drug dependency issues were well-established over a long period of time, with 'a substantial proportion' being known for greater than 10 years.¹⁵⁶⁰

Table 15.2 Intersection of drug dependence and mental illness in the study cohort

Current drug dependence	Diagnosed mental illness					
	Yes		No		Total	
	number	%	number	%	number	%
Yes – clinically documented	416	49.6	114	13.6	530	63.2
Yes – not clinically documented	35	4.2	30	3.6	65	7.8
No evidence of current dependence	161	19.2	82	9.8	243	29.0
Total	612	73.0	226	27.0	838	100.0

Source: Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 44.

The AIHW report reflected similar findings among misuse of pharmaceuticals in the general population, in that 29 per cent of people who recently misused such a substance also reported a mental illness under the 2016 NDSHS. This was particularly higher for the use of benzodiazepines, typically used to treat conditions such as depression and anxiety, with a rate of 35 per cent reporting a mental illness. It also found that recent use of pharmaceuticals was accompanied by high rates of psychological distress (24.1 per cent compared to 10.9 per cent for those that had not recently used a pharmaceutical).¹⁵⁶¹

These issues should also be considered in the context of high rates of reported pain among Australians, particularly chronic pain. The 2016 NDSHS reported the presence of more health conditions for people who had recently used a pharmaceutical, with this cohort reporting chronic pain at a rate of 15.9 per cent compared with 10.3 per cent of those that did not. The AIHW report stated that, '[w]ith such a high number of Australians experiencing pain, the demand to access effective pharmaceutical medication is high'.¹⁵⁶²

¹⁵⁵⁹ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 15.

¹⁵⁶⁰ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 45.

¹⁵⁶¹ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 16.

¹⁵⁶² Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 16.

Given this demand and the risk of iatrogenic dependence, how pain issues are managed and dealt with by general practitioners (GPs) is an issue of concern and requires exploration by the relevant medical bodies and the Victorian Government. The Committee is aware that the supporting structure for GPs to deal appropriately with complex issues may not currently be in place. For example, Nicholas et al stated:

It has been noted that strong forces operate to discourage the thorough assessment, multi-disciplinary care and biopsychosocial framework needed for optimal management of patients with chronic pain. Impediments include the traditional biomedical model and Medicare funding arrangements that favour brief consultations while requiring complex and frustrating paperwork to be completed to facilitate patient access to even minimal allied health services (Wodak, Cohen, Dobbin, Hallinan, & Osborn, 2010).¹⁵⁶³

The role of medical practitioners is discussed in detail below in section 15.3.1.

Poly-drug use

Poly-drug use is common among people who misuse pharmaceuticals, and they are often one among a number of drugs involved in overdose deaths. As noted in chapters 2 and 17, reported by the Coroners Court, most deaths involved multiple drugs rather than a single drug (with the proportion involving multiple drugs increasing from 66.5 per cent in 2009 to 72.2 per cent in 2016). Pharmaceuticals contributed to the majority of deaths between 2009 and 2016, however, the Coroners Court submission noted that in 2015 and 2016 this trend shifted towards deaths involving pharmaceutical drugs in combination with illicit drugs, rather than pharmaceutical drugs alone.¹⁵⁶⁴

In terms of the general population, the 2016 NDSHS reported that other drug use among those who had recently misused a pharmaceutical was common (39 per cent had also used at least one other drug). Cannabis was the most commonly used other drug at 30 per cent, followed by ecstasy at 14 per cent, cocaine at 13.1 per cent and methamphetamines at 11.2 per cent.¹⁵⁶⁵

The Illicit Drug Reporting System (IDRS), run by NDARC, reports annually on illicit drug taking practices by a sentinel group of Australians who regularly inject drugs. It often reports misuse of pharmaceuticals among this cohort, including through injecting practices. The 2017 report highlighted rates of recent use of pharmaceutical drug use (both licit and illicitly obtained) among the cohort including: 29 per cent used morphine, 20 per cent used oxycodone, and 50 per cent used benzodiazepines.¹⁵⁶⁶

Charles Henderson, Acting Executive Officer of Harm Reduction Victoria (HRV), told the Committee of the intersection of heroin and pharmaceutical opioid use:

Heroin figures in almost one in two overdoses in Victoria over the last year and pharmaceutical opioids figure in about three in four of those overdoses. This is not a one or other dichotomy; it is a reflection of polydrug use and that relative to heroin, as indicated in the IDRS 2016 data, low-frequency patterns of use and cheaper prices

¹⁵⁶³ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. 85.

¹⁵⁶⁴ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 33.

¹⁵⁶⁵ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 17.

¹⁵⁶⁶ Karlsson, T and Burns, L, *Australian Drug Trends 2017: Findings from the Illicit Drug Reporting System*, National Drug and Alcohol Research Centre, Sydney, 2018, pp. 29-34.

suggest that pharmaceutical opioids are used opportunistically by PWID, or people who inject drugs, in Victoria as a substitute for heroin. In reality it has never been easier to get heroin.¹⁵⁶⁷

The AIHW report also stated that numbers of treatment episodes for pharmaceuticals as the principal drug of concern were low and similar to heroin (5.2 per cent of treatment episodes in 2015/16), but they were more likely to be listed as an additional drug of concern in treatment (9.0 per cent in 2015/16). Where a pharmaceutical was the principal drug of concern, 56 per cent of these episodes had at least one additional drug of concern attached, typically alcohol, benzodiazepines, amphetamines, nicotine and cannabis.¹⁵⁶⁸

15.3 Reducing reliance on prescription drugs, particularly opioids

Given the contribution of pharmaceutical drugs to a range of increasing harms across Australia, the Committee received evidence from stakeholders on various strategies to reduce reliance on these drugs in the community. Of particular concern to stakeholders were opioids, given its highly addictive properties combined with well-established community expectations for them to manage peoples' pain issues. As described in the Australian Framework, a balance is required between effectively managing pain and reducing long-term harms from high levels of misuse:

A key theme in the Framework is achieving a balance among diverse interests and ensuring that no Australians are disadvantaged or stigmatised. There is also a need to ensure continued medical access to these medications and to maximise their appropriate use, while minimising opportunities for misuse. There is a need to ensure that the clinically appropriate supply of these medications is maintained. It is also important that the Framework empowers prescribers and pharmacists, enhances the information at their disposal and informs their decision-making.¹⁵⁶⁹

15.3.1 Improved practices for medical practitioners

The Committee received evidence regarding the role of medical practitioners, particularly GPs, in prescribing pharmaceuticals. This particularly focused on addressing ineffective prescribing practices that can lead to harms. A 2010 article by Monheit, *Prescription drug misuse*, outlined that there are two main types of patients that GPs should be equipped to deal with – those who seek drugs for non-medical reasons, and those that are experiencing chronic pain but may be misusing or overusing their medications.¹⁵⁷⁰ Strategies must be in place to ensure prescribers such as GPs deal effectively with both types of patients.

The Committee is also aware that, despite high rates of prescriptions in the community, there appears to be a lack of evidence to demonstrate the effectiveness of commonly misused pharmaceuticals to treat a range of conditions. Nicholas et al affirmed that:

¹⁵⁶⁷ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 66.

¹⁵⁶⁸ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 25.

¹⁵⁶⁹ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, p. 5.

¹⁵⁷⁰ Monheit, B, 'Prescription drug misuse', *Australia Family Physician*, vol. 39, no. 8, 2010, viewed 29 January 2018, <<https://www.racgp.org.au/afp/2010/august/prescription-drug-misuse>>, p. 540.

[t]here appears to be a significant evidence-practice gap in the prescribing of opioids and benzodiazepines in Australia. The role of prescription opioids in OST, the treatment of serious acute pain and malignant pain is relatively uncontroversial. It appears, however, that opioids are increasingly prescribed for less serious acute pain and for chronic non-malignant pain, for which the evidence of efficacy has not been established.

Similarly, benzodiazepines should not be a front-line treatment for the treatment of anxiety or insomnia and nor is their use indicated for the longer-term treatment of these conditions. Benzodiazepines are, at times, prescribed in a manner inconsistent with quality use. This can result in inadvertent misuse.¹⁵⁷¹

Stakeholders told the Committee of increasing pressure on GPs and others to prescribe opioids for a broader range of indications, despite the lack of evidence. Professor Dan Lubman of Turning Point told the Committee of experiences in the US relevant to this issues:

What we have seen in the US is that there has been a very successful campaign by drug companies over a decade in terms of making pain the fifth vital sign so that everyone has to ask about pain, nobody should have unnecessary suffering and we should actively and aggressively treat people for pain, which has seen this explosion in treatment with opioids.

There is no evidence for treatment with opioids in non-malignant pain for longer than 30 days in terms of treatments. We have seen this massive explosion, and now in the US we are seeing the carnage associated with that — with doctors being sued, with a huge diversion of people from prescription opioids onto heroin.¹⁵⁷²

Other stakeholders reflected that similar concerns have emerged within Australia. Associate Professor Nadine Ezard described her own experiences in changing prescribing practices over time:

...when I first graduated we hesitated in prescribing something like codeine, 30 milligrams, and now young doctors are prescribing oxycodone quite readily for something that we may have prescribed paracetamol for in the past. There is a little bit of a decreased tolerance to the prescription of strong opioids. I think we're seeing far greater - we've got the invention of fentanyl - it's a very, very strong opioid on the market and so there is a whole increased range of medications that can be prescribed and I think that doctors aren't skilled up enough to know how and when to prescribe safely.¹⁵⁷³

Similarly, Geoff Munro, National Policy Manager of the Alcohol and Drug Foundation (ADF), stated:

I think we are aware that the medical profession is under a lot of pressure to overprescribe. I think there is a shared responsibility from the person attending the medical professional and the medical professional too, because I think our submission points to the fact that benzodiazepines, which are often given to people who are feeling unwell temporarily, are not suited for long-term use, so people can become dependent upon them very quickly. That means that they find it very hard to come off them, and the benzodiazepines are not very effective in dealing with the symptoms a person is seeking help for.¹⁵⁷⁴

1571 Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. xii.

1572 Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 28.

1573 Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 119.

1574 Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 204.

As an example of how doctors need a high level of skill to manage patient demands, David Ruschena, General Counsel of Alfred Health, told the Committee:

About three weeks ago a patient came into Alfred Health's emergency department at 6 o'clock on a Friday afternoon with a blocked nose. It was a partially blocked nose, so she could still breathe through it, but she could not sleep well at night and she demanded to see a doctor. When it was explained to her that an ENT [ear, nose and throat] consultant was not available at 6 o'clock on a Friday night to deal with a blocked nose, she demanded Stilnox. When she was told she was not going to get Stilnox — which is a very powerful sleeping tablet — she called her lawyer, and her lawyer showed up. So I, as general counsel at Alfred Health, and the ED [emergency department] consultant were standing in a cubicle in the emergency department debating the need for Stilnox for a partially blocked nose at 6 o'clock on a Friday evening.

Now, the easiest thing in the world would have been for the consultant to simply write a script and get back to the other situations, but that was not the appropriate thing and he knew it, and I daresay the lawyer kind of knew it, and I certainly knew it as well. He was lucky because he had the skills and support that are necessary in order to do the right thing...¹⁵⁷⁵

It should also be noted that doctors are not typically the main initial source of pharmaceuticals for non-medical purposes, but can be a key factor in ongoing use. A 2013 study by Nielsen et al, *The sources of pharmaceuticals for problematic users of benzodiazepines and prescription opioids* analysed the sources of benzodiazepines and prescription opioids among a cohort of entrants into alcohol and other drug (AOD) treatment. They found that approximately three quarters of entrants reported initial use was via a non-medical source and that it took between three to six years for such use to develop into harmful use. In terms of usual sources for prescription opioids, 71 per cent reported obtaining these from non-prescribed sources and less commonly from a doctor. For benzodiazepines, 78 per cent of the cohort reported a doctor as their source in the 28 days before entering treatment.¹⁵⁷⁶

Further, the Committee also refers to evidence indicating that rather than many doctors adopting inappropriate prescribing practices, it is more likely that there are a small number of doctors doing so at high rates. Nicholas et al suggested that:

The majority of prescriptions for medication shoppers in Australia are provided by a small minority of doctors (e.g. White & Tavener, 1997). This suggests that most general practitioners prescribe appropriately. Kamien (2004) cited data from the Health Insurance Commission that indicated half the prescriptions for doctor shoppers in Australia were written by 7.5% of GPs, the majority of whom were located within one of 10 residential postcodes.¹⁵⁷⁷

Similarly, Dr Nicole Lee, Director of 360Edge advised the Committee that 'it tends to be a small number of prescribers who prescribe a lot of these drugs', suggesting this requires targeted education and intervention to manage such prescribing practices.¹⁵⁷⁸ The submission of 360Edge further stated:

¹⁵⁷⁵ David Ruschena, General Counsel, Alfred Health, *Transcript of evidence*, 19 June 2017, pp. 237-238.

¹⁵⁷⁶ Nielsen, S, et al., 'The sources of pharmaceuticals for problematic users of benzodiazepines and prescription opioids', *The Medical Journal of Australia*, vol. 199, no. 10, 2013, viewed 29 January 2018, <<https://www.mja.com.au/journal/2013/199/10/sources-pharmaceuticals-problematic-users-benzodiazepines-and-prescription>>, p. 698.

¹⁵⁷⁷ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. 81.

¹⁵⁷⁸ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 375.

A small number of prescribers appear to make a large number of authority requests, suggesting that while education and training for prescribers is generally useful, providing support and education for the high volume prescribers may yield greater impacts.¹⁵⁷⁹

The Medical Insurance Group Australia (MIGA), an insurer for the healthcare profession and medical defence organisation, noted in its submission that there have been a number of disciplinary charges against practitioners for inappropriate prescribing, which can often lead to monitoring conditions, mentoring or education initiatives. It suggested that this demonstrates ‘the need for better and targeted education and training in prescribing generally and high risk medications in particular’, from university level and onwards.¹⁵⁸⁰ Dr Alex Wodak AM of ADLRF similarly discussed the importance of educating the medical profession of the risks involved with such prescribing practices:

We have to convince the community and doctors that the prescribing of prescription opioids for severe, chronic, non-malignant pain is very marginal. It does help some people but there are a lot of people who it has no benefit for and a lot of people it has significant side effects for. So prescribing of prescription opioids needs to be much more discriminating: fewer people, shorter periods, reviewed much more often, lower doses. That can only happen if we have educational campaigns directed at the community and also for doctors.¹⁵⁸¹

One strategy often discussed in this context is the development of guidance to articulate appropriate standards for prescribing and treating certain conditions. For example the Australian Framework recommended the development of national guidelines for the treatment of conditions often associated with misuse of pharmaceuticals, such as pain and mental health issues.¹⁵⁸² Of particular importance is that, in October 2017, the Royal Australian College of General Practitioners (RACGP), a professional body for GPs, published specific guidance on the role of opioids in pain management (both acute and chronic non-cancer pain) as part of its resource, *Prescribing drugs of dependence in general practice*. The Foreword stated that as an average of 20 to 40 per cent of adult consultations in general practice involve chronic pain, GPs ‘need to feel comfortable managing these patients’ while recognising that medications will only have a partial role.¹⁵⁸³ The guide, made up of two parts, provided clinical governance information including on federal and state regulations that need to be followed, as well as evidence-based guidance and advice on prescribing for pain and pain management. The Committee is also aware of a range resources produced by the Victorian DHHS on the safer use of opioids.¹⁵⁸⁴

These issues were also considered in a paper released by the Therapeutic Goods Administration (TGA) in January 2018, *Prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response*. It noted that there are already a number of guidelines that consider the role of opioids in pain, non-pharmacological ways to address pain, and reducing dosages safely. However, it also found that:

¹⁵⁷⁹ 360Edge, *Submission*, no. 229, 4 September 2017.

¹⁵⁸⁰ MIGA, *Submission*, no. 202, 20 March 2017, p. 5.

¹⁵⁸¹ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 87.

¹⁵⁸² National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, pp. 20-22.

¹⁵⁸³ The Royal Australian College of General Practitioners, *Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management*, East Melbourne, 2017, p. iii.

¹⁵⁸⁴ health.vic, ‘Safer use of opioids’, viewed 29 January 2018, <<https://www2.health.vic.gov.au/public-health/drugs-and-poisons/medical-practitioners/specific-schedule-8-poisons-requirements/safer-use-of-opioids>>.

While these resources are available they may not be readily visible to practitioners. Promoting these activities would ensure that practitioners have access to information to assist them in managing patients with acute and chronic pain according to current guidelines.¹⁵⁸⁵

It suggested that options to address this include increasing awareness among health professionals of the available guidance, such as through establishing a central location where information can be found on prescribing opioids.

The Committee also notes that, as a result of a recent decision by the federal TGA, all products containing codeine now require a prescription, eliminating any over-the-counter products.¹⁵⁸⁶ This requires significant education for the medical profession about how to handle and assist their patients to adapt to such changes.

The Committee considers that guidance and education is clearly an important aspect of changing medical practitioner behaviour to reduce reliance on opioids to manage chronic pain issues in appropriate circumstances. Noting that some of the harms of prescription opioid misuse stems from medical treatment itself through iatrogenic dependence, it is especially important that prescribing practices take into account evidence of effectiveness, as well as ways to reduce the probability of such harms occurring. The Victorian Government should consider the development of Victorian-specific guidance to assist practitioners with such issues, drawing on other relevant guidelines such as those developed by the RACGP. For example, SA Health in South Australia produced a range of resources on opioids for the treatment of pain, including a document called *Opioid Prescription in Chronic Pain Conditions - Guidelines for SA GPs* published in 2008 and a resource kit for opioid use in acute pain.¹⁵⁸⁷ Such strategies should be undertaken in conjunction with relevant bodies in this area, such as the Australian Medical Association (AMA) Victoria, and be accompanied by training, both general and targeted to individual practitioners, as recommended by stakeholders. The importance of these guidelines is also discussed below in the context of real-time prescription monitoring.

RECOMMENDATION 35: In the short term, the Victorian Government, in conjunction with the Australian Medical Association and other relevant medical bodies, develop prescription opioid medication guidelines for general practitioners and training on appropriate prescribing practices. This should include guidance on monitoring patients, lowering dosages when appropriate, education on the risks of dependence, and effective pain relief alternatives to such medication.

Stewardship framework for pharmaceutical misuse

As well as improving guidelines and education for the medical profession, the Committee was advised of a strategy currently used to promote the safe use of antibiotics that could potentially be applied to pharmaceutical misuse. This strategy, proposed by Alfred Health, involves the development and implementation of a stewardship framework comprising a structured approach to prescribing practices in hospitals. It is already being trialled in a number of Australian jurisdictions including Victoria.

¹⁵⁸⁵ Therapeutic Goods Administration, *Prescription strong (Schedule 8) opioid use and misuse in Australia - options for a regulatory response: Consultation paper*, Australian Government, Woden, 2018, p. 20.

¹⁵⁸⁶ Therapeutic Goods Administration, 'Codeine information hub', viewed 1 February 2018, <<https://www.tga.gov.au/codeine-info-hub>>.

¹⁵⁸⁷ SA Health, 'Opioids', viewed 29 January 2018, <<http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Clinical+resources/Clinical+topics/Medicines+and+drugs/opioids>>.

A key factor in pharmaceutical misuse is that often a person's use of opioids commences during their stay in hospital to treat acute pain symptoms, and may involve a prescription on their discharge. There is evidence that this may lead to misuse, even in circumstances when they have not regularly used opioids prior to that. For example, a 2017 study *Opioid-Prescribing Patterns of Emergency Physicians and Risk of Long-Term Use* analysed a sample of patients in emergency departments that had not used opioids in the six months before their stay, and the risk factors for long-term opioid use following their stay. It stated:

It is commonly thought that opioid dependence often begins through an initial, possibly chance, exposure to a physician-prescribed opioid, although data from studies to empirically evaluate this claim are lacking. Our results provide evidence that this mechanism could drive initiation of long-term opioid use through either increased rates of opioid prescription or prescription of a high, versus a low, dose of opioid.¹⁵⁸⁸

Nicholas et al in 2011 further noted that one of the factors driving pharmaceutical misuse is 'current hospital discharge planning arrangements leading to patients continuing to use medications beyond the period of time for which they are clinically indicated'.¹⁵⁸⁹ Dr Nicole Lee of 360Edge similarly advised the Committee that practices on discharge may lead to increased risks:

The same problem happens when people leave hospital as well: they get given a box of Endone, and it is like 20, 30 or 40 pills sometimes. And then they are in the cupboard. If you have a bit of pain, then that might be something you reach for rather than going back to the doctor, because you have already got it there. So it just increases the risk.¹⁵⁹⁰

Given the role of hospitals in contributing to this, Alfred Health, in their evidence to the Committee, drew from the comprehensive Antimicrobial Stewardship Initiative (ASI) as a strategy to reduce such risks while also continuing good practices in ongoing treatment in hospital and community settings. The ASI is monitored by the Australian Commission on Safety and Quality in Health Care (ACSQHC) to improve the safe use of antibiotics, reduce harms and decrease the prevalence of antibiotic resistance. In Australian hospitals since 2013, all health services have been required to meet particular standards to achieve accreditation in this area.¹⁵⁹¹ David Ruschena of Alfred Health advised the Committee that a key benefit has been the creation of robust hospital governance structures to oversee antimicrobial use, including the appointment of clinical champions, education of all stakeholders including clinicians and patients, auditing and benchmarking standards, quality improvement programs and research. He further stated that the ASI has given 'doctors the skills and support they need to respond to inappropriate patient demands and inappropriate clinician expectations relating to prescriptions for antibiotics'.¹⁵⁹²

David Ruschena told the Committee that such programs could be easily adjusted to apply to opioid analgesia, and would be just as effective in reducing rates of inappropriate prescribing. As described in Alfred Health's submission:

¹⁵⁸⁸ Barnett, M, et al., 'Opioid-Prescribing Patterns of Emergency Physicians and Risk of Long-Term Use', *The New England Journal of Medicine*, vol. 376, no. 7, 2017, viewed 29 January 2018, <<http://www.nejm.org/doi/full/10.1056/NEJMsa1610524>>, p. 669.

¹⁵⁸⁹ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. xii.

¹⁵⁹⁰ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 376.

¹⁵⁹¹ Australian Commission on Safety and Quality in Health Care, 'Antimicrobial Stewardship Initiative', viewed 15 March 2018, <<https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship>>.

¹⁵⁹² David Ruschena, General Counsel, Alfred Health, *Transcript of evidence*, 19 June 2017, p. 238.

Comprehensive antimicrobial stewardship programs have demonstrated an overall reduction in hospital antimicrobial use by 22–36% and Alfred Health has no reason to suspect that an analgesia stewardship program or a benzodiazepine stewardship program would be any less effective.¹⁵⁹³

Such a program would entail:

- a multidisciplinary panel of experts and consumers to develop guidelines on various aspects of each medication such as prescribing practices, educational programs, suitable alternatives to medication, dealing with drug-seeking behaviour and safely reducing inappropriate medication levels
- the guidelines becoming the basis for a range of activities including education programs, practice standards, and improving the dispensation of medications by pharmacists
- monitoring prescriptions and prescribing practices in real-time to determine compliance with practice standards and provide feedback.¹⁵⁹⁴

An important component of this model would be the ability to extend such practices into the community where a patient's care would be monitored by a GP, recognising that inappropriate prescribing may continue within these settings. In this regard, Alfred Health's submission stated:

For analgesia and benzodiazepines, it would be essential to extend the stewardship framework to the community. Teams operating out of a regional hub could liaise with prescribers to promote better use of medication, facilitate the feedback loop, and undertake research.¹⁵⁹⁵

Further, Alfred Health advised that a stewardship framework could assist with education broader than just hospital settings, including into universities and pharmacies, particularly to create conversations about changing expectations of pain relief.¹⁵⁹⁶

The Committee is also aware that Alfred Health established an Alfred Health Analgesic Stewardship Committee to target prescription opioids and oversee and monitor a range of activities to reduce reliance on these types of medication. Its Annual Report for 2016/17 stated:

A recent audit of 502 patients showed 44 per cent were already taking analgesics before admission, which increased to 83 per cent after admission. One in five patients were already taking opioids before coming to hospital, but this increased to one in three inpatients. The program aims to promote optimal and safe use of these and all analgesics, which are commonly used in hospital to treat pain and are widely available.¹⁵⁹⁷

The Committee met with members of the Alfred Health Analgesic Stewardship Committee, which included doctors, pharmacists, and nurses across the organisation, to discuss the benefits and challenges of its approach. The program aims to ensure effective use of analgesics by improving patient outcomes, reducing related harms and focusing on cost-effectiveness. The Committee was advised that key benefits of this approach is that it facilitates implementation of appropriate governance

¹⁵⁹³ Alfred Health, *Submission*, no. 173, 17 March 2017, p. 13.

¹⁵⁹⁴ Alfred Health, *Submission*, no. 173, 17 March 2017, pp. 11-12.

¹⁵⁹⁵ Alfred Health, *Submission*, no. 173, 17 March 2017, p. 13.

¹⁵⁹⁶ Alfred Health, *Submission*, no. 173, 17 March 2017, pp. 19-20.

¹⁵⁹⁷ Alfred Health, *Alfred Health Annual Report 2016-2017*, Melbourne, 2017, p. 28.

and structures, as well as allocation of resources to effectively reduce reliance on these medications and enhance optimal use. The Stewardship Committee identified a number of positive outcomes already achieved, including reductions in use of medications such as oxycodone and morphine, and ‘improved patient satisfaction and reduced adverse events’ as a result of pharmacists working with patients to reduce medication supply.¹⁵⁹⁸ Challenges have also been experienced, including coordinating across diverse units such as emergency departments, pain services, rehabilitation services, as well as the ability to connect with GPs to continue appropriate care in the community.

The Committee also acknowledges recent developments in relation to opioid stewardship programs across the country. A November 2017 article in the Australian Journal of Pharmacy discussed a Queensland Health trial of ‘a hospital-based, pharmacist-led opioid stewardship service’ noting some preliminary findings reported by Benita Suckling, a senior pharmacist with Queensland Health:

The Queensland Health trial has seen some early successes, with the average number of oxycodone tablets per discharge trending down.

“We’re still collecting more data and research but we’re already pleased with the results that we’ve seen,” said Ms Suckling.

Her message is to collaborate with other teams.

“Implementation of this service has revealed ways to do more about opioid prescribing in the future.”¹⁵⁹⁹

Further, St Vincent’s Hospital in Sydney is also undertaking an Opioid Stewardship Program, with the following item appearing in the Hospital’s September 2017 newsletter:

St Vincent’s Hospital Sydney - Opioid stewardship...a new approach to safe opioid discharge prescribing

Numbers of oxycodone tablets dispensed on discharge from St Vincent’s Public, Sydney, ballooned from 12,000 in 2005, to 31,000 in 2012. With the known relationship between opioid supply, and morbidity and mortality, this represents an increased risk to our patients. A novel tool was devised showing 27% of discharge oxycodone prescribing was inappropriate. A continuous quality improvement cycle to alter Junior Medical Officer (JMO) prescribing commenced in 2014. Academic detailing combined with personal audit-feedback delivered by a senior clinician to surgical JMOs through their surgical rotation was associated with immediate change in prescribing habits, with inappropriate oxycodone prescribing decreasing from 27% to 10% sustained after 2 years. This represents a 62% reduction, a very large improvement in the difficult area of implementing and sustaining change in physician prescribing behaviour. The electronic prescribing record was indispensable in identifying the problem and enabling individual prescribing to be audited and fed back to JMOs.¹⁶⁰⁰

¹⁵⁹⁸ Alfred Health, *Submission*, no. 173, 17 March 2017, p. 19.

¹⁵⁹⁹ Paola, S, ‘The Opioid Trap’, *AJP.com.au*, 22 November 2017, viewed 29 January 2018, <<https://ajp.com.au/news/the-opioid-trap>>.

¹⁶⁰⁰ St Vincent’s Health Australia, ‘Category: Clinical innovation’, viewed 29 January 2018, <<https://svha.org.au/home/newsroom/svha-newsletter/september-2017/clinical-innovation>>.

In a related development, the Committee is also aware that in January 2018, the federal Minister for Health announced that a new program, Pain MedsCheck, will be trialled through community pharmacies to support people taking medications for chronic pain issues for three or more months. The media release announcing the trial stated:

It will involve professional pharmacist face to face consultations with patients to review their medication and analgesic use and develop a written action plan, incorporating education, self-management and referral to doctors or other experts where additional support is required.

All community pharmacies will be able to participate in this service.

Community pharmacies participating in the trial will build relationships with GPs and other health professionals who support patients with chronic pain.¹⁶⁰¹

While there is no other public information available, such a model may provide further guidance on how to manage prescription, dispensing and use of pharmaceuticals in community settings, which the Committee notes is a key aspect of stewardship frameworks.

Based on this evidence, the Committee believes there is strong merit in exploring the feasibility of the broad implementation of a stewardship framework approach which targets the most commonly misused pharmaceuticals - opioids and benzodiazepines. The Committee believes that the use of such an approach in Victorian hospitals could have a beneficial impact on the rates of prescriptions issued during hospital stays and beyond. Noting the evidence of Alfred Health on this matter, it is essential that such a program be extended to cover and provide assistance to health professionals in the community, particularly GPs and other prescribers. Such an approach should be funded for a trial and supported by appropriate evaluation of outcomes, particularly in terms of whether reductions within hospitals could be translated to reductions in community settings. The stewardship program will be an essential component of preparing practitioners for the effective implementation of the Victorian real-time prescription monitoring system (discussed in detail in section 15.4), particularly around improving prescribing practices.

RECOMMENDATION 36: The Victorian Government develop and promote a sector-wide stewardship trial program for the medical profession (hospitals, specialist services and GPs) based on the Alfred Health model to promote and audit best practice regarding the prescribing and use of medications with potential for misuse (such as analgesics and benzodiazepines). This should be accompanied with promotion and education of best practice in this area and of appropriate attitudes towards pain relief among health professionals. The program should also be accompanied with an evaluation.

15.3.2 Community education

A second aspect raised by stakeholders and in broader evidence is that, as well as changing behaviour within the medical profession, there is a pressing need to educate the public about the safe use of pharmaceuticals and create community conversations to reduce reliance on medication and promote alternative pain relief strategies for issues such as chronic pain. This is particularly pertinent considering that a proportion of misused pharmaceuticals are sourced not from medical professionals,

¹⁶⁰¹ Minister for Health, *Pharmacy trial to support patients with chronic pain*, Media release, Commonwealth of Australia, Canberra, 25 January 2018.

but from non-medical sources such as friends or family. These findings suggest that '[e]ducation about risks associated with self-diagnosis, peer diagnosis, and self-medicating may help reduce medication sharing'.¹⁶⁰² On this matter, Justice Action stated in its submission:

Educating patients is valuable as evidence suggests that many users of over-the-counter medications unintentionally misuse them. Supply of addictive medication should only occur after a thorough assessment of need and risk, and in the context of a comprehensive medical management plan including non-drug treatment approaches.¹⁶⁰³

The decision made by the TGA to make all codeine products prescription-only also requires significant community education about how to deal with such changes appropriately, including getting further information and advice from doctors or pharmacists.

Community awareness initiatives should be based on public health approaches. The ABS report, *Causes of Death Australia, 2016*, noted that governments 'actively work to promote' the safe use of pharmaceutical drugs, and considered that '[p]ositive health messaging, along with policy and prevention informed by evidence are important factors for preventing drug induced deaths in Australia'.¹⁶⁰⁴ Further, the Australian Framework outlined that measures to reduce the misuse of pharmaceutical drugs should target a wide range of groups including consumers, parents and caregivers, family health professionals, schools and community-based educators, community drug information providers and residential care providers.¹⁶⁰⁵

The Committee understands that a key issue to address in this area is broader community perceptions that pharmaceutical drugs are the only response to treat medical conditions, particularly those relating to pain. As highlighted by the Australian Framework:

While medicines play an important role in the treatment of a range of conditions, there is also a need to fundamentally change the ways in which many Australians perceive the role of medications in responding to physical and psychological problems. The belief that 'there is a pill for all ills' can place pressure on prescribers to use pharmacological treatments in preference to potentially more effective measures. Likewise, it is important to ensure that consumers understand current best practice principles in the quality use of medicines and their rights and responsibilities in relation to this aspect of their health care.¹⁶⁰⁶

The promotion of alternative therapies to medications, where they are shown to be effective, must also accompany such education. Nicholas et al suggested there is evidence to support the use of non-pharmacological therapies such as cognitive behaviour therapy (CBT) and other psychological therapies to treat conditions such as anxiety, depression and chronic pain issues, and that these may be a superior

¹⁶⁰² Nielsen, S, et al., 'The sources of pharmaceuticals for problematic users of benzodiazepines and prescription opioids', *The Medical Journal of Australia*, vol. 199, no. 10, 2013, viewed 29 January 2018, <<https://www.mja.com.au/journal/2013/199/10/sources-pharmaceuticals-problematic-users-benzodiazepines-and-prescription>>, p. 699.

¹⁶⁰³ Justice Action, *Submission*, no. 207, 21 March 2017, p. 5.

¹⁶⁰⁴ Australian Bureau of Statistics, 'Drug Induced Deaths in Australia: A changing story', *3303.0 - Causes of Death, Australia, 2016*, 2017, viewed 29 January 2018, <<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0-2016-Main%20Features-Drug%20Induced%20Deaths%20in%20Australia-6>>.

¹⁶⁰⁵ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, p. 41.

¹⁶⁰⁶ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, p. 41.

treatment to medication in some instances. They suggested that, as well as ensuring that GPs and other health professionals are aware of these options, GPs are in the optimal position to encourage consumers to consider them where appropriate:

General practitioners can be very influential in advising patients about their options and may be able to use this influence to encourage them to view psychological intervention as the first line or additional treatment to medication.¹⁶⁰⁷

This was also raised by the ADF in its submission, noting the importance of non-pharmacological options, and also stating that '[t]hese treatments may not be suitable for people in all circumstances, but while they are known to be effective, their uptake is low, and they often not considered by medical professionals'.¹⁶⁰⁸ The Alcohol and Drug Foundation conducted community education in this area with its *Are You Taking a Risk?* initiative. This was funded by the Victorian DHHS to inform the public about the risks of pharmaceutical misuse and tools to prevent harm. Interestingly, the first phase, which was promoted from February to April 2017, targeted people with high levels of health literacy, men in their 30s and women in their 40s. John Rogerson, CEO of the ADF advised the Committee:

...drug use in our community is moving away from young people into being a significant issue for those people over 30. We keep making drug use in our community a young person's problem. It is actually now becoming a problem for older people, and a very significant problem. You would have got the latest results from the national household drug survey, and I think it identifies that we have got to be much more nuanced now around who we are targeting with these programs.¹⁶⁰⁹

The Alcohol and Drug Foundation further indicated that the first phase attracted a range of public engagement and reached over 3.3 million people on digital platforms and 113,000 content engagements such as comments and clicks. The campaign also registered over 5,000 visits to the website. For its next phase, the ADF will trial a local campaign in regional Victoria, including initiatives such as social marketing, posters, stakeholder engagement and information through pharmacies and medical practices.¹⁶¹⁰

The Committee agrees that such campaigns play a vital role in addressing pharmaceutical misuse, particularly by driving cultural change within communities. As noted by Dr Nicole Lee of 360Edge, 'we get a good bang for our buck if we educate the community and we increase the level of health literacy among the community so they understand they can regulate their own drug use'.¹⁶¹¹ The Committee considers that such programs should be supported and enhanced to ensure that these issues are treated as priority public health matters.

RECOMMENDATION 37: The Victorian Government develop resources and support or conduct awareness raising campaigns targeting the broader community about the safe and appropriate use of prescription medications for pain relief and promoting the role of non-pharmacological treatments for certain conditions (e.g. stress, anxiety and chronic pain). This could start with a targeted campaign that aims to reach patients in health settings and expand to a broader audience if required.

¹⁶⁰⁷ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. 85.

¹⁶⁰⁸ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 20.

¹⁶⁰⁹ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 203.

¹⁶¹⁰ Geoff Munro, *Supplementary evidence*, Alcohol and Drug Foundation, 7 August 2017, p. 6.

¹⁶¹¹ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 375.

15.3.3 Fee structure for dispensing medication

The Committee heard that another option for addressing pharmaceutical misuse is to change the fee structure for medications to ensure patients receive smaller amounts of the prescribed medication. Alfred Health indicated in its submission that its calculations showed:

...community pharmacies receive almost the same fees for dispensing four tablets of oxycodone that they receive for dispensing twenty tablets...Similarly, patients are required to pay the same amount for receiving four tablets of oxycodone that they receive for dispensing twenty tablets...This rigidity provides a presumption that patients will (automatically, reflexively, unthinkingly) receive – and expect to receive – significantly more of a risky drug than they actually need.¹⁶¹²

Similar issues were also considered in the TGA consultation paper on regulatory options to address opioids use and misuse. It suggested:

While opioids are effective in acute pain, there are many cases of patients who after dental or minor surgery that may (only) require 1-3 days of analgesia, are nonetheless being prescribed 20 or 28 unit-dose packs of high dose-codeine or oxycodone. There is evidence that continued use of strong opioids for two weeks can lead to dependence and requests for further prescriptions to ‘address the pain’.¹⁶¹³

The paper suggested a number of regulatory ways to address this situation including: making available smaller packs for treating acute pain, and appropriately sized packs for longer treatment where necessary; and changing PBS listings to better reflect the circumstances in which opioids are approved for use. It noted that while there are options currently for doctors and pharmacies to adapt their prescribing or dispensing to make available only small amounts, this is currently not a widely accepted practice:

While most oral solid dose forms of S8 opioids are packed in quantities of 20 or 28 units, there is currently nothing to stop a doctor writing a prescription for a lesser amount and to dispense quantities less than those contained in the manufacturers packaging. While some hospitals routinely use this approach for suitable patients, it is not widely done. Impacts on secure storage space in hospital and community pharmacies and on whether prescribers choose to prescribe smaller packs under the PBS or as private prescriptions would need to be considered.¹⁶¹⁴

The Australian Framework also stated:

...pharmacists do have the capacity to break up packs of medication in response to requests from prescribers. While this may be problematic for some pharmacists, it is an option that may address some of the problems associated with the provision of pack sizes that are larger than clinically indicated. An educative process is required for prescribers and pharmacists to highlight this option. This process should highlight that prescribers have the option to prescribe less than the maximum quantities and repeats available on the PBS.¹⁶¹⁵

¹⁶¹² Alfred Health, *Submission*, no. 173, 17 March 2017, pp. 14-15.

¹⁶¹³ Therapeutic Goods Administration, *Prescription strong (Schedule 8) opioid use and misuse in Australia - options for a regulatory response: Consultation paper*, Australian Government, Woden, 2018, p. 12.

¹⁶¹⁴ Therapeutic Goods Administration, *Prescription strong (Schedule 8) opioid use and misuse in Australia - options for a regulatory response: Consultation paper*, Australian Government, Woden, 2018, p. 12.

¹⁶¹⁵ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, p. 38.

To address these issues, Alfred Health advised the Committee that, as well as encouraging prescribers to prescribe less, there could be ways to subsidise or incentivise this process. First, it considered that pharmacies could be provided with a larger fee where they dispense less than a full box of tablets, compared to what they would have received for dispensing the full box. Another way would be to subsidise a patient's fee for medications where they receive a very small amount. Finally, Alfred Health suggested that certain less well-known medications or formulations of more commonly known medications could be subsidised so that they are only available in smaller numbers.¹⁶¹⁶ Dr Nicole Lee of 360Edge gave a short example of what this might look like in practice:

I have, for example, had some non-opioid medication prescribed for one of my family members and the doctor prescribed only five pills, even though the pack came with 40 or something. So the pharmacist dispensing it broke up the pack and gave me just the five pills...¹⁶¹⁷

The Committee considered how these issues could be addressed, given the differing roles and responsibilities between state and federal authorities in this area. David Ruschena of Alfred Health advised the Committee in supplementary evidence that, while this area is mainly one of Commonwealth regulation, the Victorian Government could work with pharmacies to influence dispensing practices:

If the Commonwealth, State and Territory Governments could not agree on how to change the fee structure for dispensing medication with abuse potential, there are no legal barriers preventing the Victorian Government from influencing the fee structure for Victorian community pharmacies. The Victorian Government could provide additional incentive payments to pharmacies that dispense medication in amounts less than the standard pack.

Such action would not interfere with the PBS payment structures; they would supplement such structures to compensate pharmacies for any additional work associated with breaking up the packs and then either disposing of, or securing, the drugs that remain.¹⁶¹⁸

The Committee considers that these issues are worthy of further consideration. The preference is that it be considered at the Commonwealth level for national implementation, particularly as the TGA is already examining these concerns in the context of opioid misuse. The Committee considers that the Victorian Government should advocate in this area to explore whether such changes could be made, as well as work with the Pharmacy Guild of Australia – Victoria to explore how pharmacies might influence dispensing practices.

The Committee also notes that the Victorian guidelines for opioids and appropriate prescribing to be developed by the DHHS, as proposed in recommendation 35, should particularly address the role of doctors in prescribing fewer, specified amounts of medications to complement this process.

¹⁶¹⁶ Alfred Health, *Submission*, no. 173, 17 March 2017, p. 16.

¹⁶¹⁷ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 376.

¹⁶¹⁸ David Ruschena, *Supplementary evidence*, Alfred Health, 4 August 2017.

RECOMMENDATION 38: The Victorian Government work with the Commonwealth Government to review the fee structure for dispensing medication with potential for misuse, so that the volumes prescribed and dispensed be based on individuals' needs. Fee structure changes could include: incentivising pharmacies to dispense fewer tablets and subsidising patients who receive smaller amounts of medications. As part of this, the Victorian Government should work with the Pharmacy Guild of Australia and other relevant bodies regarding the role of pharmacies in improving dispensing practices.

15.4 Real-time prescription monitoring system (RTPM)

One of the key concerns relating to the misuse of pharmaceuticals, as noted earlier in the chapter, is that some people visit multiple prescribers to obtain inappropriate amounts or types of drugs. While this is sometimes termed 'doctor shopping' or 'medication shopping', this chapter instead discusses it in terms of improving coordination of care between health professionals.

The Committee understands that it is difficult to estimate the scale of this issue, although a 2016 article in the MJA referred to figures from 2005/06 that estimated 55,000 people were identified as engaging in such conduct.¹⁶¹⁹ In Victoria, a 2007 report by the former Parliamentary Drugs and Crime Prevention Committee (DCPC), *Inquiry into Misuse/Abuse of Benzodiazepines and other forms of Pharmaceutical Drugs in Victoria*, stated:

In 1997, Australia-wide, there were 1,270 doctor shoppers per 1,000 GPs and in Victoria there were 1,447 per 1,000. Prescriptions filled by 'doctor shoppers' nationally included 59 per cent for psychotropic drugs of misuse including benzodiazepines (35%), codeine compounds (15%) and narcotic analgesics, with the remainder being medicines for other conditions, many of which appeared to be obtained on the Pharmaceutical Benefits Scheme (PBS) and then taken overseas for relatives or for sale.¹⁶²⁰

The AIHW report on the non-medical use of pharmaceuticals stated that 2.6 per cent of people who recently used opioids and 5.5 per cent who recently used benzodiazepines obtained these by visiting multiple doctors or pharmacies, although the AIHW advised of a wide margin of error in these figures.¹⁶²¹

A commonly recommended strategy to ensure that all professionals involved in a patient's care are aware of all or some prescriptions and drugs dispensed to them is the creation of a real-time prescription monitoring system (RTPM).¹⁶²² The 2007 report by the DCPC recommended that an electronic real time prescription recording service be developed in consultation with medical and pharmacy bodies, and to advocate to the Commonwealth Government to adopt the service nationally.¹⁶²³ There have

¹⁶¹⁹ Ogeil, R, et al., 'Prescription drug monitoring in Australia: capacity and coverage issues', *The Medical Journal of Australia*, vol. 204, no. 4, 2016, viewed 29 January 2018, <<https://www.mja.com.au/journal/2016/204/4/prescription-drug-monitoring-australia-capacity-and-coverage-issues>>, p. 148.

¹⁶²⁰ Drugs and Crime Prevention Committee, *Final report on the Inquiry into Misuse/Abuse of Benzodiazepines and Other Pharmaceutical Drugs*, Parliament of Victoria, East Melbourne, 2007, p. 109.

¹⁶²¹ Australian Institute of Health and Welfare, *Non-medical use of pharmaceuticals: Trends, harms, and treatment: 2006-07 to 2015-16*, Canberra, 2017, p. 14.

¹⁶²² This is also referred to as a prescription drug monitoring system (PDMP) where the system is not updated in real time.

¹⁶²³ Drugs and Crime Prevention Committee, *Final report on the Inquiry into Misuse/Abuse of Benzodiazepines and Other Pharmaceutical Drugs*, Parliament of Victoria, East Melbourne, 2007, p. ix.

also been numerous similar recommendations made by Victorian coroners over the years in response to poor coordination among health professionals that may have contributed to overdose deaths. As explained by Judge Sara Hinchey, State Coroner:

Some doctors are unable to coordinate their care because they do not know about one another, and that is the classic doctor shopping scenario. But in other instances the doctors know that their patient is seeing one or more other doctors but do not know what those other practitioners are prescribing or why. This can lead to fatal outcomes.¹⁶²⁴

Judge Hinchey noted that coroners identified a RTPM system as the most effective way ‘to support safe, clinical, appropriate prescribing and dispensing of pharmaceutical drugs’.¹⁶²⁵

There is also support for a national RTPM to address these issues. The Australian Framework noted Commonwealth support since 2012 for a national RTPM, referring to the Electronic Recording and Reporting of Controlled Drugs (ERRCD) system. It suggested that the ERRCD system provide real-time information to support decision-making of prescribers and dispensers, as well as to detect any problematic issues such as forged prescriptions and inappropriate prescribing and dispensing practices.¹⁶²⁶ While a national system did not eventuate under the duration of the Australian Framework, more recent developments on this are discussed below.

Following inaction on a national ERRCD system, the Victorian Government announced in April 2016 that the state would implement its own RTPM, with approximately \$30 million provided as part of the 2016/17 budget. The Victorian Government particularly highlighted that since 2012, 21 coronial findings have called for the system to be implemented.¹⁶²⁷

This section focuses on the experiences both internationally and domestically of implementing RTPM systems, as well as issues raised by inquiry stakeholders relevant to implementation of the Victorian model.

15.4.1 International models

Globally, experience with prescription drug monitoring systems largely emanates from state-based systems established across parts of North America. It is worth noting that there are various differences between these systems, which makes them difficult to compare and even apply learnings to the Australian context. Some of these differences relate to:

- health care systems
- whether systems’ objectives are based on law enforcement or health outcomes
- the different types of drugs included for monitoring
- whether the system updates in real-time or other modes, such as weekly updates

¹⁶²⁴ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 13.

¹⁶²⁵ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 13.

¹⁶²⁶ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, p. 17.

¹⁶²⁷ Minister for Health, Minister for Mental Health, *Real Time Prescription Monitoring Will Save Lives*, Media release, State Government of Victoria, Melbourne, 25 April 2016.

- whether the system is mandatory for use by doctors and pharmacists before they prescribe or dispense
- the types of data captured.

Given these significant variances, there has been relatively little research on effectiveness across such systems.

United States of America jurisdictions

In some US jurisdictions, systems to monitor the diversion of prescription drugs have been in place since the 1930s. However, these were paper-based and did not link back to health care services, as they largely focused on controlling and monitoring drug supply. Nowadays, they are electronic, which allows frequent information updates, although this is typically restricted to daily or weekly updates (aside from Oklahoma where data is updated within five minutes of a medication being dispensed). According to the national Substance Abuse and Mental Health Services Administration (SAMHSA) brief, *Prescription Drug Monitoring Programs: A Guide for Healthcare Providers*, state prescription drug monitoring programs (PDMPs) have been established in 49 states, in addition to the District of Columbia and the US territory of Guam. They are largely operated by state health authorities (although some are managed by law enforcement authorities), and focus on monitoring controlled, scheduled medications such as pharmaceutical opioids. Data is entered by pharmacists for each prescription dispensed with information including dates, patient names, prescribers, pharmacy, medication type and quantities.¹⁶²⁸

The SAMHSA brief identified some of the practical benefits to be achieved in improved health care for patients:

For example, when treating for chronic pain, a practitioner can check the state PDMP for data on the patient's history of prescriptions for controlled substances. This information can be used to determine whether the patient is already receiving opioid medications or other medications that, when combined with an opioid prescription, might put him or her at risk for overdose.¹⁶²⁹

Other practical uses for the systems include to: identify prescription medication misuse or risky use patterns; provide certainty of legitimate need for appropriate patients; identify risks associated with multiple prescribed drugs; indicate where patients have not filled a prescription; monitor patients with substance use disorders; and identify any inappropriate flags such as multiple or similar prescriptions, which should be dealt with by way of intervention with the patient to discuss particular circumstances.¹⁶³⁰

In terms of effectiveness, evaluations reflect mixed results. Nicholas et al noted in 2011 that, while these systems have reduced the rate of prescriptions for monitored drugs, this has not necessarily led to improved outcomes in harms such as diversion, misuse or mortality rates.¹⁶³¹

¹⁶²⁸ Substance Abuse and Mental Health Services Administration (SAMHSA), 'Prescription Drug Monitoring Programs: A Guide for Healthcare Providers', *In Brief*, vol. 10, no. 1, 2017, pp. 1-3.

¹⁶²⁹ Substance Abuse and Mental Health Services Administration (SAMHSA), 'Prescription Drug Monitoring Programs: A Guide for Healthcare Providers', *In Brief*, vol. 10, no. 1, 2017, p. 3.

¹⁶³⁰ Substance Abuse and Mental Health Services Administration (SAMHSA), 'Prescription Drug Monitoring Programs: A Guide for Healthcare Providers', *In Brief*, vol. 10, no. 1, 2017, p. 3.

¹⁶³¹ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, p. 76.

More recently, the SAMHSA brief considered that there are some indications of successes with these programs. In particular, the main benefit observed in some states was the encouragement of safer prescribing practices and informed clinical decision-making, while also reducing diversion. It particularly noted that mandatory programs in New York and Tennessee where prescribers were required to view the database before prescribing certain medications, resulted in reductions in prescriptions from five or more doctors or pharmacies in three months, equating to 75 per cent in New York and 36 per cent in Tennessee.¹⁶³²

In terms of overdose rates, although earlier research did not find links between the establishment of a monitoring system and reduced overdose or mortality, more recent studies indicated positive impacts where the systems had more robust characteristics. For example a 2016 study of 34 states between 1999 and 2013 found that the establishment of a monitoring system resulted in a 1.12 reduction in opioid-related deaths per 100,000 population in the year after implementation. It further found that programs monitoring a wider range of drugs, and updating data at least weekly were associated with even greater reductions.¹⁶³³ Similarly, a 2017 study of data between 1999 and 2014 found that states that had more robust programs were associated with increased reductions in overdose death rates than states with ‘weaker’ systems.¹⁶³⁴

A range of unintended consequences have also been reported, such as a reduction in access to medication, including pain medication, where there is a legitimate need, due to prescribers feeling pressured not to prescribe.¹⁶³⁵ However, the SAMHSA brief refuted these claims based on particular studies, while also noting it is an important concern to consider.¹⁶³⁶

The Committee is concerned about the evidence that prescription monitoring systems may have resulted in a proportion of patients who were dependent on pharmaceutical opioids switching to heroin after being denied a prescription. This is reported to have contributed to rising rates of heroin-related deaths. For example, a 2015 survey of 15,227 patients with opioid dependence showed that ‘as prescription opioid use has waned, concurrent heroin abuse has increased, with important, distinct regional variations’.¹⁶³⁷ While the reasons behind this were not clear, respondents suggested issues such as accessibility and costs contributed to switching to heroin. A study on heroin injecting use in Philadelphia and San Francisco stated:

From the accounts of younger/recent heroin injectors in this study, since the rise of the opioid pill epidemic, the barriers to heroin use and to injection have been reduced by the normalized pervasiveness of these pharmaceuticals. The widespread availability of opioid analgesics outside sanctioned channels and, paradoxically, medical and regulatory attempts to curb this through monitoring and limiting prescribing, appear to be drawing a new generation into higher risk heroin injecting.¹⁶³⁸

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- 1632** Substance Abuse and Mental Health Services Administration (SAMHSA), ‘Prescription Drug Monitoring Programs: A Guide for Healthcare Providers’, *In Brief*, vol. 10, no. 1, 2017, p. 5.
- 1633** Patrick, S, et al., ‘Implementation of Prescription Drug Monitoring Programs Associated With Reductions In Opioid-Related Death Rates’, *Health Affairs*, vol. 35, no. 7, 2016.
- 1634** Pardo, B, ‘Do more robust prescription drug monitoring programs reduce prescription opioid overdose?’, *Addiction*, vol. 112, no. 10, 2017, p. 1773.
- 1635** Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, pp. 76-77.
- 1636** Substance Abuse and Mental Health Services Administration (SAMHSA), ‘Prescription Drug Monitoring Programs: A Guide for Healthcare Providers’, *In Brief*, vol. 10, no. 1, 2017, pp. 5-6.
- 1637** Cicero, T, et al., ‘Shifting Patterns of Prescription Opioid and Heroin Abuse in the United States’, *The New England Journal of Medicine*, vol. 373, 2015, viewed 1 February 2018, <<http://www.nejm.org/doi/full/10.1056/NEJMc1505541>>.
- 1638** Mars, S, et al., ‘“Every ‘Never’ I Ever Said Came True”: Transitions from opioid pills to heroin injecting’, *International Journal of Drug Policy*, vol. 25, no. 2, 2015, p. 264.

However, the SAMHSA brief highlighted evidence suggesting that regulatory efforts to reduce prescription opioid use has not contributed to increased heroin use:

According to the report *Trends in Heroin Use in the United States: 2002 to 2013*, “The concern that efforts to prevent the illegal use of prescription opioids are causing people to turn to heroin is not supported by the trend data. . . . Although research indicates that people who previously misuse prescription pain relievers were more likely to initiate heroin use than people who had not misused prescription pain relievers, most people who misuse prescription pain relievers do not progress to heroin use.”

Furthermore, according to a 2016 review article, implementation of most policy decisions aimed at reducing rates of nonmedical use of opioid medications occurred after heroin use rates had begun trending upward. The authors point to heroin’s increased accessibility, reduced price, and high purity as factors that may have contributed to increases in the drug’s use. In addition, the review highlighted studies of Florida and Staten Island, NY, that found that policy-induced reductions in the rates of opioid prescribing were associated with reductions in overall opioid-related deaths (that is, deaths related to either heroin or opioid medication use). Based on the overall findings of the review, the authors recommended enhanced use of PDMPs as part of a comprehensive strategy to reduce initiation of nonmedical opioid use.¹⁶³⁹

Stakeholders advised the Committee that this is an issue that Victoria must keenly avoid in implementing a RTPM system. For example, the Penington Institute stated in its submission:

There is a real risk that some patients who are flagged as ‘drug-seeking’, rather than being identified and supported, will simply be locked out of health services (especially GP practices). This could result in displacement into the injection of illicit heroin or generate demand for counterfeit pharmaceuticals, an effect noted in the US as access to prescription opioids has been tightened.¹⁶⁴⁰

Similarly, Professor Dan Lubman of Turning Point cautioned:

When they brought in real-time prescribing in New York, what we saw was a 25 per cent increase in heroin-related deaths. As people were refused their pain medications, or as the doctors felt uncomfortable prescribing them, they went and got something that was much more cheap and available, which was heroin, and we saw this massive increase in heroin.¹⁶⁴¹

Therefore, while there is disputed evidence on the extent of this concern, it is a key factor to consider and avoid with the implementation of a RTPM in Victoria.

During the Committee’s overseas study tour, it met with Robert Sumner, Principal Consultant for the Assembly Committee on Business and Professionals, from the California State Legislature. The Committee discussed California’s prescription drug monitoring system, the Controlled Substance Utilization Review and Evaluation System (CURES), run by the Department of Justice since 2009. This system comprises a database monitoring the dispensation of certain controlled prescription medications to assist health, regulatory oversight and law enforcement agencies. Once information is updated on CURES, doctors and pharmacists can access patient activity reports. Alerts are also provided in particular circumstances (for example,

¹⁶³⁹ Substance Abuse and Mental Health Services Administration (SAMHSA), ‘Prescription Drug Monitoring Programs: A Guide for Healthcare Providers’, *In Brief*, vol. 10, no. 1, 2017, p. 6.

¹⁶⁴⁰ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 39.

¹⁶⁴¹ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 28.

a patient receiving four or more prescriptions within a 12 month period). While the system was originally voluntary, doctors and pharmacists are now required to register for the system under AB 679 (Allen, Chapter 778, Statutes of 2015).¹⁶⁴²

The Committee was told there is a culture among physicians where they commonly prescribe opioids over other medications or pain management methods as a way to end patient consultations. Educating the medical community about opioid alternatives, while also acknowledging the role of opioids in treating certain patients, is therefore essential.¹⁶⁴³ This highlighted to the Committee that, in order for such a system to be effective, a strong focus on instilling cultural change is required, as is buy in from the medical profession. The Committee believes that the recommendation for the DHHS to develop prescription opioid guidelines will contribute to this cultural change.

PharmaNet - British Columbia, Canada

During the inquiry, the Committee also became aware of a RTPM system operating in the Canadian province of British Columbia called PharmaNet. Run by the Ministry of Health and the College of Pharmacists since 1995, it is an online, real-time system monitoring all dispensed prescription medications, rather than focusing only on some as in the US. Legally, only pharmacists were required to enter data onto the system about all aspects of medications dispensed, and the system would include alerts on issues such as risks of interactions between medications, dosing errors and multiple prescriptions. A study of the system in 2012 found that six months after the system was established, there was a 33 per cent reduction in inappropriate prescriptions for opioids and a 49 per cent reduction in inappropriate prescriptions for benzodiazepines. The study suggested:

...the implementation of a province-wide centralized prescription network was associated with large, immediate and sustained reductions in filled prescriptions for opioid analgesics and benzodiazepines deemed inappropriate by our definition. These findings provide empirical evidence that centralized prescription networks can reduce inappropriate prescribing and dispensing of prescriptions by offering health care professionals real-time access to prescription data.¹⁶⁴⁴

Noting that historically, doctors were not mandated to access the system before issuing prescriptions, in April 2016 the College of Physicians and Surgeons of British Columbia adopted a new mandatory professional standard, *Safe Prescribing of Drugs with Potential for Misuse/Diversion*, to govern the prescribing of opioids and other high risk medications. One of the directions contained in the standard is for physicians to review PharmaNet, where access is available, before prescribing opioids, sedatives or stimulants. If access is not available, they should consult with colleagues and limit prescriptions to necessary medications until the patient's history becomes available.¹⁶⁴⁵

During a meeting with representatives of the Pharmaceutical Services Division of the Ministry of Health, the Committee heard again that cultural change is required to encourage the medical profession to utilise the system. Currently, 3,600 of 10,000 physicians use PharmaNet, with concerns of physicians relating to the

¹⁶⁴² The Medical Board of California, 'CURES Update', viewed 29 January 2018, <http://www.mbc.ca.gov/Licensees/Prescribing/CURES_Update.aspx>.

¹⁶⁴³ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 83-84.

¹⁶⁴⁴ Dormuth, C, et al., 'Effect of a centralized prescription network on inappropriate prescriptions for opioid analgesics and benzodiazepines', *CMAJ*, vol. 190, no. 3, 2018, p. E854.

¹⁶⁴⁵ 'College: New professional standard on safe prescribing', *BC Medical Journal*, vol. 58, no. 6, 2016.

cost of implementation and convenience of use. There is also a reluctance among some physicians to deal with patients experiencing substance misuse issues and addiction. The Committee was further informed of some of the broader unintended consequences of the system including:

- it created broader discussions regarding the complexity of pain management and the willingness of physicians to prescribe opioid medications
- greater awareness of overprescribing of antibiotics among physicians
- it is expensive and any amendments require extensive planning
- potential for some patients that were originally using opioid medications to divert their use to illicit opioid substances, such as heroin
- it is unclear how medicinal cannabis could be incorporated into the system.¹⁶⁴⁶

The Committee considers that the experiences of US jurisdictions and British Columbia should be front of mind for the upcoming implementation of the Victorian RTPM. Particular factors for consideration include: ensuring that programs have robust characteristics such as making data available in real-time and capturing a broad range of monitored substances; mandatory requirements for both pharmacists and doctors, particularly to support cultural change; strong evaluation components to monitor all outcomes, including unintended consequences both positive and negative; and ensuring support is in place to identify and address any displacement of pharmaceutical opioid use to heroin use.

15.4.2 Commonwealth model

As noted earlier, the Commonwealth has supported the development of national prescription monitoring through the ERRCD system. An important factor to note is that this system was designed to monitor only Schedule 8 drugs, which include strictly controlled opioid analgesics such as oxycodone, morphine and fentanyl, given their high risks of harm.

The Australian Framework discussed that the ERRCD was based on a model developed in Tasmania called the Drugs and Poisons Information System Online Remote Access (DORA) system, the only such real-time prescription monitoring system currently operating in Australia. The DORA system, run by the Department of Health and Human Services, allows clinicians to access information about dispensing and other issues for Schedule 8 drugs. In supplementary evidence to the Committee, the ADF stated:

Medical practitioners and pharmacists can view their patient's file to immediately identify their history of opioid medications, whether another practitioner has authority to prescribe for that patient and whether that patient has been identified as 'drug seeking' or drug dependent. Patients who are identified as at risk (red or yellow flags) are reviewed and where appropriate they can be referred to specialists in pain management and addiction who might recommend alternative evidence-based clinical treatments. Since the start of DORA, prescription opioid deaths in Tasmania have fallen from an average of 25 per year (for the period 2005-2009) to 17 per year (for the period 2010-2014), which represents a 34% decline in deaths. This appears to be the reverse of trends in other jurisdictions.¹⁶⁴⁷

¹⁶⁴⁶ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 83-84.-43.

¹⁶⁴⁷ Geoff Munro, *Supplementary evidence*, Alcohol and Drug Foundation, 7 August 2017, p. 5.

Inquiry stakeholders considered that the outcomes of the DORA system have been largely positive, but noted Tasmania's relatively small population size. Associate Professor Nadine Ezard told the Committee:

The experience of Tasmania is positive but at the same time, Tasmania is a very small State with a very few number of prescribers and a small population so it's perhaps more feasible to operate an effective system in a small state like that.¹⁶⁴⁸

While national implementation of the ERRCD did not occur under the Australian Framework, in July 2017 the Commonwealth announced that a national RTPM system would be implemented, with \$16 million in funding to 'provide an instant alert to pharmacists and doctors if patients received multiple supplies of prescription-only medicines'.¹⁶⁴⁹ Some inquiry stakeholders were supportive of a national RTPM system, including the Royal Australasian College of Physicians (RACP) who commended the Victorian Government for showing leadership in this area, and called for a national RTPM system to be implemented.¹⁶⁵⁰ MIGA's submission also supported the Victorian RTPM system but 'preferably as part of a national system or at a minimum involving a system which shares information between different Australian states and territories'.¹⁶⁵¹ Dr Lorraine Baker, President of the AMA Victoria emphasised to the Committee that:

...if this is rolling out Australia wide, the technology and the platforms from state to state will need to be interactive as well, or the whole premise on which it is based will fail. It will fall over because there will be border issues that cannot be addressed.¹⁶⁵²

The implications of how the Commonwealth RTPM will intersect with the Victorian RTPM is discussed further below.

It should also be noted that at the Commonwealth level, a Medicare Prescription Shopping Program exists, which aims to detect people who receive prescription medications in excessive amounts (i.e. - from six or more different prescribers and/or 25 or more target items, and/or 50 or more items within the last three months). If a person is detected at these levels, the program can provide this information to the prescriber. There is also a connected Prescription Shopping Information Service, where prescribers that register can call a hotline to check if their patient has been detected. However, the Committee is aware of a number of barriers impacting the program's effectiveness. These include: the data only relates to prescriptions tied to the PBS, with no information on prescriptions issued privately; the threshold for detection is fairly high and may not capture everyone; and there is a time lag with the collection of data.¹⁶⁵³ The Committee similarly was informed of such limitations by stakeholders, for example Associate Professor Nadine Ezard stated:

...the doctor shopping line has a very high threshold for testing positive. People can be asked to sign a document to get the information from the PBS if it's funded by the public sector. If it's privately prescribed there is no data at all and there is a time lag for about up to three months before that data comes through. So we do need some other way of actually monitoring prescriptions.¹⁶⁵⁴

¹⁶⁴⁸ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 119.

¹⁶⁴⁹ Hunt, G, Minister for Health, *National approach to prescription drug misuse*, Media release, Australian Government, 28 July 2017.

¹⁶⁵⁰ Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017, p. 5.

¹⁶⁵¹ MIGA, *Submission*, no. 202, 20 March 2017, p. 1.

¹⁶⁵² Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 255.

¹⁶⁵³ Nicholas, R, et al., *Pharmaceutical drug misuse in Australia: complex problems, balanced responses*, National Centre for Education and Training on Addiction, Adelaide, 2011, pp. 49-50.

¹⁶⁵⁴ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 119.

15.4.3 Victorian model

During the inquiry, the Victorian Government introduced and passed the *Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Act 2017* (the Act) to govern the legal framework for the RTPM, now called SafeScript. The software will be available throughout 1,900 medical clinics, 1,300 pharmacies and 200 hospitals.¹⁶⁵⁵

In February 2018, proposed Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Regulations 2018 (the proposed Regulations) were released for public consultation, along with the required Regulatory Impact Statement (RIS) and other documentation. The RIS provided further information about the implementation of SafeScript:

As Victoria will be the first state to roll out a prescription monitoring system of this scale, and to ensure it is embedded in clinical practice, appropriate transitional arrangements will be in place before this requirement comes into effect. The proposed Regulations provide for an 18 month period where the mandatory requirement for medical practitioners, nurse practitioners and pharmacists to check SafeScript is suspended until 1 April 2020 to allow clinicians to familiarise themselves with the use of SafeScript and incorporate it into their clinical practice.¹⁶⁵⁶

Inquiry stakeholders were strongly supportive of the forthcoming Victorian RTPM system.¹⁶⁵⁷ For example, the Penington Institute stated in its submission:

Penington Institute welcomes the introduction of prescription monitoring. It is an opportunity to gather real-time information about people who may be experiencing, or at risk of, drug dependence. The potential benefits in terms of early intervention are very significant.¹⁶⁵⁸

However, stakeholders also made the Committee aware of supporting issues that need to be addressed if the RTPM system is going to be successful in reducing harms and maximising effective prescribing. As stated by Sam Biondo, Executive Officer of the Victorian Alcohol and Drug Association (VAADA), it ‘is a positive reform which will save many lives by preventing fatal and non-fatal overdoses, reduce dependence and improve prescribing practices, but only if we do it in the proper and appropriate way’.¹⁶⁵⁹

¹⁶⁵⁵ Department of Health and Human Services, *SafeScript Initiative: Frequently Asked Questions*, State Government of Victoria, Melbourne, 2017.

¹⁶⁵⁶ Deloitte Touche Tohmatsu, *Regulatory Impact Statement - Proposed Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Regulations 2018*, Department of Health and Human Services, Melbourne, 2018, p. iii.

¹⁶⁵⁷ Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 203; Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 13; Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 301; Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 166; Alfred Health, *Submission*, no. 173, 17 March 2017, pp. 13-14; Australian Medical Association, *Submission*, no. 203, 20 March 2017, p. 2; City of Boroondara, *Submission*, no. 217, 31 March 2017, pp. 1-2; cohealth, *Submission*, no. 140, 16 March 2017; MIGA, *Submission*, no. 202, 20 March 2017, p. 3; Penington Institute, *Submission*, no. 209, 24 March 2017, pp. 38-39; Public Health Association Australia, *Submission*, no. 152, 17 March 2017, pp. 7-8; Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017, p. 5; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 13.

¹⁶⁵⁸ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 38.

¹⁶⁵⁹ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 301.

Key aspects of the Act

The Committee is aware that the RTPM system contains a number of factors that, based on international experiences, will ensure it is a model of best practice. Namely, information on the database will be updated in real-time, it will be mandatory for both prescribers and pharmacists to review a patient's record before writing or dispensing a prescription for high-risk medication, and it is focused on achieving improved health and clinical outcomes, rather than being focused on law enforcement issues. As stated by the Minister for Health, the Hon. Jill Hennessy MP, in introducing the Bill:

The amendments contained in this bill will require prescribers and pharmacists to review the patients' dispensing records before writing or dispensing a prescription for certain high-risk medicines. This approach will provide the greatest benefit from the system, and is consistent with international best practice, as demonstrated particularly in the United States.¹⁶⁶⁰

The Committee commends these decisions as it will provide the best opportunity to ensure SafeScript is used effectively by health professionals to improve decision-making and intervene early if there are any concerns for particular patients.

One issue subject to comment among stakeholders was the types of prescription drugs that would be captured under the system. As discussed earlier, Schedule 8 drugs are most often targeted by such programs, for example under the ERRCD and DORA, as they include high-risk opioids analgesics. However, a number of stakeholders advised the Committee that other prescription medications of concern should also be included. The preferred position of the Coroners Court was that, similar to PharmaNet in British Columbia, all prescription medications should be captured, noting the wide range of drugs involved in overdose deaths.¹⁶⁶¹ Other stakeholders highlighted that drugs such as benzodiazepines, contained on Schedule 4, and some opioids such as tramadol and codeine should also be included due to high rates of misuse.¹⁶⁶²

In anticipation of the Bill and following recommendations of an expert advisory panel, the Victorian Government announced that Schedule 8 drugs as well as other high risk medications would be captured, and that codeine will be included at a later stage following the TGA decision to re-schedule codeine products to be prescription-only from February 2018:

Based on the latest international and local research, and recommendations from our expert advisory group, the system will monitor prescription medicines that are causing the greatest harm to the Victorian community.

These include Schedule 8 medicines, which cover strong painkillers such as morphine and oxycodone. Other high-risk medicines to be monitored include all benzodiazepines used for treating conditions such as anxiety and insomnia, 'Z class' medicines also used for insomnia, as well as quetiapine, an anti-psychotic medicine.¹⁶⁶³

¹⁶⁶⁰ Victoria, *Parliamentary Debates*, Legislative Assembly, Wednesday, 9 August 2017, p. 2188 (Jill Hennessy, Minister for Health).

¹⁶⁶¹ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, pp. 13-14.

¹⁶⁶² Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, pp. 21-22; MIGA, *Submission*, no. 202, 20 March 2017, p. 3; Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017, p. 5; Turning Point, *Submission*, no. 116, 15 March 2017; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 13.

¹⁶⁶³ Minister for Health, *More Prescription Pills To Be Monitored To Save Victorian Lives*, Media release, State Government of Victoria, Melbourne, 28 July 2017.

The Committee again commends the decisions of the Victorian Government, based on international evidence to include a wider range of drugs as key to reduce harms such as mortality and overdoses.

The final issue is how the Victorian system will interact with the proposed Commonwealth system. During debates in both Houses of Parliament, it was made clear that the Victorian Government is moving ahead with the state-based system while continuing conversations with the Commonwealth and other state and territory governments about the national system. As stated by the Hon Jenny Mikakos in the Legislative Council, Minister for Families and Children:

While Victoria is now progressing with an alternative platform, it continues to work with the commonwealth and other jurisdictions to progress the establishment of a national governance framework and national data-sharing arrangements to prevent cross-border prescription shopping. I make the point that the funding the Andrews Labor government made available in the budget last year way exceeds what the commonwealth has been prepared to put on the table for the entire country. So obviously that is an issue for them to address as well. However, the software that Victoria builds will be robust enough to scale up to deliver a national platform for all states and territories to use. Other states and territories are at present committed to using the commonwealth software, but there has been interest in Victoria's software, and our government will be negotiating the case for others to join us.¹⁶⁶⁴

It should also be noted that the Act itself provided for potential for a national system, with the Explanatory Memorandum stating:

New section 30B(3) allows the Secretary to enter into an agreement or a memorandum of understanding with the Commonwealth, other States or Territories and any entity in another Australian jurisdiction in relation to the provision of information to or from the database. This is necessary to enable cross-border information sharing, and in case of a future national system for real-time prescription monitoring.¹⁶⁶⁵

In response to concerns about ensuring the Commonwealth and Victorian software and IT systems interact with one another and can easily be used by health professionals, particularly if it were a national system, as raised by the AMA Victoria, the Hon Jenny Mikakos stated:

...the commonwealth software does not currently integrate with practice software. That has been the stumbling block to us participating in their proposal. We recognise that prescribers and pharmacists are very focused on a desire to have an integrated system so that there is minimum impact on workflow and viewing a patient record. The system we are building will be based on more contemporary technology that better supports future business needs, such as increases in the volume of data, and ensures minimal disruption to clinicians' workflow. We are obviously very conscious of this issue. We will be working with medical and pharmacy organisations as well as software vendors to ensure we can achieve the best result possible.¹⁶⁶⁶

Matthew McCrone, Director of Real-time Prescription Monitoring Implementation in the DHHS also reiterated this to the Committee;

¹⁶⁶⁴ Victoria, *Parliamentary Debates*, Legislative Council, Tuesday, 17 October 2017, p. 5093 (Jenny Mikakos, Minister for Families and Children).

¹⁶⁶⁵ *Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Bill 2017 (Vic)*, section p 4.

¹⁶⁶⁶ Victoria, *Parliamentary Debates*, Legislative Council, Thursday, 19 October 2017, p. 5180 (Jenny Mikakos, Minister for Families and Children).

...something we are very focused on is how time-poor clinicians are and that we are asking them to use the system as well. So we are very, very clear that the ICT we deliver does absolutely minimal interruption to that workflow that is very established and very core to them actually getting through the patients they have.¹⁶⁶⁷

The Committee considers that, given the range of moving factors in relation to a national system, the Victorian measures are appropriate. The Committee agrees that the system's ease of use is important, noting in particular conversations the Committee had in both California and Canada about the potential role of such systems to drive cultural change. This can only occur in an effective manner if the support tools are readily accessible for health professionals.

Key issues for implementation

While the Victorian legislative framework is sound, the Committee wishes to highlight three areas for practical implementation that must accompany the implementation of the RTPM system. A key theme in stakeholder evidence to the Committee was that the system cannot exist in isolation, as it is only one component of a broader response to the misuse and overprescribing of pharmaceutical drugs, and requires a range of other measures to ensure effectiveness. Some of these have been signalled as part of the reforms, but others require more attention.

As Dr Nicole Lee of 360Edge told the Committee:

...just real-time monitoring is not going to solve the problem. That is going to go a long way to helping doctors have the right information for prescribing — and that is important — and for pharmacists to have the right information for dispensing so they can pick up on people who may be overusing medications or diverting medications. But there are a whole range of other things that are required as well.¹⁶⁶⁸

Dr Alex Wodak of the ADLRF cautioned that measures focused only on reducing supply, such as the RTPM system do not have a strong history of effectiveness:

The temptation is always to ratchet-up supply restrictions and there are calls for on-time prescription monitoring and I think that probably has a role but the history of supply restrictions is not encouraging.

Very often the results are disappointing and very often there are severe, unintended negative consequences that we didn't realise at the time so I would like to see much more emphasis put on reducing demand than reducing supply. But it's something we need to take very seriously.¹⁶⁶⁹

Dr Stefan Gruenert, CEO of Odyssey House Victoria (OHV) also told the Committee that limitations of what the RTPM system can do should be borne in mind:

It is not going to prevent the whole black market. We know that particularly drugs used in palliative care and cancer treatment end up on the black market. So they have been appropriately prescribed but they have been diverted because someone used part of them — the pain was not too bad and they thought, 'Well, I've got six tablets left; I can make a hundred bucks on these' — or sometimes they are walking out with huge quantities and they are making thousands of dollars. So it is not going

¹⁶⁶⁷ Matthew McCrone, Director, Real-time Prescription Monitoring Implementation, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 331.

¹⁶⁶⁸ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 375.

¹⁶⁶⁹ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, pp. 87-88.

to prevent everything, because many are prescribed well and it is not just the same person doctor shopping. In drug policy there is no one thing, there is no one silver bullet that will do; we need a combination of all these things to reduce the harms and find that sweet spot in the middle.¹⁶⁷⁰

Training for the medical profession

A key issue discussed by stakeholders was the need for the RTPM system to be accompanied by appropriate training and clinical support for the medical profession, particularly in terms of issues such as appropriate use of pharmaceutical drugs, the role of the RTPM system in improving clinical decisions and management of patients identified by the system as requiring further support. This was identified as essential to assist patients who have developed an iatrogenic dependence. As noted by the Australian Framework:

Australia is likely to have a large but relatively hidden population of such individuals who unintentionally misuse these medications and who have developed an iatrogenic dependence (Royal Australasian College of Physicians, RACP, 2009).¹⁶⁷¹

cohealth stated in its submission:

...we also have concerns about what the introduction of this real time prescription monitoring will mean for people with addiction who are currently accessing their drugs of addiction through legal means. We are especially concerned about the potential risks to such individuals should they switch to, or seek to 'top up' with illicit substances such as heroin. Their likely inexperience with these substances, combined with the highly variable strength of street based drugs (as opposed to prescription drugs) and the further risks that arise through using multiple types of drugs places this group potentially at very high risk of overdose and accidental death.¹⁶⁷²

Such concerns necessitate appropriate support, for example cohealth discussed 'clear prescribing guidelines, comprehensive training for health professionals, and the provision of assertive and skilled support to patients who are flagged on the system and experiencing addiction'.¹⁶⁷³ Frances Mirabelli, CEO of the AMA Victoria further emphasised that 'GPs will become the front line when this system of real-time prescription monitoring comes in' and they therefore require support.¹⁶⁷⁴

The Committee is aware that there is a significant focus on training and workforce development as part of the implementation of the RTPM system. For example, the Victorian Government has commissioned a consortium of all Victorian primary health networks (PHNs) and the organisation, NPS MedicineWise, to deliver training on safe prescribing, counselling for patients on misuse and tapering, and use of SafeScript.¹⁶⁷⁵ Matthew McCrone of the DHHS further explained to the Committee:

¹⁶⁷⁰ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 166.

¹⁶⁷¹ National Drug Strategy, *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australian Government, Canberra, 2013, p. 3.

¹⁶⁷² cohealth, *Submission*, no. 140, 16 March 2017.

¹⁶⁷³ cohealth, *Submission*, no. 140, 16 March 2017.

¹⁶⁷⁴ Frances Mirabelli, Chief Executive Officer, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 255.

¹⁶⁷⁵ Department of Health and Human Services, *SafeScript Initiative: Frequently Asked Questions*, State Government of Victoria, Melbourne, 2017, p. 2.

Ultimately what we are doing here is a massive change management piece and to change practice in terms of safer prescribing and dispensing of these medicines — and indeed you are right that the minute we turn the system on, the floodlight, there will be people who are at present unknown to their GPs and to their pharmacists but will be known once that information is available. So very much the primary attention of the workforce training package, which is significant — and the fact that we had this consortium of every primary healthcare network across the state is very useful in terms of the access of clinicians to that training — is about what happens in that instant for those clinicians in that moment when they find out about their patient, who they have got a longstanding relationship with.

You know, you are a GP. You see these patients, especially in rural and regional settings. It is more than just a clinical interaction. What happens next if there is that information brought forward? So it is about first of all having that conversation, which is part of the training, and improving skills for primary care prescribers in things like how to safely titrate doses down. It is not widely known but benzodiazepines particularly are very, very tricky in bringing the doses down, because if you bring them down too quickly, you can even induce a seizure. So getting that skill right in primary care settings, so the doses can be brought down safely, even de-prescribing some of these medicines, looking at other non-pharmacotherapy treatments for pain, anxiety and insomnia.¹⁶⁷⁶

The Regulatory Impact Statement accompanying the proposed Regulations provided the following table outlining the content streams that will be included in the training:

¹⁶⁷⁶ Matthew McCrone, Director, Real-time Prescription Monitoring Implementation, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 324.

Table 15.3 Training content streams

Stream	Content
1. SafeScript technical and other related advice.	<ul style="list-style-type: none"> • How do I register with and access SafeScript? • How do I use SafeScript in a way which integrates it within existing workflow (people, process and system?) • How do I use SafeScript and maintain patient privacy? • What are the regulatory obligations associated with SafeScript and the S8 permit system?
2. Education on better practice approaches to individual care and supports	<ul style="list-style-type: none"> • What does safe and appropriate prescribing of S8 poisons and other high-risk medicines look like? • What does better practice counselling and support for prescription medicine dependence and tapering of prescription medicines look like? • How do I maintain my safety and those of my staff members when prescribing or dispensing is not appropriate? • What does better practice clinical decision-making look like within pharmacy? • What does better practice for pain management and other issues look like? • How can better practice opioid replacement therapy be delivered? • In light of the above, what does the complete better practice model of care look like? What are the desired roles and contributions of prescribers and pharmacies?
3. Provision of advice to refer to relevant specialist pathways	<ul style="list-style-type: none"> • What should guide clinical determination of whether a patient needs referral to a specialist service? That is, what are the thresholds? • What are the localised referral pathways requiring prescription medicine addiction and support services for other conditions? • How can I continue to meet the needs of patients that are accessing these services, that are awaiting first appointment at specialist services, or that decline to engage in services? • Who can I contact for immediate clinical advice on patient related matters? Who can I contact for broader advice on whole-of-organisational changes that need to be made to deliver the complete better practice model of care?

Source: Deloitte Touche Tohmatsu, *Regulatory Impact Statement - Proposed Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Regulations 2018*, Department of Health and Human Services, Melbourne, 2018, pp. 44-45.

The Committee commends the roll-out of a comprehensive training package to underpin this significant reform. It also considers that the development of professional guidelines as recommended earlier in this chapter is all the more important in this context, to ensure there is adequate support for GPs and other health professionals on an ongoing basis. As well as providing appropriate advice to the medical profession to reduce reliance on prescription medications such as opioids, such guidelines would be the appropriate location for information and advice on the Victorian RTPM system.

Alongside targeted training for the medical profession, the RIS outlined that an awareness campaign will also be undertaken to inform the public about SafeScript. The public awareness campaign will include media and advertising to enhance community understanding of pharmaceutical misuse harms, and to create community support for SafeScript. It will also include communication materials and information sessions on details of the changes. The Committee is aware that the effectiveness of these measures in changing attitudes and awareness will be subject to an evaluation.¹⁶⁷⁷

¹⁶⁷⁷ Deloitte Touche Tohmatsu, *Regulatory Impact Statement - Proposed Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Regulations 2018*, Department of Health and Human Services, Melbourne, 2018, pp. 43-44.

Alcohol and other drug treatment

Related to the issues described above, inquiry stakeholders identified the essential need to enhance capacity of the AOD treatment sector to treat people identified as having substance use issues under the RTPM system whom require further support.

For example, VAADA's submission discussed that resourcing the AOD sector is required to deal with heightened demand as patients are likely to be referred into the sector, for example to be placed on opioid substitution therapy where required. It noted that, without extra resourcing, there is a risk that such people would transition onto more harmful substances such as heroin.¹⁶⁷⁸ The Committee discussed these issues with Kym Peake, Secretary of the DHHS, who noted that the focus is on early intervention by GPs, with less concern about people transitioning onto illicit substances:

So before we get to a point of really looking at misuse, we are really trying to do work with general practitioners around how to engage with patients to prevent them ever getting to that point, to look at how they combine the use of prescription medications with other approaches to managing pain.

...

That is work we are doing again both in work with primary health networks and the college of GPs, but also the training programs that I mentioned earlier will really go to a lot of how people actually engage their patients effectively from the start. Then we move through to using the real-time prescription system to be able to see where there are people who are starting to misuse — so the early onset of misuse. So because the misuse tends to evolve, we are probably a bit less concerned about the black market piece if we can get those pieces right on preventing people forming an addiction in the first place and helping them to manage their pain effectively.¹⁶⁷⁹

In recognition of these concerns, the Hon Jenny Mikakos in the Legislative Council discussed 'minor enhancements' that will be made to AOD treatment services, with \$916,000 over four years and recurrent funding of \$416,000 per year. She also stated, however, that:

...very few people who currently access alcohol and other drugs services identified prescription medicine as a primary drug of concern. It is expected that the majority of people identified as misusing prescription medicines will be treated within the primary health sector. This is why there will be a focus on workforce support initiatives that will strengthen the ability of primary health clinicians, particularly GPs, to respond to the needs of patients, to provide basic drug counselling, to taper prescription doses and to propose non-pharmacological alternatives for managing pain and other issues, such as insomnia or anxiety.¹⁶⁸⁰

The Committee shares the concerns of stakeholders in this area and believes that additional funding is required to AOD treatment to anticipate this increased demand. Given the high workload and pressures already placed on GPs, the Committee questions whether most patients can be treated within primary health care settings. This may not be realistic. The Victorian Government needs to be mindful of experiences in the US and proactively work to ensure that people do not 'fall through

¹⁶⁷⁸ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 13.

¹⁶⁷⁹ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, pp. 323-324.

¹⁶⁸⁰ Victoria, *Parliamentary Debates*, Legislative Council, Tuesday 17 October 2017, 5094 (Jenny Mikakos, Minister for Families and Children).

the gaps' and possibly transition onto more harmful substances. This latter possibility is also concerning to the Committee given recent increases in overdose deaths and reports of increased purity and strength of illicit substances on the illicit drug market.

RECOMMENDATION 39: The Victorian Government adopt measures to ensure the effectiveness of the real-time prescription monitoring (RTPM) system and prevent the diversion of patients with prescription misuse issues to the illicit drug market, including:

- adequately resourcing the alcohol and other drug public treatment sector to accommodate the likely influx of demand resulting from patients identified in the RTPM system with opioid dependency
- as part of Department of Health and Human Service's workforce development and training, ensure that health professionals are equipped to appropriately deal with patients identified in the RTPM system with substance use issues, for example through providing immediate and seamless access to harm reduction and/or treatment services, such as opioid substitution therapies.

Review and evaluation

A key theme throughout this report is that strong evaluation and review must accompany all reforms in drug policy, to ensure that intended and unintended consequences can be monitored, and improvements or changes to policies are evidence-based. Further, the creation of a RTPM system provides a significant opportunity for research and collection of data on the misuse of pharmaceuticals and to address 'the hidden group' of people likely to be identified as experiencing substance use issues.

The Regulatory Impact Statement accompanying the proposed Regulations provided the following information on the proposed evaluation strategy for the Victorian RTPM:

DHHS proposes that the evaluation strategy for SafeScript will comprise four distinct elements:

1. Baseline – gathering a range of data on current outcomes in order to provide a baseline for future comparisons
2. Implementation – continuing evaluation during the implementation phase to 'fine tune' the SafeScript rollout
3. Ongoing monitoring via the collection of a range of data on an annual basis
4. Three-year review – a more comprehensive mid-term review after three full years of SafeScript to determine whether it is achieving its objectives

DHHS will be responsible for evaluating and reporting on the effectiveness of SafeScript.¹⁶⁸¹

The three-year review of SafeScript will monitor whether the system contributes to the clinical process; the net benefits; the system's efficiency; and if objectives are being achieved. In terms of the proposed Regulations, the issues to be considered

¹⁶⁸¹ Deloitte Touche Tohmatsu, *Regulatory Impact Statement - Proposed Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Regulations 2018*, Department of Health and Human Services, Melbourne, 2018, p. 48.

will include the appropriateness of the scope of medication; any shifts in use towards other harmful prescription medications; and the appropriateness of any exemptions to the system.¹⁶⁸²

The Regulatory Impact Statement also outlined a range of key performance indicators that will be used to support the ongoing monitoring and three-year review processes, including:

- SafeScript and reduced harms from monitored prescriptions– number of deaths, ambulance attendances, hospitalisations and numbers of patients and registered prescribers and pharmacists
- SafeScript and the promotion of safe supply, prescription and dispensing practices – patient and prescription numbers, treatment duration on prescription medication, numbers of patients receiving opioid substitution therapy, interstate access to prescriptions and the percentage of practitioners who engaged in unsafe, inappropriate or unlawful behaviour
- SafeScript and evaluation and research – number of academic articles involving SafeScript.¹⁶⁸³

The Committee is encouraged by the strong focus on review and evaluation as discussed in the RIS, and considers that such efforts will improve Victoria’s understanding of harms related to pharmaceutical misuse. It will also allow for appropriate adjustments to the policy where required. The Committee considers that the results of these monitoring and review activities should be made publicly available to enhance community and expert understanding of these important issues.

1682 Deloitte Touche Tohmatsu, *Regulatory Impact Statement - Proposed Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Regulations 2018*, Department of Health and Human Services, Melbourne, 2018, pp. 49-50.

1683 Deloitte Touche Tohmatsu, *Regulatory Impact Statement - Proposed Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Regulations 2018*, Department of Health and Human Services, Melbourne, 2018, pp. 50-51.

Harm reduction

16 Minimising the spread of blood borne viruses

While debate continues on the more contentious harm reduction interventions such as supervised injecting rooms, most countries around the world now accept and sanction needle and syringe programs (NSPs).¹⁶⁸⁴ The purpose of NSPs is to allow people who inject illicit substances to obtain sterile injecting equipment and other injecting paraphernalia at reduced or no cost to prevent unsafe sharing practices, in addition to providing various other health-based services. Evaluation research shows that NSPs are effective in reducing the incidence and prevalence of disease; improving public amenity; and can act as a conduit for access to information, treatment and support services. They are also a proven cost-effective initiative, with an economic return in Australia of \$4 to \$1. Overall, NSPs yield a significant public health benefit.

Needle and syringe programs have been integral to Australia's harm minimisation approach to illicit drug use.¹⁶⁸⁵ As a result of establishing NSPs to address the HIV crisis in the 1980s, Australia became a leader in introducing harm reduction strategies. The program was paramount in keeping HIV infection rates and subsequent development of AIDS at relatively low levels compared to other western countries such as the United States (US), where there was up until recently a 28 year ban on federal funding for NSPs.¹⁶⁸⁶ Needle and syringe programs have also been effective in reducing transmission of hepatitis C.

Internationally, NSPs are endorsed by various peak agencies, such as the World Health Organization (WHO).¹⁶⁸⁷ The United Nations, in particular, identified it as a necessary measure on the basis that in 2014, 11.7 million people injected drugs worldwide, with

¹⁶⁸⁴ Davoli, M, et al., 'Current and future perspectives on harm reduction in the European Union', in *EMCDDA Monographs 10: Harm reduction: evidence, impacts and challenges*, Rhodes and Hedrich (eds), Office of the European Union, Luxembourg, 2010, p. 444; Harm Reduction International, *Global State of Harm Reduction 2016*, London, 2016, p. 9.

¹⁶⁸⁵ National Centre in HIV Epidemiology and Clinical Research, *Evaluating the Cost-effectiveness of Needle and Syringe Programs in Australia 2*, Commonwealth of Australia, Canberra, 2009; Anex, *With conviction: The case for controlled needle and syringe programs in Australian prisons*, Melbourne, 2010; Penington Institute, *Submission*, February 2015, Inquiry into Hepatitis C in Australia, House of Representatives Standing Committee on Health, Parliament of Australia.

¹⁶⁸⁶ Harm Reduction International, *Global State of Harm Reduction 2016*, London, 2016, p. 100.

¹⁶⁸⁷ Wodak, A and Cooney, A, *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*, World Health Organization, Geneva, 2004.

14 per cent living with HIV, 52 per cent living with hepatitis C and 9 per cent living with hepatitis B.¹⁶⁸⁸ Further, the United Nations General Assembly Special Session on Drugs (UNGASS) recently endorsed ‘injecting equipment programmes’.¹⁶⁸⁹

Given the acknowledged success of NSPs in Australia, the purpose of this chapter is to examine measures to enhance the current Victorian program and explore other measures that may complement it, such as peer distribution of injecting equipment. This chapter also explores the need for NSPs in prisons to minimise unsafe injecting practices and reduce transmission of blood borne viruses as a public health initiative both among people who inject drugs and the broader community.

16.1 Creation of needle and syringe programs in Australia and internationally

The onset of the HIV/AIDS pandemic was clearly a crucial impetus for the development of NSPs internationally,¹⁶⁹⁰ although harm reduction programs including needle distribution pre-dated this in some countries. In 1984, a drug user group in the Netherlands, the *MDHG Belangenvereniging Druggebruikers* (Interest Association for Drug Users), established the first government approved needle and syringe distribution network primarily to counter the growing rate of hepatitis B transmissions.¹⁶⁹¹ Prior to this, needle and syringe distribution was taking place within drug user groups in an ad hoc or informal manner. The HIV/AIDS pandemic, however, accelerated the establishment and expansion of NSPs across the world.

The establishment of NSPs reflected a pragmatic shift in addressing drug-related harms associated with injecting,¹⁶⁹² a shift noticeable in Australia. It also reflected a shift away from the treatment of dependence as the sole drug intervention and a move to a broader public health approach that incorporated a focus on harm reduction. As noted by Stimson in his 1990 *Revising policy and practice: new ideas about the drugs problem* text:

HIV and AIDS provide the greatest challenges to drug policies and services. Policy-makers and practitioners ... have been forced to reassess their ways of dealing with drug problems; this includes clarifying their aims, identifying their objectives and priorities for their work, their styles of working and relationships with clients, and the location of the work. Within the space of about three years, mainly between 1986 and 1988, there have been major debates about HIV, AIDS and injecting drug use. In years to come, it is likely that the late 1980s will be identified as a key period of crisis and transformation in the history of drugs policy.¹⁶⁹³

Unlike other more contentious programs such as supervised injecting rooms, NSPs have generally been accepted and established in varying numbers around the world. Even in Sweden, a country with a conservative ‘zero tolerance’ approach to drugs,

¹⁶⁸⁸ United Nations Office on Drugs and Crime, *World Drug Report 2016*, United Nations, Vienna, 2016, p. 14.

¹⁶⁸⁹ United Nations General Assembly Special Session on Drugs, ‘Our joint commitment to effectively and country the world drug problem’, *Thirtieth special session*, 2016, viewed 18 January 2018, <<https://undocs.org/A/S-30/L.1>>, p. 7.

¹⁶⁹⁰ Crofts, N and Herkt, D, ‘A History of Peer-Based Drug-User Groups in Australia’, *Journal of Drug Issues*, vol. 25, no. 3, 1995.

¹⁶⁹¹ Tops, D, ‘Stretching the limits of drug policies: an uneasy balancing act’, in *Drug users and spaces for legitimate action*, J Anker, et al. (eds), Nordic Centre for Alcohol and Drug Research, Helsinki, 2006, p. 72.

¹⁶⁹² MacGregor, S and Whiting, M, ‘The development of European drug policy and the place of harm reduction within this’, in *Harm reduction: evidence, impacts and challenges*, T Rhodes and D Hedrich (eds), Publications Office of the European Union, Luxembourg, 2010, p. 71.

¹⁶⁹³ Stimson, G, ‘Revising policy and practice: new ideas about the drugs problem’, in *AIDS and Drug Misuse: The challenge for policy and practice in the 1990s*, Strang and Stimson (eds), Routledge, London, 1990, p. 38.

six NSPs have opened in Stockholm and regional centres in recent years. In the US, opposition to NSPs has largely dissipated in response to quite serious outbreaks of HIV and hepatitis C in some parts of the country due to unsafe injecting.¹⁶⁹⁴ Despite this, NSP coverage in the US remains low in comparison to other western countries.

In Australia, the first government funded NSP was trialled in Sydney in 1986, although, as explained to the Committee by Dr Alex Wodak AM, President of the Australian Drug Law Reform Foundation (ADLRF) and Director of Australia21, there were efforts prior to this to establish a non-government approved service:

I started at St Vincent's Hospital in Sydney in July 1982 and soon after I arrived it was clear that there was a major HIV epidemic occurring in Australia and in the vicinity of St Vincent's Hospital, which is about 25 minutes' walk from where we're assembled. St Vincent's Hospital is in the middle of the largest concentration of men who have sex with men in Australia, the largest concentration of people who use drugs and also Australia's largest drug market, which is in King's Cross and the largest concentration of people dying from drug overdose, is all in walking distance of the hospital.

So that is where I started and soon after I arrived there was an estimate that some 3,000 to 4,000 men who have sex with men had acquired HIV infection in the early 1980s. When I heard that estimate I immediately thought that some of those gay men would also inject drugs, they would share their needles and syringes with men and women who did not engage in homosexual contact but injected drugs. HIV would follow in a cascade and it would follow from that second population of heterosexual men and women who use drugs to the broader community. Australia was at great risk of having a generalised HIV epidemic, which has occurred in about a dozen other countries, starting from people who inject drugs.

I was fearful that this would happen in Australia and that we would face severe health, social and economic consequences as a result. I wasn't the only one who had that view. I started working with a group of people - like-minded people - and we realised we had to do something effective very quickly and it was clear that what had to be done first off was start needle syringe programs. I ended up writing 13 submissions to the New South Wales Department of Health begging permission to be allowed to start a pilot project. Each of those 13 submissions was declined. My colleagues and I decided on 12 November 1986 that we had to resort to civil disobedience. I had four children, a wife, a new career. I happily put all that at risk in order to get needle syringe programs started. Fortunately, the New South Wales government at the end of 1986 changed its view on needle syringe programs, allowed them to go ahead.¹⁶⁹⁵

In 1989, the Commonwealth Government released the national HIV/AIDS Strategy, which provided a framework for an integrated response to the HIV epidemic across the areas of education/prevention and treatment. The NSP was an integral component of the prevention function, which was championed by then Federal Health Minister Neal Blewett. Within a few years, all states and territories had established at least one sanctioned NSP, although Victoria's program predated the Commonwealth agreement.

Paul Bodisco, Secretary of the ADLRF spoke to the Committee about the legacy of pioneers, such as former Health Minister Neal Blewett, in shielding Australia from the worst of the HIV/AIDS crisis by approving the broad implementation of the program:

¹⁶⁹⁴ Harm Reduction International, *Global State of Harm Reduction 2016*, London, 2016, p. 100.

¹⁶⁹⁵ Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, pp. 79-80.

...when you look at the statistics, a good 20 years after that decision [to introduce NSP] was made, and you look at the amount of people in Australia who contracted HIV as a result of injecting drug use, the amount was one half of a per cent. When you looked at other cities around the world - London, it was 50 per cent. Paris it was 60 per cent. The reason why these policy-makers received their 15-minute ovation¹⁶⁹⁶ was because no doubt a lot of the people in that room are able to affirm that lives have been saved as a result of that policy shift. I think that is why we should be guided by the experts.¹⁶⁹⁷

Needle and syringe programs have been well-established in Australia for many years now and receive widespread community support. According to the *2016 National Drug Strategy Household Survey* (NDSHS), NSPs are strongly supported by both the general public aged 14 years and over (67 per cent) and self-identifying injecting (heroin) drug users (84 per cent).¹⁶⁹⁸ The overwhelming number of stakeholders from the public health sector who provided evidence to the Committee spoke of the program's efficacy in improving the health of people who inject drugs and preventing or reducing the occurrence of illness and disease.¹⁶⁹⁹ It is also well understood that NSPs have a broader positive effect by minimising the spread of blood borne viruses within the community. This is reflected in the aim of the Victorian NSP, which is to 'minimise the transmission of HIV, hepatitis B and hepatitis C and other blood borne viruses among injecting drug users, their sexual partners and children, and from them to the non-injecting community'.¹⁷⁰⁰

16.1.1 The Victorian Needle and Syringe Program

The Victorian NSP commenced in 1987 with four pilot programs funded by the Department of Health, which was expanded in 1989 following the success of the pilots. Similar to the Commonwealth agreement, the Victorian NSP also received an extraordinary level of bipartisan support in the Victorian Parliament, with stewardship largely the responsibility of former pharmacist Liberal Party member, Geoff Connard and the former Cain Government Health Minister Caroline Hogg. As stated by Health Minister Hogg during the parliamentary debate for the program's establishment:

I should place on record that, again in a quiet and undramatic way, there was bipartisan support for the measure and these most difficult concepts. It has never been easy for members of Parliament to talk about drug reform, drug usage and many

¹⁶⁹⁶ Mr Bodisco is referring to a meeting of health workers in Sydney that gave a spontaneous standing ovation of 15 minutes duration to Dr Blewett and Dr Peter Baume when they entered the room. Although Dr Blewett was Minister for Health and Dr Baume, Opposition Health Spokesperson at the time HIV/AIDS was first evident in Australia, their collegiate and bi-partisanship approach to addressing the issue was instrumental in reducing any disastrous results of the disease's potential spread.

¹⁶⁹⁷ Paul Bodisco, Secretary, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 93.

¹⁶⁹⁸ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings*, Canberra, 2017, p. 129.

¹⁶⁹⁹ Dr Nicole Lee, Director, 360Edge, *Transcript of evidence*, 4 September 2017, p. 374; Melanie Eagle, Chief Executive Officer, Hepatitis Victoria, *Transcript of evidence*, 4 September 2017, p. 320; Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 320; Dr John Sherman, Director, Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 290; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 3; Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 102; Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 65; Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017, p. 79.

¹⁷⁰⁰ Department of Health, *Victorian Needle and Syringe Program: Operating Policy and Guidelines*, State Government of Victoria, Melbourne, 2008, p. 3.

of the things that have needed to be done to combat the spread of HIV/AIDS. At any moment cheap political opportunism could have undone measures that were being taken for public health and the general good.¹⁷⁰¹

Victorian NSPs are authorised for operation under the *Drugs, Poisons and Controlled Substances Act 1981* (DPCSA), which provides protection for a person selling or supplying a hypodermic needle or syringe if employed by an authorised pharmacy or organisation, or if they have been issued with an NSP Outreach Worker card by the Department of Health and Human Services (DHHS).¹⁷⁰²

The primary objective of the Victorian NSP is to reduce the unsafe practice of sharing needles and syringes and other injecting equipment among people who inject drugs. Complementary objectives include to:

- promote safe retrieval and disposal of used needles and syringes, with an emphasis on increasing return rates of injecting equipment to NSPs
- promote safer sex practices and increase the use of condoms by injecting drug users
- provide linkages and referral for injecting drug users to other health and welfare services
- facilitate two-way education between NSP staff and peer educators
- promote awareness of injecting drug user issues in the general community.¹⁷⁰³

The program also aims to increase access to NSPs for particular groups such as young people, Aboriginal and Torres Strait Islander (ATSI) people, the homeless, and people from culturally and linguistically diverse (CALD) communities.

From a policing perspective, Victoria Police guidelines and policy permit a discretionary ‘no go’ zone in the vicinity of NSPs. Victoria Police Operating Procedures instruct that ‘the vicinity of NSPs must not be targeted solely for the purpose of enforcing use or possession laws’ and that ‘attending a NSP is insufficient grounds on its own to establish reasonable grounds to search a person under s.82, *Drugs, Poisons and Controlled Substances Act 1981*’.¹⁷⁰⁴ This ‘hands off’ approach in Victoria is reflective of a practical application of a harm reduction approach, which will be important when the medically supervised injecting centre commences operation in North Richmond in mid-2018.¹⁷⁰⁵

Various NSP service models exist across Australia and in Victoria, typically in areas where illicit drug use is prevalent. These models include:

- **Primary outlets:** These are ‘stand-alone’ fixed site agencies specifically established to provide injecting equipment, and in some cases primary medical care. Staff tend to be specialist or familiar with drug and alcohol issues and

¹⁷⁰¹ Victoria, *Parliamentary Debates*, Legislative Council, Tuesday 26 April 1994, pp. 308-309 (Caroline Hogg MLC, Minister for Housing).

¹⁷⁰² Department of Human Services, *The Victorian Needle and Syringe Program: Operating Policy and Guidelines*, Victorian Government, Melbourne, 2001.

¹⁷⁰³ Department of Health, *Victorian Needle and Syringe Program: Operating Policy and Guidelines*, State Government of Victoria, Melbourne, 2008, p. 3.

¹⁷⁰⁴ Department of Health, *Victorian Needle and Syringe Program: Operating Policy and Guidelines*, State Government of Victoria, Melbourne, 2008, p. 3.

¹⁷⁰⁵ Victoria Police, *Victoria Police Manual - Procedures and Guidelines 2018: Drug Programs and Services*, Melbourne, 2018, pp. 1-3.

provide specific services ‘in a non-judgmental manner and develop a rapport with individuals who are otherwise hard to reach’.¹⁷⁰⁶ Such centres may also provide secondary health related provisions such as condoms.

- **Secondary outlets:** In these cases, needle distribution or exchange is only one of a number of other health or community services offered. Secondary outlets are often located in community health centres, pharmacies or hospitals.
- **Mobile services** are distribution and exchange services provided by outreach. Credentialed workers provide this service often out of hours when a fixed site is not operating. In some jurisdictions ‘peer distribution’ may be permitted whereby non licensed workers (often current drug users themselves) may distribute equipment to friends and associates
- **Vending machines** dispense needle and syringe packs containing several syringes for a small fee. These machines are monitored and restocked by NSP staff.¹⁷⁰⁷

According to the DHHS, there are approximately 564 registered and state funded NSP sites throughout Victoria.¹⁷⁰⁸

Unlike in some countries, Australian NSPs do not require the exchange of used needles to receive new ones. As stated in the Victorian *Needle and Syringe Program Operating Policy and Guidelines*:

NSP services are not dependent on compulsory ‘one-for-one’ exchange as this could compromise the effectiveness of the program due to reduced access to clean injecting equipment. It should be noted, however, that the safe disposal of used injecting equipment, which may include returning them to an NSP, remains a high priority of the Program.¹⁷⁰⁹

16.2 Effectiveness of needle and syringe programs

In Australia, a review by the National Centre in HIV Epidemiology and Clinical Research, *Return on Investment in Needle and Syringe Programs in Australia*, found that the effectiveness of NSPs is clearly demonstrable. In Victoria alone between 1999 and 2008, over 81 million syringes were distributed, averting an estimated 5,516 HIV infections and 18,878 HCV infections. This represented a net financial saving of \$153 million to the Victorian healthcare system in the ten-year period between 2000 and 2009.¹⁷¹⁰

Research by the National Drug and Alcohol Research Centre (NDARC) also reaffirmed in its report, *An Assessment of Illicit Drug Policy in Australia (1985 to 2010)*, that needle and syringe programs have a very strong evidence base:

¹⁷⁰⁶ Department of Health and Ageing, *Return on Investment in Needle and Syringe Programs in Australia: Summary Report*, Commonwealth of Australia, Canberra, 2002, p. 3.

¹⁷⁰⁷ Department of Health and Ageing, *Return on Investment in Needle and Syringe Programs in Australia: Summary Report*, Commonwealth of Australia, Canberra, 2002, p. 3.

¹⁷⁰⁸ This aggregate figure combines pharmacies, fixed and mobile sites. See Department of Health and Human Services, ‘DHHS-NSP-Public’, Victorian Government, 2018, viewed 17 January 2018, <https://docs.google.com/spreadsheets/d/18_ZDiuwWP_Oz107Uo9xc-qK3WkkShPP7RoEqc2200jQ/edit#gid=0>.

¹⁷⁰⁹ Department of Health, *Victorian Needle and Syringe Program: Operating Policy and Guidelines*, State Government of Victoria, Melbourne, 2008, p. 1.

¹⁷¹⁰ National Centre in HIV Epidemiology and Clinical Research, *Evaluating the Cost-effectiveness of Needle and Syringe Programs in Australia 2*, Commonwealth of Australia, Canberra, 2009, p. 91.

Meta-analyses examining changes in risk behaviour have shown positive effect sizes for needle syringe programs (Ksobiech, 2003). Reductions in HIV seroconversion associated with needle syringe programs have been extensively documented (Des Jarlais, et al., 1996; MacDonald, Law, Kaldor, Hales, & Dore, 2003; Monterroso, et al., 2000; Vlahov & Junge, 1998). The cost-effectiveness of needle syringe programs has been amply demonstrated (Commonwealth of Australia, 2002; Holtgrave, Pinkerton, Jones, Lurie, & Vlahov, 1998; Laufer, 2001; Pollack, 2001).¹⁷¹¹

With regard to HIV transmission, a 2004 study by the WHO found a ‘compelling case that NSPs substantially and cost effectively reduce the spread of HIV among IDUs [injecting drug users] and do so without evidence of exacerbating drug use at either the individual or societal level’. Needle and syringe programs were also deemed to provide a great benefit in the prison setting.¹⁷¹²

Some research analyses contest the strength of some of these findings on the basis that it is difficult to isolate the effect of one variable, such as NSPs, from other measures that may have been contemporaneously introduced to address injecting related harms. For example, the study by the National Centre in HIV Epidemiology and Clinical Research acknowledged:

It is not possible to separate the effects of implementation of NSPs from the other HIV prevention strategies (Benedikt et al. 2000). In most settings, introduction of NSPs is one component of a broader harm reduction package to reduce the risk of transmission of blood-borne viruses and other harm associated with injecting drug use. Other components include education and counselling, drug dependency treatment strategies such as methadone maintenance therapy, and provision of clean injecting equipment through other outlets in particular pharmacies.¹⁷¹³

The Committee notes, however, that despite this cautioning these studies generally conclude that NSPs are of net benefit in preventing/reducing transmission of blood borne viruses and other harms. There is a broad consensus that NSPs increase safe injecting practices, and improve local amenity by reducing the amount of injecting equipment detritus. Moreover, there is little evidence to suggest NSPs increase the uptake of illicit drug use in the community.¹⁷¹⁴

Aside from addressing drug-related harms, the Committee is aware of a number of other benefits associated with NSPs. For example, they play an important role in engaging with people who use drugs and linking them into various other health and welfare services. Often NSP workers are the only point of contact that a person has with a health or welfare service. For example, Charles Henderson, Acting Executive Officer of Harm Reduction Victoria (HRV), told the Committee:

Most needles and syringes are distributed from public sector NSPs, at 87 per cent, and these services are in contact with the majority of injecting drug users. This contact is brief and fleeting but with a large potential to do a great deal in respect of opportunistic interactions or brief interventions. Over three-quarters of attendees

¹⁷¹¹ Ritter, A, et al., *An Assessment of Illicit Drug Policy in Australia (1985 to 2010): Themes and Trends*, National Drug and Alcohol Research Centre UNSW, Sydney, 2011, p. 36.

¹⁷¹² Wodak, A and Cooney, A, *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*, World Health Organization, Geneva, 2004, p. 30.

¹⁷¹³ National Centre in HIV Epidemiology and Clinical Research, *Evaluating the Cost-effectiveness of Needle and Syringe Programs in Australia 2*, Commonwealth of Australia, Canberra, 2009, pp. 8-9.

¹⁷¹⁴ Davoli, M, et al., ‘Current and future perspectives on harm reduction in the European Union’, in *EMCDDA Monographs 10: Harm reduction: evidence, impacts and challenges*, Rhodes and Hedrich (eds), Office of the European Union, Luxembourg, 2010, p. 440.

have had an associated injection-related injury or disease. Often these take the form of abscesses, vein degradation and bacterial infections, which are entirely treatable if contact is maintained.¹⁷¹⁵

Similarly, Gino Vumbaca, President of Harm Reduction Australia told the Committee that a key positive benefit of NSPs since the program's establishment has been engagement with people who use drugs:

What we decided to do was actually engage with people no matter where they were on the spectrum or the continuum or where they were using drugs. Whether they were ready to give up, they weren't ready to give up, that wasn't the issue. The issue was that they were using drugs and if they needed assistance, we should provide it. They are entitled to know the best information available about the drugs they were using and about the treatments available, but also about how to protect themselves...¹⁷¹⁶

In this regard, NSPs are a prime example of a health-based response to illicit drug use that is compassionate, evidence-based and has resulted in few, if any, unintended consequences. As with most harm reduction measures, NSPs do not encourage or condone drug use but simply intend to ensure that people who are determined to use drugs, do so in the safest way possible.

16.2.1 Limitations of needle and syringe programs

Despite the undoubted success of NSPs, a number of stakeholders advised of issues, mainly regarding access, that could lead to serious consequences from continued sharing of injecting equipment. Evidence indicates there is inadequate coverage of the program across Victoria, either due to the limited times at which NSPs operate or the limited availability of services particularly in outer-suburban, regional and rural areas. In its submission, the Penington Institute stated:

...challenges remain in terms of HCV prevalence and persistent sharing rates. A range of factors contribute to the persistence of equipment sharing, but chief among them is restricted access: sterile equipment is not always available when injectors require it, due to geographic distance and/or the operating hours of existing NSPs. The average age of NSP clients is also increasing, presenting a new challenge for ensuring access among people whose mobility and social connectedness are diminishing.

Many of Victoria's growth corridors, especially those on Melbourne's urban fringe, have insufficient coverage for a range of services. These same communities – Melton, Casey, Wyndham, Cardinia, Mitchell, Whittlesea – are experiencing high rates of disadvantage and complex problems of health and crime. There is consistent intelligence that these communities have insufficient access to health services, including NSPs.¹⁷¹⁷

The Committee also heard that unsafe injecting practices are particularly prevalent in vulnerable communities where people might be disengaged from the community and disconnected from health and social services, such as NSPs. In her evidence to the Committee, Melanie Eagle, CEO of Hepatitis Victoria, while praising the program, advised that many people who inject drugs simply do not access this service:

I asked a staff member on Friday who is our lead in the AOD [alcohol and other drug] area and has worked in this sector for a long time, and they said there are about 10 to 15 per cent who access needle and syringe programs intermittently but not regularly

¹⁷¹⁵ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 65.

¹⁷¹⁶ Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 101.

¹⁷¹⁷ Penington Institute, *Submission*, no. 209, 24 March 2017, pp. 40-41.

and so do not have safe injecting practices. So they might access needle and syringe programs but only intermittently, not sufficiently so that they are safe users, and are still exposing themselves to risk, for a range of reasons. Some are fatalistic about it, presume they have already got it — you know, this is the feedback — have been told for ages that there is no cure and still believe they are not going to be worthy recipients of treatment or do not engage in health services generally. Many of them are totally disconnected from many formal systems of service delivery. They might be homeless. They might be transient, so they do not make appointments certainly with doctors. They might only erratically turn up to bother to exchange needles, and they are living that very immediate situation of, ‘I’ve got money; I’m going to use now. I’ll do it where it’s easiest’.¹⁷¹⁸

In the broader evidence, some people from ATSI communities are identified as having limited access to and engagement with NSP services. The most recent *Global State of Harm Reduction Report* by Harm Reduction International noted in particular:

Although harm reduction initiatives have been well-established in Australia, there are still reportedly significant disparities in service provision among Indigenous Australians. Injecting drug use is less prevalent than other drug use among this population, yet there is a high incidence of unsafe injecting practices, and higher rates of HIV infection associated with injecting drug use.¹⁷¹⁹

Similarly, John Ryan, CEO of the Pennington Institute told the Committee:

Unsafe injecting practices and communities that are particularly vulnerable, including Aboriginal and Torres Strait Islander communities, are therefore at risk of an outbreak of HIV.

...

In Victoria, off the top of my head, about 18 per cent in the last month have used somebody else’s needle. It is about 18 per cent. The reason I mentioned Aboriginal and Torres Strait Islanders is that if you look at their data specifically, the sharing rates are actually higher, in which case they are much more vulnerable to infection with hepatitis C and HIV.¹⁷²⁰

A number of stakeholders advised the Committee that persistent syringe sharing among people disengaged from health services or whom have limited access to NSPs (either due to insufficient NSP coverage or non-existent coverage, for example in prisons) are a likely contributing factor to increased transmission of hepatitis C.¹⁷²¹ According to Melanie Eagle from Hepatitis Victoria, ‘[h]epatitis C is over 90 per cent transmitted in First World countries such as Australia through unsafe injecting practices’.¹⁷²²

The fact that NSPs have not significantly reduced the prevalence of hepatitis C among people who inject drugs was documented in a 2015 policy brief by the Centre for Research Excellence into Injecting Drug Use (CREIDU). Acknowledging the success of NSPs in reducing levels of HIV transmission, CREIDU nonetheless stated that increases in hepatitis C transmission remain of concern. It estimated that 20 per cent of people who inject drugs in Australia have inadequate access to NSPs but increasing

¹⁷¹⁸ Melanie Eagle, Chief Executive Officer, Hepatitis Victoria, *Transcript of evidence*, 4 September 2017, p. 335.

¹⁷¹⁹ Harm Reduction International, *Global State of Harm Reduction 2016*, London, 2016, p. 114.

¹⁷²⁰ John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017, pp. 4,6.

¹⁷²¹ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017; Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017; John Ryan, Chief Executive Officer, Pennington Institute, *Transcript of evidence*, 8 May 2017; Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017.

¹⁷²² Melanie Eagle, Chief Executive Officer, Hepatitis Victoria, *Transcript of evidence*, 4 September 2017, p. 335.

that coverage would reduce hepatitis C prevalence by 50 per cent. The CREIDU also estimated that if syringe sharing decreased from 15 per cent to 10 per cent, a 33 per cent reduction in HCV incidence would result.¹⁷²³

The Committee is also aware that issues arising from insufficient NSP coverage may be exacerbated by the increasing injection of stimulant type substances, such as methamphetamines. Injecting stimulant drugs, compared to other drugs such as opiates, involves more frequent injection due to the substances' shorter lasting effects. Recent reports from the Illicit Drug Reporting System (IDRS) managed by NDARC indicated an increase in the proportion of participants who inject methamphetamines (commonly crystal methamphetamine), with two thirds of IDRS interviewees injecting heroin/opioids and just over one third injecting amphetamine type substances.¹⁷²⁴ If NSPs have restricted opening hours and there is limited availability of other services, such as vending machines, the higher frequency of injecting may consequently carry a higher risk of injecting related infection and/or disease transmission.

16.2.2 Enhancing needle and syringe program coverage

The Committee received extensive evidence regarding how the Victorian Government could enhance syringe coverage across the State, and ultimately improve the quantity and quality of NSP services. In particular, there were calls to provide 24-hour access to sterile injecting equipment. Both the City of Yarra and Beyond Blue proposed in their submissions that greater outreach services were required in the evenings and on weekends to engage with people who inject drugs.¹⁷²⁵ Beyond Blue advised that this outreach service should be available 24-hours, and access should also be extended through strategic placement of vending machines.¹⁷²⁶

A submission from Penelope Hill, a mobile drug safety worker for the Eastern Metropolitan Region of Melbourne, claimed that while NSPs are beneficial to those who can readily access them, it has limited effect for others. She also offered some useful suggestions to enhance accessibility of the services:

Clients generally believe that they have easy access to NSP, and applaud the government for funding fixed site and mobile services. However, this comes up in discussions with clients already accessing services, rather than clients struggling to access. When we experience 'knockbacks' (people calling the mobile night outreach service too late for us to reach them, and therefore missing out on accessing the service), we know that clients are struggling to access services. Suggestions for improved access include funding the night service for longer hours, having better access in the Outer East region, and providing syringe dispensing units at key locations across the region. The bulk of our knockbacks are in the Outer East and we struggle to access the Outer East part of our region, with our base in Box Hill (as a service, we are funded to cover 7 LGA areas, approximately 54 suburbs, so struggle to get to all parts of the region in a night).¹⁷²⁷

¹⁷²³ Kirwan, A, et al., *Syringe coverage and Australian NSPs*, Centre for Research Excellence and Injecting Drug Use, Melbourne, 2015, p. 1.

¹⁷²⁴ Salom, C and Alati, R, 'Is the wellbeing of people who inject drugs worse for those who use methamphetamines rather than heroin?', *Illicit Drug Reporting System: Drug Trends Bulletin*, National Drug and Alcohol Research Centre, 2017, viewed 25 May 2017, <https://dlstorage.blob.core.windows.net/drt101/1905/idrs-july-2017_final_website.pdf>, p. 2.

¹⁷²⁵ City of Yarra, *Submission*, no. 127, 16 March 2017; Beyond Blue, *Submission*, no. 175, 17 March 2017.

¹⁷²⁶ Beyond Blue, *Submission*, no. 175, 17 March 2017.

¹⁷²⁷ Penelope Hill, *Submission*, no. 211, 27 March 2017.

Similarly, the submission from Hepatitis Victoria called for a greater spread of NSPs including mobile NSPs and vending machines, particularly in rural and regional Victoria:

Hepatitis Victoria seeks increased access to needle and syringe programs in the community across Victoria. This includes an extension to the current program through the provision of injecting equipment through appropriately located syringe vending machines which provide 24hour access to safe injecting equipment. In regional and rural areas where there are fewer NSPs operating and where users may have practical concerns over anonymity, vending machines have considerable potential to reduce harmful behaviours.¹⁷²⁸

The Committee acknowledges that access to NSPs in rural and regional areas is particularly difficult, and other services that provide sterile injecting equipment are relatively scarce. In Western Australia, all regional and rural hospitals with emergency after-hours services are required to provide after-hours access to needles and syringes for injecting drug users. After-hours access is defined as the hours during which the local or nearest community pharmacy is closed. If the local pharmacy does not retail needles and syringes, or if there is no local pharmacy, local hospitals are required to provide 24-hour access, or in the event that a hospital is not open 24 hours, access must be provided at all times when the hospital is open. This is a model that HRV believes should be implemented in Victoria.¹⁷²⁹ The Committee agrees that this is an appropriate intervention to increase coverage of needle and syringe distribution throughout Victoria.

The Committee also notes that there have been issues in the past with pharmacies not perceiving NSPs as a core strategy for community pharmacy, in addition to the tendency to stereotype people who use drugs as challenging customers. Similar to increasing pharmacies' participation in the opioid substitution therapy program, this is an area of ongoing work between DHHS and the Pharmacy Guild of Australia.¹⁷³⁰

Noting concerns regarding NSP accessibility and transmission of hepatitis C, clearly more can be done to improve Victoria's NSP service delivery. This will not only affect health outcomes in the community but will also provide greater opportunities to engage with people who may have complex needs and are disconnected from health and social services. In this context, it is essential that NSP staff are also culturally aware and sensitive to the needs of people who identify as ATSI and others from CALD communities.

The Committee also learnt that enhanced NSP coverage is essential to not compromise recent advancements in the treatment of HCV. Melanie Eagle from Hepatitis Victoria noted that while the antiviral treatments for HCV are very effective, limited access to sterile injecting equipment could compromise this success if a person who injects drugs continues to share needles.¹⁷³¹ Expanding NSPs, particularly in rural and regional areas, and improving the capacity of NSP staff could create more opportunities to educate people with hepatitis C about the treatment and refer them accordingly to the appropriate health services.

¹⁷²⁸ Hepatitis Victoria, *Submission*, no. 135, 16 March 2017.

¹⁷²⁹ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, pp. 13-14.

¹⁷³⁰ Department of Health and Human Services, *Community Pharmacy NSP Recruitment Project Final Report*, Department of Health / The Pharmacy Guild of Australia, Melbourne, 2010, p. 20.

¹⁷³¹ Melanie Eagle, Chief Executive Officer, Hepatitis Victoria, *Transcript of evidence*, 4 September 2017, p. 337.

Overall, the Committee is of the opinion that the evidence base supporting NSPs as a harm reduction measure is overwhelming. They have stood Australia in good stead in preventing and reducing the harms associated with illicit drug use, particularly the transmission of blood borne viruses. However, as the Penington Institute stated in its submission, the Victorian NSP requires a new strategic framework:

A new strategic framework would consider a range of high-value opportunities to expand access, review and increase quality (including appropriateness of consumables), expand referral pathways, and identify a workforce development program that is tailored to a refreshed set of NSP priorities. Utilising NSPs to engage people at risk of problematic drug use and dependence is a chance to integrate and scale up good practice already demonstrated by Victoria's NSP sector. They can positively engage parts of the Victorian community and find solutions that criminal justice responses have so far failed to produce.¹⁷³²

RECOMMENDATION 40: The Victorian Government review Victoria's needle and syringe program (NSP) in order to strengthen the aims, coverage, service models, harm reduction information and equipment distributed to people who use illicit substances. This should include:

- exploring avenues to increase NSP availability in areas where there is an identified shortfall particularly after-hours, such as in public hospitals, vending machines/dispensing units, and community pharmacies
- ensuring that staff of NSPs are culturally aware and sensitive to the needs of people who identify as Aboriginal and Torres Strait Islander and others from culturally and linguistically diverse communities
- enhancing the capacity of the NSP workforce to engage with people with hepatitis C to educate them about potential treatment options and refer them accordingly.

16.3 Peer or secondary distribution of injecting equipment

As noted by Dr Kate Seear, Senior Lecturer in Law at Monash University in her submission, peer distribution refers to 'the giving or receiving of new sterile needles and syringes to/from another individual that were originally obtained from formal or "safe" sources'. It may include 'trading, purchasing or selling of needles and syringes for money, drugs or other commodities or services; or it can simply involve the giving or receiving outright of needles and syringes'.¹⁷³³ Until relatively recently, it had been illegal in all Australian jurisdictions for people not authorised under a NSP to distribute or pass on sterile injecting equipment to people who inject drugs. In the past two years, the governments of the Northern Territory (NT), Australian Capital Territory (ACT) and Tasmania have passed laws allowing secondary distribution of sterile injecting equipment.¹⁷³⁴

In Victoria, it is illegal for unauthorised individuals, including family members, to collect sterile injecting equipment from a government authorised NSP (including pharmacies) and distribute this equipment to others. Prohibition of peer distribution or 'secondary supply' is outlined in Section 80 of the DPCSA as follows:

¹⁷³² Penington Institute, *Submission*, no. 209, 24 March 2017, p. 42.

¹⁷³³ Dr Kate Seear, *Submission*, no. 126, 16 March 2017, p. 8.

¹⁷³⁴ Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 3.

80 (5) A person who sells or supplies a hypodermic needle or a syringe is not guilty of an offence under this section or of being involved in the commission of an offence against any provision referred to in this section by reason only of that sale or supply—

- (a) if the person is, or is engaged or employed by, a pharmacist and the sale or supply is made in the course of the lawful practice of a pharmacist; or
- (b) if the sale or supply is by a specified person or organisation or specified class of persons or organisations in specified circumstances as authorised by Order in Council published in the Government Gazette.¹⁷³⁵

According to Dr Kate Seear from Monash University, peer distribution is recognised as an ‘unofficial adjunct’ to NSPs and is ‘common in Australia and other parts of the world’.¹⁷³⁶ Data from a 2009 Australian NSP Survey found that despite its illegality, 37 per cent of survey respondents reported onward peer distribution.¹⁷³⁷ Further, HRV indicated in its submission that the Victorian Government is aware of the practice, as NSP workers are required to ask clients (and record data accordingly) ‘How many people are you collecting for?’¹⁷³⁸

Various stakeholders recommended to the Committee that Victoria pass legislation similar to that in Tasmania, NT and the ACT. The National Drug and Alcohol Research Centre explained the benefits of peer distribution as follows:

The main motivation for [peer distribution] is to support other people who inject drugs in their desire to use drugs in the safest way possible. Peer distribution is regarded as an important low-cost strategy for preventing BBV transmission, with potential for a wider geographic reach than is achieved through existing services (Anderson et al 2003). Drug paraphernalia laws which prohibit distribution of injecting equipment, lead people who inject drugs to fear carrying syringes and force them to share equipment or dispose of it unsafely.¹⁷³⁹

It also stated that laws banning peer distribution ‘go against Australia’s blood borne virus strategies, public health recommendations and everyday practices in the community’.¹⁷⁴⁰

Dr Kate Seear told the Committee that allowing peer distribution would enhance syringe coverage and potentially encourage a greater number of disengaged people not currently accessing NSPs to use sterile injecting equipment. She also advised that it would send a strong message to the community:

Lifting the criminal prohibition on that practice would be very important for a number of reasons: one, it would send a clear signal to those people who already engage in that practice that harm reduction practices like that are valued; also I think there is some anecdotal evidence, and certainly perhaps those of us who work in the field know, that the prohibition certainly has some effect on people’s willingness to distribute clean needles in that way.¹⁷⁴¹

¹⁷³⁵ *Drugs, Poisons and Controlled Substances Act 1981* (Vic).

¹⁷³⁶ Dr Kate Seear, *Submission*, no. 126, 16 March 2017, p. 8.

¹⁷³⁷ Australian Injecting and Illicit Drug Users League (AIVL), *Legislative and Policy Barriers to Needle & Syringe Programs and Injecting Equipment Access for People Who Inject Drugs*, Canberra, 2010, p. 4.

¹⁷³⁸ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 10.

¹⁷³⁹ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 7.

¹⁷⁴⁰ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 7.

¹⁷⁴¹ Dr Kate Seear, Senior Lecturer in Law, Monash University, *Transcript of evidence*, 5 June 2017, p. 174.

Professor Paul Dietze, Director of the Behaviours and Health Risks Program at Burnet Institute agreed that peer distribution, although rarely prosecuted, should be made lawful in Victoria:

The reality is that at the moment we criminalise peer-to-peer distribution, and we really just need to decriminalise this. It is a very straightforward thing to do.

...

It is simply so that if someone picks up a box of needles and syringes and they come across someone else who needs one at the time, to prevent blood borne virus transmission these are the people who can easily distribute it to them so they do not have to go and get needles and syringes from a fixed site or exchange somewhere or something like that. It prevents blood borne virus transmission, and that is ultimately the aim of the program. We have got documented cases of some of the people in our studies who have them. They will give them out to some of their friends and they will at the same time be imparting safe injecting advice and all of those sorts of things. They are at least as skilled as the people we have staffing the needle and syringe programs.

...

...it is not something that gets prosecuted. So already people are using discretion around that. It would be rare that you would see it. But the reality is we should decriminalise it just to make sure that people are fully protected and they are not at risk of this kind of thing biting them.¹⁷⁴²

Further, Burnet Institute stated in its submission that decriminalising peer distribution of equipment also 'aligns with the policy frameworks of the National Drug Strategy, the Fourth National Hepatitis C Strategy 2014– 2017, the Seventh National HIV Strategy 2014–2017 and the Victorian Hepatitis C Strategy 2016–2020'.¹⁷⁴³

As noted earlier, it is arguable that limiting access to clean needles through maintaining bans on peer distribution may compromise new pharmacological treatments for HCV. Dr Kate Seear from Monash University expressed such concerns in her submission:

Importantly, since our research into the prohibition on peer distribution was published, new drugs (direct acting anti-virals) for the treatment of hepatitis C have appeared on the horizon. These have been heralded as revolutionary, with the potential to cure hepatitis C. These medicines have now been added to Australia's Pharmaceutical Benefits Scheme, leading to claims that Australia might eliminate hepatitis C altogether within the next decade. Although these medicines are promising, there is a risk that efforts to control new infections may be undermined if complementary harm reduction strategies are not available. In other words, treatment should not be the sole focus of government policy; instead, it should form part of a complementary suite of measures designed to tackle hepatitis C, including harm reduction strategies designed to increase coverage of clean needles and syringes across the state. There is a real risk, should these measures not be introduced, that work underway to eradicate hepatitis C through treatment will be compromised.¹⁷⁴⁴

1742 Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 39.

1743 Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 10.

1744 Dr Kate Seear, *Submission*, no. 126, 16 March 2017, p. 9.

The Committee agrees with the evidence received on this matter and proposes that the ban on peer distribution be removed from the DPCSA. Peer distribution of sterile injecting equipment provides a useful avenue to enhance syringe coverage, particularly within vulnerable communities. As Jane Dicka, Health Promotion Leader at HRV told the Committee '[d]rug users listen to other drug users. It is not rocket science'.¹⁷⁴⁵ Allowing peer distribution could also enhance existing peer-based approaches, such as HRV's Peer Network Program (PNP). This involves HRV training groups of volunteers to distribute sterile equipment and brief interventions to hard-to-reach communities where people do not usually attend NSPs or generalist health centres due to experiences of social isolation and negative labelling. A clear advantage of using peers to distribute needles and syringes is that they are trusted by fellow users in ways that a more formal service may not be.

The Committee wishes to commend the important work of peer-based approaches in supporting people who use drugs, as well as working with governments to enhance the delivery and acceptance of harm reduction services, such as NSPs, among people who inject drugs. Removing the ban on peer distribution of sterile injecting equipment sends a clear message that these approaches are integral to addressing the harms arising from illicit substances in the community.

RECOMMENDATION 41: The Victorian Government remove the prohibition of peer distribution of sterile needles and syringes in the *Drugs, Poisons and Controlled Substances Act 1981*.

16.4 Other drug use paraphernalia

Related to the ban on peer distribution of injecting equipment, is the broader issue of the illegality of distribution of non-injecting drug paraphernalia. Under section 80HC of the DPCSA, it is illegal to sell or supply paraphernalia for smoking drugs such as 'ice pipes', which are typically used to consume methamphetamine. In particular, it states:

A person must not sell or supply an ice pipe.

Penalty: In the case of a natural person 240 penalty units;

In the case of a body corporate 600 penalty units.¹⁷⁴⁶

The Committee is aware that such drug paraphernalia laws make it difficult for people to obtain the appropriate smoking equipment and may lead them to use less sanitary apparatuses to consume their drug, for example a cracked or previously used homemade pipe. More alarmingly, people may turn to alternative and more dangerous consumption methods, such as injecting. On this basis, Eros Foundation stated in its submission that these laws are counterproductive:

Laws banning paraphernalia are not effective at any of their intended purposes, shifting markets online and pushing consumers to make home-made products which can have other negative effects.

...

¹⁷⁴⁵ Jane Dicka, Health Promotion Team Leader, Specialising in Drug Overdose Prevention Education, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 69.

¹⁷⁴⁶ *Drugs, Poisons and Controlled Substances Act 1981* (Vic.), s. 80D.

Properly constructed, high quality devices are less likely to result in people consuming extra, toxic by-products or substances and as such, the sale of such devices ought to be allowed in order to provide consumers with safer, alternative options. It is quite clear that the pursuit of prohibition as a method of drug control has failed by nearly every manner it can be measured.

Banning paraphernalia is not effective at reducing harms and may exacerbate some. Paraphernalia prohibitions cause Victorians to use poor equipment or purchase equipment online (send business overseas).¹⁷⁴⁷

Associate Professor Nadine Ezard also highlighted the negative consequences of such laws. In her submission, she stated that many jurisdictions in Australia now have a contradictory situation where smoking paraphernalia is criminalised but injecting paraphernalia is not. She also told the Committee that a ban on smoking paraphernalia was illogical and counterproductive:

One of the issues around that differential illegality if you like, is the issue we see with the drug-use paraphernalia. So we're fortunate in New South Wales that we have quite large access to needle syringe programs but we have a situation - it's the same in Victoria since 2010 - where the pipes for smoking amphetamine are actually criminalised.

So I've had clients that have transitioned to injecting because it's easier to get injecting equipment than smoking equipment, albeit they're engaged in treatment and we're working with them to try and do something about that drug use. They don't want to be injecting but they've transitioned because of this kind of slightly contradictory public health situation.¹⁷⁴⁸

Associate Professor Nadine Ezard recommended decriminalising the possession of all types of drug use paraphernalia.¹⁷⁴⁹ Eros Foundation's preferred compromise position is to adopt a similar model to that in the ACT whereby retailers are allowed to sell but not overtly display drug paraphernalia products including hash pipes, ice pipes and bongs.¹⁷⁵⁰

While the Committee acknowledges the harms arising from crystal methamphetamine (and other drug) use, it does not believe that prohibiting 'ice pipes' is likely to have any impact on reducing use. It may, however, increase the risk of harms if people shift to injecting. As part of its overseas study tour, the Committee learnt that in the drug consumption room in Geneva, Quai 9, staff actively encourage people who inject drugs to think about alternative modes of consumption to minimise the adverse health effects associated with injecting.¹⁷⁵¹ The Committee also notes the contradictory nature of the laws that ban one type of drug paraphernalia and actively distribute another type.

RECOMMENDATION 42: The proposed Advisory Council on Drugs Policy review harms arising from current laws that prohibit or discourage non-injecting routes of drug administration, such as increased injecting use of methamphetamines and other drugs, and make recommendations to the Government accordingly.

¹⁷⁴⁷ Eros Association, *Submission*, no. 186, 17 March 2017.

¹⁷⁴⁸ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 115.

¹⁷⁴⁹ Associate Professor Nadine Ezard, *Submission*, no. 221, 13 April 2017, p. 1.

¹⁷⁵⁰ Eros Association, *Submission*, no. 186, 17 March 2017.

¹⁷⁵¹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 34.

16.5 Needle and syringe programs in prisons

One of the most contentious issues in drug policy is whether prisoners should have access to sterile injecting equipment to reduce the possibility of blood borne viruses and injecting injuries while they are incarcerated. The clear consensus in the research literature and views of inquiry stakeholders is that NSPs in prisons are a harm reduction intervention that should be utilised. Traditionally, prisoners typically have histories of high levels of substance use prior to entering prison, including injecting use and high rates of blood borne viruses. Prisoners are identified as a group particularly at risk of contracting hepatitis C through unsafe injecting practices while in prison.¹⁷⁵²

The first prison based NSP in the world was established in Switzerland in 1992, followed by Germany in 1996 and Spain in 1997. In 2016, eight countries had implemented an NSP in at least one prison with Spain having 22 across the country.¹⁷⁵³ Service models vary between prisons and include 'one-to-one' exchanges conducted by prison staff, external non-government organisations or by peer workers, as well as vending machines.¹⁷⁵⁴ They typically involve an exchange component as authorities naturally wish to minimise the number of needles circulating in the prison environment.

Based on international experiences of NSPs in prisons, their presence is correlated with reduced sharing of injecting equipment among prisoners, reductions in drug use and overdoses, and referrals to drug treatment programs.¹⁷⁵⁵ Most importantly, according to cohealth, there has not been one recorded case of HIV or hepatitis C infection due to injecting in any prison with a NSP.¹⁷⁵⁶ An evaluation of the Spanish prison NSP reported that the prevalence of HIV infection fell from 21 per cent in 1999 to 8.5 per cent in 2009, and hepatitis C infection fell from 40 per cent to 26.1 per cent.¹⁷⁵⁷ The Committee also learnt while overseas that in Switzerland, NSPs in women's prisons have resulted in no overdose deaths among women who inject drugs because they openly discuss their drug use and the associated risks with prison staff, leading to a reduction in risky injecting practices.¹⁷⁵⁸

A summary review of international developments in prison NSPs by NDARC concluded with the following findings:

Evaluation of pilot prison syringe exchange programs in Switzerland, Germany and Spain has been favourable in all cases. Drug use patterns reported at interview were stable or decreased over time (six prisons). Reported syringe sharing declined dramatically and was virtually non-existent at the conclusion of most pilot studies. No cases of inmates seroconverting for HIV, hepatitis B or hepatitis C have

¹⁷⁵² Kinner, S, et al., 'High-risk drug-use practices among a large sample of Australian prisoners', *Drug and Alcohol Dependence*, vol. 126, no. 1-2, 2012; Harm Reduction International, *Global State of Harm Reduction 2016*, London, 2016, p. 19.

¹⁷⁵³ The countries with NSPs in prison are Armenia, Germany, Kyrgyzstan, Luxembourg, Moldova, Spain, Switzerland and Tajikistan. France is possibly considering a prison based NSP in the next year. France did however pass legislation in 2015 (the *Loi Sante*) requiring equivalence between health services provided in prison with those in the community. Such a law would suggest NSP are mandated in French prisons. See Harm Reduction International, *Global State of Harm Reduction 2016*, London, 2016, p. 54.

¹⁷⁵⁴ Davoli, M, et al., 'Current and future perspectives on harm reduction in the European Union', in *EMCDDA Monographs 10: Harm reduction: evidence, impacts and challenges*, Rhodes and Hedrich (eds), Office of the European Union, Luxembourg, 2010, pp. 437-448.

¹⁷⁵⁵ Carter, C and Macpherson, D, *Getting To Tomorrow: A Report on Canadian Drug Policy*, Canadian Drug Policy Coalition, Vancouver, 2013, p. 49.

¹⁷⁵⁶ cohealth, *Submission*, no. 140, 16 March 2017.

¹⁷⁵⁷ Hepatitis Victoria, *Submission*, no. 135, 16 March 2017.

¹⁷⁵⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 33.

been reported in any prison with a prison syringe exchange program. No serious unintended negative consequences have been reported. There have been no reported instances of initiation of injecting. The use of needles or syringes as weapons has not been reported. One inmate (in Germany) is reported to have been injured by a discarded used needle. The number of needles and syringes distributed correlated with increased quantities of drugs detected in prisons and also when inmates receive payment.¹⁷⁵⁹

16.5.1 Drugs in prisons

The Committee received evidence from various stakeholders about the existence of illicit drug use within prisons. Indeed, it would be naïve and unrealistic to believe such drug use does not occur. As advised by Professor Dan Lubman, Director of Turning Point, people do use and inject drugs in prisons and this is very difficult to eradicate.¹⁷⁶⁰ In response to a question from the Committee about the availability of drugs in prisons, Melissa Westin, Assistant Commissioner of Corrections Victoria stated that ‘prisons are a reflection of the broader community. We see drugs available in the broader community’.¹⁷⁶¹

She also provided an overview of Corrections Victoria’s current measures to reduce the supply of drugs in Victorian prisons:

Some of the current measures that we use to reduce the supply of drugs into the facility include physical searching of our prisoners and visitors. We also search our staff. We do vehicle searches within our car parks. We have got drug detection dogs. We have also got ion scanning devices in the gatehouses of some of our facilities, camera surveillance footage, intelligence, breath testing and the extensive drug testing that I mentioned earlier. Each of these measures is not necessarily the most effective in its own right. It is the combination of all of these things that helps us address the supply into prisons. When it comes to searching prisoners and visitors, physical searches are an important way of us controlling the supply into our facilities. We conduct searches as part of our barrier control, but we also conduct searches in our car parks and inside our facilities. We use drug detection dogs within our facilities also. They are also capable of detecting tobacco and buprenorphine, which is one of the opioid substitution therapies that we mentioned earlier.¹⁷⁶²

Drug use in prisons is unsurprising given the high proportion of people who enter prison with drug dependencies or other related issues, in addition to drugs and alcohol being identified as ‘a key driver in much offending behaviour’.¹⁷⁶³ According to the 2015 Australian Institute of Health and Welfare (AIHW) report, *The health of Australia’s prisoners*, illicit drug use as reported by prison entrants was much higher than that of the general community for almost every drug type:

For many drug types, prison entrants were more than 2–3 times as likely as the general community to report recent use. Cannabis use was reported by more than one-half (53%) of 18–24 year old entrants, compared with just under one-quarter (23%) of their general community counterparts.¹⁷⁶⁴

¹⁷⁵⁹ Ritter, S, et al., *Prison-Based Syringe Exchange Programs: A Review of International Research and Program Development*, National Drug and Alcohol Research Centre, Sydney, 2001, p. 1.

¹⁷⁶⁰ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25.

¹⁷⁶¹ Assistant Commissioner Melissa Westin, Corrections Victoria, *Transcript of evidence*, 4 September 2017, p. 350.

¹⁷⁶² Assistant Commissioner Melissa Westin, Corrections Victoria, *Transcript of evidence*, 4 September 2017, p. 348.

¹⁷⁶³ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 4.

¹⁷⁶⁴ Australian Institute of Health and Welfare, *The health of Australia’s prisoners*, Australian Government, Canberra, 2015, p. 100.

The report also noted that the use of some drugs in the general community declined or remained stable as people aged, however, prisoners' use of drugs increased as they aged. For example, 4 per cent of prison entrants aged 18 to 24 used heroin, whereas 12 per cent of prison entrants aged 35 to 44 used heroin.¹⁷⁶⁵

There were also reports of high levels of injecting drug use among prison populations with 45 per cent of prison entrants reporting having injected a drug at least once in their lifetime.¹⁷⁶⁶ Further, ten per cent of people on discharge reported using while in prison and six per cent reported injecting drugs. Men (12 per cent) more often reported using drugs in prison compared to women (3 per cent).¹⁷⁶⁷

Regarding drug use in Victorian prisons, Corrections Victoria compiles a monthly *Drugs in Victorian Prisons Report*, which provides comprehensive data on drug testing and contraband seizures across the prison system.¹⁷⁶⁸ A key component of the report is urinalysis results from the following results:

- random general testing: random testing of a proportion of the general population each week
- targeted testing: of prisoners suspected of drug use
- random identified drug user testing: more frequent testing of five per cent of prisoners identified as engaging in drug-related behaviours. This is done weekly.
- Drug-Free Incentive Program testing: more frequent testing of prisoners who participate in the Program.¹⁷⁶⁹

Assistant Commissioner Melissa Westin explained the drug testing program in her evidence to the Committee:

...the testing of 1.25 per cent of our entire prisoner population every week, and the results are measured against the benchmarks that are set for each individual facility. Those benchmarks are set based on the profile of the prison — you know, its security rating but also the types of prisoners that we have in the facility, like sentenced, remand and so on.

We also do targeted testing of those who we suspect to be actively engaging in drug use. We use a lot of intelligence-led searching and information to target those particular searches. We mentioned the identified drug user program earlier — the IDU. That is for prisoners who have previously tested positive for drugs within a correctional facility. We test 5 per cent of prisoners with an IDU status within our facilities each week. We also do additional testing for those prisoners.¹⁷⁷⁰

The most recently published report available on Corrections Victoria's website indicated that in December 2017, 1,573 targeted urinalysis tests were collected, of which 10.36 per cent were positive. In the previous month, 1,508 targeted urinalysis tests were collected and 10.15 per cent were positive. Further, the 2017-18 average (thus

¹⁷⁶⁵ Australian Institute of Health and Welfare, *The health of Australia's prisoners*, Australian Government, Canberra, 2015, p. 100.

¹⁷⁶⁶ Australian Institute of Health and Welfare, *The health of Australia's prisoners*, Australian Government, Canberra, 2015, p. 100.

¹⁷⁶⁷ Australian Institute of Health and Welfare, *The health of Australia's prisoners*, Australian Government, Canberra, 2015, p. 102.

¹⁷⁶⁸ Corrections Victoria, *2017-18 Drugs in Victorian Prisons Report: December 2017*, Victorian Government, Melbourne, 2017.

¹⁷⁶⁹ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 9.

¹⁷⁷⁰ Assistant Commissioner Melissa Westin, Corrections Victoria, *Transcript of evidence*, 4 September 2017, pp. 348-349.

far) targeted positive rate across all prison locations was 10.09 per cent.¹⁷⁷¹ Further, Assistant Commissioner Melissa Westin indicated that the five year average of random positive tests is 4.92 per cent.¹⁷⁷²

16.5.2 Harmful drug taking practices in prisons

Given the reported availability of illicit substances in prisons, it is safe to assume that a proportion of prisoners who use drugs in prison are injecting them and sharing injecting equipment with others. This is a significant public health issue given the high prevalence of hepatitis C among the Australian prison population. As acknowledged in the *National Hepatitis C Strategy 2014–2017*:

The prevalence of hepatitis C is disproportionately high in custodial settings due to a high rate of imprisonment for drug related offences, and unsafe injecting drug use. Up to two-thirds of females in custodial settings are hepatitis C infected, compared to one-third of their male counterparts, and 43 per cent of Aboriginal and Torres Strait Islander people in custodial settings screened are infected with hepatitis C, compared with 33 per cent of non-Indigenous detainees.¹⁷⁷³

On the basis of these figures, the absence of NSPs in prison is deemed among public health advocates as ‘a glaring weak link in Australia’s response to blood borne infection control’.¹⁷⁷⁴

In Australia, a recent study found that prisoners were paying AU\$100-AU\$150 on average, and up to AU\$350, for one sterile needle/syringe, ‘demonstrating the inherent value of sterile injecting equipment in prisons’. The study also found that risk of blood borne virus infection relating to ‘the informal prison needle/syringe economy’ was high and concluded that provision of NSPs would greatly reduce the risk of disease transmission, as well as violence between inmates.¹⁷⁷⁵

The following excerpts are from two Australian prisoners who recounted disturbing experiences of drug use in prison. The first account is from a prisoner who is HIV positive:

In the cell, you got your bottom bunk and top bunk. About four blokes would sit on the bottom bunk, and then you’ve got your toilet and a couple of blokes sitting around that area. Then you’ve got your table for your TV and stuff, people would be sitting on them waiting their turn. Once they have their taste they leave, and another one goes around – ‘bang bang’ with the same fit [needle].¹⁷⁷⁶

Another prisoner gave an equally candid account of an incident that resulted in him being infected with hepatitis C:

¹⁷⁷¹ Corrections Victoria, *2017-18 Drugs in Victorian Prisons Report: December 2017*, Victorian Government, Melbourne, 2017, p. 5.

¹⁷⁷² Assistant Commissioner Melissa Westin, Corrections Victoria, *Transcript of evidence*, 4 September 2017, p. 350.

¹⁷⁷³ Department of Health, *Fourth National Hepatitis C Strategy*, Commonwealth of Australia, Canberra, 2014, pp. 25-26.

¹⁷⁷⁴ Ritter, A, et al., *An Assessment of Illicit Drug Policy in Australia (1985 to 2010): Themes and Trends*, National Drug and Alcohol Research Centre UNSW, Sydney, 2011, p. 36.

¹⁷⁷⁵ Treloar, C, et al., ‘The Prison Economy of Needles and Syringes: What Opportunities Exist for Blood Borne Virus Risk Reduction When Prices Are So High?’, *PLoS One*, vol. 11, no. 9, 2016, viewed 25 September 2017, <<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0162399>>.

¹⁷⁷⁶ Anex, *With conviction: The case for controlled needle and syringe programs in Australian prisons*, Melbourne, 2010, p. 8.

[Some inmates] pulled me aside later and said ‘We’re gonna score [heroin] - we’ll shout you a taste’. I thought ‘oh shit, I don’t really want to’, but then again I thought ‘if I say no it’s gonna look bad, they will want to know why. They could start getting paranoid, thinking I’m gonna lag them in or this or that’. So I gave in. But unfortunately I was the new guy and had to go last. It’s just the rules. It was my first time in, so of course I’ve gotta go last. I’d say easily 10 people had used that needle, it was really blunt. It was cut down, not a proper syringe by then. When it got to me, it was pretty bloody useless. Bloody hurt that’s for sure. And boom, I got hep C.¹⁷⁷⁷

Prior to entering prison this person regularly accessed NSPs in the community to prevent HIV/HCV infection. As ANEX, now the Penington Institute, stated ‘in gaol he had almost no choice but to take a life-threatening risk in order to avoid other risks to his welfare’.¹⁷⁷⁸

Melanie Eagle from Hepatitis Victoria gave equally graphic accounts of harmful injecting practices in prisons in her evidence to the Committee:

When I said to the nurse... — ‘Yes, but how does it [unsafe injecting] happen? ... he said, ‘Show me your pen’. ... You take the end off apparently — that is not hard — you cut it down, and he said the smaller you cut it down the easier it is to hide. You wash it out, the ink, and you put the drug in it that you have been able to get access to, and you inject. You do it unsafely because you do not want to be seen. If you are the kingpin you have it first, and then it is shared around. It becomes contraband. That is actually a currency.

So in fact it can be an aggravating factor — I am saying ‘can’; he says it is. The fact that there are syringes aggravates the problems, because people can use them. They are very valuable. They are more valuable apparently; a properly crafted and able-to-be-hidden syringe is more valuable than the drug itself. The drug is actually quite readily available, and these have to be hidden. So I guess the philosophy behind having safe needle and syringe programs is at multiple levels but one where you will not have an aggravating kind of power structure built around the access to unsafe injecting equipment.¹⁷⁷⁹

While a number of countries do not permit NSPs in prisons, including Australia, many provide bleach and disinfectant to prisoners to clean their needles, an admission that illicit drug use is prevalent within the prison environment. As noted in Correction Victoria’s *Corrections Alcohol and Drug Strategy 2015*, the *Communicable Diseases Framework* includes initiatives such as ‘education and health promotion, including peer education, to raise awareness’ and ‘safe access to powdered bleach sachets’ as part of addressing the factors that contribute to the spread of disease between prisoners and other members of the community.¹⁷⁸⁰ This again recognises that drug use and harmful drug taking practices are a reality within the prison environment.¹⁷⁸¹ In a submission to a separate inquiry, the Penington Institute, in pointing out the contradictions in such approaches, asserted that by not providing NSPs in prison, state authorities are in breach of their legally enforceable duty of care to those people under their care.¹⁷⁸²

¹⁷⁷⁷ Anex, *With conviction: The case for controlled needle and syringe programs in Australian prisons*, Melbourne, 2010, p. 9.

¹⁷⁷⁸ Anex, *With conviction: The case for controlled needle and syringe programs in Australian prisons*, Melbourne, 2010, p. 9.

¹⁷⁷⁹ Melanie Eagle, Chief Executive Officer, Hepatitis Victoria, *Transcript of evidence*, 4 September 2017, pp. 337-338.

¹⁷⁸⁰ Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview*, State Government of Victoria, Melbourne, 2015, p. 15.

¹⁷⁸¹ Kevin, M, *Drug use in the Inmate Population - prevalence, nature and context: DUIP NSW - 6th Biennial Data Collection 2009-10: Overview and series trends*, Corrective Services NSW, Sydney, 2013, p. 18.

¹⁷⁸² Penington Institute, *Submission*, February 2015, Inquiry into Hepatitis C in Australia, House of Representatives Standing Committee on Health, Parliament of Australia, p. 5.

16.5.3 Human Rights Obligations – equivalence of care

Internationally, a number of framework documents and guidelines recommend approaches to address drug use by prisoners (before, during and after their incarceration). On 22 May 2015, the United Nations Office on Drugs and Crime adopted updated standard minimum rules on the treatment of prisoners (the ‘Mandela Rules’). These detail the provision of health care to prisoners, including ‘principles of equivalence’ (to the community standard); independence; multidisciplinary care including psychological and psychiatric, and dental; and continuity of care back to the community upon release from prison.¹⁷⁸³ Other important frameworks include the WHO’s *Health in Prisons: A WHO guide to the essentials in prison health*,¹⁷⁸⁴ the WHO/UNAIDS/United Nations Office on Drugs and Crime’s briefing on *HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*,¹⁷⁸⁵ and the European Union’s *Prison Rules* drafted by the Council of Europe.¹⁷⁸⁶ This in particular promotes equivalence of treatment and service provision between prison and non-prison populations. According to the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) report, *Prisons and drugs in Europe: the problems and responses*, many European countries:

[h]ave transferred or are in the process of transferring competence for delivering prisoner healthcare to the same structures that provide healthcare in the community. An important rationale for this change has been the need to integrate prison health structures with those in the community and improve the continuity of care for prisoners. In some countries, the move followed recognition of the need to tackle prison health problems more effectively, and to improve the quality of care for prisoners through easier access to medical specialists from public health structures. In some countries, such as Sweden and the United Kingdom, this move seems to have been accompanied by increased funding to engage prisoners in drug treatment programmes.¹⁷⁸⁷

In the Australian context, a 2013 Australian Medical Association (AMA) position statement on medical ethics in custodial settings states that prisoners should have the same right of access, equity and quality of health care as the general population.¹⁷⁸⁸ The AMA endorsed this to include alcohol and drug services, such as NSPs in prisons.

In her submission, Dr Kate Seear from Monash University drew attention to international human rights obligations in the context of safeguarding the health of prisoners:

There are also other reasons to consider establishing prison NSPs. Recently, for instance, it was argued that the absence of prison NSPs represents a significant human rights violation, a proposition that appears to be supported that numerous international human rights principles and instruments. For instance, Principle 9 of the *United Nations Basic Principles for the Treatment of Prisoners* states that:

¹⁷⁸³ United Nations Office on Drugs and Crime, *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, Vienna, 2015.

¹⁷⁸⁴ World Health Organization, *Health in prisons: A WHO guide to the essentials in prison health*, Denmark, 2007.

¹⁷⁸⁵ United Nations Office on Drugs and Crime, et al., *HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*, Austria, 2013.

¹⁷⁸⁶ Council of Europe, ‘European Prison Rules’, viewed 16 March 2018, <<https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae>>.

¹⁷⁸⁷ European Monitoring Centre for Drugs and Drug Addiction, *Prisons and drugs in Europe: the problems and responses*, Luxembourg, 2012, p. 17.

¹⁷⁸⁸ Australian Medical Association, ‘AMA Position Statement: Medical Ethics in Custodial Settings [Amended 2015]’, viewed 19 October 2017, <<https://ama.com.au/position-statement/medical-ethics-custodial-settings-2013>>.

Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

Some interpret this to mean that where countries offer NSPs outside prisons, there is a positive obligation to provide them within prisons. As well, principle 24 of the *World Health Organisation Guidelines on HIV Infection and AIDS in Prisons* states that in countries where NSPs operate within the community:

Consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this.¹⁷⁸⁹

Harm Reduction Victoria made a similar point in its submission:

The failure to provide access to essential BBV prevention measures to prisoners is contrary to Australia's obligations under the Universal Declaration of Human Rights and other international instruments that deal with the rights of prisoners and prison health services which, in respect to the 'right to health', requires States to provide prisoners with access to preventative measures that are 'equivalent' to that available in the community - without discrimination on the grounds of their legal situation. Failure to provide access to such standardised preventative measures is also contrary to domestic obligations in Australia in relation to protecting the health of prisoners.¹⁷⁹⁰

Some commentators argue that equivalence should be seen as a minimum requirement rather than the optimal. At the very least, it is posited that the health of prisoners should not be worsened by their incarceration.¹⁷⁹¹ The Committee notes that in Canada, a coalition of interest groups including the Canadian HIV/AIDS Legal Network have challenged the lack of provision of prison based NSPs in Canada's federal courts, arguing that the Federal Government is negligent in not safeguarding the health of prisoners under their care. They also claimed that the Government's failure to provide equivalent services to prisoners is discrimination.¹⁷⁹²

The Committee notes that in Victoria, however, Justice Health's *Communicable Diseases Framework 2017* indicates that while striving to achieve equivalence of care, this is not always possible in a prison setting:

Victorian prison health services seek to provide prisoners with healthcare of a quality and standard equivalent to that provided in the community through the Victorian public health system. However, the poor health status of prisoners, the complexities of the correctional setting, and loss of liberty means that services may not always be directly comparable to those in the community. In addition to this, not all intervention models that are effective in the community are readily transferable to the prison setting.¹⁷⁹³

¹⁷⁸⁹ Dr Kate Seear, *Submission*, no. 126, 16 March 2017, pp. 10-11.

¹⁷⁹⁰ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, pp. 15-16.

¹⁷⁹¹ Australian Institute of Health and Welfare, *Bulletin 123: Prisoner health services in Australia 2012*, Canberra, 2014, p. 8.

¹⁷⁹² Canadian HIV/AIDS Legal Network, 'Lawsuit Filed Against Government of Canada for Failing to Protect the Health of Federal Prisoners', 25 September 2012, viewed 25 May 2017, <<http://www.ohtn.on.ca/Documents/Whats-On/Did-You-Know/12-09-27/Sept-25-Lawsuit-Prison-Health.pdf>>.

¹⁷⁹³ Department of Justice and Regulation, *Justice Health Communicable Diseases Framework 2017: Reducing the disease burden of bloodborne viruses and sexually transmissible infections in Victoria's prisons*, State Government of Victoria, Melbourne, 2017, p. 6.

16.5.4 The risks of needle and syringe programs in prisons

Key concerns regarding the implementation of NSPs in prison is the potential risk of needle stick injuries to prison staff and other inmates, in addition to the use of syringes as weapons. Assistant Commissioner Melissa Westin from Corrections Victoria identified this as the key reason for not implementing such a program in Victorian prisons:

A needle and syringe program within Corrections Victoria is not something that is being considered or has been considered, essentially because it has the potential to compromise a safe and secure corrections system. Probably one of the broader reasons for that is in relation to the introduction of a potential weapon into an otherwise sterile environment. I know your next question will be, 'But you find syringes in jail, don't you?'

...

It is about not further putting the safe and secure operation of the prison at risk, and it really goes against the rehabilitative framework that we have walked through today.¹⁷⁹⁴

The Committee understands that in 2012 a trial for a NSP in prison was proposed for the Alexander Maconochie Centre (AMC) in Canberra, however, it was strongly opposed by the Community and Public Sector Union (CPSU), the union covering prison officers, and it did not eventuate.¹⁷⁹⁵ When the issue was raised again in January 2017, corrections officers opposed the proposal, which according to the ACT Regional Director of the CPSU, Vince McDevitt, was based on 'safety reasons'.¹⁷⁹⁶

Interestingly, a survey of prison officers in two Australian jurisdictions found that two thirds had encountered a contraband needle/syringe in the course of their work and ten per cent of these had received a needle stick injury, or seven per cent of the total sample.¹⁷⁹⁷ Based on current risks in Victorian prisons, some commentators suggest that prison officers are less at risk in prisons with NSPs than those without, including Justice Action as stated in its submission:

...NSPs have increased safety for prison staff as well as prisoners. The international evidence has shown that prisons operating NSPs have reduced the number of accidental needle stick injuries. This is due to prison NSPs having strict regulations regarding the storage and disposal of needles and syringes, including keeping puncture proof containers in designated places within cells and having reliable supply of sterile needles and syringes to prisoners. This provides greater safety, as needles do not need to be hidden in common areas that pose a risk for accidental needle stick injuries.¹⁷⁹⁸

In this context, prison NSPs are arguably in the best interests of prison officers, in that a regulated NSP should form part of a safe working environment that officers are entitled to:

¹⁷⁹⁴ Assistant Commissioner Melissa Westin, Corrections Victoria, *Transcript of evidence*, 4 September 2017, p. 351.

¹⁷⁹⁵ 'Needle exchange program rejected for Canberra's jail', *ABC News*, 17 September 2016, viewed 29 May 2017, <<http://www.abc.net.au/news/2016-09-17/needle-exchange-program-rejected-at-canberra-jail/7854290>>.

¹⁷⁹⁶ Justice Action, *Submission*, no. 207, 21 March 2017, p. 17.

¹⁷⁹⁷ Larney, S and Dolan, K, 'An exploratory study of needlestick injuries among Australian prison officers', *International Journal of Prisoner Health*, vol. 4, no. 3, 2008, pp. 164-165.

¹⁷⁹⁸ Justice Action, *Submission*, no. 207, 21 March 2017, p. 16.

Providing a regulated NSP to prisoners meets the State's obligation to ensure prison facilities are safe and secure for staff. Accordingly, the provision of NSPs to prisoners is compatible with the standard of care required by the State in fulfilling its duty of care towards the workforce. It also provides prison staff with greater control of their work environment.¹⁷⁹⁹

Evidence from the various international evaluations of NSPs in prisons indicates that concerns regarding needle stick injuries or their use as weapons remain unfounded:

A meta-analysis (based on 11 evaluations of the implementation of prison-based NSP) revealed that none of the fears often associated with planned NSP occurred in any project: syringe distribution was followed neither by an increase in drug intake nor in administration by injection. Syringes were not misused as weapons against staff or other prisoners, and disposal of used syringes was uncomplicated. Sharing of syringes among drug users disappeared almost completely or was apparent in very few cases. These studies demonstrate both the feasibility, safety and efficacy of harm reduction including NSP in prison settings.¹⁸⁰⁰

During its overseas study tour, the Committee met with Dr Rick Lines, Executive Director of Harm Reduction International who told the Committee that in countries with NSPs in prisons, they had improved workplace safety because syringes were no longer hidden and there were fewer accidental stick injuries during random cell searches. In Germany, corrections staff advocated for NSPs to remain on the basis of improved safety.¹⁸⁰¹

16.5.5 Support for needle and syringe programs in prisons

Numerous inquiry stakeholders advocated for NSPs to be implemented in Victorian prisons on a harm reduction basis, including major medical peak bodies, such as the Royal Australasian College of Physicians and AMA Victoria.¹⁸⁰² The Australian Medical Association argued that NSPs in prison 'will lower blood-borne infection rates, and the health and safety of prisoners, prison staff and the public will improve'.¹⁸⁰³ From a broader public health perspective, many commentators argue that the rationale for establishing syringe exchange programs in prisons is 'even stronger than in communities'.¹⁸⁰⁴ For example, the United Nations and some of its key agencies,

¹⁷⁹⁹ Anex, *With conviction: The case for controlled needle and syringe programs in Australian prisons*, Melbourne, 2010, p. 4.

¹⁸⁰⁰ Stevens, A, et al., 'Criminal justice approaches to harm reduction in Europe', in *Harm reduction: evidence, impacts and challenges*, Rhodes, T and Hedrich, D (eds), Publications Office of the European Union, Luxembourg, 2010, p.385..

¹⁸⁰¹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 33.

¹⁸⁰² Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017; Victorian AIDS Council, *Submission*, no. 206, 21 March 2017; Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017; Odyssey House Victoria, *Submission*, no. 179, 17 March 2017; Justice Action, *Submission*, no. 207, 21 March 2017; Hepatitis Victoria, *Submission*, no. 135, 16 March 2017; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017; cohealth, *Submission*, no. 140, 16 March 2017; Burnet Institute, *Submission*, no. 165, 17 March 2017; Australian Medical Association, *Submission*, no. 203, 20 March 2017; Australasian College for Emergency Medicine, *Submission*, no. 223, 21 April 2017; Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017.

¹⁸⁰³ Australian Medical Association, *Submission*, no. 203, 20 March 2017, p. 5. NSP are also supported by other major medical associations including: The Royal Australasian College of Physicians, 'Position Statement: Needle and Syringe Exchange Programs in Prisons', viewed 29 May 2017, <<https://www.racp.edu.au/docs/default-source/advocacy-library/needle-and-syringe-exchange-programs-in-prisons.pdf>>; Public Health Association Australia, *Policy-at-a-glance - Illicit Drug Policy*, Canberra, 2017; Kerr, T, et al., 'Harm-reduction activism: a case study of an unsanctioned user-run safe injection site', *Canadian HIV/AIDS Policy and Law Review*, vol. 9, no. 2, 2004.

¹⁸⁰⁴ Ritter, S, et al., *Prison-Based Syringe Exchange Programs: A Review of International Research and Program Development*, National Drug and Alcohol Research Centre, Sydney, 2001, p. 1.

including the WHO and UNAIDS emphatically endorse NSPs in prisons on the basis that prisoners eventually return to their communities and the possibility of spreading blood borne viruses into the broader community is a real one.¹⁸⁰⁵

The Victorian Alcohol and Drug Association (VAADA) indicated that the reality of drug use in prisons, particularly the significantly higher rates of sharing injecting equipment, make the implementation of an NSP a necessity:

A survey of PWUD [people who use drugs] within Australian prisons noted that 46 percent had injected while in prison (Fetherston et al 2013) which is accompanied by the epidemic of hepatitis C within the prison environment with estimates indicating that between 25 to 40 percent of prisoners live with hepatitis C (Victorian government 2016; Victorian Ombudsman 2011). These disturbing figures are not surprising in that 70.7 percent of all hepatitis C infections result from intravenous substance use (Boston Consulting Group 2012). Yet, despite the high prevalence of people who inject drugs residing in prison, with almost half of this population reporting on having injected drugs in prison before, and the high prevalence of hepatitis C within this cohort, successive governments have issued blunt refusals on implementing a prison based NSP. Within the community, NSP provides a significant return on investment which would likely be greater still if applied to a prison environment. There is no record of syringes being used in assaults on prison personnel within any jurisdictions where prison based NSP currently operates.

All Victorian prisons should provide sterile injecting equipment.¹⁸⁰⁶

Interestingly, the Penington Institute advised that NSPs in prison could also encourage prisoners to seek treatment for their drug use:

Drug rehabilitation programs should be part of a comprehensive package of health services offered to prisoners. Prisons that provide NSP have found they help facilitate prison drug rehabilitation programs. In introducing a NSP, a prison adopts a harm reduction philosophy which can enhance staff and prisoner interaction. Prisoners no longer have to pretend to be “drug free”, allowing for honest and open communication about the risks of drug use. As a result, prisons have found since the establishment of NSPs, more prisoners have sought treatment for their drug problems.¹⁸⁰⁷

Melanie Eagle from Hepatitis Victoria offered a very practical but important reason to implement NSPs in prison in the context of the anti-viral HCV treatment program that is now available to prisoners with hepatitis C. She told the Committee:

...they have cured about 500 people already. This is a fantastic opportunity in that closed environment of treating people where they can be relatively stable and ensuring that they have got pathways out as they leave also to maintain service delivery and support. Victoria has got something it can be proud of there. Our concern then is that it can be undermined — all that investment can be undermined by people actually using in prison in an unsafe manner.

...

A fantastic [HCV] treatment program is being rolled out, but there is this unfortunate potential to have it undermined, that investment.¹⁸⁰⁸

1805 United Nations Office on Drugs and Crime, *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings*, Vienna, 2014; World Health Organization, *Prisons and Health*, Geneva, 2014.

1806 Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 9.

1807 Penington Institute, *Submission*, no. 209, 24 March 2017, p. 43.

1808 Melanie Eagle, Chief Executive Officer, Hepatitis Victoria, *Transcript of evidence*, 4 September 2017, p. 337.

Melanie Eagle added that even if only looked at from an economic perspective, the fact that successful HCV treatment was being undermined by ongoing needle sharing and reinfection in prison was reason enough for introducing NSPs in prisons:

[T]hat is likely to be an underestimate because it is not something people actually boast of, and they probably feel a bit foolish for having received treatment and actually being cured and still using. There is actually concrete proof of people who have relapsed and acquired hepatitis as a result. Yes, we can all be angry that there has been this investment in care. Largely it has been fantastically successful, but there had been 10 people who had relapsed. Of those, half — 50 per cent of those — had admitted to sharing since they had been receiving treatment. That was five, so we are not talking mammoth numbers, but a course of treatment is not cheap and it is a significant investment in time and it is being undermined.¹⁸⁰⁹

Similarly, VAADA, while commending the Victorian Government for recent initiatives to roll out HCV treatment in the prison system, also suggested that not providing sterile injecting equipment is indeed hampering the benefits of this initiative.¹⁸¹⁰

Whatever the evidence in support of prison NSPs, the Committee acknowledges that this is a highly contentious issue. A key barrier is the clear tension between the objects of the criminal justice and corrections system and the aims of harm minimisation and reduction. This is amplified by the key contradiction between ‘the pursuit of abstinence and the acknowledgement of continuing drug use’, which is clearly present in many prison environments, including those in Victoria.¹⁸¹¹ For example, Assistant Commissioner Melissa Westin of Corrections Victoria indicated that another reason NSPs are not supported in Victorian prisons is because they go ‘against the rehabilitative framework’ of Corrections Victoria.¹⁸¹²

The Committee notes there has been some support for such a program within areas of the Australian public service in the past. The Victorian Auditor-General’s Office report, *Prevention and Management of Drug Use in Prisons* acknowledged the benefits of NSPs in prison and evaluations from other countries which demonstrated that prison NSPs have not resulted in negative outcomes.¹⁸¹³ Moreover, the *Third National Hepatitis C Strategy 2010–2013* proposed that governments identify opportunities to trial NSPs in Australian prisons.¹⁸¹⁴ The strategy was endorsed by the Australian Health Minister’s Conference, which included health ministers from each Australian jurisdiction.

Needle and syringe programs in prison are understandably a contentious issue. Not only because it is a tacit acknowledgment that despite the best efforts of prison authorities, illicit drug use does take place in prisons but also because it possibly sends out the message that such drug use in prison, if not acceptable, is at least tolerable. Despite the evidence to the contrary, the concerns of prison officers that NSPs may endanger their health and wellbeing must also be respected and factored into any proposal. As proposed by the former harm reduction body, ANEX – now the Pennington Institute, addressing illicit drug use in prisons requires a suite of strategies, including NSPs and supply and demand reduction initiatives:

¹⁸⁰⁹ Melanie Eagle, Chief Executive Officer, Hepatitis Victoria, *Transcript of evidence*, 4 September 2017, p. 337.

¹⁸¹⁰ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 10.

¹⁸¹¹ Stevens, A, et al., ‘Criminal justice approaches to harm reduction in Europe’, in *Harm reduction: evidence, impacts and challenges*, T Rhodes and D Hedrich (eds), Publications Office of the European Union, Luxembourg, 2010, p. 380.

¹⁸¹² Assistant Commissioner Melissa Westin, Corrections Victoria, *Transcript of evidence*, 4 September 2017, p. 351.

¹⁸¹³ Victorian Auditor-General, *Prevention and Management of Drug Use in Prisons*, Melbourne, 2013, p. 28.

¹⁸¹⁴ Department of Health and Ageing, *Third National Hepatitis C Strategy 2010–2013* Commonwealth of Australia, Canberra, 2010, p. 18.

Any introduction of a NSP trial in prison would need to include concerted education programs with all prison staff and their unions to address their concerns by showing that such programs do not put their safety at risk. Prison-based NSPs could be integrated within the primary health care services, including health promotion, preventative care and drug treatment provided to prisoners.¹⁸¹⁵

The Committee also understands that upon entering a prison or transfer between prisons, prisoners are offered screening for blood borne viruses, with the intention of referring prisoners who receive a positive test result to the hepatitis service. The Committee believes that this screening should also be offered upon release to determine the health status of prisoners who originally entered prison with a negative test result. This information will contribute to further understanding the risk of blood borne virus infection while in prison, and the potential value of NSPs in reducing this risk.

RECOMMENDATION 43: The Victorian Government review its screening policies for blood borne viruses in prisons to:

- offer screening to prisoners upon release, in the same way they are offered screening upon entering prison or transferring between prisons
- explore the feasibility of introducing compulsory blood screening of prisoners upon entering and exiting prisons to determine transmission of blood borne viruses within prisons. This review should consider all human rights implications associated with mandatory screening.

RECOMMENDATION 44: The Victorian Government monitor data from screening processes, as recommended above, and monitor international needle and syringe prison programs to consider their potential value to minimise transmission of blood borne viruses. The Victorian Government share information with prison staff and relevant bodies to increase awareness and open dialogue about the benefits and risks of needle and syringe programs in prisons.

¹⁸¹⁵ Anex, *With conviction: The case for controlled needle and syringe programs in Australian prisons*, Melbourne, 2010, p. 12.

17 Overdose prevention strategies

During the last decade, there has been a steady increase in the number of drug overdoses in Victoria, with fatalities now exceeding the number of road crash-related deaths.¹⁸¹⁶ The misuse of pharmaceutical drugs is a significant contributing factor, as is the greater purity of illicit substances, such as heroin, combined with increased prevalence of poly-drug use. In its submission, the Penington Institute referred to the disturbing number of deaths in Australia:

...well over 2500 accidental overdose deaths since 2004. Further, it has been estimated that for each drug-related death, there are 20 to 25 non-fatal overdoses, many of which come with significant, ongoing costs to people's health and the health system. Non-fatal overdose can cause serious harm, including brain damage, pulmonary oedema, pneumonia and heart attack.

While there is no Australian estimate of the economic cost of overdose, it almost certainly runs to the billions of dollars each year. Overdose is also a problem around the world, with between 69,000 and 103,500 deaths in 2014 alone.¹⁸¹⁷

A key objective of this inquiry has been exploring how drug policy and laws can be reformed to prevent and minimise drug-related harms. The greatest harm is death, and it is an absolute tragedy that drug-related deaths are increasing. Throughout its evidence gathering, the Committee heard deeply personal stories by loved ones of people who had lost their lives due to overdose. While inquiries like this focus largely on data, the Committee is acutely aware that behind each number represents the loss of someone's child, partner, parent or friend. The Committee also acknowledges that telling these stories brings a unique voice to the drug policy debate, as they are based on real life experiences and compassion. These stories are a powerful way to draw attention to the reality of illicit drug use in the community.

The purpose of this chapter is to provide an overview of overdose deaths in Victoria, including coronial data and evidence from a broad range of stakeholders about the impact of these deaths on them and their local communities. Drawing on the experience of North America regarding the opioid crisis and local reports of increased purity and strength of illicit substances, this chapter also explores strategies to prevent a continued rapid rise in overdoses in Victoria. This includes naloxone and supervised injecting centres, in addition to various other interventions, to form a population-based overdose prevention strategy.

¹⁸¹⁶ Turning Point, *Submission*, no. 116, 15 March 2017.

¹⁸¹⁷ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 19.

17.1 Current overdose data and harms

In Victoria, all non-natural deaths including overdose deaths must be reported to the Coroners Court of Victoria (CCOV) for investigation. If the investigation establishes the death was an overdose, it is entered into the Victorian Overdose Deaths Register ('the Register'). It defines an overdose as:

...a death where the expert death investigators (the coroner, forensic pathologist and forensic toxicologist) established that the acute toxic effects of a drug or drugs played a contributory role. Overdose deaths include deaths where acute toxic effects of drugs were the only cause, and deaths where acute drug toxicity contributed in combination with other non-drug causes such as cardiovascular or respiratory disease. Deaths associated with the behavioural effects of drug taking (for example a fatal motor vehicle collision while affected by drugs and alcohol) or its chronic effects (for example haemorrhage of a gastrointestinal ulcer caused by chronic ibuprofen consumption) are excluded from the Register.¹⁸¹⁸

In a submission to the Committee, the State Coroner of Victoria, Judge Sara Hinchey provided a summary of overdose deaths investigated by Victorian coroners during the period of 2009 to 2016. Some of the key findings included:

- The annual frequency of Victorian overdose deaths declined between 2009 and 2010, but then climbed steadily over following years to reach 492 deaths in 2016.¹⁸¹⁹
- The proportion of Victorian overdose deaths involving multiple drugs increased slightly across this period, from 66.5 per cent of deaths (252 of 379) in 2009 to 72.2 per cent of deaths (355 of 492) in 2016.¹⁸²⁰
- The overall five most frequent contributing individual drugs to Victorian overdose deaths between 2009 and 2016 were (in descending order) diazepam, heroin, alcohol, codeine and methadone.¹⁸²¹
- There was only a minor difference between the average annual rate of overdose deaths, for metropolitan Melbourne (7 deaths per 100,000 population per year) and regional Victoria (6.6 deaths). However, there was strong variation in overdose death rate between individual local government areas.¹⁸²²

In 2016, 369 overdose deaths occurred in metropolitan local government areas and 121 in rural and regional areas. The three local government areas with the most number of overdose deaths were the City of Yarra with 26; closely followed by the City of Port Phillip (St Kilda), with 23 deaths; and the City of Melbourne with 21 deaths. The most overdose deaths in a regional local government area was in Greater Geelong (20), followed by LaTrobe (Gippsland) (10) and Greater Bendigo (6).¹⁸²³

Contributing drugs across all Victorian overdose deaths were classified into three main types: pharmaceutical drugs, illegal drugs, and alcohol. Figure 17.1 shows the annual frequency of Victorian overdose deaths involving each of these three contributing drug types. The proportion of annual Victorian overdose deaths involving pharmaceutical drugs was relatively steady during the period, ranging

¹⁸¹⁸ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 29.

¹⁸¹⁹ Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, p. 2.

¹⁸²⁰ Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, p. 2.

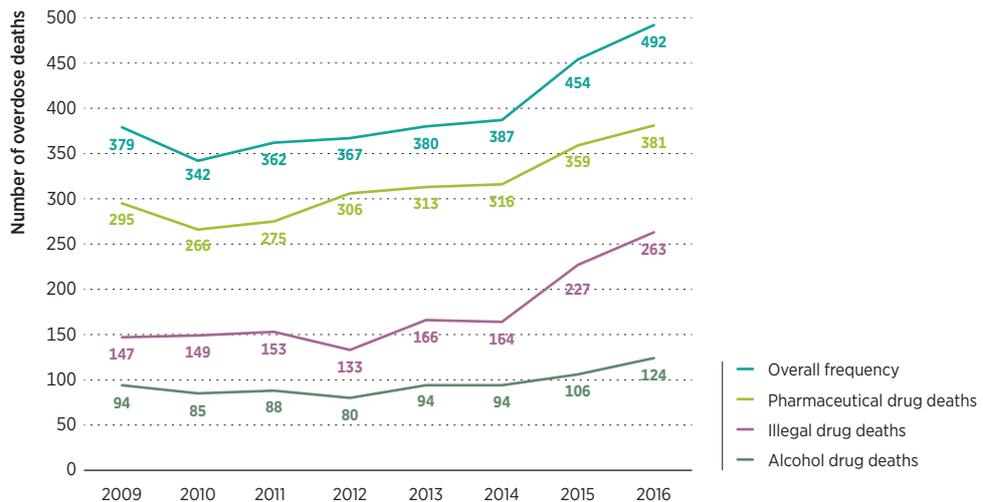
¹⁸²¹ Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, p. 6.

¹⁸²² Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, pp. 11-12.

¹⁸²³ Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018, pp. 8-9..

between 76 per cent (2011) and 83.4 per cent (2012). Across the period 2009 to 2016, pharmaceutical drugs contributed to an average of 79.5 per cent of all overdose deaths. This is discussed further in chapter 15. The Committee notes in particular the increase in overdose deaths involving illegal drugs, rising from 36.2 per cent in 2012 to 50.0 per cent in 2015 and then 53.5 per cent in 2016. In addition, the prevalence of poly-drug use and its contribution to overdose deaths in Victoria are discussed in more detail in chapter two.

Figure 17.1 Annual frequency and proportion of overdose deaths by contributing drug types, Victoria 2009-2016



Source: Judge Sara Hinchey, *Supplementary evidence*, Coroners Court of Victoria, 23 January 2018.

The National Drug and Alcohol Research Centre's (NDARC) Illicit Drug Reporting System (IDRS) also provides interesting insights into overdose experiences of people who inject drugs. In a recent analytic report *Lifetime and recent opioid overdose among a sample of people who inject drugs in Australia*, it was found that:

- 45 per cent of survey participants reported having had an opioid overdose at least once
- 14 per cent reported recently having an opioid overdose
- reports of recent opioid overdose were associated with daily alcohol use and illicit benzodiazepine use.¹⁸²⁴

Survey findings also indicated the high involvement of heroin in overdoses, with 41 per cent of the sample reporting a previous heroin overdose. Eight per cent of the sample reported an overdose related to use of an opioid other than heroin (morphine, oxycodone).¹⁸²⁵

The Committee is also aware of the value in considering coronial and academic data in conjunction with data collated by individual agencies, particularly alcohol and other drug agencies (AOD), needle and syringe programs (NSPs), and community

¹⁸²⁴ Dietze, P and Hill, P, *Lifetime and recent opioid overdose among a sample of people who inject drugs in Australia*, National Drug and Alcohol Research Centre, 2017.

¹⁸²⁵ Dietze, P and Hill, P, *Lifetime and recent opioid overdose among a sample of people who inject drugs in Australia*, National Drug and Alcohol Research Centre, 2017.

health centres. For example, North Richmond Community Health (NRCH), a community health centre located at the heart of the illicit drug trade in Victoria, stated in its submission:

- The AoD program monitors at least one person a day for overdose;
- NRCH will provide an emergency overdose response at least once a week in the area immediately surrounding the health centre building, involving around 10 people including at least two doctors and two nurses.¹⁸²⁶

Moreover, in 2015 over twenty per cent of heroin related overdose deaths occurred within a small area of North Richmond/Abbotsford.¹⁸²⁷

The City of Yarra, where NRCH is located, presented ambulance attendance data in its submission that showed between 2010 to 2015, it had the highest frequency of heroin-related ambulance attendances of any local government area in Victoria. For the 2014/2015 period alone, there were 427 attendances in total.¹⁸²⁸

In regard to specific groups that are more susceptible to overdose, the Australian Illicit and Injecting Drug Users League (AIVL) and the Penington Institute drew attention to higher rates among Aboriginal and Torres Strait Islander (ATSI) people, as well as people from rural and regional areas.¹⁸²⁹ Regarding ATSI people, the Penington Institute advised in its submission:

Victoria does not collect data on Aboriginal and Torres Strait Islander status for overdose deaths. However, all jurisdictions that do are reporting a particularly heightened rate of accidental overdose in this population. Among these jurisdictions the Indigenous overdose rate increased 141 per cent between 2004 and 2014 (to 9.4 per 100,000), compared with 45 per cent growth (to 4.8 per 100,000) among non-Indigenous people in the same period.¹⁸³⁰

The Penington Institute also indicated there are increasing rates of overdose deaths in rural and regional areas:

Although most demographics are affected by overdose, the data indicates middle aged Victorians (ages 30-60), especially men living in rural areas, are most at risk. The rate of overdose deaths in regional Victoria has grown 57 per cent (compared with 36 per cent for the state as a whole), and the number of deaths has risen 64 per cent, since 2008.¹⁸³¹

In its *Australia's Annual Overdose Report 2017*, the Penington Institute reaffirmed that on a per capita basis, 'regional Victoria is currently experiencing a significant increase in deaths from benzodiazepines, and pharmaceutical opioids at far greater per capita rates than Melbourne'.¹⁸³²

¹⁸²⁶ North Richmond Community Health, *Submission*, no. 162, 17 March 2017.

¹⁸²⁷ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 11.

¹⁸²⁸ City of Yarra, *Submission*, no. 127, 16 March 2017.

¹⁸²⁹ Australian Injecting & Illicit Drug Users League, *Submission*, no. 169, 17 March 2017.

¹⁸³⁰ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 20.

¹⁸³¹ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 20.

¹⁸³² Penington Institute, *Australia's Annual Overdose Report 2017*, Carlton, 2017, p. 28.

17.2 The role of opioids in drug overdoses

Opioid use, particularly of heroin, has grown since the late 1960s in Australia, with the first major epidemic of illicit heroin use occurring in the early 1970s. This prompted the establishment of the methadone program in 1970.¹⁸³³ Another major initiation occurred from 1982 to 1985, which again prompted specific government responses, such as the NSP.¹⁸³⁴

During the 1990s, Australia experienced a heroin glut in which high quality, low priced heroin from South East Asia was easily accessible, particularly in metropolitan areas. This led to a rapid increase in overdose deaths. Between 1979 and 1995 there was a six fold increase in fatal opioid overdose among Australians aged 15 to 44 years.¹⁸³⁵

From approximately December 2000, Australia experienced a ‘heroin drought’, with high grade heroin becoming more difficult to access, partly due to an edict forbidding opium cultivation in Afghanistan. This resulted in a nation-wide shift towards the use of other illicit drugs, especially amphetamines and to some extent benzodiazepines. Commentary on the ‘heroin drought’ claimed its impact was most felt in Victoria and New South Wales. While the decrease in the availability of heroin and a concomitant reduction in heroin-related overdoses was a positive outcome, other consequences were experienced including an increase in the price of heroin and amphetamine, and increases in the number of people reporting involvement in criminal activity.¹⁸³⁶

Since approximately 2010, the media and community have predominantly focused on methamphetamine use and the associated harms, which to some degree has masked the growing problem of opioid use, both illicit and pharmaceuticals. For example, since 2015, there has been an approximately 55 per cent increase in heroin injections at Sydney’s medically supervised injecting centre (MSIC), equating to 2250 per month compared to the previous average of 1400.¹⁸³⁷

Concerns were also raised by inquiry stakeholders about the increasing appearance of heroin in opioid overdose deaths. According to Victoria Police intelligence, there is significant re-emergence of heroin being trafficked in the streets of Melbourne and the drug is at higher purity levels than seen in previous years.¹⁸³⁸ Charles Henderson, the Acting Executive Officer of Harm Reduction Victoria (HRV), told the Committee ‘[i]n reality it has never been easier to get heroin’.¹⁸³⁹

Similarly, Peter Wearne, Chair of the Yarra Drug and Health Forum (YDHF) warned of an approaching ‘tsunami’ of heroin use about to take hold in Australia based on evidence from overseas (particularly the US and Canada) and Australia’s vulnerability to these markets. In Peter Wearne’s view, the only reason young people are not

¹⁸³³ Ward, J, et al., *Methadone maintenance treatment and other opioid replacement therapies*, Harwood Academic Press, Amsterdam, 1998, p. 2.

¹⁸³⁴ Hall, W, et al., *Heroin Use In Australia: Its Impact on Public Health and Public Order*, National Drug and Alcohol Research Centre, Sydney, 1999, p. 2.

¹⁸³⁵ Hall, W, et al., *Heroin Use In Australia: Its Impact on Public Health and Public Order*, National Drug and Alcohol Research Centre, Sydney, 1999, p. 2.

¹⁸³⁶ Degenhardt, L, et al., *The “lessons” of the Australian “heroin shortage”*, Substance Abuse Treatment, Prevention Policy, vol. 1, no. 11, 2006; Dietze, P, et al., *The course and consequences of the heroin shortage in Victoria*, National Drug Law Enforcement Research Fund, 2004.

¹⁸³⁷ 730 Report, *Heroin: a new drug epidemic with an old drug*, Television program, ABC, 27 January 2016.

¹⁸³⁸ Catherine Quinn, Assistant Director, Analytical Services, Forensic Services Department, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 453.

¹⁸³⁹ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 66.

using heroin in greater numbers is due to its still relatively high price. He advised ‘if heroin becomes cheap again, 99 per cent of all the young people we see at the Youth Substance Abuse Service will be using heroin’.¹⁸⁴⁰

Professor Margaret Hamilton, an Australian drug policy expert, also spoke of the enduring nature of heroin in her evidence to the Committee:

Some of the old products are very resilient. We know that we have got heroin back around now. We see that people are using heroin. We had a heroin glut late last century, if you like. We have got heroin back with us, and we can see that in heroin overdose or opiate overdose deaths. These drugs are resilient, and they are resilient because people will always look for the things that make them feel good.¹⁸⁴¹

17.2.1 Rising opioid use and overdoses in North America

In the US, an overwhelming increase in the number of opioid overdose deaths has occurred in recent years. Approximately 64,000 people died from drug overdoses in the US in 2016.¹⁸⁴² The vast majority involved an opioid drug, including heroin, morphine, oxycodone and synthetic drugs, such as fentanyl. Fentanyl and its related analogue carfentanil, are two of the most potent opioid drugs (see chapter two). Indeed, the number of fentanyl-related deaths in the US rose by 72 per cent between 2014 and 2015 alone.¹⁸⁴³

A 2017 report by the Global Commission on Drug Policy (GCDP), *The Opioid Crisis in North America*, described the situation as ‘an epidemic of opioid addiction and opioid overdose with an unprecedented level of mortality’.¹⁸⁴⁴ It indicated that this originated largely from an:

[e]xpansion of medical use of opioids, which began in the 1990s as a legitimate response to the under-treatment of pain, but which was soon exploited by the unethical behavior of pharmaceutical companies eager to increase their revenue.¹⁸⁴⁵

The GCDP also stated that ‘[o]verdose is now the leading cause of unintentional injury death in the United States. Annually, it kills more than car accidents and takes more lives than US soldiers were lost in the deadliest year of the Vietnam War (16,899 in 1968) or at the height of the HIV/AIDS epidemic in the United States (43,115 in 1995)’.¹⁸⁴⁶

In its call for a national strategy to address opioid overdose, the US National Academies of Sciences, Engineering and Medicine indicated that as of 2015, at least two million people in the US had an opioid use disorder that involved prescription opioids, and almost 600,000 had an opioid use disorder involving heroin. It also drew attention to the contribution of heroin and fentanyl to the rapidly rising illicit drug overdose deaths:

¹⁸⁴⁰ Peter Wearne, Chair, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 45.

¹⁸⁴¹ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 55.

¹⁸⁴² National Center for Health Statistics, ‘Provisional counts of drug overdose deaths as of 6 August 2017’, viewed 1 February 2018, <https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf>.

¹⁸⁴³ Global Commission on Drug Policy, *The opioid crisis in North America*, GCDP, Geneva, 2017, p. 6.

¹⁸⁴⁴ Global Commission on Drug Policy, *The opioid crisis in North America*, GCDP, Geneva, 2017, p. 3.

¹⁸⁴⁵ Global Commission on Drug Policy, *The opioid crisis in North America*, GCDP, Geneva, 2017, p. 3.

¹⁸⁴⁶ Global Commission on Drug Policy, *The opioid crisis in North America*, GCDP, Geneva, 2017, p. 5.

While the annual number of deaths from prescription opioids remained relatively stable between 2011 and 2015, overdose deaths from illicit opioids — including heroin and synthetic opioids such as fentanyl — nearly tripled during this time period, partially in connection to a growing number of people whose use began with prescription opioids.¹⁸⁴⁷

Canada has also experienced an alarming escalation in overdose deaths, particularly on its west coast. When the Committee met with representatives of Vancouver Coastal Health (VCH), a key public health agency addressing drug use and related harms in British Columbia (BC), it was told that the opioid overdose crisis had led to an official declaration of a public health emergency in BC. Vancouver Coastal Health advised that in 2012, there were 269 overdose deaths from illicit drugs, which increased to 931 in 2016.¹⁸⁴⁸ The Committee learnt from various public health and law enforcement stakeholders in Vancouver that heroin laced with fentanyl and carfentanil had been the greatest contributing factor to this increase in deaths. While fentanyl was detected in only four per cent of overdose deaths in 2012, it rose significantly to 68 per cent in 2016 and 72 per cent in 2017 (as of July 2017). In December 2016, when carfentanil was detected in heroin, the Vancouver MSIC, Insite, reported 120 overdoses in the centre per week, a much higher rate than the usual 30 to 40 weekly overdoses.¹⁸⁴⁹

17.2.2 The presence of fentanyl and carfentanil in overdose deaths in Australia

Based on the evidence from North America regarding the presence of fentanyl and carfentanil in overdose deaths, the Committee was interested to explore whether this might become a problem in Australia. Some experts from both clinical and law enforcement fields indicated that this is of concern and the use of such drugs is increasing, whereas other were either unsure or did not believe the issue would escalate. For example, Catherine Quinn, Assistant Director of Analytical Services, in the Forensic Services Department at Victoria Police advised that it is not an emerging problem to any significant degree:

We have not really seen any significant evidence that says that carfentanil and fentanyl are going to be an emerging problem. We will get random pieces of it — there is no doubt that that will occur. But as actual emerging substances, there is no real strength to that at the moment. That may very well be because of the nature of that drug community — in that drug user community, it is just not favoured, it just does not happen; we do not have the connectivity to that.¹⁸⁵⁰

Rick Nugent, Assistant Commissioner of Victoria Police indicated that while Australia's drug market is different to that in North America, it is difficult to say what might happen here. However, he did advise the Committee that 'at the same time part of our planning and the development of our response plan is thinking through what that would mean for us'.¹⁸⁵¹ Similarly, Shane Neilson, Head of the

¹⁸⁴⁷ Nauert, R, 'New Report Outlines National Strategy to Reduce Opioid Epidemic', Psych Central, 7 July 2017, viewed 8 January 2018, <<https://psychcentral.com/news/2017/07/17/new-report-outlines-national-strategy-to-reduce-opioid-epidemic/123355.html>>.

¹⁸⁴⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 51.

¹⁸⁴⁹ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 51.

¹⁸⁵⁰ Catherine Quinn, Assistant Director, Analytical Services, Forensic Services Department, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 463.

¹⁸⁵¹ Assistant Commissioner Rick Nugent, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 463.

High Risk and Emerging Drugs Determination of the Drug Intelligence Hub at the Australian Criminal Intelligence Commission (ACIC) told the Committee that high rates of fentanyl had not been detected in the wastewater data analysis, although it is important for law enforcement and health agencies to be vigilant in this area:

The opioids that we are particularly concerned about are obviously fentanyl and related substances. You mentioned carfentanil, which of course is a veterinary substance and there is really only a very small niche market legitimately for that substance, and oxycodone and fentanyl, which obviously have far greater legitimate uses. We see the threat more in terms of potential rather than current risk for oxycodone and fentanyl, and we are aware, having said that, that people are dying in Australia from overdoses of these drugs and others are suffering phenomenally from overdoses. So the current threat is real enough and we need to be concerned, but thankfully the level of threat in Australia has not yet reached the levels being experienced in some countries in Europe and North America. There is still time for steps to be taken to prevent the threat from escalating, and we are working with a whole range of stakeholders in the medical and health sector in the industry to achieve this.¹⁸⁵²

The Committee notes that in some instances, at least in the case of fentanyl, overdose deaths in Australia are attributable to the use of that drug. The Penington Institute's report, *Australia's Annual Overdose Report 2017*, indicated, for example, that the role of fentanyl in overdose deaths may be underestimated. Drawing from Australian Bureau of Statistics (ABS) *Causes of Death* data, it noted Australia had experienced a significant increase in fatal overdoses due to painkiller drugs fentanyl, pethidine and tramadol. In the five-year period of 2011 to 2015, 796 Australians died from an overdose from one of these drugs. Penington Institute acknowledged that while the ABS data is not disaggregated, i.e. fentanyl, tramadol and pethidine deaths are compiled as a single category, it believed fentanyl is the major contributing factor to these deaths:

We can confidently rule out pethidine as driving this growth, as it is very uncommonly prescribed and has not been on the PBS for many years. Tramadol prescriptions have been steady since 2003, whereas fentanyl prescriptions have risen steadily until plateauing in 2011. These factors, plus fentanyl's high potency, and tramadol's relatively low potency, suggest that fentanyl is the main driver behind these deaths.¹⁸⁵³

Further, an article February 2017, *A Cluster of Fentanyl-Laced Heroin Deaths in 2015 in Melbourne Australia*, also reported on a number of deaths caused by the use of heroin laced with fentanyl in Melbourne. Of 4000 coronial cases in 2015 that underwent toxicological analysis, nine deaths were identified as involving fentanyl/heroin combinations. While these numbers are small relative to those in North America, they are the first reported cases of fatalities involving heroin and fentanyl outside North America in the published literature. As the authors pointed out, such findings should be used to inform public health and prevention strategies to decrease the potential for further such fatalities in the future.¹⁸⁵⁴

¹⁸⁵² Shane Neilson, Head of the High Risk and Emerging Drugs Determination, Drug Intelligence Hub, Australian Criminal Intelligence Commission, *Transcript of evidence*, 13 November 2017, p. 467.

¹⁸⁵³ Penington Institute, *Australia's Annual Overdose Report 2017*, Carlton, 2017, p. 18.

¹⁸⁵⁴ Rodda, L, et al., 'A Cluster of Fentanyl-Laced Heroin Deaths in 2015 in Melbourne Australia', *Journal of Analytical Toxicology*, vol. May 1;41(4), 2017, pp. 318-324.

The Committee also notes a January 2018 media release by the Australian Capital Territory (ACT) Government’s Chief Health Officer, Dr Paul Kelly, regarding a recent drug seizure containing carfentanil, ‘raising a red flag for medical and law enforcement personnel’. In his statement, Dr Paul Kelly advised of the high potency of the synthetic drug:

“Carfentanil is one of the most potent Fentanyl analogues with a potency estimated to be 10,000 times that of morphine.

“The only known legitimate use for Carfentanil is the sedation of a large animal such as a rhinoceros or an elephant.

“The drug is so potent that a safe dose is so small it cannot be measured outside a scientific laboratory as domestic scales do not provide sufficient accuracy.

“A fatal overdose can be caused by accidental skin contact with a powder containing Carfentanil. A deliberate dose of less than a grain of salt could also kill.¹⁸⁵⁵

The correlation of opioid use and increasing overdose death is of great concern both in North America and here in Australia. Two specific interventions to address this growing problem include enhanced availability of the drug naloxone to reverse the effects of opioid overdose and the establishment of medically supervised injecting rooms. These are discussed below, in addition to an overdose prevention strategy.

17.3 Naloxone

Naloxone hydrochloride (trade name Narcan) is an opioid overdose reversal drug, primarily administered by doctors or paramedics responding to ambulance call outs. Naloxone works by blocking opioid drugs, such as heroin and methadone, from attaching to opioid receptors in the brain. It can be injected intravenously or intramuscularly. It can also be in the form of a nasal spray, however, such products are not currently available in Australia.¹⁸⁵⁶ According to the Victorian Alcohol and Drug Association (VAADA), ‘[t]he availability of naloxone creates the real possibility of every opioid related fatal overdose being preventable’.¹⁸⁵⁷

Naloxone cannot be used to get high, meaning that it has no potential for misuse. Nor is there evidence that extended use of naloxone can cause harmful effects or dependence. People who take naloxone do not develop a tolerance to its effects and there have been no reported deaths from naloxone, such as overdose.¹⁸⁵⁸ Prompt administration of naloxone is critical in an overdose scenario, for example as stated by HRV, ‘[t]he time lapse between reporting an overdose and the arrival of an ambulance and paramedics to administer naloxone can significantly increase the risk of fatality and/or brain damage’.¹⁸⁵⁹

International bodies such as the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO) support and encourage the use of naloxone as a measure to reduce overdose fatalities, and it is also included in the WHO Essential Medicines List allowing for greater distribution, particularly in developing nations. Regarding the need for wider availability, the WHO stated in 2014:

¹⁸⁵⁵ ACT Government, *The drug Carfentanil is for elephants not humans*, Media release, 25 January 2018.

¹⁸⁵⁶ Alcohol and Drug Foundation, ‘Naloxone’, viewed 15 March 2018, <<https://adf.org.au/drug-facts/naloxone>>.

¹⁸⁵⁷ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 12.

¹⁸⁵⁸ Alcohol and Drug Foundation, ‘Naloxone’, viewed 15 March 2018, <<https://adf.org.au/drug-facts/naloxone>>.

¹⁸⁵⁹ Harm Reduction Victoria, ‘Naloxone Position Statement’, viewed 21 December 2017, <<http://hrvic.org.au/harm-reduction/naloxone-position-statement>>.

Death does not usually occur immediately, and in the majority of cases, overdoses are witnessed by a family member, peer or someone whose work brings them into contact with people who use opioids. Increased access to naloxone for people likely to witness an overdose could significantly reduce the high numbers of opioid overdose deaths. In recent years, a number of programmes around the world have shown that it is feasible to provide naloxone to people likely to witness an opioid overdose, in combination with training on the use of naloxone and the resuscitation of people experiencing opioid overdose, prompting calls for the widespread adoption of this approach.¹⁸⁶⁰

In early 2013, the Australian Medical Association called for naloxone distribution among users and others.¹⁸⁶¹ The *National Drug Strategy 2017-2026* similarly recognised naloxone as a valuable evidenced-based intervention to reduce the risk of opioid overdose.¹⁸⁶²

This section focuses on mechanisms to expand access to naloxone, particularly through the promotion of take home naloxone (THN) harm reduction programs.

17.3.1 Naloxone programs

Broadly, a THN program aims to expand access of naloxone to people who are not medical professionals but who may witness an opioid overdose such as people who use opioids, families and friends. In the 2016 report, *Preventing opioid overdose deaths with take-home naloxone*, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) summarised a systematic review of 21 naloxone studies and described the following outcomes of THN programs:

- they improved knowledge on overdoses and attitudes on the use of naloxone
- naloxone was administered in a median of 67 per cent of overdoses witnessed (where recorded)
- adverse events from naloxone were rarely reported, other than withdrawal symptoms
- overdose mortality was 'significantly lower in communities with active take-home naloxone programmes, and all take-home naloxone programmes had a high survival rate'.¹⁸⁶³

The first THN program in Australia was established in the ACT in 2012. The program provides comprehensive opioid overdose management training and the prescription and supply of THN to eligible participants who are not health professionals. The program, funded by ACT Health, is delivered by the drug user organisation, Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), with prescriptions provided by local physicians. As advised in HRV's submission, over 200 participants were trained in overdose prevention and naloxone between April 2012 and December 2014, with the majority receiving a prescription for naloxone.¹⁸⁶⁴

¹⁸⁶⁰ World Health Organization, *Substance use: Community management of opioid overdose*, Geneva, 2014, p. ix.

¹⁸⁶¹ 'AMA backs naloxone overdose prevention rollout', *Anex Bulletin*, vol. 11, no. 4, 2013.

¹⁸⁶² Department of Health, *National Drug Strategy 2017-2026*, Commonwealth of Australia, Canberra, 2017, p. 51.

¹⁸⁶³ European Monitoring Centre for Drugs and Drug Addiction, *Preventing opioid overdose deaths with take-home naloxone*, Luxembourg, 2016, pp. 80-81.

¹⁸⁶⁴ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 21.

The ACT program was formally evaluated in 2015, reporting 57 overdose reversals using program-issued naloxone during the evaluation period. All reversals were successful, with no serious adverse events reported. The evaluation also identified various enhancements such as the need to modify the workshop content and delivery by shortening its length, reinforce the importance of calling an ambulance in overdose situations, and offer refresher workshops to reinforce knowledge and practice.¹⁸⁶⁵ Following the success of the program, other states adopted similar approaches such as Western Australia, New South Wales and Victoria.

In Victoria, the Department of Health and Human Services (DHHS) funds two relevant programs. The first one, the Drug Overdose Peer Education (DOPE) program, is run by HRV. This is a peer-based program which involves a one to two hour training session of small groups of people who use opioids (five to ten people) to recognise the signs of overdose and respond to it, including through administering naloxone. The service is delivered in conjunction with specialist primary health services and NSPs. Their role is to recruit trainees, host the training, and provide access to a general practitioner (GP) who writes prescriptions for naloxone for attendees once the training is complete. The staff then take these scripts to the pharmacy and provide attendees with the naloxone. Along with this training, the HRV peer educator also runs individual training sessions lasting 15 to 20 minutes when requested.¹⁸⁶⁶

The second program is run by the Penington Institute through its Community Overdose Prevention Education (COPE) program. Under the COPE ‘train-the-trainer’ program, workers from alcohol and other drug (AOD) organisations and other community workers are trained to use naloxone so that they can then deliver this training to people who use opioids. It also provides information materials for GPs and pharmacists. The program, however, does not directly provide naloxone to participants.¹⁸⁶⁷

In terms of program participation, HRV most recently reported that during 2016/17 the DOPE program trained 290 individuals in overdose prevention and/or including the provision of naloxone and conducted over 40 workshops.¹⁸⁶⁸ Charles Henderson of HRV also advised the Committee that it has only one worker to cover the whole state.¹⁸⁶⁹ For the COPE program, the Penington Institute reported in its Annual Review 2016 that it trained 195 health professionals and frontline workers from 27 agencies, and undertook three awareness presentations to 185 people in the year.¹⁸⁷⁰

The Committee understands that the Victorian Government recently increased funding to further enhance implementation of the DOPE and COPE programs.

¹⁸⁶⁵ Olsen A, et al., *Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT)' Program, 2011-2014*, Centre for Research Into Injecting Drug Use, Melbourne, 2015, pp. 6-7.

¹⁸⁶⁶ Dwyer, R, et al., 'Benefits and barriers to expanding the availability of take-home naloxone in Australia: A qualitative interview study with service providers', *Drugs: Education, Prevention and Policy*, vol. 23, no. 5, 2016, p. 389.

¹⁸⁶⁷ Dwyer, R, et al., 'Benefits and barriers to expanding the availability of take-home naloxone in Australia: A qualitative interview study with service providers', *Drugs: Education, Prevention and Policy*, vol. 23, no. 5, 2016, p. 389.

¹⁸⁶⁸ Australian Injecting & Illicit Drug Users League, *AIVL Annual Report 2017*, Canberra, 2017, p. 32.

¹⁸⁶⁹ Charles Henderson, Acting Executive Officer, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 69.

¹⁸⁷⁰ Penington Institute, *Annual Review 2016*, Melbourne, 2016, p. 14.

17.3.2 Concerns with the current provision of naloxone

A number of inquiry stakeholders discussed the benefits of naloxone in reducing or preventing overdose deaths, however, they also raised concerns about the availability of naloxone programs that enhance access to this drug. For example, Professor Paul Dietze, Director of the Behaviours and Health Risks Program at Burnet Institute, raised the limited funding allocated to this valuable intervention:

Take-home naloxone is not a silver bullet for opioid overdose. Not everyone is going to take it up, and we have not had the reach that we need. It is an additional intervention to those that are already there. We know from work overseas that it does actually work, and in Victoria we really need to continue with wider implementation. I should have mentioned that in 2013 a number of organisations moved to start distributing take-home naloxone, but they were really doing it on the smell of an oily rag when you have a look at how much funding was allocated to them.¹⁸⁷¹

Access to naloxone

Despite the intentions of THN programs, stakeholders considered that naloxone was insufficiently available to those who require it, in addition to families and peers. In its submission, the Penington Institute noted issues with current coverage of naloxone provision:

...despite a conservative estimate indicating at least 306,000 Australians use opioids in an illicit way each year, consumer need for naloxone has failed to convert to market demand. This has led to frequent changes in the forms and distributors of naloxone in Australia, generating uncertainty in supply and stopping overdose prevention programs from designing functional, scalable programs.

On top of this, governments are yet to establish funding and distribution mechanisms that make sense for both the medicine and the end consumer.¹⁸⁷²

Professor Paul Dietze of the Burnet Institute further advised the Committee that programs throughout Australia ‘are all relatively small scale with limited reach and very little funding allocated towards them’.¹⁸⁷³ He also highlighted that inconsistent practices exist across states and there is no federal coordination of these efforts.

Similarly, Dr Stefan Gruenert, CEO of Odyssey House Victoria (OHV) told the Committee that while naloxone was becoming more readily available to users and their peers, there were still obstacles in the way of greater access:

As a health service we cannot simply go and buy a whole lot of naloxone and have that in our waiting rooms or for staff to carry. The way it is scheduled and prescribed, that is not accessible to us; it needs to be through a GP for someone who is a user of opiates. That, I think, limits its potential for widescale use across the community. We would like to see some reduction in the barriers for securing naloxone for friends, family and health service providers.¹⁸⁷⁴

¹⁸⁷¹ Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 36.

¹⁸⁷² Penington Institute, *Submission*, no. 209, 24 March 2017, p. 37.

¹⁸⁷³ Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 36.

¹⁸⁷⁴ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, *Transcript of evidence*, 5 June 2017, p. 162.

Limited availability of and access to naloxone is also an issue internationally, with various agencies developing new ways to make it more accessible to the appropriate people. For example, the Advisory Council on the Misuse of Drugs (ACMD) in the United Kingdom (UK) recently recommended in its report, *Reducing opioid-related deaths in the UK*, that naloxone ‘be made available routinely, cheaply and easily to people who use opioids, and to their families and friends’.¹⁸⁷⁵

During its overseas study tour, the Committee heard of efforts to improve availability of naloxone as a response to the opioid overdose crisis in North America. In the Canadian province of BC, naloxone is more readily available to those who need it through a variety of agencies and localities. Since December 2016, the British Columbia Center for Disease Control (BCCDC) has distributed over 300 Facility Overdose Response Boxes (comprising naloxone and other overdose supplies) to various registered places, mainly non-profit community organisations where people may overdose, such as shelters, supportive housing, and drop-in centres. Registered sites commit to developing an overdose response policy; conduct staff training, debriefing and support; plan exercises/drills to maintain staff competencies and train new staff; and provide documentation to BCCDC, including reports of naloxone use. Key figures from an evaluation and input from the community advisory board included:

- 49,766 naloxone kits were distributed between 2012 to 2017, with up to 20 per cent used
- there were 558 THN distribution sites throughout BC, including to people released from prison
- 10,000 reversals, with 5,000 in 2017 to date alone.¹⁸⁷⁶

However, the Committee was also told by the BCCDC that an unintended consequence of enhanced access to naloxone is that people become less inclined to seek medical assistance or attend hospital after an overdose.¹⁸⁷⁷ This has resulted in a lost opportunity for a potential medical intervention or referral to treatment.

The Committee also spoke with Staff Sergeant Mark Horlsey of the Beat Enforcement Team and Marine Unit at the Vancouver Police Department (VPD), who advised that VPD police carry naloxone on them, mainly to protect themselves if exposed to fentanyl but they also use it on others if necessary.¹⁸⁷⁸ Dr Christian Smyth, Special Adviser to Turning Point also advised the Committee of similar developments in New York:

It is worth also pointing out that just recently in New York the 27 000 Manhattan police force has been issued with naloxone so that they can attend to people straightaway, because that first half an hour or so is when you can address an overdose most effectively. There is a much more compassionate relationship with people and overdose. The fact that we know that more people overdose here than in the UK or elsewhere is something that perhaps we should be thinking about.¹⁸⁷⁹

¹⁸⁷⁵ Advisory Council on the Misuse of Drugs, *Reducing Opioid-Related Deaths in the UK*, UK Government, London, 2016, p. 36.

¹⁸⁷⁶ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 58.

¹⁸⁷⁷ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 58.

¹⁸⁷⁸ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 46.

¹⁸⁷⁹ Dr Christian Smyth, Special Adviser, Turning Point, *Transcript of evidence*, 8 May 2017, p. 27.

The California Department of Public Health (CDPH) told the Committee that access to naloxone has also been enhanced throughout that jurisdiction, with legislators themselves funding its increase of availability in appropriate places, such as harm reduction services and among first responders, including law enforcement officers. Physicians also now co-prescribe naloxone to patients who use prescription opioids to allow them to pick up both scripts from the pharmacy at the same time.¹⁸⁸⁰

Inquiry stakeholders similarly focused on ways to improve access to naloxone in the broader community in Victoria. As noted by the Coroners Court of Victoria's submission, a number of coronial findings recommend an expansion of the provision and distribution of naloxone across Victoria and training in its use.¹⁸⁸¹ To do this, Professor Paul Dietze of the Burnet Institute considered that:

...the best way to get it to people is to actually get it into the hands of the people who are going to come into contact with people who use these substances, and those are people like needle and syringe program workers, drug and alcohol counsellors and so forth; and if we were actually able to accredit them to be able to dispense naloxone themselves, to hand it out themselves rather than going through a convoluted process of getting a prescription or getting it through a pharmacy and so forth, we could actually get it out there more effectively...¹⁸⁸²

Professor Paul Dietze suggested that this could be achieved through issuing standing orders to allow trained non-medical professionals to hand out naloxone:

What that means is there is almost a general prescription for the substance that then covers people who are credentialled or accredited under that standing order to actually give it out. So the standing order will rest with the senior medical practitioner, but anyone who is properly accredited and credentialled will be able to hand it out. Naloxone really has no side-effects apart from reversing the effects of opioids like heroin and so forth, so it is really not a dangerous drug to be giving out to the community.¹⁸⁸³

In its position statement, HRV stated that if Victoria's naloxone program is to be expanded, users themselves must be at the frontline of its administration:

Harm Reduction Victoria acknowledges the wide range of stakeholders implicated in the potential expansion of naloxone availability and supports a broad-based systems approach to naloxone training and distribution across Victoria...However, HRV also highlights the centrality of the involvement of people who inject drugs (PWIDs); drug users must be regarded as the 'front line' and primary target group for overdose prevention and response education, including naloxone. HRV believes that unless we prioritise PWIDs' access to naloxone and their ability to administer it, the roll-out of naloxone will have less than optimal impact.¹⁸⁸⁴

Harm Reduction Victoria also argued that despite fears that peers and indeed users themselves might administer the drug incorrectly or unsafely, this is far from the case:

¹⁸⁸⁰ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 80.

¹⁸⁸¹ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017.

¹⁸⁸² Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 36.

¹⁸⁸³ Professor Paul Dietze, Director, Behaviours and Health Risks Program, Burnet Institute, *Transcript of evidence*, 8 May 2017, p. 36.

¹⁸⁸⁴ Harm Reduction Victoria, 'Naloxone Position Statement', viewed 21 December 2017, <<http://hrvic.org.au/harm-reduction/naloxone-position-statement>>.

Peer distribution of naloxone has operated internationally for a number of years without negative consequences. Initial concerns (that naloxone may be administered or stored incorrectly, that re-intoxication could result in fatalities, or that drug users may increase risky behaviour if opioids were considered less dangerous) have not been realised. Indeed, research shows that appropriately trained drug users are as skilled as medical practitioners in recognizing an overdose and understanding when naloxone should be administered. Peer administration of naloxone carries even lower risks than peer administration of adrenaline for anaphylaxis, or glucagon for diabetic insulin reaction. Unexpected benefits of peer administration of naloxone have also been demonstrated: naloxone training programs have reinforced and expanded overdose prevention and overdose response capacity and participants have reported a sense of empowerment due to their ability to administer naloxone.¹⁸⁸⁵

It suggested in its submission making naloxone available in NSPs, as it ‘may be the only health service that people who inject opiates access on a regular basis, and they are usually the only health service that injectors trust’.¹⁸⁸⁶

Michael Stephenson from Ambulance Victoria also supported the drug becoming more widely available, noting that paramedics currently administer naloxone on a regular basis:

...from our point of view again if it were widely available to the community and it reduced harm and improved outcomes for patients, then we would be supportive of it.

Clearly I would think that in many of the overdoses we attend, in terms of narcotic overdose, if someone with that patient at the time had naloxone and was trained to use it, then we probably would not be there. There is no great risk with that item. A large majority of patients that are resuscitated from narcotic overdose with naloxone do not need ongoing care.¹⁸⁸⁷

Additionally and in line with some of the reforms outlined in Vancouver and California, the Burnet Institute’s submission indicated that, as police and fire fighters are often first responders to overdose calls, the Victorian Government should consider distributing naloxone to those working in areas with high concentrations of injecting heroin use, accompanied with appropriate training.¹⁸⁸⁸ Similarly, the EMCDDA advised in its naloxone report that ‘non-medical first responders such as police officers and firefighters can be instructed in overdose management and naloxone administration, as has already been successfully implemented in several states in the United States’.¹⁸⁸⁹

The ability for naloxone to reduce overdose deaths means that consideration of a range of ways to expand its access in the broader community is warranted. The Committee particularly highlights that, as there are low risk of adverse events occurring and a strong opportunity for reductions in overdose deaths, all options should be explored by the Victorian Government in a concerted effort to improve its use where needed.

¹⁸⁸⁵ Harm Reduction Victoria, ‘Naloxone Position Statement’, viewed 21 December 2017, <<http://hrvic.org.au/harm-reduction/naloxone-position-statement>>.

¹⁸⁸⁶ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 20.

¹⁸⁸⁷ Michael Stephenson, Executive Director, Ambulance Victoria, *Transcript of evidence*, 19 June 2017, p. 220.

¹⁸⁸⁸ Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 3.

¹⁸⁸⁹ European Monitoring Centre for Drugs and Drug Addiction, *Preventing opioid overdose deaths with take-home naloxone*, Luxembourg, 2016, p. 86.

RECOMMENDATION 45: The Victorian Government explore avenues to distribute naloxone more effectively. Such avenues might include:

- needle and syringe programs and other community health services where staff are trained to educate others in administering naloxone
- making naloxone available in appropriate settings where people who use opioids may frequent, such as treatment services (detox and residential rehabilitation services), crisis and emergency accommodation, which staff can administer when necessary
- making naloxone available to first responders to overdose calls in areas with high concentrations of injecting heroin use, accompanied with appropriate training
- other ways to make naloxone available, including through enhanced peer distribution.

Cost of naloxone

Closely associated with the issue of access is the current cost of naloxone. Traditionally, naloxone is made available through the Pharmaceutical Benefits Scheme (PBS) under a prescription as a Schedule 4 drug for approximately \$38 for five units. On 1 February 2016, the Therapeutic Goods Administration (TGA) changed naloxone scheduling to make it also available for purchase over the counter (OTC) as a Schedule 3 drug ‘when used for the treatment of opioid overdose’. This made Australia the second country in the world (after Italy) to have naloxone formally available over the counter.¹⁸⁹⁰ However, stakeholders such as the Penington Institute advised that if purchased OTC, the cost is significantly more than under prescription:

Naloxone is fairly affordable if prescribed by a doctor (attracting a PBS subsidy under Schedule 4).

...Naloxone can be fairly conveniently obtained directly from a pharmacist (without a prescription, under Schedule 3). However, under Schedule 3 the medicine is not subsidised, and costs around \$70. This is simply too expensive for the vast majority of people who need it. Further, the pharmacist must stock the medicine and be willing to spend the time showing their customer how to use it.

To sum up the quandary: naloxone, if accessed via a doctor, is affordable but inconvenient; via a pharmacist, it is fairly convenient but unaffordable. Neither is ideal.¹⁸⁹¹

Harm Reduction Victoria also considered it inequitable that naloxone with a script is much cheaper than without a script. It provided the following cost figures to the Committee:

¹⁸⁹⁰ Lenton S, et al., ‘Australia reschedules naloxone for opioid overdose’, *The Medical Journal of Australia*, vol. 204, no. 4, 2016.

¹⁸⁹¹ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 37.

Table 17.1 Cost of Naloxone

Ampoules/doses	Concession card	Prescription	Cost
5	Yes	Yes	\$6.30
5	No	Yes	\$38.80
1 ^(a)	N/A	No – purchase over the counter	\$25+

(a) Not all pharmacies stock naloxone and if they do, prices will vary, starting at \$25 for a single ampoule.

Source: Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 21.

Jane Dicka, Health Promotion Team Leader specialising in the DOPE Program at HRV, considered that the public benefit in naloxone being available at minimal or no cost should be compared to public access to defibrillators:

...at the end of the day you are asking people to pay for something they might need or they might not need, and really they do not need it for themselves. They are not going to use it on themselves. They are going to use it on someone else, and perhaps a total stranger. It is a fantastic thing. It should just be freely available. We have defibrillators in public places. You should in cases of emergency be able to break glass with a naloxone dose there. It should be in everybody's first aid kit. It is just crazy that there is still so many barriers for people to be able to access it when we know that it is worth its weight in gold.¹⁸⁹²

Harm Reduction Victoria recommended that the Victorian Government lobby the Commonwealth Government to place OTC naloxone on the PBS.¹⁸⁹³ Even where naloxone is on the PBS, stakeholders discussed that for a person who injects drugs, particularly one existing on social security benefits, the cost can be prohibitive. On this issue, VAADA suggested that this could be addressed by subsidising naloxone for people on the Victorian opioid substitution therapy (OST) program so that they are not charged:

We would advocate for naloxone being made available at no cost to any individual who is receiving takeaway methadone through the pharmacotherapy program – this would necessitate ensuring that adequate training is available to family and peers.¹⁸⁹⁴

A related issue is that, as part of HRV's DOPE Program, training participants are provided with the drug at the end of the training. However, HRV noted that '[u]nfortunately, the DHHS funding does not cover the cost of purchasing naloxone for distribution to participants as part of the training'.¹⁸⁹⁵ As further advised by Jane Dicka of HRV:

I refuse to train someone unless I can actually put it in their hand at the end of the training. That is the barrier: putting it in their hand at the end of the training. It is a prescription drug so we need a doctor to write a prescription. I cannot get a doctor willing to follow me around wherever I go. They said, 'We made it dual listing. We made it S3 and S4 so now you can buy it over the counter', but to buy it over the counter it is not covered by the PBS so the cost is just not affordable.¹⁸⁹⁶

¹⁸⁹² Jane Dicka, Health Promotion Team Leader, Specialising in Drug Overdose Prevention Education, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 69.

¹⁸⁹³ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 23.

¹⁸⁹⁴ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 12.

¹⁸⁹⁵ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 21.

¹⁸⁹⁶ Jane Dicka, Health Promotion Team Leader, Specialising in Drug Overdose Prevention Education, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 69.

On a positive note, the Committee is aware that the Victorian Government announced in February 2017 the establishment of a dedicated fund to subsidise naloxone at the state level. The \$1.3 million package ‘will subsidise the cost of Naloxone to drug users or families struggling to afford it’.¹⁸⁹⁷ It will also offer an outreach service to personally follow up people who have survived an overdose. Given the concern raised by the BCCDC in Vancouver regarding the lost opportunity of people no longer seeking medical assistance following an overdose, the Committee believes this outreach service is an important initiative. The service will focus on six overdose hotspots in the municipalities of Yarra, Melbourne, Port Phillip, Geelong, Dandenong and Brimbank/Maribyrnong where the highest numbers of [metropolitan] overdoses are recorded.¹⁸⁹⁸ The Victorian Government’s *Drug Rehabilitation Plan* issued in October 2017 similarly noted this initiative,¹⁸⁹⁹ and Kym Peake, Secretary of the DHHS also advised the Committee of its implementation:

We have a new initiative to expand access to naloxone by subsidising its cost. That is very much focused on high-volume needle and syringe program outlets, as well as engaging with the commonwealth to try and improve access to more user-friendly forms of naloxone in Australia and to reduce some of the barriers to distribution of that important medication.¹⁹⁰⁰

Further Judith Abbott, Director of Community-based Health Policy and Programs at the DHHS explained how the subsidy would operate in practice:

Basically with naloxone one of the things we hear is that the cost can be a barrier, and the cost varies. If you have it on prescription, it can cost from around \$6 if you are on a healthcare card through to about \$40 or so if you are not. If you get it as an over-the-counter drug, it can be between \$70 and \$100. To tackle that problem, the government has announced it is going to roll out a naloxone subsidy scheme.

What we are doing is we are looking at high-volume needle and syringe providers as the place to start, because they have the access to the most number of users. What that would involve is those agencies will have, in effect, a pool of money that they can use to basically meet the cost of that out-of-pocket cost. We will be encouraging where possible naloxone to be sought on prescription because we can get a whole lot more people to get access to naloxone under that circumstance, but it will accommodate both because really what we try to do is get as many people with naloxone available in case an overdose is possible. It couples with the work we are supporting for funder training. We have got the Penington Institute, which is delivering frontline worker training, and we have got Harm Reduction Victoria also delivering training for heroin users. That is all about how we make people confident and safe in being able to use naloxone if they are witness to an overdose.¹⁹⁰¹

While stakeholders such as the Penington Institute welcomed the subsidy initiative, they believe the ‘devil is in the detail’:

¹⁸⁹⁷ Minister for Mental Health, *Saving Lives - Preventing and Treating Overdose*, Media release, State Government of Victoria, Melbourne, 18 January 2018.

¹⁸⁹⁸ Minister for Mental Health, *Saving Lives - Preventing and Treating Overdose*, Media release, State Government of Victoria, Melbourne, 18 January 2018.

¹⁸⁹⁹ Department of Premier and Cabinet, *Drug Rehabilitation Plan*, State Government of Victoria, Melbourne, 2017, p. 13.

¹⁹⁰⁰ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 320.

¹⁹⁰¹ Judith Abbott, Director, Community-based Health Policy and Programs, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 12.

It is currently unclear how the fund will work – who will get access to it, if it is large enough, who will dispense the medicine and where. Nevertheless, this would be a significant step toward unlocking the true life-saving potential of naloxone.¹⁹⁰²

The Committee acknowledges and commends the efforts of the Victorian Government to address the cost barriers involved with naloxone, as well as enhancing provision in a range of services. As part of such efforts, the Committee notes that addressing costs for the DOPE program to provide naloxone at the end of training is also an important issue.

Naloxone and prisoners

A key access point discussed by stakeholders was the need to make naloxone available to prisoners with a history of injecting drug use upon their release from prison. As discussed in chapter 13, release and post-release periods for prisoners are when they are most vulnerable to a range of harms including relapse into illicit drug-taking and heightened risk of overdose, particularly if they did not use opioids while in prison or for an extended time. As stated in the Abolitionist and Transformative Justice Centre’s submission to the Committee:

People recently released from prison have also been noted to be at higher risk of overdose, due to a complexity of factors including poor health, lowered drug tolerance, use of prescription medicine during incarceration, and lack of knowledge of street quality and purity of drugs purchased.¹⁹⁰³

According to a report from the Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, prisoners are 12 times more likely to die in the first four weeks after their release.¹⁹⁰⁴ The EMCDDA also stated in its 2012 report, *Prisons and drugs in Europe: the problem and responses*:

[f]or prisoners with a history of problematic drug use, this is a time of very high overdose risk, as a result of reduced tolerance to opioids and frequent relapse into heroin use. A review of drug-related deaths that occurred shortly after release from prison in Europe, Australia and the United States showed that six out of 10 deaths in the first 12 weeks after release were drug-related (Merrall et al., 2010). The authors concluded that there is an increased risk of drug-related death during the first two weeks after release from prison, and that the risk remains elevated up to at least the fourth week.¹⁹⁰⁵

This is therefore a critical time ‘when ensuring continuity of care and targeted interventions can both support recovery and save lives’.¹⁹⁰⁶ The services offered to prisoners, however, have historically compared poorly with those provided in the community. The Burnet Institute’s submission indicated that the provision of a THN program for prisoners, with appropriate training and instruction in its use, is essential:

¹⁹⁰² Penington Institute, *Submission*, no. 209, 24 March 2017, p. 37.

¹⁹⁰³ Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017.

¹⁹⁰⁴ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, Melbourne, 2015, p. 102.

¹⁹⁰⁵ European Monitoring Centre for Drugs and Drug Addiction, *Prisons and drugs in Europe: the problem and responses*, Lisbon, 2012, p. 15.

¹⁹⁰⁶ European Monitoring Centre for Drugs and Drug Addiction, *Prisons and drugs in Europe: the problem and responses*, Lisbon, 2012, p. 7.

...evidence from rigorous evaluation of the Scottish take-home naloxone program, in which prisoners with a history of injecting drug use are provided take-home naloxone on release, shows that the program reduces mortality in this key period of overdose mortality risk (Bird, McAuley, Perry, & Hunter, 2016).¹⁹⁰⁷

The Victorian Alcohol and Drug Association also suggested that, because of the high post release mortality rate for prisoners, naloxone should be available to any person released from prison who is on the prison post release pharmacotherapy subsidy program.¹⁹⁰⁸

Jan Noblett, Executive Director of Justice Health advised the Committee that, while there is no current provision for naloxone on release, this issue is being explored:

...we have been exploring naloxone for a while...my understanding is that the current dispensing of naloxone is with a minijet, and that represents some risk at this point in time. In fact we have subsequently been advised by DHHS that the minijet is not being manufactured any further. They are also describing to us some developments in its dispensing via a nasal spray, so we are watching that particular area, but it is not currently being delivered or rolled out.¹⁹⁰⁹

The Committee commends the Victorian Government for considering ways to provide prisoners with this life-saving drug upon their release into the community. However, given the high risk of overdose for this cohort of people, it is essential that the Government finds a suitable policy solution in the immediate future and implements it across Victorian prisons.

RECOMMENDATION 46: The Victorian Government make naloxone available to prisoners with a history of opioid use upon their release from prison to minimise the high risk of overdose deaths among this cohort of people, and provide them with appropriate information and support services available in the broader community to minimise the likelihood of overdose.

17.4 Overview of medically supervised injecting centres

Aside from the wide distribution of naloxone, medically supervised injecting centres (MSICs) are recognised as a major intervention to reduce the number of overdose deaths. Clearly, if a person is injecting drugs in an environment where medical professionals are present, the chances of surviving an overdose are much higher. The other benefit of this intervention is that when visiting a facility, clients can raise their health and welfare issues with health care professionals and potentially be referred to

¹⁹⁰⁷ Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 8.

¹⁹⁰⁸ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 12.

¹⁹⁰⁹ Jan Noblett, Executive Director, Justice Health, *Transcript of evidence*, 4 September 2017, p. 359.

treatment. The Committee acknowledges that the evidence supporting these benefits is strong, both in the research literature and in the submissions and public hearings for this inquiry.¹⁹¹⁰

It is important to note that at the commencement of this inquiry, there was ongoing debate and discussion in the media, parliament and broader community about the need for a MSIC in North Richmond, similar to that operating in Sydney's King Cross since 2001. At that stage, there were rising numbers of overdoses and deaths which led to the recommendation from Victorian Coroner Hawkins on 20 February 2017 to the Victorian Minister for Mental Health to take steps to establish a safe injecting facility trial in the City of Yarra. As explained by the State Coroner of Victoria, Judge Sara Hinchey, this recommendation followed an 'exhaustive' coronial investigation:

On 20 February 2017 Coroner Hawkins handed down her findings into the death of Ms A, a young mother who fatally overdosed on heroin in a restaurant toilet in the City of Yarra. Coroner Hawkins made her findings following an exhaustive investigation that included a visit to the North Richmond area and receiving submissions from local alcohol and drug services, Victoria Police, the Department of Health and Human Services, Ambulance Victoria, local residents, traders and the City of Yarra. Coroner Hawkins also obtained expert evidence from three eminent experts in the field of drug harm reduction: Dr Alex Wodak, Professor Paul Dietze and Dr Marianne Jauncey.¹⁹¹¹

This coronial investigation prompted the introduction of the Private Members' Bill, the *Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017* into the Victorian Parliament's Legislative Council by Fiona Patten, Member for Northern Metropolitan on 8 February 2017. The Bill was referred for review to the Legislative Council's Legal and Social Issues Committee, an inquiry that ran parallel to this inquiry for six months. The final report into the Bill was tabled in September 2017, and while it did not make a specific recommendation about establishing a MSIC in North Richmond, it found that 'MSICs improve the health of injecting drug users and reduce signs of drug use in surrounding streets'.¹⁹¹²

¹⁹¹⁰ Windana Drug and Alcohol Recovery, *Submission*, no. 114, 15 March 2017; Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017; Victorian AIDS Council, *Submission*, no. 206, 21 March 2017; Uniting Church in Australia, Synod of NSW and ACT., *Submission*, no. 219, 11 April 2017; Turning Point, *Submission*, no. 116, 15 March 2017; Royal Australasian College of Physicians, *Submission*, no. 224, 30 March 2017; Rationalist Society of Australia, *Submission*, no. 200, 20 March 2017; Public Health Association Australia, *Submission*, no. 152, 17 March 2017; Odyssey House Victoria, *Submission*, no. 179, 17 March 2017; Humanist Society of Victoria, *Submission*, no. 184, 17 March 2017; Hepatitis Victoria, *Submission*, no. 135, 16 March 2017; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017; Harm Reduction Australia / Family Drug Support, *Submission*, no. 112, 15 March 2017; Fitzroy Legal Service, *Submission*, no. 174, 17 March 2017; Dr Kate Seear, *Submission*, no. 126, 16 March 2017; cohealth, *Submission*, no. 140, 16 March 2017; City of Port Phillip, *Submission*, no. 177, 17 March 2017; Burnet Institute, *Submission*, no. 165, 17 March 2017; Beyond Blue, *Submission*, no. 175, 17 March 2017; Australian Medical Association, *Submission*, no. 203, 20 March 2017; Australasian College for Emergency Medicine, *Submission*, no. 223, 21 April 2017; Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017; Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017; (APSAAD), APSoAaod, *Submission*, no. 166, 17 March 2017; Dr Virginia Dods, Collingwood and Abbotsford Residents Association, *Transcript of evidence*, 5 June 2017; Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017; Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017; Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017; John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017; Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017; Dr Alex Wodak AM, Director, Australia 21, and President, Australian Drug Law Reform Foundation, *Transcript of evidence*, 23 May 2017.

¹⁹¹¹ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 14.

¹⁹¹² Legal and Social Issues Committee, *Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017*, Parliament of Victoria, Melbourne, 2017, p. 40.

In October 2017, the Victorian Government announced its intention to trial a single MSIC for two years at NRCH, and after some debate in the Victorian Parliament, the *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Bill 2017* was passed in December 2017. The MSIC will commence operation in June 2018.

Given the parallel inquiry and Victorian Government commitment's to conduct an MSIC trial, this section of the report will focus only on the evidence received directly as part of the current inquiry, including the Committee's overseas study tour, rather than evidence in the broader literature. Information about international evaluations of drug consumption rooms and local evaluations of the Sydney MSIC, can be obtained from the final report for the *Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017*. This report also detailed arguments supporting and opposed to the establishment of MSICs.

17.4.1 Support for medically supervised injecting centres

Throughout the inquiry, the Committee learnt of the many benefits of MSICs, with the greatest benefit being a reduction in the number of overdose deaths. As John Ryan of the Penington Institute stated to the Committee, '[t]he evidence around injecting facilities is incontrovertible – they save lives'.¹⁹¹³ Similarly, Michael Stephenson, the Executive Director of Operations at Ambulance Victoria, indicated that a MSIC would significantly reduce the risk of overdose for people who inject drugs and take the pressure off Ambulance Victoria:

I suspect that for us in many ways it would make our work somewhat easier if the large majority of patients who overdosed in a drug injecting centre would be able to be managed by the drug injecting centre. At the moment, as you know, if you overdose in a laneway or in an alley or a public toilet or whatever, the risk is considerably greater. There is some published science on this matter...¹⁹¹⁴

In its submission, cohealth provided a case study of one of its clients, Ms T, who it believes would still be alive today had she had access to a MSIC. Ms T was a young mother with three children. She struggled with heroin addiction, and attended cohealth on a regular basis for the NSP and staff had 'developed trust and rapport' with her. On one occasion, Ms T was provided with injecting equipment and advice on how to minimise overdose risks. As the staff member was unable to supervise Ms T's injecting her drugs, Ms T used a public toilet block close to cohealth, and she overdosed and died. cohealth stated:

Had our staff been allowed to supervise Ms T's injection that day it is a certainty that she would not have died. Qualified staff could have immediately administered naloxone, reversing the effects of the drug and provided oxygen and other interventions as required. It would have saved her life - and in so doing, prevented three young children from losing their mother, and avoided distress for our health services staff and the member of public who discovered Ms T's body.¹⁹¹⁵

¹⁹¹³ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 4.

¹⁹¹⁴ Michael Stephenson, Executive Director, Ambulance Victoria, *Transcript of evidence*, 19 June 2017, p. 220.

¹⁹¹⁵ cohealth, *Submission*, no. 140, 16 March 2017, p. 9.

The Committee received evidence from other stakeholders who indicated that their family and friends would still be alive today if they had access to an MSIC. For example, in his evidence to the Committee, Gino Vumbaca, President of Harm Reduction Australia referred to Tony Trimmingham, CEO of Family Drug Support Australia, whose son died of a heroin overdose:

I've known Tony Trimmingham for many, many years. Damien, his son... died not far from here. Between here and the medically-supervised injecting centre. I know Tony if he was here would tell the story about Damien - he was injecting in a public alley way... overdosed, no-one there to look after him. Overdosed and died...

Two days later he was advised that they'd found a body and it was his son. If the injecting facility was operational, there is a good chance Damien would have used that and would be alive. That is how Tony sees it and I can see the logic of that because I've been to the MSIC a number of times and I've seen how they operate.¹⁹¹⁶

Other important benefits of MSICs include improved public amenity through reduced public injecting; reduced intoxication and discarded used injecting equipment; reduced transmission of blood borne viruses; and enhanced access to medical, health and other social services.¹⁹¹⁷ Another important component of MSICs is their capacity to attract and engage with often hard to reach groups of people who as described above, may otherwise use drugs in unsafe, unhygienic and unsafe places.

Residents for Victoria Street Drug Solutions (RVSDS) referred specifically in its submission to the success of the Sydney MSIC as reflected in a 2010 evaluation by KPMG. It reported that the Centre 'managed 3,426 overdose-related events, helped more than 12,000 injecting drug users and referred more than 8,500 drug users for help including 3,870 to drug treatment. It has also distributed more than 300,000 clean needles and syringes to users'.¹⁹¹⁸ The Committee heard on numerous occasions about the success of the Sydney MSIC, which began operations in 2001 and since then has supervised 965,000 injections and most importantly, successfully managed more than 6,000 overdoses.¹⁹¹⁹ Aside from saving lives, stakeholders told the Committee that the Sydney MSIC has reduced the amount of crime and other associated activity in the area and is well received by the community.¹⁹²⁰ Judy Ryan of the RVSDS referred in her evidence to the economic savings arising from the Sydney and other similar centres:

Supervised injecting centres have significant benefits in economic terms alone. The reduction in ambulance service call-outs, as per the Sydney experience, would result in massive savings for the health budget as well as increasing availability to those residents fearful of not getting an ambulance unit because those units are occupied managing overdoses. This is a major concern for elderly residents in our community.¹⁹²¹

In its submission, HRV discussed the success of MSICs internationally, highlighting that there are around 100 MSICs worldwide. It referred to an evaluation of Insite in Vancouver, which demonstrated the centre had resulted in a 30 per cent increase in people receiving treatment, a 35 per cent reduction in fatal overdose in nearby areas,

¹⁹¹⁶ Gino Vumbaca, President, Harm Reduction Australia, *Transcript of evidence*, 23 May 2017, p. 106.

¹⁹¹⁷ Dolan, K, et al., 'Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia', *Drug and Alcohol Review*, vol. 19, no. 3, 2000, p. 338.

¹⁹¹⁸ Residents for Victoria Street Drug Solutions, *Submission*, no. 125, 16 March 2017, p. 3.

¹⁹¹⁹ Uniting, 'What the Uniting MSIC does', viewed 18 March 2018, <<https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/what-the-uniting-sydney-msic-does>>.

¹⁹²⁰ Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, p. 25.

¹⁹²¹ Judy Ryan, Residents for Victoria Street Drug Solutions, *Transcript of evidence*, 5 June 2017, p. 188.

as well as positive changes in public order.¹⁹²² While in Vancouver, the Committee was unable to visit Insite because it was open 24 hours at the time in response to the opioid crisis. The Committee was advised that 500-600 injections occur there in a standard day. The Canadian Federal Government is currently establishing another 15 supervised injecting sites across the country.¹⁹²³

Multiple medically supervised injecting sites

A number of stakeholders advised the Committee of the value in having multiple MSICs and/or mobile MSICs ‘to move across changing locations and areas of need’.¹⁹²⁴ Given that overdose rates have been noted as disproportionately high in regional and rural areas, some stakeholders indicated that one metropolitan based centre is inadequate. This was of great concern to the Abolitionist and Transformative Justice Centre on the basis that most Victorian prisons are located outside the Melbourne metropolitan district and newly released prisoners are at high risk of overdose.¹⁹²⁵

Harm Reduction Victoria noted that in Barcelona and Berlin, mobile MSIC vans are common due to numerous drug markets located in various areas.¹⁹²⁶ In Vancouver, the Committee learnt that volunteer run sites have been established in various parts of the city in response to the opioid overdose crisis. In Downtown Eastside, the Committee visited an overdose prevention site where people can use drugs and be monitored (but not medically supervised) by community staff trained in overdose responses. While these sites were initially established without government funding nor approval for three months, once the BC Health Minister and the Provincial Health Authority did so, another 20 overdose prevention sites were established across a range of locations, including a repurposed health centre and a portable classroom outside a community centre. The Committee was advised that since December 2016, there have been over 107,000 visits to these sites and reversal of more than 1,200 overdoses with zero deaths.¹⁹²⁷

Medically supervised injecting centre as part of a comprehensive health service

Another key theme in the evidence about MSICs is the value of such services forming part of a comprehensive health service to address illicit drug use and its consequent harms. This was reaffirmed in the evidence provided by John Ryan of the Penington Institute who referred to the opportunities that arise from MSICs as a result of comprehensive and wrap around services offered to clients:

So there is an opportunity to save somebody’s life, and once you have built that relationship with them, knowing that that is where they are at in their life, that they are willing to take those risks, then there is the opportunity to actually talk to them about what sort of dream they do have for their life, what sorts of opportunities they would like to pursue, whether it is to access secure housing, whether it is to rehabilitate their relationship with their family or — most often — whether it is to actually control their drug addiction, to better manage their drug use. They are the

¹⁹²² Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 40.

¹⁹²³ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 49.

¹⁹²⁴ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 49.

¹⁹²⁵ Abolitionist and Transformative Justice Centre, *Submission*, no. 183, 17 March 2017.

¹⁹²⁶ Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 40.

¹⁹²⁷ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 47.

opportunities that a consumption room provides that are just as important, I think, as the supervised ingestion; it is actually about providing an opportunity to deal with people's complex health and social issues and a pathway for them away from that extremely vulnerable and dangerous lifestyle.¹⁹²⁸

In its submission, the Coroners Court referred to a detailed study of 838 Victorian overdose deaths that occurred between 2011 and 2013, in collaboration with researchers from Turning Point. The study found that 49.6 per cent of deceased had both clinically documented drug dependence and a diagnosed mental illness (other than a mental illness relating to substance misuse).¹⁹²⁹ This figure alone suggests that at a minimum MSICs should partner with a specialised mental health service. Employing a mental health clinician is also advisable as often the MSIC is the only service that many people who inject drugs engage with on an ongoing basis.¹⁹³⁰

Support of law enforcement authorities

The Committee also heard that the support of law enforcement is crucial to the establishment and effective management of a MSIC, with relationships between police and MSIC staff affecting the success or otherwise of services. According to the EMCDDA, police support for drug consumption rooms and MSICs have typically been strong:

In most countries where they operate, these facilities are not only tolerated, but also demanded and supported by the police, who also facilitate their use (DeBeck et al., 2008). Furthermore, the police mostly see drug consumption rooms as a 'win-win' situation, as they spend less of their time dealing with users, and therefore have more resources available to target dealers.¹⁹³¹

This has certainly been the case in Europe, Vancouver and Sydney Kings Cross. The Committee also witnessed this support when it was overseas, in both Geneva and Vancouver. At Quai 9, the drug consumption room in Geneva, the head of operations, Emmanuel Ducret advised that collaboration between health and law enforcement agencies was essential to its establishment and ongoing management.¹⁹³² Further, the Vancouver Police Department were overwhelmingly supportive of Insite, the MSIC in Downtown Eastside; the overdose prevention sites; and the Crosstown Clinic which administers heroin-assisted treatment, in recognition that substance use and addiction is a medical issue and should be dealt with accordingly.¹⁹³³

In its evidence to the Committee, Victoria Police reaffirmed that it is working collaboratively with the Victorian Government on the MSIC trial in North Richmond and future policing of the area. Wendy Steendam, Deputy Commissioner of Capability, advised the Committee:

...we are working collaboratively on a range of working groups around how we implement that initiative that has been announced based on that policy position. We will work, from a local perspective, on how we police in and around that facility when

¹⁹²⁸ John Ryan, Chief Executive Officer, Penington Institute, *Transcript of evidence*, 8 May 2017, p. 7.

¹⁹²⁹ Coroners Court of Victoria, *Submission*, no. 178, 17 March 2017, p. 43.

¹⁹³⁰ Goodhew, M, et al., 'Mental health among clients of the Sydney Medically Supervised Injecting Centre', *Harm Reduction Journal*, vol. 13, no. 29, 2016.

¹⁹³¹ Stevens, A, et al., 'Criminal justice approaches to harm reduction in Europe', in *Harm reduction: evidence, impacts and challenges*, Rhodes and Hedrich (eds), Publications Office of the European Union, Luxembourg, 2010, p. 392.

¹⁹³² Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 4.

¹⁹³³ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, pp. 46-50.

that is set up. We do not support it or otherwise. We actually support government policy of the day. There has been a decision made, and we are working through how we coexist and actually operationally police in that area whilst that facility is in place.¹⁹³⁴

...

I think in the context of policy positions such as the needle exchange program and now the government announcement about the trial, we have policy positions and ways in which we actually operationalise our policing responses around those types of facilities, and we have coexisted with the needle exchange program and found ways to actually make that effective. We can still police the environment in the way that we need to, but those facilities can coexist.¹⁹³⁵

17.4.2 Support for a medically supervised injecting centre in North Richmond

In response to the broader debate and discussion about the need for a MSIC in Melbourne, this was the most commonly raised area of drug policy in submissions to the inquiry, and again in public evidence to the Committee. The Committee heard that Richmond is identified as the last open street-based drug market in Victoria, mainly selling heroin although other drugs are available including amphetamines and prescription medications.¹⁹³⁶ This market has existed for a long period of time, and combined with a high-density housing estate, various public transport options, and numerous hidden laneways and streets, it is Melbourne's drug epicentre. Demos Krouskos, CEO of NRCH advised the Committee:

Probably only about 20 per cent of our clients would reside in the City of Yarra — those that actually have a residence. More than 80 per cent come from outside of the City of Yarra, and this is a pattern — an inner-city pattern, if you like — owing to the confluence of a number of public transport routes. It is quite easy to get to the City of Yarra. People go to the City of Yarra for various reasons. It is an entertainment precinct, particularly Victoria Street, and there is a restaurant precinct, and people enjoy that street. It is quite an easy place to get to. That sort of pattern has been there for many years. People are coming into the city. They do not come for the syringes, by the way. They come to purchase drugs — that's 80 per cent of our clients.¹⁹³⁷

According to the State Coroner, Judge Sara Hinchey, many people who died from an overdose in the City of Yarra were not local residents, indicating that while people travel there to obtain their drugs, many use the drugs there rather than take them home.¹⁹³⁸ Greg Denham and Peter Wearne, both of the YDHF advised the Committee of the transient nature of many of the people who come to the City of Yarra to buy and use drugs, many of whom are homeless, chronic heroin users and with little choice but to inject their drugs in public and often visible places. Greg Denham explained:

¹⁹³⁴ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 453.

¹⁹³⁵ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 453.

¹⁹³⁶ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 157.

¹⁹³⁷ Demos Krouskos, Chief Executive Officer, North Richmond Community Health, *Transcript of evidence*, 5 June 2017, p. 153.

¹⁹³⁸ Judge Sara Hinchey, State Coroner of Victoria, Coroners Court of Victoria, *Transcript of evidence*, 8 May 2017, p. 19.

Yarra is going through a huge transformation at the moment. The boarding houses are going, and there are far more street-based people around. But people move around. I was talking to a guy on Saturday afternoon in North Richmond. I asked him, 'Where are you off to tonight?'. 'I'm not sure. I have to sleep rough. Maybe go to the city and find a car park, somewhere to sleep'. 'Where are your blankets?'. 'Haven't got any'. We went down to the Salvos and got some free blankets and a sleeping bag. By the time we get back to North Richmond he has gone into the city. That is the nature of people's lives, and there are literally dozens, if not hundreds, of people like that who frequent that area every week, every month. People find that hard to believe, but I can assure you it is real. I have been to places and seen people's lives — and thank goodness that that is not my life — but I do not think I have ever seen it as bad as I have seen it in North Richmond and Abbotsford.¹⁹³⁹

Apart from the Australian Christian Lobby and Drug Free Australia, all other inquiry stakeholders supported this intervention. This included many local residents, who highlighted in their submissions the daily problems and dangers they experience as a result of the drug market in North Richmond and Abbotsford. These include public injecting incidents, needle and syringe waste, risk of seeing overdose, and generally feeling unsafe. One submitter stated that, 'the current environment in Yarra is a health hazard, it is unsafe, it is shameful, and it must not be allowed to continue'.¹⁹⁴⁰ The local residents proposed that the establishment of an MSIC in the area would improve public amenity, and some also acknowledged the health and safety benefits of the service for the people using it.

In presenting evidence to the Committee, Judy Ryan and Kylie Troy-West of RVSDS spoke of their experiences of living in an area with significant rates of public injecting and overdoses. Judy Ryan stated:

Personally, last Wednesday afternoon, 31 May, I was walking along Victoria Street and I was near what we call the Abbotsford unsupervised injecting centre, which is a toilet block on the corner of Lithgow and Victoria streets, which Virginia mentioned before. While I was walking past, a woman came out of those toilets, overdosed and collapsed on the footpath in front of me, with her partner beside her — he had also injected. She collapsed and died. I just want to tell you from here that we are really exposed to these overdoses, but I am still shocked by them.

I think I have still got a bit of post-traumatic stress here. That another human being could take their last breath in such an undignified space, next to me, who is a stranger, is overwhelming. It took about an hour and a quarter. You are trying to hang on to this guy and ring 000 and explain where to go. It was about 3.30 p.m., and there were kids coming out of the school. You know, it is shocking. It was just terrible. The thing is that the trauma of witnessing this sort of stuff is taking a heavy toll on residents, as Coroner Audrey Jamieson suggested.¹⁹⁴¹

Kylie Tory-West stated:

On my street I have multiple neighbours that have performed CPR on people that have overdosed, some of whom have died, which is an awful fact. All of the houses on my street have removable tap heads, and that was a decision that was taken nine years ago as a preventative measure. So if you cannot access any water on the street, then your ability to inject on the street is reduced. Now they give out water when you pick up your syringes from the needle exchange, so it is not so effective anymore. But nine years ago that was one of the ways that neighbours all banded together to tackle that problem.

¹⁹³⁹ Greg Denham, Executive Officer, Yarra Drug and Health Forum, *Transcript of evidence*, 8 May 2017, p. 50.

¹⁹⁴⁰ Name withheld, *Submission*, no. 102, 10 March 2017; Name withheld, *Submission*, no. 102, 10 March 2017.

¹⁹⁴¹ Judy Ryan, Residents for Victoria Street Drug Solutions, *Transcript of evidence*, 5 June 2017, p. 187.

On my street I cannot pick up a piece of litter from the gutter in the autumn because I might get a needle stick injury. And every time my son wants to go and draw chalk animals on the footpath, I have to go out before him, check up and down. Is there anyone injecting? Are there any dealers? Are there any syringes?¹⁹⁴²

In its submission, City of Yarra highlighted that of 172 overdose deaths in 2015, 20 occurred in its municipality and there was evidence in 15 more cases that the drugs were purchased in the area. It also referred to a 2013 study by the Burnet Institute that found widespread public injecting in North Richmond and Abbotsford. City of Yarra indicated its support for Victorian Coroner Hawkins recommendation regarding the trial of an supervised injecting facility in North Richmond.¹⁹⁴³

The MSIC trial will take place at NRCH, which has provided health, medical and social services, such as an NSP, to the local community for 42 years. During the inquiry, the Committee visited the area surrounding the centre and learnt that the public housing estate’s carpark adjacent to the centre is typically used by people to inject drugs, with overdoses occurring there weekly. According to Dr Lorraine Baker, the President of the AMA Victoria, doctors and staff of NRCH often resuscitate people in the car park but not in an official capacity.¹⁹⁴⁴ Virginia Dods of the Collingwood and Abbotsford Residents Association also referred to this car park in her evidence, highlighting the distressing scenes that children who live in the housing estate have witnessed there:

What my children experience is nothing compared to their peers on the North Richmond housing estate who have told me stories of the woman shooting up in the car park with blood everywhere who threatened them with a needle not to tell anyone, or my attempts to ensure trauma counselling for a child who happened to see on the CCTV monitor in the security office a man in the lift slit the throat of a security officer whom he apparently believed was investigating him. Because the families must continue to live in this environment, and many are from non-English-speaking backgrounds, the parents tell their children not to tell anyone about what they have seen and make trouble for them.¹⁹⁴⁵

17.4.3 Implementation of the medically supervised injecting centre in North Richmond

The Committee understands that as part of the Victorian Government’s commitment to establish a MSIC in North Richmond, an Expert Advisory Group was appointed to provide advice on the development of the regulations to govern the MSIC. Based on the evidence received throughout the inquiry, including from the overseas study tour, the Committee suggests that the Advisory Group consider the following two points in order to enhance the effectiveness of the MSIC once in operation.

Allowing various illicit substances to be consumed onsite

Drawing on observations of drug consumption rooms in Europe and the Sydney MSIC, it is worthwhile considering the use of both opioid and non-opioid type substances onsite. Clearly, there is a high correlation between opioid use and overdose and the reduction of overdose is the key objective of the MSIC. It is also true that drug overdoses are not as prevalent with regard to stimulant drugs such as methamphetamine. Nonetheless, people who inject amphetamine-type substances

¹⁹⁴² Kylie Troy-West, Residents for Victoria Street Drug Solutions, *Transcript of evidence*, 5 June 2017, pp. 188-189.

¹⁹⁴³ City of Yarra, *Submission*, no. 127, 16 March 2017, p. 1.

¹⁹⁴⁴ Dr Lorraine Baker, President, Australian Medical Association Victoria, *Transcript of evidence*, 28 June 2017, p. 260.

¹⁹⁴⁵ Dr Virginia Dods, Collingwood and Abbotsford Residents Association, *Transcript of evidence*, 5 June 2017, p. 181.

also require medical supervision. Aside from a reduction in overdose numbers, other objectives in the Act which relate to reduced transmission of blood borne viruses and improved amenity in areas surrounding the MSIC, support expanding the types of substances allowed to be consumed onsite.

Low thresholds for people to access the medically supervised injecting centre

Again, drawing on international evidence and from the Sydney MSIC, there is merit in considering whether potential MSIC clients should be required to provide identification to use the facilities. This is not required at the MSIC in Sydney's King Cross on the basis that it might dissuade some people from using the centre. There may be some circumstances where it is appropriate to request identification, for example in establishing whether a potential client is over the age of 18. However, this should be the exception rather than the rule. In Vancouver, Darwin Fisher who works at Insite spoke of the importance of identifying the 'non-starters' that might discourage people from using such a service. When establishing Insite, one of the non-starters identified was requiring people to provide identification or fill out registration forms. This was particularly concerning for people with low literacy skills. In response, Insite 'dialled down the bureaucracy' and people are now greeted upon entry with an informal conversation. Once clients feel more comfortable using the service, they can register their details.¹⁹⁴⁶

17.5 Population-based overdose prevention strategy

While opioid overdose deaths have increased in recent years, it is unclear whether Victoria will experience a similar crisis to North America. The Committee is aware, however, that if fentanyl and carfentanil become more available on the Australian illicit drug market and/or if heroin purity increases, it is likely that overdose rates will continue to rise. In this scenario, the Committee acknowledges the views of Shane Neilson of the ACIC and Assistant Commissioner Rick Nugent of Victoria Police that it is important to prepare an appropriate response to prevent it from becoming an epidemic. In this situation, a population-based prevention strategy that combines a range of interventions is essential.

The report by GCDP, *The Opioid Crisis in North America*, recommended that one strategy to address the opioid crisis in North America is to make widely available harm reduction measures and treatment, 'especially naloxone distribution and training, low-threshold opioid substitution therapy, heroin-assisted treatment, needle and syringe programs, supervised injection facilities, and drug checking'.¹⁹⁴⁷

In Vancouver, the Committee met with Dr Kenneth Tupper of the British Columbia Centre for Substance Use (BCCSU) who advised that two responses are required to avoid the opioid overdose crisis affecting North America. The first is to provide chronic, dependent opioid users with a regular supply of pharmaceutical-grade opioids (HAT). The second is to provide other users (both recreational and those with an opioid-related substance use disorders) with drug checking services to ensure they

¹⁹⁴⁶ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 49.

¹⁹⁴⁷ Global Commission on Drug Policy, *The opioid crisis in North America*, GCDP, Geneva, 2017, p. 12.

have as much information as possible about the substance they intend to consume and to potentially affect the illicit drug market through influencing trafficking behaviours.¹⁹⁴⁸

From July 2016, VCH commenced a pilot drug checking service at the Vancouver MSIC, Insite, to enable clients to test their drugs for fentanyl. The test involves clients using a test strip at an injection booth (either before or after consumption), with the result available in seconds. Results are regularly posted so that all clients can see them. In August 2017, VCH announced it was expanding this service to the four Vancouver overdose prevention sites, and another MSIC. It also reported that, in the first year of the pilot, 1,400 drug checks had been undertaken and 80 per cent of the checks tested positive for fentanyl (84 per cent of heroin samples and 65 per cent of other drugs such as crystal methamphetamine, ecstasy/MDMA and cocaine).¹⁹⁴⁹ In November 2017, VCH announced a further expansion, with the purchase of a fourier-transform infrared spectroscopy (FT-IR) machine to analyse a range of substances such as opioids, stimulants and MDMA at the two MSICs, alongside fentanyl test strips.¹⁹⁵⁰

Vancouver Coastal Health indicated that clients who tested their drugs prior to consumption and where the results showed fentanyl were ten times more likely to reduce the amount that they consumed. For these clients, they were also 25 per cent less likely to overdose.¹⁹⁵¹ Vancouver Coastal Health also noted, however, that it was keen to encourage more people to test their drugs prior to consumption, with an earlier report in May 2017 indicating that most clients (62 per cent) were checking their drugs after consuming them.¹⁹⁵²

The Committee was also advised by Dr Marianne Jauncey, the Medical Director of the Sydney MSIC, that the Centre allows voluntary urine drug screening for fentanyl, using a simple dipstick test. This is offered to approximately 100 clients every three months, or so, to anyone who has used heroin in the 48 hours before their visit. She advised the testing is:

...regarded as sentinel surveillance, in that it's done in one particular at-risk site, namely here, with a view to providing an early warning if we do start seeing any positives. We did our first batch in November last year, and are due to do it again late Feb/early March. At this stage there has been no unexpected positives.¹⁹⁵³

In Victoria, under a population-based overdose prevention strategy, drug checking could be established at the MSIC in North Richmond.¹⁹⁵⁴

1948 Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 56.

1949 'Fentanyl checking expanding to overdose prevention sites', *Vancouver Coastal Health*, 31 August 2017, viewed 26 June 2017, <<http://www.vch.ca/about-us/news/news-releases/fentanyl-checking-expanding-to-overdose-prevention-sites>>.

1950 'Fentanyl checking expanding to overdose prevention sites', *Vancouver Coastal Health*, 31 August 2017, viewed 26 June 2017, <<http://www.vch.ca/about-us/news/news-releases/fentanyl-checking-expanding-to-overdose-prevention-sites>>.

1951 'Fentanyl checking expanding to overdose prevention sites', *Vancouver Coastal Health*, 31 August 2017, viewed 26 June 2017, <<http://www.vch.ca/about-us/news/news-releases/fentanyl-checking-expanding-to-overdose-prevention-sites>>.

1952 'Drug checking at Insite shows potential for preventing fentanyl-related overdoses', *Vancouver Coastal Health*, 15 May 2017, viewed 26 June 2017, <<http://www.vch.ca/about-us/news/news-releases/drug-checking-at-insite-shows-potential-for-preventing-fentanyl-related-overdoses>>.

1953 Correspondence from Dr Marianne Jauncey, Email, Secretariat of the Law Reform, Road and Community Safety Committee, 15 February 2018.

1954 Unharm, *Submission*, no. 182, 17 March 2017, p. 18.

Drawing on the experience of Portugal, the Committee notes its very low rates of overdose deaths, which has declined considerably since decriminalisation was introduced in 2001. In its submission, Turning Point cited UNODC statistics, which reflect Portugal's low rate compared to other countries:

Among Portuguese adults today, there are 3 drug overdoses for every 1,000,000 citizens compared to 10.2 per million in Netherlands, 44.6 per million in the UK. The EU average is 17.3 per million. In Australia, it is 88.1 per million people.¹⁹⁵⁵

Stakeholders advised the Committee that along with decriminalisation, other contributing factors to the decline in overdoses in Portugal was the significant investment in health and social programs. Indeed, a key driver of the decriminalisation reforms was the unacceptably high rate of overdose deaths (and transmission of blood borne disease) under the previous regime. In its submission, VAADA indicated that 'people living in Victoria are 43 times more likely to fatally overdose than those living in Portugal'.¹⁹⁵⁶

The Committee is of the view that access to quality and flexible treatment services is also an important component of a population-based overdose prevention strategy, although it is essential that other interventions are implemented to target those people not yet ready to engage in treatment. The Committee acknowledges that keeping people alive should be the first priority, with the intention and hope that people will soon commence their journey to recovery with the appropriate support.

An overdose prevention strategy that combines harm reduction and demand reduction interventions should be viewed as a continuum of care for people who use drugs to keep them safe and alive. In the event of continued and rising overdose deaths, the overdose prevention strategy would achieve this at a population level and through targeted approaches. For example, the Committee understands that regional overdose deaths have different contributing factors to those that occur in metropolitan areas. This is likely to require particular strategies for people who use drugs in rural and regional areas. The Penington Institute also recommended a more wide-ranging awareness campaign that targets all Victorians and aims to help people reduce their risk of overdose. This campaign could also target families, friends and peers, and the broader community in order to raise awareness of this important issue.¹⁹⁵⁷

¹⁹⁵⁵ Turning Point, *Submission*, no. 116, 15 March 2017.

¹⁹⁵⁶ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 15.

¹⁹⁵⁷ Penington Institute, *Submission*, no. 209, 24 March 2017, p. 39.

RECOMMENDATION 47: The Victorian Government develop an emergency action plan to respond to a potential increase in deaths or overdoses as a result of high strength and purity of illicit substances, for example the presence of fentanyl and carfentanil in the drug market. This could include:

- targeted strategies for specific cohorts of people that use substances, such as those based in regional and rural areas, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, and people experiencing mental health issues
- wider distribution of naloxone to people who inject drugs (recommendations 45 and 46)
- explore avenues to enhance availability of opioid substitution therapies, such as lowering thresholds for access and reducing costs (recommendations 32 and 33), and expanding opioid-based treatment for people with a chronic heroin addiction (recommendation 34)
- possible establishment of temporary medically supervised injecting facilities in areas with high concentrations of injecting drug use and overdoses
- drug checking at the Medically Supervised Injecting Centre to test for heroin purity and other contaminants.

18 Safe events

As identified in chapter one, a key component of drug policy is understanding different types of drug use, why people engage in certain behaviours, and the associated harms arising from these behaviours. While a predominant focus in this report has been on people with substance use disorders, this chapter deals specifically with people who use illicit substances on a recreational basis, many of whom do so in party environments, such as music festivals, rave events and nightclubs. These people are predominantly young, and in most circumstances mature out of drug-taking behaviour. The Committee understands that many of them do not often encounter health or law enforcement authorities, despite them sometimes engaging in harmful behaviours.

It is acknowledged, both locally and internationally, that the party environments referred to above often involve higher levels of recreational drug use compared to general settings:

Studies of drug use and music festivals from across the globe have found that the people who attend music festivals are more likely to have used drugs (Hesse & Tutenges, 2012; Lim, Hellard, Hocking, & Aitken, 2008; Lim, Hellard, Hocking, Spelman, & Aitken, 2010; Martinus, McAlaney, McLaughlin, & Smith, 2010; Measham, Parker, & Aldridge, 1998). For example, Lim et al. (2010) showed that people attending the Big Day Out music festival in Australia were 3.5 times more likely to have used drugs in the last month than the general population. Outdoor music festivals elevate drivers for use due to multiple factors, including the type of music played, the high cost of alcohol within venues, and because social bonding and connectedness is an important part of participation in music festivals (Duff, 2005; Measham et al., 1998).¹⁹⁵⁸

According to the Students for Sensible Drug Policy (SSDP) Australia has the highest per capita use of ecstasy in the world.¹⁹⁵⁹

In Victoria, the presence of illicit substances at these events has been accompanied by increased risks of harms such as overdose and rising hospitalisations.¹⁹⁶⁰ Ambulance Victoria raised in its submission that illicit drug use has recently increased at public events, with concerns arising from some of these events being held in remote areas:

Ambulance Victoria has observed an increase in the use of illicit drugs at public events over recent years. This had led to the death of individual patrons and several mass-overdose incidents. These mass overdose incidents involve multiple

¹⁹⁵⁸ Hughes, C, et al., 'The deterrent effects of Australian street-level drug law enforcement on illicit drug offending at outdoor music festivals', *The International Journal of Drug Policy*, vol. 41, 2017, p. 92.

¹⁹⁵⁹ Nicholas Kent, Chapter President, University of Melbourne, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 309.

¹⁹⁶⁰ Hughes, C, et al., 'The deterrent effects of Australian street-level drug law enforcement on illicit drug offending at outdoor music festivals', *The International Journal of Drug Policy*, vol. 41, 2017, p. 92.

patients with an immediate threat to their life due to depressed conscious states and depressed respiratory function. These events are occurring increasingly in regional and remote areas where access to suitable medical facilities, including intensive care, is both limited and delayed by distance. These events resultantly impact not only on health of patrons, but also on the availability of ambulance services to the broader community.¹⁹⁶¹

Harm Reduction Victoria (HRV), a user-driven community based organisation, advised the Committee that there have been ‘many well publicised, but also other discreetly-managed, cases of drug related deaths’ at a range of events such as festivals and nightclubs.¹⁹⁶² There are also frequent media reports of drug overdose incidents and deaths. Most recently, in January 2018, the media reported that nine people were taken to hospital, including one in critical condition, following ‘a mass drug overdose’ during an electronic dance festival at Festival Hall.¹⁹⁶³ Other reported incidents include: overdoses in January 2017 from a batch of ecstasy purchases in a nightclub on Chapel Street, the death in January 2017 of a 22-year old man at a music festival north west of Ballarat, and the hospitalisation of dozens of people in February 2017 after taking drugs suspected to be GHB at an event held at Sidney Myer Music Bowl.¹⁹⁶⁴

Given the profile of this cohort of people who use illicit substances, the Committee received evidence about the need to keep them safe through appropriate and targeted harm reduction interventions. Combined with this is the acknowledgement that other strategies, such as an increased law enforcement presence, have not successfully reduced the prevalence of illicit drug use at these events, nor among this group of young and recreational users of illicit substances. As noted by Associate Professor Nadine Ezard:

...people are already using drugs and taking alcohol and what we’re doing at the moment isn’t working. So the question for us is how can we keep our young people safe and what could we be doing differently to prevent some of those avoidable deaths and some of those avoidable harms?¹⁹⁶⁵

As argued elsewhere in this report, a balanced approach is required between health and law enforcement.

The key strategy proposed by stakeholders in this area was the use of drug checking services to allow people who attend such events to test their substances and receive information and counselling about the contents, in addition to the role of event organisers to reduce harm at their events.

The chapter also discusses an initiative of Victoria Police, namely the presence of drug detection dogs at public events, particularly in regard to their potential contribution to increasing harms, and their effectiveness in deterring offending behaviour.

¹⁹⁶¹ Ambulance Victoria, *Submission*, no. 208, 24 March 2017, p. 2.

¹⁹⁶² Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 33.

¹⁹⁶³ ‘Nine in hospital after suspected drug overdoses at Festival Hall dance party’, *ABC News*, 27 January 2018, viewed 5 February 2018, <<http://www.abc.net.au/news/2018-01-27/nine-in-hospital-after-drug-overdose-at-festival-hall/9366624>>.

¹⁹⁶⁴ ‘Bush doof’ festivals to be targeted in new drug search powers for Victoria Police’, *ABC News*, 18 June 2017, viewed 25 August 2017, <<http://www.abc.net.au/news/2017-06-18/music-festival-drug-search-powers-for-victorian-police/8628436>>.

¹⁹⁶⁵ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 118.

18.1 The role of event organisers

The Committee heard evidence during the inquiry about the ways in which harm reduction and safety at music festivals and similar events relating to illicit drugs could be improved by event organisers themselves. In his evidence to the Committee, Michael Stephenson, Executive Director of Operations at Ambulance Victoria, described the challenges the organisation currently faces regarding the lack of regulation over the conduct of events:

This is an unregulated environment, and the event organisers are essentially unregulated. There are some rules obviously they have in place for themselves in terms of insurance and medical care and other bits and pieces, but the variations in practice at these events are marked. As a consequence it can have a very significant impact on us and obviously a very significant impact on people who use drugs at those events.¹⁹⁶⁶

Michael Stephenson discussed the need to regulate in this area to address health concerns and the risks associated with these events being held in isolated locations without the necessary supports in place:

From Ambulance Victoria's point of view, regulation in this area is very, very important, understanding that at most of these events we would see on average five or six significant overdoses. You have seen in the recent media where we had an event where there were 30, and more than 20 of those patients were critically ill. It is a complex matter.

It is also compounded by the fact that the organisers seek to put these events on often outside of the public eye, so they are often outside of areas where you would have good quality medical support. If you have a rave party out in the middle of the bush, there is not a big hospital nearby, there is not an intensive care nearby. Ambulance resources will obviously be limited in those areas. Understand that when we are working at these events and if we are resuscitating four, five or six people, then that ambulance will not be available for the general community at that time either, so it is a very complex matter for us in terms of resourcing.

We engage with the event organisers as best we can in an unregulated environment to see that they have our services, but that is not always the case. Certainly the quantum of service that we would like to provide for many would not be provided because there is a cost to it.¹⁹⁶⁷

Media reports in June 2017 suggested that some reforms might be forthcoming in relation to music festivals, particularly to increase search powers of police and, relevantly for the purposes of this chapter, to increase responsibility of organisers around planning and security.¹⁹⁶⁸ While further information was not available at the time of writing this report, evidence received by the Committee could contribute to further development of these responses.

Current obligations on event organisers are detailed in the *Victorian Government Code of Practice for running safer music festivals and events* (the Victorian Code of Practice), which sets a standard of practice to assist event organisers run safe events and meet all legal requirements.¹⁹⁶⁹ The legal requirements articulated include the

¹⁹⁶⁶ Michael Stephenson, Executive Director, Ambulance Victoria, *Transcript of evidence*, 19 June 2017, p. 220.

¹⁹⁶⁷ Michael Stephenson, Executive Director, Ambulance Victoria, *Transcript of evidence*, 19 June 2017, pp. 220-221.

¹⁹⁶⁸ Hosking, W, 'Police to get stop-and-search powers to end overdose epidemic: Drug Party Blitz', *Sunday Herald Sun*, 18 June 2017.

¹⁹⁶⁹ Department of Health and Human Services, *Code of practice for running safer music festivals and events*, State Government of Victoria, Melbourne, 2011.

Occupational Health and Safety Act 2004 and related guidelines, and service of liquor and food safety standards. The Victorian Code of Practice also discusses a range of public health and safety considerations including: the provision of on-site first aid, medical care and drinking water; dealing with overcrowding; risks of exposure and hypothermia; noise; and the development of an emergency response plan. Security and crowd control standards are also outlined in terms of managing events, including establishing a working relationship between security and police, and providing relevant notifications to a range of bodies including local police, Ambulance Victoria, and local hospitals. There is also a strong focus on harm reduction initiatives, as outlined below.

18.1.1 Harm reduction and medical care at events

A key component of the Victorian Code of Practice is the role of event organisers in providing harm reduction and education services:

It is acknowledged that licit and illicit drug misuse can occur in the festival and dance party culture. While this behaviour is not condoned, organisers need to be prepared to deal with the potentially serious health issues that may result.

The Victorian Government supports a harm reduction approach, which aims to eliminate or minimise illness or injury (which may result in death) associated with drug use, which may occur at dance party events. Event organisers and staff have a pivotal role in delivering health messages to partygoers and in promoting harm reduction practices and measures encouraging partygoers' safety (see section 3.5).¹⁹⁷⁰

Kym Peake, Secretary of the Department of Health and Human Services (DHHS) confirmed that the Victorian Government supports the approach of harm reduction:

The government policy, as you know, at the moment is not in support of pill testing but is in support of a range of other strategies for both having peer engagement and having input information and support, particularly at events, to try and reduce the misuse of drugs...¹⁹⁷¹

The Victorian Code of Practice specifies harm reduction measures including ways to deal with dehydration and elevated body temperature, providing a chill out or cool down area, organisers providing messages about drink spiking and health promotion, and providing needle and syringe disposal units. It also describes the value of event organisers ensuring peer based education and peer based services are provided, such as through HRV's program, *DanceWize*:

Peer support and education groups provide a range of harm reduction resources, services and information on drug safety that will enhance the safety and wellbeing of partygoers. Peer educators also identify 'at risk' partygoers and provide support, intervention and referral to health services.¹⁹⁷²

The Committee received evidence about the role played by *DanceWize*, a program of HRV that is funded by the DHHS.¹⁹⁷³ Stephanie Tzanetis, the program coordinator of *DanceWize*, advised the Committee that it is a harm reduction program focusing on

¹⁹⁷⁰ Department of Health and Human Services, *Code of practice for running safer music festivals and events* State Government of Victoria, Melbourne, 2011, p. 22.

¹⁹⁷¹ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 326.

¹⁹⁷² Department of Health and Human Services, *Code of practice for running safer music festivals and events*, State Government of Victoria, Melbourne, 2011, p. 22.

¹⁹⁷³ Name withheld, *Submission*, no. 151, 17 March 2017; Name withheld, *Submission*, no. 176, 17 March 2017.

outreach, harm reduction education and support at music events and festivals, and also conducts activities at universities as well as other special projects. She also told the Committee that she is the only staff member for the program, and uses a team of 100 volunteers to assist.¹⁹⁷⁴ In its submission, the SSDP Australia discussed the importance of such services at events:

Harm reduction within the dance/festival community is well established with the *Dancewize* program providing an important information, welfare and outreach services. People in the festival community know to refer people having a difficult time to, or needing information to *Dancewize*, including police, medical and security staff.¹⁹⁷⁵

Phoebe Logan-Jacobson, a representative from RMIT University of SSDP Australia further reported on the positive impact of DanceWize in providing harm reduction education:

For me, I have actually seen in the community and I have been at events and I have been to nightclubs when people have experienced adverse effects from substance use, and I have found, like I said, that proper education around that has been a big protective factor — that is, in terms of dosing, the dangers of mixing alcohol with certain substances, and also around self-care and the care of others when you are engaging in substance use. I believe that the places that I have found this education have not been in the common and dominant discourse but through places and supportive, safe spaces such as DanceWize, which I find have served as a massive protective factor in the festival community, insofar as they provide a non-judgemental area where people feel safe to come and be provided with this information...¹⁹⁷⁶

DanceWize was also described by Associate Professor David Caldicott, an emergency consultant involved in proposing drug checking services in Australia, as ‘head and shoulders’ above other Australian organisations in providing responsible harm reduction services at events.¹⁹⁷⁷ Given the supportive evidence received, the Committee considers that expanding the provision of harm reduction services, such as DanceWize, at public events could help to guard against increased risks of drug-related overdose and deaths, as well as improve the capacity of such services to be present across a range of public events held in Victoria.

In terms of medical care provided, Michael Stephenson from Ambulance Victoria suggested increasing responsibility of event organisers to ensure adequate care is provided onsite:

Given that this is unregulated, the risk to patients is grave where there is not the appropriate level of medical care. There is no obligation on an event organiser, for example, to have us, Ambulance Victoria, at their events. But clearly given the gravity of the consequences of some of the overdoses, it is absolutely sensible that we would be there — so some form of insistence that at least the level of medical care that Ambulance Victoria or another agency could provide to a patient who is critically ill. These patients are often patients who require intensive care, and your first aid provider for the largest part is not able to provide that level of care.¹⁹⁷⁸

¹⁹⁷⁴ Stephanie Tzanetis, Program Coordinator, DanceWize, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 67.

¹⁹⁷⁵ Students for Sensible Drug Policy Australia, *Submission*, no. 214, 29 March 2017, p. 9.

¹⁹⁷⁶ Phoebe Logan-Jacobson, Representative, RMIT University, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 310.

¹⁹⁷⁷ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 480.

¹⁹⁷⁸ Michael Stephenson, Executive Director, Ambulance Victoria, *Transcript of evidence*, 19 June 2017, p. 220.

Associate Professor Nadine Ezard further suggested improving training and understanding of event organisers to ensure events are run more safely:

...I think there is some work that can be done in the kind of education environment with the organisers of parties and clubs and festivals to create safer environments and this - and not create a potentially hazardous environment...

So that environment - we could be doing a lot more in terms of training party providers and organisers.¹⁹⁷⁹

One way in which these issues could be managed is to improve partnerships between all relevant stakeholders, including event organisers, police, Victorian Government health authorities, ambulance services and harm reduction services. A useful example of a music festival where such partnerships were well-established is the Secret Garden Party in Cambridgeshire in the United Kingdom (UK), which the Committee attended as part of its overseas study tour (see further details in section 18.2.1). A memorandum of understanding (MoU) was established, outlining the roles and responsibility of each agency in contributing to the health and safety of people attending the event. These agencies included the festival organiser, Cambridgeshire Constabulary, local health authorities, event paramedics and The Loop, a non-government organisation (NGO) that conducts drug testing.

The Committee received a copy of the MoU, which stated that, '[a]ll partners supporting the Harm Reduction objectives clearly state that no agency or organisation is encouraging or condoning the use of substances in any way and all partners agree that the supply of controlled substances is an offence.' All partners were encouraged to share information to ensure harm reduction goals were met throughout the four day festival.¹⁹⁸⁰

The Committee is of the view that similar steps should be taken by the Victorian Government to work with event organisers to enhance public safety and harm reduction initiatives at music festivals. Particular issues that require attention include ensuring event organisers establish clear communications with relevant authorities, requiring that medical services be readily available; addressing any location concerns; providing appropriate harm reduction services and prevention information; coordination of responses to medical incidents; and coordination of drug alerts to event attendees when necessary. The mechanism to achieve this should include developing MoUs or accords between event organisers, local police, local health authorities, ambulance services and harm reduction services that specify each stakeholder's responsibilities regarding the running of events. It should also be accompanied by training for event organisers to understand and carry out their responsibilities.

18.2 Drug checking services

There are currently no government-approved or legal drug checking services operating in Australia (also referred to in evidence as pill testing/drug testing/drug safety testing). This issue was considered by the former Parliamentary Drugs and Crime Prevention Committee (DCPC) in 2004 as part of the *Inquiry into Amphetamine*

¹⁹⁷⁹ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 116.

¹⁹⁸⁰ Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 36.

and ‘Party Drug’ Use in Victoria, which recommended that ‘pill testing kits should not be available to the public as they are potentially a dangerous and inaccurate tool to measure the content of particular pills’.¹⁹⁸¹

The Committee notes, however, there was a strong consensus in the evidence to this inquiry supporting drug checking, from both individual submitters as well as organisations, noting that technology has developed significantly since the time of the DCPC report. Second only to the establishment of a medically supervised injecting centre, it was the most commonly raised matter in submissions and public hearings, with most recommending that the Victorian Government take ‘immediate steps to establish pill testing services in the State, modelled on international best practice’.¹⁹⁸²

A range of drug checking models have been trialled and established in various European jurisdictions, as well as in North America. While it is unclear whether international bodies such as the United Nations Office on Drugs and Crime have a view on drug checking, in Europe many projects have been supported by the European Union and in some ways is considered widely accepted practice. For example, standards for the operation of drug checking services in Europe, *Drug Checking Service Good Practice Standards*, have been developed by a project funded by the European Union, the Nightlife Empowerment and Well-being Implementation Project (NEWIP). The Standards incorporate expert advice and practical experiences to support the establishment and improvement of such services.¹⁹⁸³

Drug checking is defined as ‘an integrated service that basically enables individual drug users to have their synthetic drugs (e.g., cocaine, ecstasy, GHB, or LSD) chemically analysed as well as receiving advice, and, if necessary, counselling’.¹⁹⁸⁴ The key objectives are to raise awareness about a drug’s contents, effects and side effects, provide education on harm reduction to service users, and issue warnings about risks of particular drugs where required.¹⁹⁸⁵ Drug checking typically involves:

- a service user submitting a sample of their drugs
- scientific testing of the sample to determine the substances in the drug
- provision of results to the user accompanied by harm reduction/counselling advice
- sharing relevant information on a broader system that monitors the drug market
- issuing public health alerts on particularly concerning drugs.

An important component of drug checking is the focus on harm reduction information and advice provided to service users by trained health professionals and/or peers. Similarly, the ability to detect particularly concerning drugs, as well as their established links with people using drugs, makes drug checking services an ideal partner for both obtaining and disseminating information on an early warning

¹⁹⁸¹ Drugs and Crime Prevention Committee, *Discussion Paper and Final Report Inquiry into Amphetamines and ‘Party Drugs’*, Parliament of Victoria, East Melbourne, 2004, p. xxi.

¹⁹⁸² cohealth, *Submission*, no. 140, 16 March 2017.

¹⁹⁸³ Ventura, M, et al., ‘Drug Checking Service Good Practice Standards’, Nightlife Empowerment & Well-Being Implementation Project, 2013, viewed 17 August 2017, <http://newip.safernightlife.org/pdfs/standards/NEWIP_D_standards-final_20.12-A4.pdf>.

¹⁹⁸⁴ Ventura, M, et al., ‘Drug Checking Service Good Practice Standards’, Nightlife Empowerment & Well-Being Implementation Project, 2013, viewed 17 August 2017, <http://newip.safernightlife.org/pdfs/standards/NEWIP_D_standards-final_20.12-A4.pdf>, p. 16.

¹⁹⁸⁵ Ventura, M, et al., ‘Drug Checking Service Good Practice Standards’, Nightlife Empowerment & Well-Being Implementation Project, 2013, viewed 17 August 2017, <http://newip.safernightlife.org/pdfs/standards/NEWIP_D_standards-final_20.12-A4.pdf>, p. 16.

system (EWS). The emergence of new psychoactive substances (NPS) means that drug checking services play a key role in identifying unknown substances and reporting such information to a broader audience and for monitoring purposes.

According to a recent report published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Health and social responses to drug problems: A European Guide*, there are 16 drug checking services across 11 European countries, with some covering the whole country while others operate in specific areas or venues.¹⁹⁸⁶ Other key variables in drug checking service models include: whether the main aim is to gather data and information or to provide harm reduction services, or a combination of both; the types of technology used; and whether the service is offered at fixed laboratories away from public events, or onsite at public events through mobile laboratories.¹⁹⁸⁷ The Committee notes that different countries use different models and while there is no clear best practice model, each works according to their objectives and environment.

The following statement from the EMCDDA broadly outlines the key benefits and potential issues stemming from drug checking services, and offers an appropriate summary of the issues explored by the Committee during the inquiry:

Drug-checking services are controversial. They have certainly provided a valuable contribution to early warning systems in the European Union. However, evidence of their impact on drug use or risk behaviours remains limited. Advocates argue that there are case examples in which information from drug-checking services has had a positive public health impact and that drug checking can potentially reduce harm by engaging with young recreational drug users not seen by existing services; identifying drugs that contain unwanted or unknown chemicals allowing an early public health response; and helping avoid overdose by providing information on potency. On the other hand, critics suggest that drug checking may give a false feeling of safety because the reliability of some of the testing approaches used is questionable; may give the impression that drug taking is normal and acceptable behaviour, potentially undermining prevention efforts; and that drug users will go ahead and use their drugs regardless of results.¹⁹⁸⁸

The EMCDDA further stated that there is a lack of sufficient research in this area and it is difficult to assess the effectiveness of drug checking services as a whole given the range of models that are used.¹⁹⁸⁹ Advocates for these services have also noted that this area has received less research attention than other harm reduction services, which has made it challenging to demonstrate its effects.¹⁹⁹⁰

18.2.1 International models of drug checking services

Drug checking service models can be divided into two different types: the first operates onsite at music festivals and other events, usually through a mobile laboratory; and the second operates offsite and away from events, where people can

¹⁹⁸⁶ European Monitoring Centre for Drugs and Drug Addiction, *Health and social responses to drug problems: A European Guide*, Publications Office of the European Union, Luxembourg, 2017, p. 142.

¹⁹⁸⁷ European Monitoring Centre for Drugs and Drug Addiction, *Health and social responses to drug problems: A European Guide*, Publications Office of the European Union, Luxembourg, 2017, p. 139.

¹⁹⁸⁸ European Monitoring Centre for Drugs and Drug Addiction, *Health and social responses to drug problems: A European Guide*, Publications Office of the European Union, Luxembourg, 2017, p. 139.

¹⁹⁸⁹ European Monitoring Centre for Drugs and Drug Addiction, *Health and social responses to drug problems: A European Guide*, Publications Office of the European Union, Luxembourg, 2017, p. 140.

¹⁹⁹⁰ Gine, C, et al., 'The utility of drug checking services as monitoring tools and more: A response to Pirona et al.', *The International Journal of Drug Policy*, vol. 45, 2017, p. 47.

take their samples in advance for testing at a fixed laboratory. While the components of both types are broadly similar, the testing offered at each varies significantly (for example, onsite drug checking requires testing to be done quickly, while fixed site drug checking can use more sophisticated laboratory technology that takes more time). Some jurisdictions operate only one type, and others operate both. This section describes how the models work in practice, including a description of the technology used and the legal foundations.

Onsite drug checking at public events

One of the most well-known onsite drug checking services, ChEck iT! in Austria, began in 1997 in Vienna, subsidized by the City of Vienna and run jointly by an NGO (Suchthilfe Wien) and the Medical University of Vienna. As well as providing other harm reduction services, ChEck iT! undertakes drug checking at music festivals and other events through a mobile laboratory, while also collecting data about the drug market.¹⁹⁹¹ A 2001 EMCDDA report, *An Inventory of On-Site Pill-Testing Interventions in the EU*, described that the legal basis for the service is based on:

...official statements by the Ministry of Justice and the Ministry of Social Affairs and Health declaring pill testing a legal procedure, if it is done by a scientific institution. No illicit substances may be touched or handled by the project members, for giving back or passing on illicit substances would be a violation of the Austrian law on controlled substances. ChEck iT! has a good working base with the local police who support the preventive measures of the project: the police are present at raves where ChEck iT! is offering chemical analysis, but do not concentrate their actions on visitors of ChEck iT!¹⁹⁹²

In terms of technology used, the service uses high-performance liquid chromatography-mass spectrometry (HPLC) instruments and HPLC-Mass Spectrometry (LC-MS) to analyse samples. An explanation of these methods from the European Trans European Drug Information (TEDI) project, particularly for detecting NPS, states that combining liquid chromatography and mass spectrometry 'provides a powerful analytical tool and is the method of choice for screening recreational drug samples'.¹⁹⁹³ ChEck iT! is one of three main partners that provide information to the Austrian EWS on new substances, impurities or high doses.¹⁹⁹⁴

ChEck iT! can provide up to 600 information and counselling sessions on site per night, and can analyse up to 100 samples per night. Its website receives approximately 150,000 hits per year, and the service also receives about 450 online requests and 500 telephone requests in a year. Following the testing of substances, results of the drug checking are posted anonymously on a wall (individuals are given a unique number so they can search for their result) about 20 minutes after testing. The results include information about risks (e.g. - caution, high dosage), and includes counselling.¹⁹⁹⁵

¹⁹⁹¹ Schmid, R, 'Drug testing at music events - A low threshold drug prevention program for young consumers of synthetic drugs', ChEck iT!, 2013, viewed 19 July 2017, <<http://www.ewdts.org/data/uploads/vienna/ewdts2013-schmid.pdf>>.

¹⁹⁹² European Monitoring Centre for Drugs and Drug Addiction, *An Inventory of On-Site Pill-Testing Interventions in the EU: Fact Files*, Vienna, 2001, p. 4.

¹⁹⁹³ Trans European Drug Information (TEDI) and Nightlife Empowerment and Well-Being Implementation Project, 'Guidelines for Drug Checking Methodology', 2012, viewed 13 November 2017, <http://newip.safernightlife.org/pdfs/digital_library/Guidelines%20for%20Drug%20Checking%20Methodology.pdf>, p. 18.

¹⁹⁹⁴ European Monitoring Centre for Drugs and Drug Addiction, *Early Warning System: National Profiles*, Lisbon, 2012, p. 11.

¹⁹⁹⁵ Schmid, R, 'Drug testing at music events - A low threshold drug prevention program for young consumers of synthetic drugs', ChEck iT!, 2013, viewed 19 July 2017, <<http://www.ewdts.org/data/uploads/vienna/ewdts2013-schmid.pdf>>.

In Portugal, CHECK!N is operated by a Portuguese NGO called APDES (Agência Piaget para o Desenvolvimento). As part of various harm reduction services run at clubs and festivals, CHECK!N provides a drug checking service using a mobile laboratory. The service was established as a partly government funded one in 2001, and mainly uses a form of technology called thin layer chromatography (TLC).¹⁹⁹⁶ An evaluation of CHECK!N at one festival in 2014 found that 45 per cent of the samples were not what users expected and, as a result, 29 per cent indicated that they would not consume them. Of the 71 per cent that intended to consume them, 10 per cent aimed to obtain more information, 15 per cent would take a smaller amount and 30 per cent would not mix it with other substances.¹⁹⁹⁷

In New Zealand (NZ), a community group called KnowYourStuffNZ has run a free drug checking service since 2014 in conjunction with the NZ Drug Foundation. According to its website, it aims to:

- provide factual information about illicit drugs, signs of excessive use and help available
- test substances to identify their contents, to provide accurate information on issues such as toxic dose, reasons not to take a substance, what to expect from a substance, and how to reduce harms.¹⁹⁹⁸

The Committee met with the NZ Drug Foundation and KnowYourStuffNZ in October 2017 and learnt that the technology used includes reagent tests and a Fourier transform infra-red spectrometer (FT-IR). KnowYourStuffNZ indicated that they are able to identify over 95 per cent of the samples with these methods. Staff do not handle any substances, but guide service users through the process of preparing the sample and undertaking the tests. The staff also provide tailored harm reduction advice with the results.¹⁹⁹⁹ According to the results from the 2015/2016 festival season, the drug checking service identified 37 psychoactive substances from over 300 samples at eight festivals. Thirty per cent of the drugs were not what the service users expected, and half of these service users indicated that they did not intend to take the substance.²⁰⁰⁰ The NZ Drug Foundation, which supported the service by purchasing its equipment, told the Committee that KnowYourStuffNZ operates in a 'legal grey area' which places festival organisers, service staff and service users at risk.²⁰⁰¹ Both organisations emphasised that the current legal situation is of concern and presents a barrier to the expansion of the service, for example into nightclub areas. However, they also noted that the service was positively received in the media when it released interim results from the 2015/2016 festival season.

In the UK in 2016, The Loop, trialled drug checking at two festivals, where substances provided by attendants were forensically tested to establish content and potency levels. The trials took place with the support of local police, local authorities and public health officials. The trials operated 'Multi Agency Safety Testing' (MAST), where an individual submitted a drug sample in an 'amnesty bin' and received the results with a confidential, tailored harm reduction package about 30 minutes later. The samples were generally destroyed during testing and drugs were not returned to the user (remnants were destroyed later by police). Users could then dispose of any

¹⁹⁹⁶ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, pp. 5, 8.

¹⁹⁹⁷ European Monitoring Centre for Drugs and Drug Addiction, *Health responses to new psychoactive substances*, Lisbon, 2016, p. 9.

¹⁹⁹⁸ KnowYourStuffNZ, 'Our Service', viewed 17 August 2017, <<https://knowyourstuff.nz/our-service/>>.

¹⁹⁹⁹ KnowYourStuffNZ, 'Our Service', viewed 17 August 2017, <<https://knowyourstuff.nz/our-service/>>.

²⁰⁰⁰ KnowYourStuffNZ, 'Our results', viewed 17 August 2017, <<https://knowyourstuff.nz/our-results/>>.

²⁰⁰¹ NZ Drug Foundation, 'Drug Checking Frequently Asked Questions', viewed 17 August 2017, <<https://www.drugfoundation.org.nz/info/being-safer/party-drug-checking/faq/>>.

other substances they had. The process tested the purity and strength of samples, and involved ‘four different analytical methods including FT-IR spectroscopy (linked to a computer database of all known legal and illegal substances), UV spectroscopy, a number of reagent tests, and wet chemistry’.²⁰⁰² This technology has been described as ‘very promising’ in terms of providing accuracy and improved information.²⁰⁰³

As part of the overseas study tour, the Committee observed the drug checking service provided by The Loop during a music event called The Secret Garden Party in Cambridgeshire in July 2017. The Loop is a not-for-profit community interest company established in 2013, which provides drug safety testing, welfare and harm reduction services at nightclubs, festivals and other events. The textbox below summarises the information and observations of the Committee during this event.

The Loop at Secret Garden Party, UK

At the Secret Garden Party, The Loop conducted drug checking services in order to reduce harm among festival attendees from contaminated substances. This intervention was part of a broader ‘Harm Reduction Initiative’ at the festival that was supported by various agencies, including the festival organiser, Cambridgeshire Constabulary, local health authorities, event paramedics and The Loop. This initiative was formalised through a MOU between these agencies, as discussed in section 18.1.1. The 2017 Secret Garden Party was the second year that The Loop was present at this event.

The Loop’s drug checking service involved MAST that included the use of a variety of forensic tests (Bruker Alpha Fourier Transform Infrared FT-IR spectrometers) of the substance of concern. The service offered an eight hour ‘drop in’ service each day, in addition to 24 hours ‘on call’ emergency provision to test and identify substances that may have caused harm. The MoU explains The Loop’s drug checking service, particularly liability issues:

The multi-agency drug testing model involves users voluntarily supplying samples of substances (including controlled drugs). The samples are given a unique reference, prior to testing. The indicative results are then given to the user by a drugs worker, as part of the harm reduction advice. The substance is destroyed in the testing process...

No drug taking can be assumed to be safe, however this form of testing can assist organisers to understand the nature of drug harms connected with their event and it can help inform individual users of dangers associated with the substances in their possession, whether through composition or strength. However, it should be noted that the tests are indicative rather than conclusive.

In the first year of The Loop’s presence at the Secret Garden Party, a total of 247 people used the drug checking service over the four day period. In the second year, at least 400 people had used the service by the end of the second day. Of these people, 45 per cent indicated that they would take less after having their substances tested and receiving harm reduction information from the health workers. The Loop volunteers also indicated that over the festival, 97 per cent of tested substances were identifiable using the TicTac database.

²⁰⁰² Royal Society for Public Health, *Drug safety testing at festivals and nightclubs*, London, 2017.

²⁰⁰³ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 15.

Key components of the service are the harm reduction message provided to people who use the service and to give them as much information about the substance as the test allows. A volunteer with The Loop wrote an article about his experiences at the Secret Garden Festival and identified the important role of these harm reduction messages:

Every bit as important as the testing, however, was the information provided to those using the service by our team of drug workers. Together with the results of the drug tests, advice on the specific risks of the identified drugs were provided, as well as an opportunity for people ask any questions, or discuss any concerns, they may have with their drug use.

...What has been demonstrated in a small corner of a field this weekend is something more fundamental: treat people who want to use drugs with respect, and they will respond to the advice given to them sensibly.²⁰⁰⁴

As part of its service, The Loop was also able to collect information from people about what they thought the substance was, and when and where they purchased it. The purpose of this was to allow The Loop to coordinate and distribute drug alerts about contaminated substances if necessary.

The partnership approach between The Loop and the Cambridgeshire Constabulary was key a contributing factor to the success of the drug checking service. The Committee spent time with local police while at the Secret Garden Party and was impressed with its approach that ultimately aimed to keep people safe. The Committee observed that the police presence was a welcomed and positive experience. The local police's support of The Loop was reflected in the below testimony of the Cambridgeshire Police Service Commander:

As the Police Silver Commander for the Secret Garden Party it is my role to tactically deliver the strategy set for me by my Gold Commander...namely, to safeguard, to work in partnership, to prevent and detect crime.

...Using the same drug-testing equipment as that used by Cambridgeshire Constabulary, individuals can learn from [The Loop] professionals the exact nature of the substance that they have provided for testing. It is real front-of-house stuff, and, as evidenced by the figures, many individuals, once they had heard from the drug workers, indicated their intention to dispose of their remaining substances.

...I work with my police colleagues and others to do everything that I can to prevent controlled drugs coming onto the site; to detect and prosecute those intent on supplying. That stated, and, indeed, despite large numbers of confiscations, seizures and finds, it is reasonable to suppose that some substances will get on site. 'The Loop' provides an additional layer of safeguarding and protection.²⁰⁰⁵

²⁰⁰⁴ Fisher, H, 'I spent my weekend testing drugs at a festival – and I provided a service everyone should have access to', *Independent*, 25 July 2016, viewed 19 March 2018, <<http://www.independent.co.uk/voices/secret-garden-party-drugs-service-i-tested-drugs-at-festival-service-for-everyone-a7155376.html>>.

²⁰⁰⁵ The Loop, 'Testimonials', viewed 19 March 2018, <<https://wearetheloop.org/testimonials>>.

Fixed site drug checking

Along with, or instead of, mobile drug checking services, a range of jurisdictions have employed fixed site services away from the event itself. The example most regularly discussed by stakeholders was the Netherlands Drugs Information and Monitoring System (DIMS).²⁰⁰⁶

The Netherlands system was established in 1992, the first country in Europe to begin drug checking, and involves approximately 30 testing and drop off facilities around the country where service users can submit their drug samples. Its aims include monitoring NPS, reporting on the illicit drug market and identifying any health issues. The Trimbos Institute (the Netherlands Institute of Mental Health and Addiction) centrally manages DIMS and the laboratory where samples are sent for testing and cataloguing. Importantly, DIMS is part of the official drugs policy of the Netherlands and receives funding from the Ministry of Health, Welfare and Sport.²⁰⁰⁷ More than 100,000 samples were collected and analysed by DIMS between 1992 and 2010.²⁰⁰⁸

The DIMS works by people submitting their samples anonymously. If a person attends a drop off centre, the sample is sent directly to the central laboratory. If a person attends a testing facility, 'office testing' is conducted there to check contents, with staff firstly registering characteristics of the sample (e.g. logo, colour, weight) and performing a Marquis reagent test - a simple colour test to determine if the sample contains ecstasy, amphetamine, hallucinogens or none of these. Staff also refer to an online database (updated weekly) to see if the substance has been recognised and registered elsewhere. If it has been, the staff, made up of health and prevention professionals, provide the service user with information about the effects and risks of identified substances. Thirty per cent of ecstasy samples can be identified at testing facilities through office testing, rather than being sent to the central laboratory for identification. The other samples, as well as all powders, capsules and liquids are sent to the central laboratory for further testing, and results are provided to service users about a week later. The central laboratory uses a range of sophisticated qualitative and quantitative tests to determine known and unknown substances.²⁰⁰⁹

As the DIMS plays an integral role in the Netherlands EWS, it also issues a range of warnings for dangerous substances or doses that are limited to a specific sub-group of users or region, as well as nationwide warnings ('red alerts'). It analyses substances such as ecstasy/3,4-Methylenedioxymethamphetamine (MDMA), cocaine, and a range of NPS.²⁰¹⁰ Further, the system focuses primarily on monitoring drug trends and conducting surveillance to address public health concerns, and also presents an opportunity to gather information on drug market changes over time by working alongside other testing mechanisms from forensic institutions.²⁰¹¹ Dr Monica Barratt,

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- 2006** Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 12; Unharm, *Submission*, no. 182, 17 March 2017, p. 16; Students for Sensible Drug Policy Australia, *Submission*, no. 214, 29 March 2017; National Drug Research Institute, *Submission*, no. 136, 16 March 2017; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 33; Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 24; Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, pp. 115-116; Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 198; Professor Dan Lubman, Director, Turning Point, *Transcript of evidence*, 8 May 2017, pp. 29-30.
- 2007** European Monitoring Centre for Drugs and Drug Addiction, *Early Warning System: National Profiles*, Lisbon, 2012, pp. 105-106.
- 2008** Brunt, T and Niesink, R, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results, and international comparison', *Drug Testing and Analysis*, vol. 3, no. 9, 2011, p. 621.
- 2009** Brunt, T and Niesink, R, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results, and international comparison', *Drug Testing and Analysis*, vol. 3, no. 9, 2011, p. 622.
- 2010** Drugs Information and Monitoring System, *Annual Report 2016*, Trimbos Institute, Utrecht, 2016, p. 1.
- 2011** Brunt, T and Niesink, R, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results, and international comparison', *Drug Testing and Analysis*, vol. 3, no. 9, 2011, p. 629.

Research Fellow with the Drug Policy Modelling Program (DPMP) at the National Drug and Alcohol Research Centre (NDARC), referred to DIMS as ‘ideal’ for monitoring the drug market while ensuring a harm reduction approach.²⁰¹² Further, the National Drug Research Institute (NDRI) suggested in its submission that:

There is also evidence from the Netherlands that the safety of the illicit drug market can be improved as the proportion of contaminated and excessively dangerous substances declines in locations where drug checking services operate (Laar, Cruts et al. 2007).²⁰¹³

A range of benefits of the DIMS can be attributed to the fact that it operates as a fixed site system away from events, rather than onsite:

Although on-site drug checking might very well work in terms of transferring warnings and offering prevention advice, even entailing counselling or motivational interviewing, the noisy atmosphere at large venues is often a challenge, reducing the effectiveness of this tactic. Moreover, users in such settings might already be under the influence of substances. For this reason, in the Netherlands, drug checking at stationary offices has become the usual practice, often on uneventful weekdays. This gives prevention professionals the opportunity to speak with drug users in a quiet environment, and provides possibilities for motivational counselling. In fact, nowadays, many young drug users seem to purchase drugs from alternative sources, rather than from dealers at events (Global Drug Survey, 2016), making it possible for them to have their drugs tested before consumption at such events. Another practical drawback of onsite drug-checking services that use crude and inaccurate ‘quick tests’ is that such tests often lead to unreliable or meaningless results, which nullify the harm reduction function.²⁰¹⁴

Zurich is another example of a jurisdiction that uses a fixed site drug checking service, along with drug checking on site at public events, through an initiative called SaferParty by the City of Zurich. Following a number of years of onsite drug checking, the Drug Information Centre (DIZ) was established in 2006, and comprises free analysis of substances and a consultation with a social worker.²⁰¹⁵ In terms of its legal basis, a recent article from the International Drug Policy Consortium (IDPC) provided some information:

Christian Kobel of SaferParty says that though legislation surrounding testing “is not completely clear”, harm reduction is one of the four pillars of the Swiss Narcotics Act and Swiss states have an obligation to provide “harm reduction and survival support measures”. SaferParty’s relationship with the police is crystal clear: they meet to discuss best practice, provide statistics on tested drugs, and discuss emerging drug trends such as the darkweb. In 15 years, there has been no police intervention on any drug-checking site, whether mobile or static.²⁰¹⁶

The Drug Information Centre is open twice a week and conducts 40 analyses per week. Obligatory counselling includes drug information, safer use advice and referrals, and clients must also complete a questionnaire. Mobile drug checking

²⁰¹² Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 424.

²⁰¹³ National Drug Research Institute, *Submission*, no. 136, 16 March 2017, pp. 1-2.

²⁰¹⁴ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, pp. 11-12.

²⁰¹⁵ Hungerbuehler, I, et al., ‘Drug Checking: A prevention measure for a heterogeneous group with high consumption frequency and polydrug use - evaluation of zurich’s drug checking services’, *Harm Reduction Journal*, vol. 8, no. 16, 2011, p. 2.

²⁰¹⁶ Stevens, O, ‘Recreational MDMA testing - a European perspective’, *International Drug Policy Consortium*, 5 January 2017, viewed 20 July 2017, <<http://idpc.net/blog/2017/01/recreational-mdma-testing-a-european-perspective>>.

occurs eight to ten times a year, with up to 60 analyses and 200 consultations conducted each night.²⁰¹⁷ Some of the main drugs analysed include amphetamines, cocaine, ecstasy and various NPS. Importantly, a 2011 evaluation of the service reported that the service ‘reaches individuals with high (risky) or even dependent consumption’.²⁰¹⁸

The SaferParty website publishes alerts about substances and distributes these to approximately 500 organisations including harm reduction and prevention, doctors, hospitals and scientists. In 2016, the service published 794 alerts from 2078 drug samples, covering issues such as adulterants, unexpected compounds and high dosages.²⁰¹⁹

Similarly, since 1998 an organisation called Energy Control in Spain provides drug checking both onsite at public events and through four fixed sites in different regions, and samples can also be sent to the service by post. While the legal basis for the service is unclear, the recent article from the IDPC states that ‘the quantities received by post are so small that they are considered for research purposes and need no further legislative changes’.²⁰²⁰ The service is partly funded by the government, and also charges users for some services. The technology used includes thin layer chromatography (TLC), which can be done at their fixed sites, as well as gas chromatography-mass spectrometry (GC-MS) methods that can be conducted at an associated research institute, Institute de Recerca Hospital del Mar. As at 2014, the service had analysed more than 12,000 substances.²⁰²¹

Some of the main drugs tested include MDMA, cocaine, speed and a range of NPS. In 2015, Energy Control reported that it tested 275 NPS, identifying 81 substances. It also has the ability to issue alerts when toxic substances or high doses are detected. For example, in 2015 it issued 158 alerts to consumers and made 49 reports to the Spanish EWS (this is done when new or dangerous substances are detected).²⁰²²

18.2.2 Drug checking in Australia

As already indicated, the Committee received considerable stakeholder support for trialling a drug checking service in Victoria, only some of which is outlined here.²⁰²³ Both the ADF and Dr Barratt highlighted that, despite public perceptions that drug

²⁰¹⁷ City of Zurich Safer Party, ‘Drug-Checking in Zürich: Results, Alerts, Methods, Counselling, Impressions’, viewed 4 July 2017, <http://www.saferparty.ch/tl_files/images/download/file/aktuelles%202017/Poster_Dublin.pdf>.

²⁰¹⁸ Hungerbuehler, I, et al., ‘Drug Checking: A prevention measure for a heterogeneous group with high consumption frequency and polydrug use - evaluation of zurich’s drug checking services’, *Harm Reduction Journal*, vol. 8, no. 16, 2011, p. 5.

²⁰¹⁹ City of Zurich Safer Party, ‘Drug-Checking in Zürich: Results, Alerts, Methods, Counselling, Impressions’, viewed 4 July 2017, <http://www.saferparty.ch/tl_files/images/download/file/aktuelles%202017/Poster_Dublin.pdf>.

²⁰²⁰ Stevens, O, ‘Recreational MDMA testing - a European perspective’, *International Drug Policy Consortium*, 5 January 2017, viewed 20 July 2017, <<http://idpc.net/blog/2017/01/recreational-mdma-testing-a-european-perspective>>.

²⁰²¹ Giné, C, et al., ‘New psychoactive substances as adulterants of controlled drugs. A worrying phenomenon?’, *Drug Testing and Analysis*, vol. 6, no. 7-8, 2014, p. 819.

²⁰²² Energy Control, *Report on the Analyzed Substances in Spain by Energy Control During 2015*, Madrid, 2015, pp. 8-9.

²⁰²³ Victorian Alcohol and Drug Association, *Submission*, no. 163, 17 March 2017, p. 12; Unharm, *Submission*, no. 182, 17 March 2017, pp. 14-20; National Drug Research Institute, *Submission*, no. 136, 16 March 2017; National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, pp. 7-8; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, pp. 33-38; Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 9; Australasian College for Emergency Medicine, *Submission*, no. 223, 21 April 2017, p. 3; Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, pp. 24-25.

checking is a relatively new area in Australia, drug checking has been going on for some time and is currently occurring through the use of colorimetric reagent testing kits, which were described as ‘rudimentary’ by Dr Monica Barratt from the DPMP:

I think the debate about pill testing is such that in Australia it tends to be based on this erroneous assumption that nothing is currently happening in Australia, and this is not the case. Australians have access to the most rudimentary of testing: colour reagent testing kits. There are many individuals across Australia using these testing kits in an attempt to understand the content and purity of illicit drugs that they may be deciding to take.

Australians have also been integral in the development of pillreports.net and other crowd-sourced information websites like that. These community-run websites involve experienced reports, photos, measurements and in many cases actually the reagent test kit results themselves. Also surveys of Australians who use drugs, some of which I have conducted, indicate that many are aware of and use these sorts of services. Further to the contribution of consumers to pillreports.net, there are cases where community members have taken this into their own hands and conducted this kind of testing as an unsanctioned practice, mainly because the demand is there for such testing.²⁰²⁴

Students for Sensible Drug Policy Australia advised the Committee of discussions within the University of Melbourne Student Union to provide reagent testing kits to students. This was unanimously supported by the student council, which comprises a broad array of representatives. Nicholas Kent, Chapter President for the SSDP at the University of Melbourne summarised data from a survey of approximately 500 students on this, with the results demonstrating a strong interest in the service and broader harm reduction services that aim to assist students:

Interestingly 87 per cent of people indicated that they would access this kind of service. The major statistic there that is of interest, I think, is that 92 per cent of those people said that they would discard a substance if their test showed that it was adulterated. We have some of the most adulterated drugs in the world. We are also the highest users of ecstasy per capita in the world. We have significant interest from student unions looking to foster wellbeing and safety within their student bodies through measures like this, largely I believe in the absence of government action.²⁰²⁵

The media also reported in November 2017 that more than 300 community members used publicly available reagent testing kits to check drugs through a ‘rogue’ testing tent at a music festival held in Victoria in January 2017. The report stated that 99 per cent of people discarded their drugs when they were told they contained unknown substances, and that the testing also identified the substance linked to hospitalisations from Chapel Street that occurred in January 2017.²⁰²⁶

A further media report noted that, in response to calls for drug checking to be introduced following reports of a mass overdose event at Festival Hall in January 2018, the Victorian Premier, The Hon Daniel Andrews MP, was quoted:

²⁰²⁴ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 422.

²⁰²⁵ Nicholas Kent, Chapter President, University of Melbourne, Students for Sensible Drug Policy Australia, *Transcript of evidence*, 21 August 2017, p. 309.

²⁰²⁶ Zimmerman, J and Hore, M, ‘Rogue pill testing tent at Victorian festival prompts renewed calls for drug check trial’, *Herald Sun*, 6 November 2017, viewed 13 November 2017, <<http://www.heraldsun.com.au/news/victoria/rogue-pill-testing-tent-at-victorian-festival-prompts-renewed-calls-for-drug-check-trial/news-story/91aafb60c2566a1e13b217180a4aedf1>>.

Yesterday, Mr Andrews said he was not prepared to reconsider his and Victoria Police's position on recreational pill testing. "There is no safe level at which these substances can be taken and there was proof positive of that yesterday," Mr Andrews said. "We are not having pill testing in this state, not under a government I lead anyway."²⁰²⁷

In light of the clear demand for such services and the increased risks of deaths and overdose due to increasing toxicity of substances, the Alcohol and Drug Foundation (ADF) considered that a new approach to harm reduction is required.²⁰²⁸ Geoff Munro, National Policy Manager of the ADF, highlighted how it came to support a trial of drug checking, which involved gaining an understanding that illicit drug use is already firmly part of the culture of such events:

I might just cite a conversation with a single person I had just a few months ago, a young woman of about 30. I was talking with her about this issue. We were talking about the issue of pill testing at festivals. She said to me, 'I have been going to festivals for 20 years, and this is just part of the background'. For her it is almost not an issue because drug use has been part of the festivals since she started attending them. So the broader community might see this as something else, but for people who attend them it is just ordinary practice. We share your concerns, and that is why we have taken some time to come to our position. The drug testing, pill testing regimes have been taking place in Europe for many years now, and they have not led to the particular outcomes that we and you have been concerned about.²⁰²⁹

Professor Alison Ritter, Director of the DPMP at NDARC, indicated that, given the breadth of international evidence, a trial of drug checking services with evaluation would determine whether benefits demonstrated in other parts of the world could be replicated here:

The international research evidence that has been developed over many years in relation to pill testing suggests that it is a very plausible harm reduction strategy. We know that people who have their pills tested reduce their consumption of those substances when the pills or drugs contain substances that they do not expect. We know that it can shift the black market over time. We know that it provides an opportunity for excellent education and information in situ.

What we do not know is whether pill testing will work the same ways in Australia. The drug policy modelling program [within NDARC] is very keen to support a trial of pill testing that has a rigorous evaluation component to be able to assess whether the benefits that have been shown overseas would still apply in Australia.

...

Again, we want to know whether that evidence applies in the Australian context, so any study or trial of pill testing would involve also assessing what the risks or the perceived risks might be and evaluating the extent to which it did or did not increase drug use amongst patrons.²⁰³⁰

A number of individual community members also submitted to the Committee in support of drug checking services. For example, Marelle Davey considered that:

²⁰²⁷ Choahan, N and Kirkham, R, 'No testing of party drugs, Premier says', *The Age*, 29 January 2018.

²⁰²⁸ Alcohol and Drug Foundation, *Submission*, no. 218, 31 March 2017, p. 24.

²⁰²⁹ Geoff Munro, National Policy Manager, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 199.

²⁰³⁰ Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 19 June 2017, pp. 249-250.

When sources are unknown, proper pill testing can help party drug users make informed decisions about the drugs that they are taking and help them to avoid highly dangerous chemicals that could be present in these drugs. In my opinion, there is nothing to lose from pill testing and everything to lose from banning it.²⁰³¹

In her submissions, Avigale Bischard noted that she has two 18-year-old daughters that attend music festivals and supports drug checking to provide some protection from harmful substances.²⁰³² In supporting drug checking services, Greta Allen gave some background about the use of illicit substances at events and suggested that current approaches are not working:

After recent tragedies along Chapel street, Prahran in January 2017, I visited a nightclub in which I do fortnightly at least. Although deaths were reported the previous week at the venue, I still saw people taking drugs from strangers at [their] own risk, which occurs week in week out. It should be enough that if a person dies from taking unknown substance, we stop doing this procedure. But, it is 2017 and the party drug scene in Melbourne is larger than ever, and young adults are still taking drugs no matter what happens. Us young people have the belief that “it won’t be me, there is such a small chance I will die, I know what bad drugs look like” etc. But in reality, this is not true. No one knows what is in a bright coloured ecstasy pill, or a clear plastic capsule, but they are so used to being ‘safe’ when taking drugs that any caution is now irrelevant. Nightclubbers will still take drugs, festival goers will still dance for three days under the influence of drugs, because they are used to doing it and it is a repeating occurrence for some, after all “it won’t be them”, “I took this last week and it was fine”. It is completely ignorant of the government to push the issue of drugs aside and ignore it until something tragic like death occurs, death should never occur from something that can be prevented, and I believe life should be valued much higher than what it must be within the law of Australia.²⁰³³

The Port Phillip City Council’s submission indicated its support for a trial of drug checking services at consenting clubs, festivals and dance parties in its municipality. The submission provided data demonstrating that ambulance attendances, hospital admissions and crime rates occur more frequently in the City of Port Phillip than the Victorian average. It recommended that the Victorian Government legislate accordingly to enable such a trial, and expressed a desire to work with the Government to facilitate a trial in its area.²⁰³⁴

In order to determine the appropriateness of drug checking, the Committee considered evidence referred to by stakeholders and the broader literature examining the experiences of overseas drug checking models. The main benefits identified were its ability to reduce risk of harms of illicit substance use and to enhance monitoring of the drug market. The Committee was also very mindful about the potential unintended consequences of drug checking, such as increased substance use or perceptions of ‘safe’ illicit substances and technological limitations of drug checking equipment. In this context, it is useful to note the evidence of Associate Professor David Caldicott. In response to queries about unintended consequences, he highlighted that these concerns have not arisen in countries that have employed drug checking for over 20 years, and that the current situation itself creates unintended consequences:

This has been going on now for 20 years overseas, and these mythical unintended consequences have yet to evolve. I would appreciate that it is entirely possible that ‘unintended consequences’ might occur in an Australian jurisdiction. We do know

²⁰³¹ Marelle Davey, *Submission*, no. 32, 16 February 2017.

²⁰³² Avigale Bischard, *Submission*, no. 25, 16 February 2017.

²⁰³³ Greta Allen, *Submission*, no. 28, 16 February 2017.

²⁰³⁴ City of Port Phillip, *Submission*, no. 177, 17 March 2017.

that in the context of what is currently being done young consumers are happy to consume their drugs with gay abandon. They are certainly not being discouraged in any shape or form by the presence of sniffer dogs or laws or crackdowns. That has not changed anything whatsoever. So it is probably the case that we might be able to change behaviour by trying something new.²⁰³⁵

The Committee also notes there have been recent experiences in the Australian Capital Territory (ACT) regarding onsite drug checking. In September 2017, the ACT Government announced it would support a trial of a drug checking service at the music festival, Spilt Milk, in November 2017. Associate Professor David Caldicott, who was involved in proposing the ACT trial, advised the Committee that ‘certainly south of the equator we have been one of the first to get political support’.²⁰³⁶

According to a webpage on the ACT Government website, the service would be provided by a consortium of non-government organisations onsite at the festival free of charge as part of broader harm reduction services. The website indicated that legislative change was not envisaged as part of the trial, and listed key operational elements of the trial:

- A separate stand-alone service will be established, located in close proximity to the event’s medical area.
- The staff undertaking pill testing will be appropriately trained in using pill testing equipment
- Staff who are trained in drug counselling will deliver advice and intervention about drug use
- The equipment used for pill testing must be able to reliably, within an acceptable timeframe, identify the major drug present in an unknown tablet or powder as well as potentially detect adulterants and/or substances that are unknown.
- Regular communication should flow between the event organiser as well as ambulance and medical personnel in the nearby medical area to share information on the results of pill testing; this regular communication should assist with informing medical procedures in the case of overdose or other adverse event.
- Pill testing has limitations and these must be communicated to patrons of the pill testing service. This includes communicating that pill testing does not guarantee identification of each substance contained within a substance.
- Each patron must be directly notified, regardless of the pill testing result, that drug taking is inherently unsafe. Each patron must be notified that safe disposal of drugs is the best way to avoid health risk.
- The service must provide an amnesty bin for safe disposal of drugs. The drugs contained in amnesty bins must be destroyed on site, such that they cannot be reconstituted and safely disposed of at the conclusion of the event by the harm reduction service.
- The harm reduction service will collect evaluative data, which would include but not be limited to:
 - The number of patrons attending the service
 - The number of brief interventions as well as pill tests delivered
 - The number of patrons who discarded their drug at the service
 - The chemical content detected in each sample tested

²⁰³⁵ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 482.

²⁰³⁶ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 477.

- This data must be shared with key stakeholders so that it may inform possible pill testing in the future, both for safety and operational aspects. This might include for example, communicating to police and public health of the circulation of illicit drugs, notably contaminated drugs, substances of high purity or novel psychoactive substances.²⁰³⁷

The Committee was advised by Associate Professor David Caldicott that in terms of how the service would work, a service user would approach the tent in the medical precinct at a music festival, where a trained staff member would conduct an interview to gather information about the person. They would then be taken to the testing facility to scrape a piece of the tablet or substance and place it on the device for analysis. Regarding the database, the consortium intended to use the world's largest and most comprehensive library to provide a result. Where dangerous substances are found, this information would be distributed across the venue:

We will be able to give a result, usually very quickly. That result sometimes will be nothing at all — 'I'm sorry, mate; you've been sold a paracetamol tablet'. Sometimes it will be, 'This tablet contains less than 100 milligrams of MDMA'. All of these results will be contextualised to the individual. If we know anything about the millennial generation, we know that they are very interested in themselves. So we can actually give them personal medical information according to what we analyse. At no stage is anything ever returned to the consumer; at no stage is anyone ever advised that their pill is good or their pill is safe. These are just furrphies. They are fireworks hoisted by our opposition, who have never seen this being done. Then that information is added to a database, which is available to anyone who is involved in this.

If, for example, we were to identify something like PMA, God forbid, in one of the pills, we would have an understanding with the promoters that we would be in a position to actually put that over the big screens. So that information would become immediately available. The actual product itself is then placed with an alcohol wipe into a sharps bin that has got bleach in the bottom of it for subsequent repatriation and destruction with other sharps at the event.²⁰³⁸

In October 2017, media reports indicated that the trial was no longer going ahead as event organisers cited a lack of documents required to obtain necessary federal licenses.²⁰³⁹ Associate Professor David Caldicott advised, however, that the real reason related to federal opposition to the trial, also referring back to the federal opposition experienced by the ACT Government when it attempted to conduct a trial of heroin-assisted treatment in the 1990s (see chapter 14 for further details):

We have very firm state political support to conduct pill testing, and that has not changed. What changed, unfortunately — and it is not too dissimilar from the situation as I understand it, which pre-dates my era, of what was going to be a heroin trial in the ACT — is the ACT government wanted to run a trial which seemed to run against the ideologies of the then federal government. That seems to have been what happened in these circumstances.²⁰⁴⁰

He also emphasised that the consortium is still intending to undertake a trial, given the continued ACT Government support.

²⁰³⁷ ACT Health, 'Pill Testing at Spilt Milk', viewed 13 November 2017, <<http://www.health.act.gov.au/pilltesting>>.

²⁰³⁸ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 481.

²⁰³⁹ 'Spilt Milk pulls out of Australia's first pill testing trial', *Triple J: Hack*, 12 October 2017, viewed 15 November 2017, <<http://www.abc.net.au/triplej/programs/hack/spilt-milk-pulls-out-of-australia-first-pill-testing-trial/9044724>>.

²⁰⁴⁰ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 477.

18.2.3 Benefits of drug checking

Reducing harms of illicit substance use

The key objective of drug checking services is to reduce the harmful use of illicit substances, and many stakeholders agreed there is ample evidence to support that such services typically meet this objective. For example, Professor Margaret Hamilton, Australian drug policy expert stated:

I think there is pretty good and emerging evidence in a range of places — Austria is one that I am familiar with — that drug users at those sorts of partying and music events will make different decisions about using it based on that knowledge. If they are given information — if people say, ‘Well, it hasn’t got any of what you think you’ve purchased in it’, users say, ‘Well, I’m not going to use it’. Or if they are told, ‘It’s got a tiny little bit, but hardly any of that. It’s got a lot of other stuff, and we can’t afford and we’re not going to be able to tell you what else is in it’, they tend not to use it.²⁰⁴¹

In its submission to the inquiry, NDARC noted a 2005 study from the Austrian drug checking service, ChEck iT!, that found:

...50 per cent of people who used the pill testing/drug checking service said the results affect their consumption; most users will wait for a result before taking the drug; and when presented with a ‘bad result’, two-thirds say they will not consume the drug and will warn friends (Kriener & Schmid, 2005).²⁰⁴²

The National Drug Research Institute indicated in its submission that as ‘large proportions of patrons at music festivals attend with the intention to take these drugs’, drug checking services can reduce risks including that people may choose to discard their drugs. It cited a study from Canada that found almost a third of people discarded their drugs when advised that they potentially contained dangerous substances such as paramethoxyamphetamine (PMA).²⁰⁴³

Similarly, John Rogerson, CEO of the ADF, stated that the goal of drug checking is to provide accurate information to encourage better choices about harmful use:

There is no illicit drug that is safe. It is about giving information to young people to help them make better-informed decisions. At the end of the day it is their call; it is not my call, our call or your call. This is about providing them with information to help them at least make a decision. We know that a lot of young people, when they get information from the evidence that says, ‘There’s something in this pill that’s a major concern’, will not use it. At the end of the day we cannot decide for them, but we can actually give them better information.²⁰⁴⁴

Associate Professor David Caldicott also referred to the clear benefits of this service for prompting behavioural change in people. He noted that as many of these people are largely intent on consuming drugs at these events, such behavioural change could be effective in reducing the risk of harms:

Remember, these are not primary school-goers or Catholic school attendees; these are people who are firmly committed to the consumption of drugs. They go to a music festival with the intent of consuming drugs. That is a fairly hardcore intent. One of

²⁰⁴¹ Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne, *Transcript of evidence*, 8 May 2017, p. 57.

²⁰⁴² National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 7.

²⁰⁴³ National Drug Research Institute, *Submission*, no. 136, 16 March 2017, p. 1.

²⁰⁴⁴ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 197.

the interesting things was that it changed the way people consumed drugs. In fact, it caused them to alter their behaviour, to change their opinion and their 'sureness' of their behaviour.²⁰⁴⁵

He also considered that, even if only 60 per cent of people changed their mind as a result of a test, this would be a positive outcome instead of the current situation where no drug checking is offered.²⁰⁴⁶ Dr Monica Barratt from the DPMP at NDARC also reiterated that if most people are likely to take the substances anyhow, any reductions in harmful use as a result of drug checking is beneficial:

We have evidence that many people will discard or at least say that they will not take a drug when you ask them, 'What will you do now you have this information?'. Given that almost all of them would have taken the drug anyway, we think it is a pretty good outcome if a large proportion of people say they will not.²⁰⁴⁷

Sam Biondo, Executive Officer of the Victorian Alcohol and Drug Association (VAADA), advised the Committee that the Royal Society for Public Health (RSPH) in the UK recently endorsed a policy position in support of drug checking services.²⁰⁴⁸ This policy position highlighted initial results from the pilot drug checking service conducted at two festivals in 2016 by The Loop, which showed that close to one in five service users (18 per cent) chose to discard their drugs in amnesty bins once they were told of the results.²⁰⁴⁹ Gine et al in an article, *The utility of drug checking services as monitoring tools and more: A response to Pirona et al.*, discussed that such results provide 'more concrete evidence that drug checking does result in behavioural modifications that undoubtedly reduce harm, if particularly suspect drug samples are discarded instead of consumed'.²⁰⁵⁰

Another key function of drug checking services is to facilitate contact between people who use illicit drugs in these contexts with harm reduction services, a group that would rarely otherwise do so. Gine et al explained that reports from two drug checking services (one in Spain and one in UK) 'shows that a great majority of drug checking users have never been in touch with drug services before so these services are able to access a new and "hidden" user group from a service perspective'.²⁰⁵¹

In Zurich, it was found that drug checking reached users who were engaging in frequent drug use in substantial amounts, as well as those engaging in poly-drug use and experiencing concerns associated with their drug use, suggesting that the service was able to reach 'individuals with high (risky) or even dependent consumption'. Further:

...by offering these consumers a concrete service (substance analysis), it is easier to motivate them to participate in a consultation or a counseling session. As experience shows, the "obligation" to take part in a counseling session is, for very

²⁰⁴⁵ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 476.

²⁰⁴⁶ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 483.

²⁰⁴⁷ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 425.

²⁰⁴⁸ Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, *Transcript of evidence*, 21 August 2017, p. 301.

²⁰⁴⁹ Royal Society for Public Health, *Drug safety testing at festivals and nightclubs*, London, 2017.

²⁰⁵⁰ Gine, C, et al., 'The utility of drug checking services as monitoring tools and more: A response to Pirona et al.', *The International Journal of Drug Policy*, vol. 45, 2017, p. 47.

²⁰⁵¹ Gine, C, et al., 'The utility of drug checking services as monitoring tools and more: A response to Pirona et al.', *The International Journal of Drug Policy*, vol. 45, 2017, p. 47.

few individuals, a reason for not analyzing a substance. Additionally, as shown in a study by Benschop et al. (2003), most Drug Checking users rated the counselling that accompanied the testing as highly important.²⁰⁵²

The Committee is also aware of the benefits arising from people seeking advice from the service at the same time as they receive the drug checking results. In 2017, a background paper by Brunt, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, commissioned by the EMCDDA (but not necessarily representing the views of the EMCDDA or its partners) further highlighted that drug checking services are viewed as more trustworthy than abstinence-based messages. This is particularly because they provide anonymity and confidentiality and are more effective when staffed by health professionals and informed peers.²⁰⁵³

It is important to highlight, however, that it is not possible to directly correlate drug checking services with the avoidance of specific deaths or overdose incidents. Dr Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences of the Victorian Institute of Forensic Medicine (VIFM), stated that it would not be possible currently to determine ‘whether if you had had pill testing at a particular party, you would have prevented those deaths’.²⁰⁵⁴ He suggested that this issue be explored further. Professor Noel Woodford, Director of the VIFM, also explained that, in relation to deaths, it is difficult to be certain that NPS did not contribute given the difficulties in identifying them:

...sometimes we do not know what we are testing for, and just because we have tested for drugs and have not found them does not mean that they were not there. So there is a bit more work that needs to be done. So the setting for a death at a rave party suggests drugs, but we have still got a lot more knowledge to get in terms of what drugs are out there.²⁰⁵⁵

It should also be noted that a proportion of people may still use the substance despite the testing result, which Dr Gerostamoulos also noted.²⁰⁵⁶ According to the EMCDDA-commissioned background paper, this might be more prominent in relation to drug checking services that operate on site at events, as it would be more difficult for a service user to procure other drugs and therefore may choose to take the substance.²⁰⁵⁷ This reaffirms that such services are not able to prevent all harmful illicit substance use.

To estimate the possible use of such a service in the Australian context, a 2017 study co-authored by Dr Barratt, Associate Professor Nadine Ezard and Professor Ritter (among others), conducted a web survey of 851 Australians that reported using illicit psychoactive stimulants and/or hallucinogens and had attended venues or festivals past midnight in the last 12 months (‘partygoers’). The survey specifically asked participants about whether they would use a drug checking service. It found that 94 per cent would use a mobile drug checking service at venues, and 85 per cent would use a fixed site external to venues (with assurance that there would be no

²⁰⁵² Hungerbuehler, I, et al., ‘Drug Checking: A prevention measure for a heterogeneous group with high consumption frequency and polydrug use - evaluation of zurich’s drug checking services’, *Harm Reduction Journal*, vol. 8, no. 16, 2011, p. 5.

²⁰⁵³ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 10.

²⁰⁵⁴ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 216.

²⁰⁵⁵ Professor Noel Woodford, Director, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 216.

²⁰⁵⁶ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 215.

²⁰⁵⁷ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 12.

possibility of arrest). Eighty per cent of participants indicated that they would wait up to one hour for results, and 93 per cent would pay up to \$5.00 per test (68 per cent would pay up to \$10.00).²⁰⁵⁸ These findings suggest that the vast majority would make use of a drug checking service in the right circumstances.

Monitoring the illicit drug market

Drug checking services can play a significant role in monitoring drug markets at local, regional, and national levels. As discussed in chapter 11, unintentional use of NPS is a significant concern, particularly as these substances are used as adulterants in more well-known drugs, such as MDMA and lysergic acid diethylamide (LSD), without the knowledge of people intending to use them. The Burnet Institute highlighted in its submission that there is currently limited knowledge about how to address NPS-related harms in Australia in this context:

We have very limited data on health harms from new/novel psychoactive substances (NPS) in Australia because it is likely that most NPS use here is unintentional, and likely to be incorrectly associated with MDMA, LSD or even heroin. As a result we continue to guess the extent to which newer and lesser known substances are contributing to hospitalisations and deaths. However, this kind of information is crucial for developing evidence-informed responses to prevent NPS-related harms among young Victorians.²⁰⁵⁹

Associate Professor David Caldicott advised the Committee of the changing landscape in relation to substances of concern stating that, while there may have been roughly a dozen substances of concern in the past, in 2016 the 750th NPS was formally detected. This has necessitated changes in the types of technology required for drug checking.²⁰⁶⁰ It also provides an opportunity for drug checking to make a contribution to enhanced NPS detection.²⁰⁶¹ Butterfield et al importantly listed the ways drug checking can improve monitoring and responses to NPS by:

- identifying the NPS and other contents of the pills powders;
- monitoring NPS availability and use trends to enable an effective public health response;
- identifying emerging hazards from specific NPS and the formulations available;
- improving the knowledge base for effective clinical management of acute and chronic presentations;
- providing an opportunity for users to seek help, obtain health information to reduce potential harms and to offer options for individual behaviour change; and
- providing intelligence that could influence supply dynamics.²⁰⁶²

Harm Reduction Victoria considered that drug checking services are 'an ideal opportunity to monitor trends in drug markets and note new and emerging drugs of concern'.²⁰⁶³

2058 Barratt, M, et al., 'Pill testing or drug checking in Australia: Acceptability of service design features', *Drug and Alcohol Review*, vol. epub ahead of print, 2017.

2059 Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 8.

2060 Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 478.

2061 Gine, C, et al., 'The utility of drug checking services as monitoring tools and more: A response to Pirona et al.', *The International Journal of Drug Policy*, vol. 45, 2017.

2062 Butterfield, R, et al., 'Drug checking to improve monitoring of new psychoactive substances in Australia', *Medical Journal of Australia*, vol. 204, no. 4, 2016, p. 144.

2063 Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 33.

On these issues, the Netherlands DIMS model for drug checking was viewed by a number of stakeholders as a best practice model for how drug checking services can contribute to drug monitoring. In describing the system as 'ideal', Dr Monica Barratt from the DPMP at NDARC stated:

What is really interesting about the Dutch system is that the Drug Information Monitoring System understands that in order to have consumers submit drugs voluntarily it needs to also have a harm-reduction focus, but the actual primary reason why it is funded is to monitor trends in drugs. What they are able to do is look across 20 years of data or 25 years of data, and say, 'Look, we can see exactly what's happening with the purity of ecstasy. We can see it go down at this point and go up at this point'. We can actually start to really understand the drugs market in a way that unfortunately is quite difficult to do in Australia.²⁰⁶⁴

Similarly, Associate Professor Nadine Ezard advised:

...the real strength for me for this system is you then have a network of 20 facilities around the country that is feeding into a diagnostic laboratory that has then the capacity to test in a real time of new and emerging substances that are appearing on the market.²⁰⁶⁵

Another important feature of the Netherlands DIMS is that it operates alongside other testing mechanisms from law enforcement and health officials (including national forensic institutions), providing useful, correlated information about the drug market:

The presence of two independent systems offering quantitative and qualitative information about the state of the illicit drug market creates an ideal situation to compare and validate results. It also adds to a more complete picture of the illicit drug market and allows for the specification of which batches of drugs were distributed domestically and which were probably meant for export.²⁰⁶⁶

From an international perspective, the European Trans European Drug Information (TEDI) project combines information from drug checking services in Spain, Switzerland, Belgium, Austria, Portugal, and the Netherlands, and presents a European picture of drug markets. It allows trend analysis and consideration of differences in drug markets between countries. As information about the effects of substances and where drugs were obtained is provided directly by users, this 'creates a system of pharmacovigilance that can be used, and has been used, for further risk assessments of substances'.²⁰⁶⁷

In addition to monitoring NPS and other drugs on the market, drug checking services also facilitate monitoring the profile of people who use drugs, as well as their patterns of drug use. A 2001 EMCDDA report stated that drug checking services typically require service users to fill out questionnaires, which makes them 'very effective in acquiring information that could otherwise only be gathered by using large financial and personnel resources and in assuring a high level of credibility in the eyes of potential consumers of illicit substances'.²⁰⁶⁸ For example, people who use DIMS are considered 'a reasonable reflection of all recreational drug users' in the Netherlands,

²⁰⁶⁴ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, pp. 423-424.

²⁰⁶⁵ Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, pp. 115-116.

²⁰⁶⁶ Brunt, T and Niesink, R, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results, and international comparison', *Drug Testing and Analysis*, vol. 3, no. 9, 2011, p. 629.

²⁰⁶⁷ Brunt, T, et al., 'Drug testing in Europe: monitoring results of the Trans European Drug Information (TEDI) project', *Drug Testing and Analysis*, vol. 9, no. 2, 2016, p. 196.

²⁰⁶⁸ Kriener, H, *An inventory of on-site pill-testing interventions in the EU*, European Monitoring Centre for Drugs and Drug Addiction, Vienna, 2001, p. 15.

enabling DIMS to profile demographic characteristics of recreational users.²⁰⁶⁹ At the Secret Garden Festival in the UK that the Committee attended in July 2017, the drug checking service, The Loop, asked service users to fill out a questionnaire. This information was collected for research being conducted by the University of Durham into trends and perceptions about drinking and drug use. The types of questions asked included demographic information, such as age, where they live, education, ethnicity, and sexuality; in addition to questions about their drug and alcohol consumption practices. From a public health perspective, this is important information to have and otherwise would be very difficult to obtain given that this user group is not typically visible to health authorities. This information can also be used for prevention and early intervention initiatives. Associate Professor David Caldicott similarly noted this benefit when explaining the process of drug checking:

The price of your test is an interview, a discussion about who you are, what you do, what your intentions are, what you think is going on — getting a little bit more information about this otherwise invisible population that we have not a lot of information about.²⁰⁷⁰

Further, Dr Monica Barratt described how drug checking, through the collection of information currently unavailable in Australia, would strengthen the ability to correlate information across a broader range of sources, as well as monitor the impacts of policy changes on the ground:

...there are particular areas where we do not have the sort of information that I see our other colleagues in other countries have. So when I see how they are able to say, 'We have thousands and thousands of samples per year that we're rapidly testing. We're able to see what this discrepancy is between what people expect the drug to be and what it actually is. We're also able to link that to hospitalisations and deaths, and we're able to see connections', then of course when a policy is implemented, that means they have got a system there without spending any additional money to generate the data. They can then say, 'Well, this policy came in there and we can then see this change' or 'no change' or 'an unintended change'. So I think there are some systems we could increase in that respect.²⁰⁷¹

Drug checking services as part of an early warning system

As discussed in chapter four, the Committee supports the development of an early warning system (EWS) to identify and respond to NPS. The EMCDDA-commissioned background paper highlighted the contributions of drug checking services to warnings about specific substances, whether to individuals, event patrons or the public through an EWS. For example, under the Netherland's DIMS that is largely used to monitor drug markets, there are a range of warnings that can be targeted to specific groups or publicised through public media campaigns. Other systems use mechanisms such as publishing results on boards at events, or online for greater access, and where possible and depending on the circumstances, warnings can also be issued within the country or internationally.²⁰⁷²

²⁰⁶⁹ Brunt, T and Niesink, R, 'The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results, and international comparison', *Drug Testing and Analysis*, vol. 3, no. 9, 2011, pp. 623-624.

²⁰⁷⁰ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 481.

²⁰⁷¹ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 429.

²⁰⁷² Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 9.

Given the growing challenge of NPS, the ability to issue swift warnings may have tangible effects in reducing the risk of harms among the broader community. For example, as part of the European EWS, a NPS called 5-IT was ‘quickly withdrawn from sale on the internet’ following news of its riskiness in 2014.²⁰⁷³ Further, other NPS contained in a range of traditional drugs such as MDMA have also been ‘uncovered by drug checking services’.²⁰⁷⁴ Another example explored in chapter four referred to the identification of the substance PMA by the DIMS, which led to wide and rapid distribution of public health alerts. An important comparison is with the UK, which did not have the appropriate systems in place to issue similar warnings and resulted in tragic events:

...DIMS recently reported that each of a batch of pink pills bearing a Superman logo contained 170 mg of PMMA (para-methoxymetamphetamine), an unpredictable compound, and one much more toxic compound than MDMA. In the Netherlands and Belgium, this immediately led to national mass media warning campaigns that included national radio and television broadcasts, posts on social media and on the internet, and flyers and posters at large dance events (Keijsers et al., 2008). The Healthy Nightlife Network (prevention professionals, peer coaches) and first aid professionals were also informed. In the United Kingdom, however, where no drug-checking system was in place at the time, the same pills caused the death of four young people (Hill, 2015).²⁰⁷⁵

The Committee notes that the recent spate of overdoses in Melbourne in late January 2018 were also reported to have likely involved PMA, and drew speculation in the media about the potential role of issuing public alerts. Similarly, stakeholders speculated to the Committee about whether such alerts could also have prevented overdoses that occurred in January 2017 on Chapel Street as a result of concerning substances being sold as MDMA. For example, Dr Monica Barratt advised that, ‘being able to warn that that is out there immediately’ would have been beneficial.²⁰⁷⁶

Influencing the supply of illicit substances

Given the role of drug checking services in monitoring and alerting the public to health concerns, there are some indications that they may have an impact on the types of substances available on the illicit drug market and could lead to the removal of substances found to be unknown or concerning. The 2001 EMCDDA report stated:

From a methodological point of view, it is difficult to assess the influence of pill-testing projects upon the black-market situation. It is, however, realistic to assume that pill-testing projects that offer chemical analyses on a regular basis have some influence at least upon local markets. Overall, to alter black markets is “not a primary goal” or “no goal at all” for most pill-testing projects, even though it may be assumed that in the long run pills that are labelled with “unexpected or especially dangerous content” cannot be sold easily anymore which subsequently has to be seen as a success for public health.²⁰⁷⁷

²⁰⁷³ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 14.

²⁰⁷⁴ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 14.

²⁰⁷⁵ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 13.

²⁰⁷⁶ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 425.

²⁰⁷⁷ Kriener, H, *An inventory of on-site pill-testing interventions in the EU*, European Monitoring Centre for Drugs and Drug Addiction, Vienna, 2001, p. 17.

Further, the 2017 EMCDDA-commissioned background paper suggested that warnings could reduce the availability of these drugs by ‘creating awareness among drug users and deterring dealers from selling the product’ and that:

...the chemical composition of illicit drugs seems to correspond more closely to what is expected in countries with drug-checking systems than in countries without such systems, suggesting that drug testing has some kind of influence on the illicit drug market (Kriener et al., 2001; Parrott, 2004).²⁰⁷⁸

Another recent article regarding the European TEDI project similarly suggested that drug checking:

...can be an instrument to offer some control over a market that is otherwise unpredictable and treacherous. For example, drug dealers and manufacturers will be less inclined to trade in dangerous substances or adulterants if they know that there is a way for consumers to test their product. Also, if a dangerous substance can be identified and localised via a warning campaign, drug traders are more inclined to rapidly withdraw their products from the market.²⁰⁷⁹

Dr Monica Barratt noted that there might be some unease with the idea of such services acting as ‘quality control’ for the illicit drug market, but that the potential benefits outweigh such concerns:

In a way although playing the role of being a quality controller is obviously concerning to people to imagine, if, the other way around, it meant that suppliers were less likely to supply adulterated products, then in the end that is going to be a good outcome.²⁰⁸⁰

18.2.4 Potential issues of concern

The general use of illicit substances

A key concern often expressed about drug checking services is that it will lead to an increase in the prevalence of drug use generally, as people may assume that the presence of these services indicate that drug taking is sanctioned. However, evaluations from some European drug checking services have found that this concern has not been borne out in practice. The European NEWIP Good Practice Standards stated:

Research involving three nations reveals that integrated drug testing methods do not stimulate increased drug use and may even slightly reduce drug use levels among the target audience (Benshop, 2002). In addition, evaluations of the Party Drug Prevention in the City of Zurich shows that since Drug Checking was implemented, the number of people who consume more than one drug or abuse one substance is on the decline (Hungerbuehler, Buecheli, Schaub, 2011).²⁰⁸¹

As identified below, a number of inquiry stakeholders also reiterated this view.

²⁰⁷⁸ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 13.

²⁰⁷⁹ Brunt, T, et al., ‘Drug testing in Europe: monitoring results of the Trans European Drug Information (TEDI) project’, *Drug Testing and Analysis*, vol. 9, no. 2, 2016, p. 196.

²⁰⁸⁰ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 426.

²⁰⁸¹ Ventura, M, et al., ‘Drug Checking Service Good Practice Standards’, Nightlife Empowerment & Well-Being Implementation Project, 2013, viewed 17 August 2017, <http://newip.safenightlife.org/pdfs/standards/NEWIP_D_standards-final_20.12-A4.pdf>, p. 16.

In recommending drug checking services in Victoria, Associate Professor Nadine Ezard noted that, if anything, there would be limited effect on drug use rates:

I think if we look to experience from overseas the presence of those pill-testing facilities - whether they're very accurate or not-so accurate - doesn't seem to change the prevalence of drug use or the acceptance of drug use in those festivals. So if the festival is already one in which people are using drugs, despite the presence of sniffer dogs and other deterrent activities the presence of public health responses doesn't seem to - there seems to be no evidence that it makes things worse, if you like. It doesn't make people take more drugs. On the contrary, there are examples from some of those facilities where people have actually discarded their drugs because they found out it's not what they intended to take.²⁰⁸²

Professor Alison Ritter from the DPMP at NDARC also indicated that evidence from overseas jurisdictions demonstrates the presence of drug checking services does not in and of itself increase drug use:

We also know that one of the risks with pill testing that has been mooted is that it increases the perception that the drugs are safe to use and therefore may inadvertently increase the likelihood of people consuming drugs. The international evidence on this has shown that that is not the case. Pill testing, in association with festivals and entertainment venues, has not been associated with an increase in drug use.²⁰⁸³

In response to a question on this issue, John Rogerson from the ADF emphasised that such concerns are the reason why a trial, and not permanent implementation, would be an important step:

The answer is yes, it could. But the evidence would show that it does not do that. And again that is exactly why we do a pilot on it — to see what the impact is on all the players that are involved in illicit drugs. Particularly if people are contemplating drug use or are using drugs, there is some connection point back to having a conversation with them about that. Yes, the answer is it could. But unless we pilot it and try it we are actually not going to know what the consequences are. Certainly the evidence from overseas is quite positive.²⁰⁸⁴

In 2001, the EMCDDA noted that the lack of evaluation evidence means there is no 'strict scientific proof for the protective impact' of onsite pill testing, but there is also no conclusive evidence that these services promote drug use either.²⁰⁸⁵ In 2017, the EMCDDA-commissioned background paper took a stronger position in refuting claims that these services could result in more illicit drug use:

This criticism appears to be unfounded, and, in fact, it has been shown that drug use does not increase following the introduction of a drug-testing service in a country (Bücheli et al., 2010). In addition, the prevalence of drug use does not seem to be higher in countries that have drug-checking systems in place (EMCDDA, 2016). In addition, previous research has shown that drug users who use testing services

²⁰⁸² Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 118.

²⁰⁸³ Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 19 June 2017, p. 250.

²⁰⁸⁴ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 199.

²⁰⁸⁵ Kriener, H, *An inventory of on-site pill-testing interventions in the EU*, European Monitoring Centre for Drugs and Drug Addiction, Vienna, 2001, pp. 60-61.

do not use more drugs than drug users who do not do so (Benschop et al., 2002). In fact, the same study also found that the presence of drug-checking services did not encourage those who do not use drugs to begin drug use.²⁰⁸⁶

While the possibility of increased substance use as a result of drug checking will continue to be subject to careful consideration, this concern does not appear to be borne out in practice.

Perceptions of 'safe' illicit substance use

A key concern of the Committee regarding drug checking is that it may lead to a perception among individuals who use drugs that, once substances are tested, they are 'safe' to consume. Such concerns include that providing testing information to individuals might 'be seen as affirming the quality and purity of the pill', which may indicate to users that consuming the drug is safe, and that 'false reassurance because of false negative results is a concern'.²⁰⁸⁷ Related to this is the potential for liability issues to arise, although the Committee acknowledges that there have been no such issues from any of the existing international services.

Throughout the inquiry, the perception of the 'safety' of tested substances was a question raised by the Committee with various stakeholders. The overwhelming response from stakeholders was that no drug is ever safe to consume and drug checking services take various steps to ensure that service users are made aware of this, regardless of the results. As explained by John Rogerson from the ADF:

You are actually not saying to a user, 'This drug is safe'. No-one is trying to suggest that. The message has to be to anyone using illicit drugs — it is often with legal drugs, by the way; there is a risk with any drug that we take — we are not saying there is zero risk. We are just helping them understand that the product they are thinking of using has got some ingredients in it which are high risk for them.²⁰⁸⁸

Professor Alison Ritter from the DPMP at NDARC reiterated the firm view that drug checking services never provide messages of safe use:

...no pill testing service — and they operate around the globe — ever says that a drug is safe. The message is always, 'This drug contains X or Y. Let's talk about the potential impacts that this drug might have on a person consuming it'.

Unfortunately Dr Monica Barratt could not join us due to technical difficulties, but she has been spending the last month visiting a number of the pill testing facilities around Europe and has personally confirmed to us that there is no verbal or written message that because a drug comes back with X substance in it, it is then advised that it is safe to consume, because everybody knows that no drug is safe to consume.²⁰⁸⁹

When Dr Monica Barratt was able to speak to the Committee herself, she elaborated on the approach adopted by various drug checking services to ensure that a perception of 'safe' illicit drug use is avoided:

²⁰⁸⁶ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 12.

²⁰⁸⁷ Schneider, J, et al., 'Pill testing at music festivals: can we do more harm?', *Internal Medicine Journal*, vol. 46, no. 11, December 2016, p. 1249.

²⁰⁸⁸ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, *Transcript of evidence*, 19 June 2017, p. 199.

²⁰⁸⁹ Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 19 June 2017, p. 250.

...a program such as this can never say that a drug is safe to take. A drug is never safe to take. There are safer situations and there are more dangerous situations, but there is never a safe situation when it comes to taking a drug. If you want to remove all possible risk, then there would be no psychoactive drug taking at all. We know that for many people that is not the way that they living; that is not the way that most of us live in terms of all psychoactive substances. So psychoactive substances are out there. This is quite a pragmatic response in that respect.

I guess that what I have noticed is that the services that have been running for many years, for decades — the Spanish service and the Dutch service — all make the point that these drugs are not safe to take.²⁰⁹⁰

A number of stakeholders also emphasised the role of clear communications to service users to ensure they are aware that no drug taking is safe. Bevan Warner, Managing Director of Victoria Legal Aid (VLA) considered that:

...I do not think a testing regime is risk-free, nor do I think making a testing regime available to people creates an admission of liability on the part of the person who is providing the testing regime to say, 'Well, I'm guaranteeing something for you in terms of a consumer outcome'. I think what it is doing is saying, 'There's a personal responsibility you have got about what you put into your body. We wish you didn't, but if you're going to, you might want to understand the facts of this particular pill as best we know it'.²⁰⁹¹

Associate Professor David Caldicott also refuted these claims as a misrepresentation, describing an example that, while 75 milligrams of MDMA is currently being trialled in the United States as a medicine, he has 'seen people who have been harmed by 50 milligrams', and thus, in terms of the advice given to a person as part of drug checking:

...I will not be telling them that this is a good batch or that it is cleared. When somebody returns something that appears to be less than 100 milligrams, they will be advised that — and it is part of the advice that is given in the script — that at no stage on any occasion for any drug is drug consumption in this environment safe. If you intend to be — and this is in the script — 100 per cent safe from illicit drugs for this music festival, you should not consume any drugs. This is quite explicit.²⁰⁹²

A related concern of the Committee is that drug checking services might be misused by drug suppliers, by using information provided by drug checking services to promote 'the safety' of their products.²⁰⁹³ While acknowledging this possibility, Dr Monica Barratt considered that there are strategies that can be used to mitigate against this risk, for example through providing verbal advice only and having strict entry requirements:

Dr BARRATT — So I think a lot of testing services have tried to reduce that chance — I do not think that they can fully eliminate the chance of word of mouth. They cannot eliminate the word of mouth. If someone wants to come in posing as a consumer and they have one ecstasy tablet on them and they put that forward and then they go off and want to use word of mouth to promote that they got it tested, it is hard to reduce

²⁰⁹⁰ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 425.

²⁰⁹¹ Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 232.

²⁰⁹² Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 483.

²⁰⁹³ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 12.

that. Having said that, that is not really any different from hearsay when it comes to a consumer talking to a dealer about their drugs. The dealers already say things like this. They already say ‘It’s great. It’s quality’.

Ms PATTEN — ‘It is the best you will find.’

Dr BARRATT — So what all these services do is they do not, for example, provide written information, because written information that says, ‘This contains X, Y, Z’, could then be passed off or passed around. So there are different variations on what they have tried to do. Many of them have also said, ‘Look, you must never bring a suppliable amount to our service’. So they make it clear that you cannot do that. There is a whole bunch of things they try to do.²⁰⁹⁴

Associate Professor David Caldicott similarly highlighted that, currently, suppliers rely on personal recommendations of individual users, an issue that would not necessarily be affected by the presence of drug checking services:

The knock-off effect of illicit drugs is already happening on the basis of individuals’ personal recommendations. So what we would be doing is merely reflecting the true nature of what is in substances. The information that we would be releasing publically and hammering home would be pertaining to the drugs which are harmful. I would put it to you, Sir, that a regular stream of information regarding drugs that are potentially harmful to your health serves as a significant disincentive to the market at large, rather than providing any reassurance, particularly if that information is coming from a neutral source such as a medical one.²⁰⁹⁵

The Committee acknowledges the evidence provided in response to these concerns and wishes to reiterate the harm reduction information and advice that accompanies the test results, and the benefits arising from this. As explained by the EMCDDA-commissioned background paper, drug checking services must be equipped to provide clear messages that avoid perceptions of ‘safe’ use:

Every form of drug use is potentially hazardous, and there is no way to completely eradicate the risk. However, when drug checking is thoroughly embedded in a prevention unit, staff have to the opportunity to communicate scientific information about the test results and educate users about general drug risks, thereby eliminating this false sense of security.²⁰⁹⁶

Technological limitations

A key concern explored by stakeholders was the limitations of the technology used in drug checking. The range of techniques vary from colorimetric reagent testing (inexpensive but low rates of accuracy) to more sophisticated models that are expensive but provide greater accuracy of results.²⁰⁹⁷ Some stakeholders indicated that, despite progress, some limitations still exist with all types of current testing mechanisms. These concerns are particularly pertinent in relation to the emergence of NPS as an adulterant in drugs, for example as stated by Dr Dimitri Gerostamoulos from the VIFM:

²⁰⁹⁴ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 425.

²⁰⁹⁵ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 483.

²⁰⁹⁶ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 11.

²⁰⁹⁷ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 7.

So, for example, if we hypothetically are saying that we are the agency that is providing that pill testing, we can only test for about 140 of those and we know there are some other 500 of those compounds that we cannot test for. So that would be a problem in terms of saying, 'This pill contains this particular drug, but we just do not know what else it may contain'. That is the difficulty with pill testing. So there are pros and cons to that. There are some good European papers that point to the effectiveness of pill testing, but there are still some holes in the approach.²⁰⁹⁸

Similarly, David Ruschena, General Counsel of Alfred Health stated:

...the assumption that pill testing makes is that it is possible to identify the substance in the pill. With the massive proliferation of new synthetic substances that are not yet identifiable, as well as the accidental creation of synthetic substances from variations in the manufacturing process, the idea that a pill tester will actually be able to accurately identify everything that is brought to a rave is a little bit optimistic.²⁰⁹⁹

A related issue discussed is that reactions to substances may be influenced by individual factors and poly-drug use, rather than the drug itself, which would reduce the utility of undertaking the drug checking:

The same dose of drug administered to different people may produce markedly different responses. Observed differences may be because of any number of factors, including genetic polymorphism, interaction with other co-administered drugs and physiological factors affecting drug distribution and elimination.²¹⁰⁰

In terms of the Victorian Government's opposition to drug checking, Kym Peake, Secretary of the DHHS advised that:

...there are limitations on the ability to actually know exactly what is in any particular pill...as well as of course all of those factors around an individual, such as their weight, their general health condition and all of the factors that contribute to overdose.²¹⁰¹

Mr Gary Christian, Research Director from Drug Free Australia also considered that the harms stem from individual reactions to the drug, rather than issues such as purity:

When you go to the science on it and you consult coronial findings, you find that ecstasy is the thing which is named every time as the killer; it is not the additives, and it is not the purity. People are dying because of individual physiological reactions to the drug, or they are having it with drug cocktails. It is not purity that is the big issue, and it is certainly not additives that are the issue, certainly in Australia.²¹⁰²

In the context of rapid testing kits, Dr Dimitri Gerostamoulos of the VIFM noted that these tests are largely ineffective and inaccurate. In terms of being able to have a mobile laboratory with more sophisticated equipment, he suggested this:

...requires people who can test a range of these compounds, and even then they will not detect all of the compounds that are available. You will not be able to determine potency from these. You will be able to identify that it is a particular drug and the

²⁰⁹⁸ Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 216.

²⁰⁹⁹ David Ruschena, General Counsel, Alfred Health, *Transcript of evidence*, 19 June 2017, p. 244.

²¹⁰⁰ Schneider, J, et al., 'Pill testing at music festivals: can we do more harm?', *Internal Medicine Journal*, vol. 46, no. 11, December 2016, p. 1250.

²¹⁰¹ Kym Peake, Secretary, Department of Health and Human Services, *Transcript of evidence*, 4 September 2017, p. 326.

²¹⁰² Gary Christian, Research Director, Drug Free Australia, *Transcript of evidence*, 21 August 2017, p. 280.

relative potency depending on how much you use and who uses that and what other drugs they are taking — that is an important component — so additionally whether there is alcohol present or a number of other serotonin drugs that potentiate these drugs.²¹⁰³

Dr Dimitri Gerostamoulos also explained that the nature of the illicit drug market means that there is no certainty that testing a substance in one batch would be reflective of other batches:

...there is no quality control with any of these drugs. You do not know that if you get a particular batch that contains this particular agent it will also contain the same amount in a subsequent batch or in a comparative batch. These drugs are not manufactured to a pharmaceutical standard. Often there is a range of impurities, a range of other drugs that are unknowingly produced as part of the synthesis surrounding these drugs. So you can get differences in batches. While they might contain ideally the one agent, they may contain a number of agents, and often agents that are not thought to be there, which is often the way that these drugs are presented.²¹⁰⁴

This concern has been echoed in relation to drugs produced within one batch, noting the the lack of standards in the production of illicit substances means there is likely to be ‘uneven distribution of drug’, so that some tablets in a batch would have a small dose whereas others could have higher doses.²¹⁰⁵ The Committee is aware, however, that when advising service users of their test results, drug checking services are very clear that the result relates only to that specific substance.

Catherine Quinn, Assistant Director, Analytical Services of the Forensic Services Department at Victoria Police, also told the Committee of her concerns with current drug checking technology:

The 20-minute pill test for somebody’s safety in taking it does raise questions with me about the science that can be applied, because I can spend a lot of time analysing an illicit substance and never determine everything that is in it. That is after 32 years in that. So I think there is always that question when you do it. You might analyse it in that 20-minute analysis, and depending on the degree of technology that you apply to that you might find a particular substance like an NBOMe, which is dangerous — yes, that is a dangerous substance — but you may not identify other things in there. Or you may identify MDMA in there and not identify the PMA because of the level or purity, and that has an effect.

So I think the complexity in our market is very complex. It is not as straightforward as ‘there is methamphetamine’, ‘there is ecstasy’ or ‘there is whatever’. It is very poly drug — often in the same substance, in the same presentation.²¹⁰⁶

On the other hand, Associate Professor David Caldicott emphasised that the objective of the technology is not to provide information to a service user to a legal standard, but rather to provide accurate information that may result in a change of behaviour.

2103 Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 211.

2104 Dimitri Gerostamoulos, Chief Toxicologist, and Head, Forensic Sciences, Victorian Institute of Forensic Medicine, *Transcript of evidence*, 19 June 2017, p. 215.

2105 Schneider, J, et al., ‘Pill testing at music festivals: can we do more harm?’, *Internal Medicine Journal*, vol. 46, no. 11, December 2016, p. 1250.

2106 Catherine Quinn, Assistant Director, Analytical Services, Forensic Services Department, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 458.

Consequently, while there are things that cannot be measured through drug checking, major issues such as particularly harmful drugs, can be identified, and warnings where there are gaps are used to mitigate against risks:

...in the testing that we do or that we propose it would be difficult for me to say that I could prosecute a legal case on the basis of what our results would be. But I am not trying to do that. I am trying to do something far more subtle than that. What am I trying to do is I am trying to change a behaviour. So it is not just the testing results that we use. The fact that I am there, a very senior element of the medical community, dressed up like a clown in my white coat, for what it is worth, and providing advice about why young people should not consume drugs, has a very much super-added effect on the behaviour of young people. What I know our testing can do is identify anything that is going to kill someone, and that is very important. Can I identify all of the different sugars that might be present in the make-up or the filling of the drug? No. Could I identify a novel psychotropic substance that has been identified previously? Yes. Could I identify a novel psychotropic substance that has never been identified before now? No. That is why we have tiers of warning.²¹⁰⁷

The 2017 EMCDDA-commissioned paper further suggested that such concerns particularly highlight that advanced laboratory equipment is required to ensure service users are provided with results that are as accurate as possible, but that this is an issue of funding, rather than the drug checking service itself:

...most of these techniques require complex sample preparation and specialised operating staff, and take a relatively long time and incur high costs... In fact, the criticism that the results of some drug-checking services are unreliable and of limited utility, which can be attributed to a lack of advanced drug-testing equipment, is a problem not so much of drug checking as of a lack of proper funding.²¹⁰⁸

Bevan Warner from VLA also suggested that advancements in the available technology would naturally follow suit if drug checking became a priority for governments and the appropriate investments are made:

If there was a positive commitment to testing, the science would quickly follow and the means of actually communicating results to people's handheld devices would follow pretty quickly. Because we do not have a permissive regime, we have not done all the things as a society that we would normally do to produce a consumer chain or a product or an appropriate response.²¹⁰⁹

This sentiment was shown to be true, as following approval from the ACT Government for its drug checking trial as discussed earlier, Associate Professor David Caldicott informed the Committee that numerous companies contacted the drug checking service to offer their equipment, resulting in an "embarras de choix" of technologies to choose from...²¹¹⁰

Further, the EMCDDA-commissioned background paper encouragingly highlighted that the accuracy of drug checking technology is progressing and may provide more reliable testing of substances. In particular, the UK's drug checking service and the Netherlands DIMS use particular technology, Fourier transform infrared spectroscopy (FT-IR), that enables qualitative and quantitative testing, and can be undertaken on site at events. However, there is still a continuing challenge of identifying NPS,

²¹⁰⁷ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 478.

²¹⁰⁸ Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, p. 15.

²¹⁰⁹ Bevan Warner, Managing Director, Victoria Legal Aid, *Transcript of evidence*, 19 June 2017, p. 232.

²¹¹⁰ Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 478.

as well as small amounts of known compounds.²¹¹¹ As discussed earlier, during the Committee's study tour, it observed the FT-IR in practice at The Loop's drug checking service, including that 97 per cent of tested substances were identifiable using the TicTac database.²¹¹² With the FT-IR and other advanced technologies, the Committee also heard that a key barrier is obtaining approval for trained professionals to operate it. Again, this highlights that shortcomings in testing processes are not necessarily related to technological limitations, but to surrounding arrangements requiring government support as noted by Associate Professor David Caldicott:

If legislators and law enforcement want a better technology, then they have to agree that there should be a dispensation for the testers to be able to, say, grind up, handle, solubilise product, so there is a compromise between the technology and what law enforcement feels comfortable in letting the testers do. If we had carte blanche, I could quite easily deploy, probably within a fortnight, the very best of what is available in Europe, certainly in my jurisdiction.²¹¹³

The Committee acknowledges that it received a diversity of views on this issue, and that technology will continue to be a key issue that requires ongoing development. It also requires a general understanding among service users and the public of current capabilities and limitations of drug checking services. However, the Committee also considers that new technologies are being developed, and testing processes used today have also progressed significantly since the early days of reagent testing kits to now where there is greater utilisation of laboratory-grade equipment. These developments signify to the Committee that, while the technological barriers are significant, they are not insurmountable to the issue of drug checking.

18.2.5 'Back of house' or 'halfway house' onsite testing

The *Victorian Government Code of Practice for running safer music festivals and events*, published in 2013, outlines that while illicit drug use is not condoned, 'the Victorian Government supports a harm reduction approach, which aims to eliminate or minimise illness or injury (which may result in death) associated with drug use, which may occur at dance party events'.²¹¹⁴

The Committee considers that, as an effective first step in this area, 'back of house' or 'halfway house' testing should be established at appropriate music festivals, where police, health authorities and harm reduction organisations work together to identify substances of concern through testing, and notify patrons and the broader community of this where relevant. These services would not be public facing, meaning that patrons themselves would not have their substances tested, but such decisions would fall to authorities to test substances in particular circumstances, including when there is a suspected overdose or serious adverse consequences arising from use of an illicit substance. The Loop has been conducting these services since 2013:

The Loop, a not for profit NGO, introduced forensic drug testing for public safety at nightclubs in autumn 2013 (at the Warehouse Project) and at festivals in summer 2014 (at Parklife). This testing has been characterized as 'halfway house' testing because

2111 Brunt, T, *Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges*, European Monitoring Centre for Drug and Drug Addiction, Lisbon, 2017, pp. 15-16.

2112 Law Reform, Road and Community Safety Committee, *Report on international study tour: Inquiry into drug law reform*, Parliament of Victoria, East Melbourne, 2017, p. 36.

2113 Associate Professor David Caldicott, Emergency Consultant, *Transcript of evidence*, 13 November 2017, p. 479.

2114 Department of Health and Human Services, *Code of practice for running safer music festivals and events*, State Government of Victoria, Melbourne, 2011, p. 22.

it involves testing substances of concern obtained from on-site services including (primarily) police and security seizures on the door and inside the venue; amnesty bin contents; and also to a lesser extent substances given to the testers by medical, welfare and cleaning services on site. Results are disseminated to emergency services and staff on site and, where appropriate, to the wider public via on-site signage and social media. On site testing is carried out by a team of experienced volunteer chemists through The Loop and under the guidance of Fiona Measham, Director of The Loop and Professor of Criminology in the School of Applied Social Sciences at Durham University.²¹¹⁵

Professor Fiona Measham, Director of The Loop provided further details on this form of testing in an article she wrote in 2016:

Three years ago, frustrated at the absence of harm reduction advice for recreational drug users, I co-founded The Loop to provide on site information and interventions. We also introduced what I call ‘halfway house’ testing as an additional limb of The Loop’s service delivery, facilitated by developments in testing technology. It is possible to carry a suitcase-sized laser to a festival that can identify any known drug to an impressive level of accuracy in 60 seconds. We introduced forensic testing at the Warehouse Project (still the only UK club to have on site testing for public safety) in 2013, and then at a number of festivals including Parklife, for which we won the UK Festival Award 2014 for Best Use of New Technology.

‘Halfway house’ testing is distinct from ‘back of house’ police operations because we test substances of concern obtained from *any* on site services, not just seizures, confiscations or amnesty bin donations. This includes medical, welfare and security incidents, with results circulated to *all* on-site services. This also allows The Loop to monitor drug trends, identify risky substances in circulation and put out real-time alerts to inform festival goers and the wider public about drugs in circulation. For example, at a Manchester festival this summer The Loop tested ecstasy pills varying in strength from 20-250mg of MDMA on just one day at just one festival. The risks of festival drug use can also extend beyond the festival and irresponsible retail practices on site. For example, high strength ecstasy pills recently led to the hospitalisation of three young girls who raided their uncle’s festival stash.²¹¹⁶

The Committee also heard from Dr Monica Barratt from the DPMP at NDARC on this type of testing, who shadowed Professor Fiona Measham when it was being conducted:

I think what was interesting shadowing Fiona at The Loop in Manchester was that I was there for about 5 hours in this place — we were not doing front-of-house testing at that point; what they were doing there was back of house — and police and welfare officers were coming in with samples occasionally and saying, ‘Can you please put these at the front of the queue because so-and-so has brought this in and we want to know what it is’. That happened five times within about 3 hours. This service was dealing mainly with police-seized drugs that were not needed for any kind of prosecution and trying to understand what kinds of substances would have been on-site — and one would assume were on site but were not getting caught. They were able to look at that through that system as a monitoring service.²¹¹⁷

The Committee considers that such a service would be an integral part of the Committee’s recommendation for an EWS and a 24/7 clinical toxicology service (see chapter four) to provide crucial information to relevant authorities on substances

²¹¹⁵ The Loop, ‘On-site Drug Safety Testing’, viewed 1 February 2018, <<https://wearetheloop.org/testing/>>.

²¹¹⁶ Measham, F, ‘Time To Test: The Festival Drug Report - Part II’, volteface, 2018, viewed 1 February 2018, <<http://volteface.me/features/the-festival-drug-report-part-ii/>>.

²¹¹⁷ Dr Monica Barratt, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre - UNSW, *Transcript of evidence*, 18 September 2017, p. 424.

of concern. It would also assist to provide effective and timely responses, including in health settings where clinicians would be equipped with greater knowledge of the substances involved in emergency cases. This will also ensure that relevant information is provided to patrons and the general public through alerts if there is a risk posed by particular substances. All authorities and relevant organisations, particularly DanceWize, should be involved with determining the parameters of this service; the information flows; and maintaining a strong level of collaboration to ensure the service's effective operations.

RECOMMENDATION 48: The Victorian Government work with the Department of Health and Human Services, Victoria Police, Ambulance Victoria and DanceWize to facilitate the availability of an onsite drug testing unit for health and law enforcement authorities at an appropriate music festival to be used in the event of a suspected overdose or other serious adverse effects due to an illicit substance. The unit would not be public facing and its purpose is to test substances to determine their composition to assist health authorities treat the patient and, where appropriate, release a public alert to prevent further incidents. The unit will operate as part of the early warning system as recommended in chapter four.

18.2.6 Fixed laboratory drug checking service

There are a range of fixed site drug checking models proven to be effective in reducing harms from illicit drug use and improving monitoring, while mitigating risks such as perceptions of 'safe' substance use. As already outlined, many stakeholders supported the establishment of a fixed drug checking model, particularly noting the effectiveness of the Netherlands DIMS. For example, NDARC recommended the adoption of a model similar to the DIMS, which would require: legislative change to allow its operation; trained health workers and technicians to operate laboratory equipment providing both qualitative and quantitative information on samples; staff providing brief interventions and harm reduction advice to all service users; and sharing information obtained through the service to police and health workers, particularly in the case of dangerous substances or new substances.²¹¹⁸ The Burnet Institute also recommended a similar fixed site system, to provide laboratory-grade testing and 'identify misrepresentations and mixtures of particular danger, and issue public warnings as needed'.²¹¹⁹

As discussed earlier in the chapter, fixed laboratory drug checking services can offer a range of benefits, such as a greater opportunity to engage meaningfully with service users in quiet environments, and the ability for more sophisticated technologies to be used to improve accuracy of results.

Guidelines to support a fixed site may cover issues such as appropriate technology, data collection, communication to individual service users on issues such as harm reduction and avoiding perceptions of safety, and articulating its links to the broader EWS. Other issues for consideration include protecting staff and service users from arrest and prosecution, and protecting against potential civil liability claims. Broadly, these concerns can be addressed in similar ways to other harm reduction services, such as needle and syringe programs (NSPs) and medically supervised injecting centres (MSIC). In its submission, Unharm suggested that Victoria Police protocols which protect people who access NSPs could be used to protect users of drug checking services:

²¹¹⁸ National Drug and Alcohol Research Centre - UNSW, *Submission*, no. 164, 17 March 2017, p. 8.

²¹¹⁹ Burnet Institute, *Submission*, no. 165, 17 March 2017, p. 9.

Victoria Police Operating Procedures instruct police that ‘the vicinity of NSPs [needle and syringe program sites] must not be targeted solely for the purpose of enforcing use or possession laws’ and that ‘attending a NSP is insufficient grounds on its own to establish reasonable grounds to search a person under s.82, Drugs, Poisons and Controlled Substances Act 1981.’ This provides a model for how police could operate in relation to drug safety testing services.²¹²⁰

According to Butterfield et al, the Sydney MSIC also provides an example of how harm reduction service staff and users are exempt from laws that prohibit the handling of materials suspected to be illicit substances.²¹²¹ The *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017* to establish a MSIC in North Richmond contains similar provisions.

According to Unharm, civil liability issues also need to be considered as there is the potential for claims to be made where a substance has been tested by a service and then consumed, but the person experiences adverse events from that consumption. These issues have not yet been clearly settled in law or policy. It suggested that the Sydney MSIC legislation provides ‘an example of an enabling legislative framework that could be adapted’ for this purpose:

The Sydney Medically Supervised Injecting Centre is a place where people can inject drugs under the supervision of medical staff. NSW Drugs Misuse & Trafficking Act 1985 Part 2a - Medically Supervised Injecting Centres, Division 4 exempts users of the centre from liability for possession of, administering or attempting to administer a small quantity of a prohibited drug. The Division also exempts ‘persons engaged in conduct of licensed injecting centre’ from offences prescribed by the Act and from ‘civil liability in connection with conduct of licensed injecting centre’.²¹²²

The *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017* also contains similar provisions regarding civil liability issues.

As has been emphasised throughout this report, there is a very clear need for health and law enforcement authorities to work collaboratively to reduce drug-related harms. On this basis, the Committee believes that Victorian Police should continue their role in disrupting the trafficking of illicit substances, while also recognising that individual users respond better to supportive and non-judgmental harm reduction messages.

RECOMMENDATION 49: The Victorian Government refer to the proposed Advisory Council on Drugs Policy the issue of drug checking services, and request that it monitor overseas and domestic models to obtain relevant evidence to inform consideration of a trial in Victoria. If appropriate, the Council should develop guidelines for such a trial (and include appropriate messaging e.g. not condoning drug use nor indicating that drug use is safe, appropriate technology, data collection and clear liability safeguards). The Council should also consider an evaluation framework to measure the future trial’s effectiveness in minimising drug-related harms.

²¹²⁰ Unharm, *Submission*, no. 182, 17 March 2017, p. 18.

²¹²¹ Butterfield, R, et al., ‘Drug checking to improve monitoring of new psychoactive substances in Australia’, *Medical Journal of Australia*, vol. 204, no. 4, 2016.

²¹²² Unharm, *Submission*, no. 182, 17 March 2017, p. 19.

18.3 Drug detection dogs

A number of submissions addressed the role of drug detection dogs (also called passive alert detection, or PAD, dogs) that are employed as a law enforcement strategy by Victoria Police at public events such as music festivals where illicit drug use is likely. The purpose of this strategy is to deter and reduce the personal use and possession of illicit substances, and prevent the supply and trafficking of such substances at these events. Dr Peta Malins, Lecturer in Justice and Legal Studies at RMIT University, explained that this strategy uses drug detection dogs for ‘general’ detection work as opposed to ‘specific’ detection work, where the dogs are relied upon to support reasonable suspicion for police to undertake a search:

In contrast to ‘specific’ detection work, where dogs are used to locate drugs on a property following a search warrant, in these contexts the dogs are used for ‘general’ detection work. This means that they are used to home in on people who may be carrying drugs and to support the reasonable suspicion needed to justify a search of them or their property.²¹²³

Dr Peta Malins also contextualised the situation of drug detection dogs in Victoria, compared to Sydney where there is a much greater use of dogs in areas such as train stations, streets, nightclub areas, parks and beaches. In Melbourne, they are typically deployed at festivals and dance party events, in the city and further out. However, Dr Peta Malins noted that recent police initiatives in Melbourne, particularly Operation SafeNight, have seen drug detection dogs ‘brought out in a much more intensive way’.²¹²⁴ Wendy Steendam, Deputy Commissioner of Capability at Victoria Police, told the Committee that drug detection dogs in the context of music festivals are ‘a key component of our operational response and critical to part of our policing of the supply of illicit drugs’.²¹²⁵

Stakeholders who commented on drug detection dogs focused on two particular issues – their potential role in increasing drug-related harms, and evidence demonstrating their lack of efficacy in deterring the supply and use of illicit drugs. The Committee notes there is limited research in this area in the broader literature, with the main research piece being a 2006 Review of the New South Wales (NSW) *Police Powers (Drug Detection Dogs) Act 2001* by the New South Wales Ombudsman (the NSW Ombudsman report).²¹²⁶ Relevant findings from this are discussed below.

18.3.1 Potential role in increasing drug-related harms

A range of stakeholders expressed concern with the possible risk of increased harms resulting from the presence of drug detection dogs at events such as music festivals.²¹²⁷ Dr Peta Malins presented findings of her qualitative research in this area, based on interviews with ten stakeholders and 20 people that had been searched by drug detection dogs. She suggested that these operations do not deter illicit drug use,

²¹²³ Dr Peta Malins, *Submission*, no. 196, 17 March 2017, p. 2.

²¹²⁴ Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 362.

²¹²⁵ Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 463.

²¹²⁶ NSW Ombudsman, *Review of the Police Powers (Drug Detection Dogs) Act 2001*, Sydney, 2006.

²¹²⁷ Victorian AIDS Council, *Submission*, no. 206, 21 March 2017, p. 6; Unharm, *Submission*, no. 182, 17 March 2017, p. 11; Students for Sensible Drug Policy Australia, *Submission*, no. 214, 29 March 2017; Harm Reduction Victoria, *Submission*, no. 188, 17 March 2017, p. 38; Harm Reduction Australia / Family Drug Support, *Submission*, no. 112, 15 March 2017; Aran Burns, *Submission*, no. 157, 17 March 2017, p. 1; Associate Professor Nadine Ezard, *Transcript of evidence*, 23 May 2017, p. 115.

but rather transform use practices among individuals to avoid detection, for example through: consuming drugs immediately when they see the dogs rather than spacing out use over time, using drugs prior to arriving at an event ('pre-loading'), hiding drugs internally, buying drugs inside the venue, and carrying drugs that are less likely to be detected.²¹²⁸ Dr Peta Malins believes that these practices increase the risk of harms:

Most of the adaptations that people talked about carry with them significant increased risks of harm. The risks of harm from panicked ingestion obviously have a higher likelihood that somebody might overdose or run into some significant health impacts from that panicked ingestion, or simply just feel really sick for that whole weekend that they are away — or the whole day that they are at the festival.

Preloading — similarly the kinds of ways in which the temporality of the drug use affects people means that they might be experiencing peaks — taking more drugs beforehand because they know they are not going to have any inside an event or festival and then already experiencing increased drug effects on the way to an event or lining up for an event or as soon as they get to the event. So it impacts the ways in which people manage their experiences of drug use.

Buying drugs inside is similarly problematic because of the ways in which people's quality control goes down when they are buying from people that they do not know rather than somebody that they might have already purchased drugs from before. That can impact also on their experiences of knowing how much of a drug to take and those kinds of things. Changing drugs can be a huge risk. If people are taking drugs they are less familiar with and they do not know the effects of, they can run into trouble with that. Stashing drugs internally also runs other particular health risks.²¹²⁹

Dr Peta Malins suggested that there are also broader social and emotional harms caused by drug detection dogs, for example that 'there were emotional and social harms emerging from the dog use as well — people are talking about stigma, shame, service avoidance'.²¹³⁰

Some stakeholders highlighted particular deaths where they speculated that the presence of drug detection dogs contributed to a person ingesting their substances all at once. In its submission, Unharm described that:

...fear of being detected with prohibited substances has been implicated directly in the deaths of young people in Australia. Twenty-three year old James Munro died after taking three ecstasy tablets prior to entering Defqon1 in NSW in 2013. His father Stephen explained to ABC's 7:30 Report 'There was a police presence at the gates and a concern he would be detected.' The coronial investigation into the death of Gemma Thoms at the Perth Big Day Out 2009 found that 'the deceased started to panic and she became scared of getting caught by the police with the drugs. She was concerned that there were police sniffer dogs in the area that would be able to detect the drugs... The deceased swallowed the remaining 2 tablets in her possession.'²¹³¹

Stephanie Tzanetis from DanceWize at HRV similarly discussed anecdotal evidence, suggesting she knew 'at least two anecdotal situations where people died' due to panicking and ingesting substances.²¹³²

²¹²⁸ Dr Peta Malins, *Submission*, no. 196, 17 March 2017, p. 2.

²¹²⁹ Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 363.

²¹³⁰ Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 363.

²¹³¹ Unharm, *Submission*, no. 182, 17 March 2017, p. 11.

²¹³² Stephanie Tzanetis, Program Coordinator, DanceWize, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 68.

The NSW Ombudsman report also explained anecdotal concerns that drug detection dogs have an impact on the behaviour of people who use drugs, broadly similar to the issues raised by Dr Peta Malins:

The police use of drug detection dogs in public places where drug users either consume drugs, or access health services, may actually encourage harm, albeit unintentionally. We received various reports suggesting that drug users were engaging in risky drug taking strategies in an attempt to avoid detection. Such strategies included: the consumption of larger amounts of drugs at once instead of taking smaller amounts over a period of time; consuming drugs at home and then driving to entertainment venues; purchasing drugs from unknown sources at venues to avoid carrying drugs; and switching to potentially more harmful drugs such as GHB in the belief that these drugs are less likely to be detected by drug detection dogs.²¹³³

Further, a study in 2012 where people who use drugs across Australia were interviewed about their experiences with drug detection dogs found that ‘a minority of illicit drug users fear persecution and hastily consume their drugs upon sighting the dogs,’ which could signify a public health concern.²¹³⁴

On the other hand, Wendy Steendam, Deputy Commissioner of Victoria Police, considered that, while this is an issue that has been raised over a long period of time, this needs to be balanced against ‘the affect of actually allowing a drug trafficker into those environments and the harm that can actually occur’.²¹³⁵

18.3.2 Effectiveness in reducing the supply and use of illicit drugs

As well as being concerned with the potential for harms, some stakeholders indicated there is limited evidence demonstrating the effectiveness of drug detection dogs in reducing the supply and use of illicit drugs.²¹³⁶ For example, according to Dr Peta Malins:

Despite being presented as reliable, effective and efficient, general drug detection dogs:

- (1) have a high false positive rate (of up to 75%), resulting in many people undergoing body and property searches without drugs being found (NSW Ombudsman 2006);
- (2) are not detecting the majority of people carrying drugs past them;
- (3) are very resource intensive (including costs of breeding, training, feeding, housing, medical care, and staffing) relative to incidences of drug seizures or arrests (Parliament of NSW 2016);
- (4) do not act as a substantial drug consumption deterrent or reduce overall drug use levels (Hughes *et al* 2017, Dunn & Dengarten 2009).²¹³⁷

2133 NSW Ombudsman, *Review of the Police Powers (Drug Detection Dogs) Act 2001*, Sydney, 2006, p. vii.

2134 Hickey, S, et al., ‘Drug detection dogs in Australia: more bark than bite?’, *Drug and Alcohol Review*, vol. 31, no. 6, 2012, p. 781.

2135 Deputy Commissioner Wendy Steendam, Deputy Commissioner Capability, Victoria Police, *Transcript of evidence*, 13 November 2017, p. 464.

2136 Victorian AIDS Council, *Submission*, no. 206, 21 March 2017, pp. 6-7; Drug Policy Australia, *Submission*, no. 192, 17 March 2017, p. 1; Stephanie Tzanetis, Program Coordinator, DanceWize, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 68.

2137 Dr Peta Malins, *Submission*, no. 196, 17 March 2017, p. 4.

In supplementary evidence, Victoria Police advised the Committee that it measures the effectiveness of these operations according to arrest numbers:

...during 2017, these dogs were used by Victoria Police at 16 music festivals and 330 arrests were made as a result of detections. During the previous year (2016), PAD dogs were used by Victoria Police at 12 music festivals and 249 arrests were made as a result of detections.

The effectiveness of PAD dogs in reducing the supply and use of illicit drugs is measured by Victoria Police by the number of arrests made as a result of these deployments, as detailed above.²¹³⁸

The NSW Ombudsman report discussed a range of issues relating to the accuracy and effectiveness of drug detection dogs. It reported that, over a two-year period and 470 drug detection dog operations at various locations including dance parties, illicit drugs were only found in 26 per cent of searches that were conducted following an indication by a drug detection dog (based on scent). This result raised questions for the NSW Ombudsman regarding the accuracy of drug detection dogs, stating that it ‘casts doubt’ about police relying on the indications of drug detection dogs to search people.²¹³⁹ The report also stated that the dogs were not effective in targeting drug supply:

We were not able to find, nor were NSW Police able to provide, any evidence that the use of drug detection dogs disrupted low-level street dealing in a sustained manner. Similarly, we were not able to identify any evidence that the use of drug detection dogs has had a deterrent effect on drug users, or led to a reduction in drug-related crime. Nor were we able to measure any appreciable increase in perceptions of public safety as a result of high visibility policing operations utilising drug detection dogs. Further, there was no evidence that police obtained intelligence information during drug detection dog operations that led to further investigation of drug supply.²¹⁴⁰

Stephanie Tzanetis from HRV expressed similar concerns about the effectiveness of drug detection dogs, and suggested that this has implications for relations between people attending music festivals and police:

The thing I am also very concerned about is the false detections, where people do not have substances on them but they get strip-searched. Approximately 80 per cent of detections are false detections and that can be the first encounter that people ever have with police...Now, the first encounter most young people are going to have with police is being screened by sniffer dogs and then possibly strip searched when they have not done anything wrong. That is worrying, especially if people get inside and they are doing something which might be high risk, like using drugs — and unfortunately that is something that does happen; that is a reality — people are less likely to put their hand up and ask police for help when something is going wrong. So that is sniffer dogs. It is ineffective and it is potentially more dangerous as well.²¹⁴¹

Further, Dr Peta Malins of RMIT University indicated that a particular concern for Victoria is that the general drug detection dogs operate ‘in a legal grey area’, as the question of whether identification by a dog would be enough ‘to support grounds of reasonable suspicion necessary to conduct a search of the person has not yet

²¹³⁸ Deputy Commissioner Wendy Steendam, *Supplementary evidence*, Victoria Police, 1 February 2018, p. 2.

²¹³⁹ NSW Ombudsman, *Review of the Police Powers (Drug Detection Dogs) Act 2001*, Sydney, 2006, pp. ii-iii.

²¹⁴⁰ NSW Ombudsman, *Review of the Police Powers (Drug Detection Dogs) Act 2001*, Sydney, 2006, p. iv.

²¹⁴¹ Stephanie Tzanetis, Program Coordinator, DanceWize, Harm Reduction Victoria, *Transcript of evidence*, 8 May 2017, p. 68.

been tested'.²¹⁴² She also told the Committee that the current situation is 'not based on or governed by clear guidelines about civil liberties and safeguarding those civil liberties'.²¹⁴³

Hughes et al in 2017, *The deterrent effects of Australian street-level drug law enforcement on illicit drug offending at outdoor music festivals*, considered the deterrent effects of a range of law enforcement methods at outdoor music festivals in Australia, including the use of drug detection dogs. They suggested that 'police presence can elicit some deterrent effects on engagement in illicit drug offending', and that drug detection dogs 'elicited the largest reductions in use and possession' (compared to riot policing and high visibility policing). However, the authors noted that these strategies appear to mainly reduce use and possession, rather than supply or purchasing offending behaviour. They also identified an unintended consequence of using of drug detection dogs in that 'it may deter people from bringing their own drugs into the venue in favour of buying drugs at the venue'.²¹⁴⁴ This leads to concerns regarding increased risks of people purchasing adulterated or mislabelled drugs inside the venue from unknown sources, and potential higher profits for drug traffickers through increased sales at festivals.²¹⁴⁵

Stakeholders that commented on this issue broadly recommended that the use of drug detection operations at music events cease or be reviewed in Victoria. Students for Sensible Drug Policy Australia stated:

The practice of using sniffer dogs should be immediately ceased or at the very least put under review. For any limited success they may have, the risks and collateral damage is too high. Victoria police regularly update and review things such as motor vehicle pursuit policies to ensure that community safety is considered as a priority. The same consideration should be applied, whether people are breaking drug laws, they are still members of the community and their safety should be valued.²¹⁴⁶

Unharm similarly noted there is 'no publicly-accessible evaluation' of the use of drug detection dogs against their objectives.²¹⁴⁷ Further, Dr Peta Malins discussed her recommendation in the context of a broader focus on harm reduction:

...instead of deploying drug detection dogs in all of those contexts, police should be equipped to better work with the harm reduction services that are already operating in many of those contexts, and that their role should be focused on keeping people safe, whether that is in terms of broader violence or keeping people safe in relation to drugs and their health and things like that, and getting them in touch with the health supports that they need and focusing on that.²¹⁴⁸

The Committee notes the range of concerns expressed about the use of drug detection dogs at music festivals and other venues and locations where illicit drug use is concentrated, including their effectiveness in deterring drug offending and potential impact on drug-related harms and other consequences. The Committee considers that there is a lack of information regarding the prevalence and implementation of these

2142 Dr Peta Malins, *Submission*, no. 196, 17 March 2017, p. 4.

2143 Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 364.

2144 Hughes, C, et al., 'The deterrent effects of Australian street-level drug law enforcement on illicit drug offending at outdoor music festivals', *The International Journal of Drug Policy*, vol. 41, 2017, p. 98.

2145 Hughes, C, et al., 'The deterrent effects of Australian street-level drug law enforcement on illicit drug offending at outdoor music festivals', *The International Journal of Drug Policy*, vol. 41, 2017, p. 98.

2146 Students for Sensible Drug Policy Australia, *Submission*, no. 214, 29 March 2017, p. 11.

2147 Unharm, *Submission*, no. 182, 17 March 2017, p. 11.

2148 Dr Peta Malins, Lecturer, Justice and Legal Studies, RMIT University, *Transcript of evidence*, 4 September 2017, p. 365.

operations in Victoria. While Victoria Police considers that the number of arrests is an appropriate measure for determining effectiveness, the Committee considers that a broader review is required, similar to the one undertaken in NSW in 2006. This would establish whether the goals of drug detection dog operations are being appropriately met in the context of reducing harm at such events, as well as their effectiveness in deterring the use and trafficking of illicit substances.

RECOMMENDATION 50: Victoria Police commission an independent evaluation of the use of drug detection dogs at music festivals and other public spaces to determine their effectiveness in deterring the use and trafficking of illicit substances, and any unintended consequences or risk of harms resulting from this strategy.

Appendix 1

Original terms of reference

Inquiry into Illicit and Synthetic Drugs and Prescription Medicine

Received from the Legislative Council on 11 November 2015

That pursuant to section 33 of the *Parliamentary Committees Act 2003* this house requires the Law Reform, Road and Community Safety Committee to inquire into, consider and report, no later than 3 March 2017 on the effectiveness of laws and procedures relating to illicit and synthetic drugs and prescription medication, including—

1. reviewing the effectiveness of drug treatment programs in Victoria with recommendations on how treatment and harm minimisation strategies could be used as an alternative to criminal penalties;
2. reviewing the effectiveness of Victorian government investment into illicit drug supply reduction, demand reduction and harm reduction strategies and programs;
3. reviewing effectiveness of drug detection programs including roadside testing and procedures for deploying drug detection activities at events;
4. assessing the impact of prescription medication on road safety;
5. reviewing and assessing the effectiveness of laws and regulations relating to illicit and synthetic drugs; and
6. assessing practices of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted to Victorian law.

Appendix 2

Submissions

Submission no.	Name of individual or organisation
1	Doug Steley
2	Ingrid Pezzoni
3	Marina Stehle
4	Regina Clark
5	Alana Brown
6	Confidential
7	Confidential
8	Max Robinson
9	Paxi Wright Cheah
10	Confidential
11	Melanie Audrey
12	Confidential
13	Confidential
14	Confidential
15	Reg Henry
16	Confidential
17	Neomi Amit
18	Confidential
19	Coralie Richmond
20	Rebecca McLean
21	Stephanie Elder
22	Joe Lenzo
23	David Hutchinson
24	Name withheld
25	Avigale Bischard
26	Confidential
27	Confidential
28	Greta Allen
29	Steve West
30	Confidential
31	Name withheld
32	Marelle Davey
33	Confidential
34	Name withheld
35	Justin Kent
36	Name withheld
37	Confidential
38	Name withheld

Submission no.	Name of individual or organisation
39	Name withheld
40	Confidential
41	Georgie Taylor
42	Roz McNaught
43	John Brandenburg
44	Confidential
45	Maarten Van Yzendoorn
46	Chris Fletcher
47	Louis Vorstermans
48	Confidential
49	Joan Lynn
50	Celeste Biancofiore
51	Confidential
52	Jeremy Press
53	Patsy Lisle
54	Leslie Courtney
55	Confidential
56	Mira Ederer
57	Graeme Lindenmayer
58	Colin Smith
59	Confidential
60	Harli Bishop
61	Janet Massey
62	Dr Angela Munro
63	Don Ray
64	Dr Tony Krins
65	Confidential
66	Rosa Roberts
67	Confidential
68	Laurie Hamilton-Grundy
69	Dr Jonathan Niclis
70	Don Humphries
71	Confidential
72	Confidential
73	Confidential
74	Sam Murray
75	Confidential
76	Confidential
77	Bree McKilligan
78	Confidential
79	Name withheld
80	Colette Leber
81	Confidential
82	Name withheld

Submission no.	Name of individual or organisation
83	Cassidy Connor
84	Jesse Moran
85	Gerard J Drake-Feary
86	T. Collins
87	Kevin Cooper
88	Richard Smithers
89	Confidential
90	Name withheld
91	Paul Martin
92	Ben Yonson
93	Name withheld
94	Confidential
95	Confidential
96	Margot Foster
97	Behn Payten
98	William Summers
99	Tesla Kavanagh
100	Andris Blums
101	Name withheld
102	Name withheld
103	Confidential
104	Dr Katinka van de Ven and Dr Renee Zahnow
105	Alice Torpy
106	Imperial Tobacco Australia Limited
107	Yarra Drug and Health Forum
108	Confidential
109	Andrew Le
110	Michael O'Brien
111	Lisa Doyle
112	Harm Reduction Australia / Family Drug Support
113	Lachlan Hayes
114	Windana Drug and Alcohol Recovery
115	Confidential
116	Turning Point
117	Sally Thompson
118	Confidential
119	Name withheld
120	Confidential
121	Confidential
122	Confidential
123	Families and Friends for Drug Law Reform
124	Confidential
125	Residents for Victoria Street Drug Solutions
126	Dr Kate Seear

Submission no.	Name of individual or organisation
127	City of Yarra
128	Confidential
129	Name withheld
130	Confidential
131	Confidential
132	Drug Free Australia
133	City of Monash
134	Name withheld
135	Hepatitis Victoria
136	National Drug Research Institute
137	Confidential
138	Confidential
139	Tim Fraser
140	cohealth
141	Confidential
142	Marion McConnell
143	Confidential
144	Alan Graham
145	Dr John Sherman
146	Siobhan Haines
147	Australian Drug Law Reform Foundation
148	Confidential
149	What Can Be Done Steering Committee
150	James Miller
151	Name withheld
152	Public Health Association Australia
153	WAYSS Ltd
154	Craig Capel
155	Students for Sensible Drug Policy LaTrobe
156	Name withheld
157	Aran Burns
158	Confidential
159	Name withheld
160	Springvale Monash Legal Service
161	Steven Merriel
162	North Richmond Community Health
163	Victorian Alcohol and Drug Association
164	National Drug and Alcohol Research Centre - UNSW
165	Burnet Institute
166	Australasian Professional Society on Alcohol and Other Drugs
167	Greg Hordacre
168	UnitingCare ReGen
169	Australian Injecting and Illicit Drug Users League
170	Echuca Regional Health

Submission no.	Name of individual or organisation
171	Adult Parole Board of Victoria
172	Name withheld
173	Alfred Health
174	Fitzroy Legal Service
175	Beyond Blue
176	Name withheld
177	City of Port Philip
178	Coroners Court of Victoria
179	Odyssey House Victoria
180	Municipal Association of Victoria
181	Australian Christian Lobby
182	Unharm
183	Abolitionist and Transformative Justice Centre
184	Humanist Society of Victoria
185	Justice and Community Safety Directorate / ACT Health (joint submission)
186	Eros
187	The Australian Psychedelic Society
188	Harm Reduction Victoria
189	Owen Smith
190	Confidential
191	Students for Sensible Drug Policy UniMelb
192	Drug Policy Australia
193	Confidential
194	Andrew Foreman-Duncan
195	Kathleen Maltzahn
196	Dr Peta Malins
197	Greg Chipp
198	Casey Scott
199	Greg Kašarik
200	Rationalist Society of Australia
201	Confidential
202	MIGA
203	Australian Medical Association Victoria
204	Victoria Legal Aid
205	Liberty Victoria
206	Victorian AIDS Council
207	Justice Action
208	Ambulance Victorian
209	Penington Institute
210	Victorian Multicultural Commission
211	Penelope Hill
212	Jonathon Goodfellow
213	Living Positive Victoria
214	Students for Sensible Drug Policy Australia

Submission no.	Name of individual or organisation
215	Name withheld
216	Victorian Institute of Forensic Medicine
217	City of Boroondara
218	Alcohol and Drug Foundation
219	Uniting Church in Australia, Synod of NSW and the ACT
220	Magistrate Tony Parsons
221	Associate Professor Nadine Ezard
222	Jennifer Lee
223	Australasian College for Emergency Medicine
224	Royal Australasian College of Physicians
225	Confidential
226	Martha Tsamis
227	Confidential
228	Confidential
229	360Edge
230	Jesuit Social Services
231	Victoria Police

Appendix 3

Public hearings

Monday 8 May 2017 — Meeting Room G.7 and G.8, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
John Ryan	Chief Executive Officer	Penington Institute
Tom Lyons	Senior Policy and Research Officer	
Judge Sara Hinchey	State Coroner of Victoria	Coroners Court of Victoria
Jeremy Dwyer	Case Investigation Officer	
Professor Dan Lubman	Director	Turning Point
Dr Matthew Frei	Clinical Director	
Dr Christian Smyth	Special Adviser	
Professor Paul Dietze	Director, Behaviours and Health Risks Program	Burnet Institute
Greg Denham	Executive Officer	Yarra Drug and Health Forum
Peter Wearne	Chair	
Professor Margaret Hamilton	Melbourne School of Population and Global Health	University of Melbourne
Charles Henderson	Acting Executive Officer	Harm Reduction Victoria
Sarah Lord	Program Manager, Pharmacotherapy Advice and Mediation Service	
Jane Dicka	Health Promotion Team Leader Specialising in Drug Overdose Prevention Education	
Stephanie Tzanetis	Program Coordinator, DanceWize	

Tuesday 23 May 2017 – Macquarie Room, Parliament of NSW, Sydney

Name	Title	Organisation
Mick Palmer AO APM	Vic President, Australia 21	
Dr Alex Wodak AM	Director, Australia 21 President, Australian Drug Law Reform Foundation	Australia 21 / Australian Drug Law Reform Foundation
Paul Bodisco	Secretary, Australian Drug Law Reform Foundation	
Gino Vumbaca	President, Harm Reduction Australia	Harm Reduction Australia / Family Drug Support
Debbie Warner	Volunteer Manager, Family Drug Support	
Associate Professor Nadine Ezard		
Jon O'Brien	Head of Social Justice Forum	
Marion McConnell	Member	Uniting Church in Australia, Synod of NSW and the ACT
Keith Hamilton	Senior Minister/Group CEO, Parramatta Mission of the Uniting Church of Australia	

Monday 5 June 2017 – Meeting Room G.7 and G.8, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
Magistrate Tony Parsons		Drug Court of Victoria
Demos Krouskos	Chief Executive Officer	North Richmond Community Health
Dr Stefan Gruenert	Chief Executive Officer	Odyssey House Victoria
Dr Kate Seear	Senior Lecturer in Law	Monash University
Dr Virginia Dods		
Oscar Lang		Collingwood and Abbotsford Residents Association Inc. (CARA)
Emma Wise		
Judy Ryan		Residents for Victoria Street Drug Solutions Inc.
Kylie Troy-West		

Monday 19 June 2017 — Meeting Room G.7 and G.8, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
John Rogerson	Chief Executive Officer	Alcohol and Drug Foundation
Geoff Munro	National Policy Manager	
Professor Noel Woodford	Director	Victorian Institute of Forensic Medicine
Dr Dimitri Gerostamoulos	Chief Toxicologist, Head, Forensic Sciences	
Michael Stephenson	Executive Director, Operations	Ambulance Victoria
Bevan Warner	Managing Director	Victoria Legal Aid
Tazmyn Jewell	Senior Lawyer	
David Ruschena	General Counsel	Alfred Health
Dr Helen Stergiou	Emergency and Trauma Physician	
Dr Caitlin Hughes	Senior Research Fellow, Drug Policy Modelling Program	National Drug and Alcohol Research Centre
Professor Alison Ritter	Director, Drug Policy Modelling Program	

Wednesday 28 June 2017 — Meeting Room G.7 and G.8, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
Dr Lorraine Baker	President	Australian Medical Association Victoria
Frances Mirabelli	Chief Executive Officer	
Meghan Fitzgerald	Social Action, Policy and Reform Manager	Fitzroy Legal Service

Monday 21 August 2017 — Meeting Room G.7 and G.8, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
Trevor King	Director, Programs	UnitingCare ReGen
Paul Aiken	Evaluation and Advocacy Team Leader	
Josephine Baxter	Executive Director	Drug Free Australia
Gary Christian	Research Director	
Greg Chipp	Chief Executive Officer and Director	Drug Policy Australia
Dr John Sherman	Director	
Sam Biondo	Executive Officer	Victorian Alcohol and Drug Association (VAADA)
David Taylor	Policy and Media Officer	
Penelope Hill	President	Students for Sensible Drug Policy Australia
Ashley Blackwell	Vice-President	
Dean Rossiter	Chapter President, La Trobe University	
Gulliver McLean	Member	
Nicholas Kent	Chapter President, University of Melbourne	
Phoebe Logan-Jacobson	Representative, RMIT	

Monday 4 September 2017 — Meeting Room G.7 and G.8, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
Kym Peake	Secretary	
Matthew McCrone	Director, Real-time Prescription Monitoring Implementation	Department of Health and Human Services
Judith Abbott	Director, Community-based Health Policy and Programs	
Melanie Eagle	Chief Executive Officer	Hepatitis Victoria
Jan Noblett	Executive Director, Justice Health	Justice Health / Corrections Victoria
Assistant Commissioner Melissa Westin	Corrections Victoria	
Dr Peta Malins	Lecturer, Justice and Legal Studies	RMIT University
Dr Nicole Lee	Director	360Edge

Monday 18 September 2017 — Meeting Room G.7 and G.8, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
Sonia Vignjevic	Acting Chairperson	Victorian Multicultural Commission
Tina Hosseini	Commissioner	
William Bush	President	Families and Friends for Drug Law Reform
Jo Wade		
Brenda Irwin		
Judge Peter Couzens	Chair	Adult Parole Board of Victoria
Magistrate Jennifer Bowles	2014 Churchill Fellow	<i>What Can Be Done</i> Steering Committee
Frank Dixon	Chair	
Dr Monica Barratt	Research Fellow, Drug Policy Modelling Program	National Drug and Alcohol Research Centre

Monday 13 November 2017 — Meeting Room G.2, 55 St Andrews Place, East Melbourne

Name	Title	Organisation
Maira Hewitt	Head, Tobacco Alcohol and Other Drugs Unit	Australia Institute of Health and Welfare
Commander Bruce Hill	Manager, Organised Crime	Australian Federal Police
Detective Superintendent Matt Warren		
Wendy Steendam	Deputy Commissioner, Capability	Victoria Police
Rick Nugent	Assistant Commissioner, Eastern Region	
Catherine Quinn	Assistant Director, Analytical Services, Forensic Services Department	
Geraldine Green	Manager, Drug and Alcohol Strategy Unit	
Shane Neilson	Head of the High Risk and Emerging Drugs (HRED) Determination, Drug Intelligence Hub	Australian Criminal Intelligence Commission
Associate Professor David Caldicott		

Appendix 4

Domestic and international site visits

A4.1 Domestic site visits

23 May 2017

Participant	Title	Organisation
Dr Marianne Jauncey	Medical Director	Uniting Medically Supervised Injecting Centre, Sydney

28 June 2017

Participant	Title	Organisation
Greg Denham	Executive Officer, Yarra Drug and Health Forum	Victoria Street, North Richmond area

A4.2 Geneva, Switzerland site visits

17 July 2017

Participant	Title	Organisation
Jean-Félix Savary	Secretary-General, GREA (Association of French-speaking addiction professionals)	Quai 9 - Première Ligne
Emmanuel Ducret	Head of Operations, Quai 9	
Dr Suzanne Hill	Director, Essential Medicines and Health Products Department	World Health Organisation
Dr Giles Forte	Coordinator, Essential Medicines and Health Products Department	
Professor Michael Kazatchkine	Global Commissioner	Global Commission on Drug Policy
Khalid Tinasti	Executive Secretary	
Professor Dr Daniele Zullino	Head of Division of HUG Addictology Services	Consultation Ambulatoire D'addictologie Psychiatrique

A4.3 Lisbon, Portugal site visits

18 July 2017

Participant	Title	Organisation
Dr João Goulão	General Director and National Drug Co-ordinator	SICAD - General Directorate for Intervention on Addictive Behaviours and Dependencies
Dr Nuno Capaz	Vice President	Lisbon Drug Addiction Dissuasion Commission (Comissões para a Dissuasão da Toxicoddependência)
José Queiroz	Executive Director	APDES - Piaget Agency for Development
Rui Coimbra	President of CASO (the Portuguese Drug Users Union)	

19 July 2017

Participant	Title	Organisation
Sandra Simoes	Clinical Psychologist	Centro das Taipas
Alex Goosdeel	Director	European Monitoring Centre for Drugs and Drug Addiction
Ilze Jekasbone	Capacity Development Officer	
Marica Ferry	Head of Content Coordination and Trend Analysis	
Brendan Hughes	Principal Scientific Analyst	
Peter Rayner	Portuguese Ambassador of Australia	
José Carlos Bastos Leitão	Superintendent and Director of Criminal Investigation Department	

A4.4 London, United Kingdom site visits

20 July 2017

Participant	Title	Organisation
Ann Fordham	Executive Director	International Drug Policy Consortium
Marie Nougier	Senior Research and Communications Officer	
Steve Rolles	Senior Policy Analyst	Transform

21 July 2017

Participant	Title	Organisation
Lauren Comber	Head of International Drug Policy	Drug and Alcohol Unit, Home Office, UK Government
Ben Bryant	Drug Strategy	
Peter Burkinshaw	Alcohol and Drug Treatment and Recovery Lead, Public Health England	
Dr Owen Bowden-Jones	Chair	Advisory Council on the Misuse of Drugs
Linsey Urquhard	Secretariat	
Dr Rick Lines	Executive Director	Harm Reduction International

Participant	Title	Organisation
Craig Mackey	Deputy Commissioner	
Martin Hewitt	Assistant Commissioner - Territorial Policing	Metropolitan Police Service, New Scotland Yard
Roy Smith	Superintendent	

22 July 2017

Participant	Organisation
Various volunteers from The Loop and Transform	The Loop, Secret Garden Party
Cambridgeshire Police	

A4.5 Vancouver, Canada site visits

25 July 2017

Participant	Title	Organisation
Lynn Pelletier	Vice President	
Dr Johann Brink	Vice President, Medical Affairs and Research	
Rebecca Hahn	Executive Director, Corporate and Clinical Services	
Connie Coniglio	Executive Director, Adult Mental Health and Substance Use	British Columbia Mental Health and Substance Use Services, Provincial Health Services Authority
Andrew MacFarlane	Executive Director, Correctional Health Services	
John Jacobson	Manager, Forensic Psychiatric Services, Regional Clinic - Vancouver	
Michelle DeGroot	Executive Director, Programs and Community Wellness Services, First National Health Authority	
Mitch Moneo	Acting Assistant Deputy Minister	
Erin Lun	Executive Director, Drug Intelligence	
John Capelli	Acting Executive Director, PharmaCare Information, Policy and Evaluation	Pharmaceuticals Services Division, BC Ministry of Health
Kelly Uyeno	Executive Director, Business Management, Supplier Relations and Systems	
Cam Egli	Pharmacist, PharmaNet Systems Initiatives	
Walton Pang	Director, Information, Drug Use Optimization	
Donald MacPherson	Executive Director	Canadian Drug Policy Coalition

26 July 2017

Participant	Title	Organisation
Deputy Chief Constable Warren Lemcke	Commanding Operations Division	
Inspector Martin Bruce	Investigation Division, Organized Crime Section	Vancouver Police Department
Staff Sergeant Mark Horlsey	Beat Enforcement Team and Marine Unit	

Participant	Title	Organisation
Dr Patricia Day	Vice President, Public Health & Chief Medical Officer	
Laura Case	Chief Operating Officer, Vancouver Community	
Bonnie Wilson	Operations Director, Inner City Eastside & Co-Program Lead for Mental Health & Substance Use	
Caitlin Etherington	Acting Director, Strategy Deployment	Vancouver Coastal Health
Blain Bray	Director of Operations, Urban Health, Mental Health and Substance Use	
Dr Scott MacDonald	Physician Lead, Providence Health Crosstown Clinic	
Dr Mark Lysyshyn	Mental Health Officer, North Shore	
Ms Miranda Compton	Regional Director, Prevention	
Major Neill Franklin (ret.)	Executive Director, Law Enforcement Action Partnership	
Sheriff Stacey Kincaid	Fairfax County Sheriff's Office, Virginia	Law Enforcement Action Partnership (via teleconference)
Pete Holmes	Seattle City Attorney, Washington	
Chief Steve Moore	Hurst Police Department, Texas	

27 July 2017

Participant	Title	Organisation
Dr Kenneth Tupper	Director of Implementation & Partnerships	BC Centre on Substance Use
Kevin Hollet	Communications Lead	
Dr Jane Buxton	Harm Reduction Lead	
Dr Mark Tyndall	Executive Medical Director	
Dr Marcus Lem	Senior Medical Adviser	BC Centre for Disease Control
Dr Alexis Crabtree	Post Doc	
Laura MacDougall	Director, Public Health Analytics	

A4.6 Denver, Colorado, United States site visits

28 July 2017

Participant	Title	Organisation
Kristi Kelly	Executive Director	
Bruce Nassau	Chairman of the Board	
Kara Miller	State Lobbyist	
Landon Gates	State Lobbyist	
Brock Herzberg	State Lobbyist	
Chris Holbert	Majority Leader, Colorado Senate, State of Colorado	Marijuana Industry Group
Dan Pabon	State Representative, State of Colorado	
Glenn Davis	Colorado Department of Transportation	
Shawn Mitchell	former Republican Member of the Colorado Senate	

Participant	Title	Organisation
Taylor West	Deputy Director	National Cannabis Industry Association
Dr Tista Ghosh	Public Health Programs Director and Deputy Chief Medical Officer	Colorado Department of Public Health and Environment
Dr Mike Van Dyke	Branch Chief of the Environmental Epidemiology, Occupational Health and Toxicology Branch	
Heather Krug	Marijuana Laboratory Inspection Program Coordinator	
Art Way	Colorado State Director	

31 July 2017

Participant	Title	Organisation
Jordan Wellington	Director of Compliance	Council on Responsible Cannabis Regulation
Andrew Livingston	Director of Economics & Research, Vicente Sederberg Law Firm	
Jodi Duke	Executive Director & Planner, CORE Network	
Elan Nelson	Business Strategy and Development	Tour of Medicine Man Cultivation Facility
Bill Ludow	Bronnor Group	Tour of Bronnor Corporation Facility
Kevin McNulty	ZOOTS Sales and Marketing	
Barbara Brohl	Executive Director	Colorado Department of Revenue
Heidi Humphreys	Deputy Executive Director	
Ron Kammerzell	Senior Director	
Paul Northrup	Deputy Director of Taxation	
Cory Amend		
Matthew Scott		
Michael Hartman		
Ashley Weber	Executive Director	
Aaron Gray	Board member	
Larisa Bolivar	Board member	
Rachel Gillette	Board member	Colorado NORML
Bobby Rodrigo	Peachtree NORML	Tour of Mary's Medicinals
Jeri Shepherd	Board member	
Larisa Boliva	Board member	
Ashley Weber	Executive Director, Colorado NORML	
Eduardo A Provencio	General Counsel, Mary's Medicinals	
Tyler Prock	Mary's Medicinals	
Garrett Graff	Associate Attorney, Hoban Law Group	

A4.7 Sacramento, California, United States site visits

1 August 2017

Participant	Title	Organisation
Lori Ajax	Chief	
Alex Traverso	Chief of Communications	California Bureau of Marijuana Control
Amelia Hicks	Policy Analyst	
Sara Gardner	Attorney	
Mark Starr	Deputy Director for Environment Health	California Department of Public Health
Stephen Woods	Chief, Division of Food, Drug and Cannabis Safety	
Mr Bill Quirk	20th Assembly District Member, Alameda County Democratic Party	Mr Bill Quirk, 20th Assembly District Member
Tomas Duenas	Chief of Staff to Assemblymember Quirk	
Charles Lawlor	Deputy Director, Speaker's Office of International Relations and Protocol	California State Legislature
Darcie Sears	Policy Consultant to the Speaker	
Robert Sumner	Principal Consultant for the Assembly Committee on Business and Professionals	

A4.8 Wellington, New Zealand site visits

11 October 2017

Participant	Title	Organisation
Mark Evans	Deputy Chief Executive Strategy	
Mike Clement	Deputy Commission National Operations	
Richard Chambers	Assistant Commission Investigations	
Detective Superintendent Tim Anderson	National Manager, Criminal Investigations	New Zealand Police
Detective Superintendent Greg Williams	National Manager, Organised Crime Group	
Detective Inspector Iain Chapman	National Manager, Financial Crime Group	
Jeremy Wood	Director, Policy and Partnerships	
Tina Chong	Team Leader, International and National Security	
Kath Noble	Principal Advisor	
Lynda Duncan	Senior Policy Advisor	New Zealand Drug Foundation
Leon Grice	Programme Manager	
Jacinda Lean	Project Manager	
Ross Bell	Executive Director	
Samuel Andrews	Policy and Information Officer	
Melanie Saxton	Administrator	
Natalie Bould	Communications Adviser	

12 October 2017

Participant	Title	Organisation
Wendy Allison	Director	KnowYourStuffNZ
Dr Jez Weston		
Dr Vanessa Caldwell	National Manager	Matua Raki
Ashley Konig	Proejct Lead	
Anna Nelson	Programme Manager	
Emma Hindson	Manager Prevention, Regulatory Policy	Ministry of Health NZ
Oliver Poppelwell	Principal Policy Analyst, Regulatory Policy	
Sharon Woollaston	Senior Policy Analyst, Regulatory Policy	
Sophia Haynes	Senior Policy Analyst, Regulatory Policy	
Asti Laloli	Policy Analyst, Regulatory Policy	
John Crawshaw	Director of Mental Health	
Richard Taylor	Manager Addictions, System Outcomes	
Jenny Hawes	Principal Advisor, Mental Health Protection	
Haley Ataera	Senior Advisor, Regulatory Practice and Analysis	

Appendix 5

Table of background information on illicit substances and pharmaceutical drugs

Information contained in this table is summarised from the Alcohol and Drug Foundation's 'Drug Facts' webpage (<https://adf.org.au/drug-facts>).

A5.1 Stimulant drugs

Drug	Amphetamines	Crystal methamphetamine
Appearance	<p>Can be in the form of:</p> <ul style="list-style-type: none"> • Powder (can range in colour from brown to white, sometimes with traces of grey or pink. It has a strong smell and bitter taste) • Tablets and capsules (vary in size or colour) • Crystals • Paste or resin <p>Can be packaged in:</p> <ul style="list-style-type: none"> • Foils (aluminium foil) • Plastic bags • Small balloons <p>Illegally produced amphetamines (particularly in 'backyard laboratories') can be a mix of drugs, binding agents such as baking or talcum powder, caffeine and sugar. <i>New psychoactive substances</i> may also be added.</p>	<p>Can be in the form of:</p> <ul style="list-style-type: none"> • Small, chunky clear crystals • White or brownish crystal-like powder (with a strong smell and bitter taste)
Street name/s	Speed, uppers, louee, goey, and whiz	Ice, shabu, crystal, glass, shard, P (particularly used in New Zealand)
Mode of administration	Swallowed, injected or smoked. Can also be snorted and 'shelved' or 'shafted' (used as a suppository).	Smoked (in a glass pipe or makeshift apparatus – including broken light bulbs), injected (the effects can be felt in 3 to 7 seconds), swallowed (15 to 30 minutes to feel the effects), snorted or used as a suppository (3 to 5 minutes to feel the effects).

Drug	Amphetamines	Crystal methamphetamine
Effects	<p>The following effects may be experienced:</p> <ul style="list-style-type: none"> • Euphoria and confidence • Talking more and feeling energetic (In extreme cases – <i>mania</i>) • Repeating simple actions like itching and scratching • Large pupils and dry mouth • Fast heart beat or arrhythmia • Hyperventilation • Teeth grinding (bruxism) • Reduced appetite • Excessive sweating • Increased and unguarded libido or sex drive <p>These effects may be felt immediately (if injected or smoked) or longer (within 30 minutes to an hour if snorted or swallowed). Snorting amphetamines can damage the nasal passage and cause nose bleeds.</p>	<p>The immediate effects of crystal methamphetamine, particularly euphoria can last for up to 6 hours.</p> <p>Common effects:</p> <ul style="list-style-type: none"> • Feelings of pleasure, euphoria and confidence • Increased alertness and energy • Repeating simple actions like itching and scratching • Enlarged pupils and dry mouth • Teeth grinding and excessive sweating • Fast heart rate and breathing • Reduced appetite • Increased and unguarded libido or sex drive
Overdose	<p>Characteristics of an amphetamine overdose may involve:</p> <ul style="list-style-type: none"> • Racing or irregular heartbeat • Fits • Passing out • Stroke, heart attack and in extreme cases death 	<p>Same as amphetamines.</p>
Other serious consequences	<p>Injecting amphetamines and sharing needles can increase the risk of blood borne diseases such as:</p> <ul style="list-style-type: none"> • Hepatitis B • Hepatitis C • HIV/AIDS • Tetanus 	<p>Same as amphetamines.</p>
Coming down	<p>Usually experienced 2 to 4 days after use and characterised by:</p> <ul style="list-style-type: none"> • Restless sleep and exhaustion • Headaches • Dizziness and blurred vision • Paranoia, hallucinations and confusion • Irritability, mood swings and depression 	<p>Similar to amphetamines, however given the higher potency of the drug, the coming down period may be longer and the symptoms may be experienced more intensely.</p>

Drug	Amphetamines	Crystal methamphetamine
Long-term effects	<ul style="list-style-type: none"> • Reduced appetite and extreme weight loss • Insomnia, restless or irregular sleep patterns • Dry mouth and dental problems • Regular colds and flu • Reduced concentration • Difficulty breathing • Muscle stiffness • Anxiety and paranoia • Depression • Heart and kidney problems • Increased risk of stroke • Needing to use more to get the same effect – the phenomenon of tolerance • Dependence on amphetamines • Financial, employment, family and social problems 	<p>Similar to amphetamines, however, even more pronounced with crystal methamphetamine are mental health issues, including the potential for anxiety, paranoia and violence. Of particular concern is the possible occurrence of 'ice psychosis'.</p>
Withdrawal	<p>Withdrawal symptoms from basic amphetamines usually settle down after a week and will mostly disappear after a month. Withdrawal symptoms include:</p> <ul style="list-style-type: none"> • Cravings for amphetamines • Increased appetite • Confusion and irritability • Aches and pains • Exhaustion • Restless sleep and nightmares • Anxiety, depression and paranoia 	<p>Similar to amphetamine, although arguably of greater duration and intensity. Symptoms generally settle down after a fortnight to a month, although it is not unknown for some symptoms particularly relating to mental health issues to subsist for a much longer period.</p>

Drug	Amphetamines	Crystal methamphetamine
Poly-drug use	The Alcohol and Drug Foundation has warned that the effects of taking amphetamines with other drugs – including over-the-counter or prescribed medications – can be unpredictable and dangerous, particularly in the following combinations: Amphetamines and antidepressants can result in elevated blood pressure, which can lead to irregular heartbeat, heart failure and stroke. Amphetamines and alcohol, cannabis or benzodiazepines can result in the body being placed under a high degree of stress as it attempts to deal with the conflicting effects of both types of drugs, which can lead to an overdose.	As with amphetamine, the effects of taking crystal methamphetamine with other drugs – including over-the-counter or prescribed medications – can be unpredictable and dangerous: Ice and speed or ecstasy: This can result in an enormous strain on the heart and other parts of the body, which can lead to stroke. Ice and alcohol, cannabis or benzodiazepines: The combination of stimulants and depressants can result in overdose. The stimulant effects of ice may mask the effects of depressant drugs like benzodiazepines and can increase the risk of overdose. A cycle can be created where benzodiazepines (see below) are used to assist in the ‘coming down’ period but result in a particularly toxic cocktail of drugs leading to these deleterious consequences.

A5.2 Party and other stimulant drugs

Drug	Ecstasy/MDMA	Cocaine	GHB (gamma hydroxybutyrate)	Ketamine
Appearance	In the form of a pill, which come in different colours and sizes and are often imprinted with a picture or symbol. It can also come as capsules, powder or crystal/rock (MDMA).	Most commonly a white powder but also in crystals.	Usually a colourless, odourless, bitter or salty liquid sold in small bottles or vials. It can also come as a bright blue liquid known as ‘blue nitro’, and less commonly as a crystal powder.	When sold illegally, ketamine usually comes as a white crystalline powder. It can also be made into tablets and pills, or dissolved in a liquid.
Street name/s	Eckies, E, XTC, pills, pingers, Scooby snacks, googs, bikkies, flippers, molly.	C, coke, nose candy, snow, white lady, toot, charlie, blow, white dust or stardust.	G, fantasy, grievous bodily harm (GBH), juice, liquid ecstasy, liquid E, liquid X, Georgia Home Boy, soap, scoop, cherry meth, blue nitro, fishes.	Special K, K, ket, kitkat, super k or horse trunk.
Mode of administration	Usually swallowed, but can also be used as a suppository.	Cocaine is most commonly snorted. It can also be injected, rubbed into the gums, added to drinks or food. Freebase and crack cocaine are usually smoked.	Usually swallowed, but sometimes it’s injected or used as a suppository.	Can be swallowed, snorted or injected. It is also sometimes smoked with cannabis or tobacco.

Drug	Ecstasy/MDMA	Cocaine	GHB (gamma hydroxybutyrate)	Ketamine
Effects	<p>Usually felt about 20 minutes to an hour after taken and last for around 6 hours:</p> <ul style="list-style-type: none"> • Feeling happy, energetic and confident • Large pupils • Jaw clenching and teeth grinding • Heightened senses (sight, hearing and touch) • Excessive sweating and skin tingles • Muscle aches and pains • Nausea and reduced appetite • Fast heartbeat • Dehydration • Heat stroke • Drinking excessive amounts of water (in extreme cases causing death) <p>The uncertainty of what is in ecstasy pills and the possibility that they have been contaminated with adulterants make it hard to know what effects will ensue after ingesting.</p>	<p>The intensity depends on the amount and potency of the drug and the mode of administration employed. Effects can be:</p> <ul style="list-style-type: none"> • Happiness, euphoria and confidence • Loquaciousness • Increased energy • Feeling physically strong and mentally sharp • Reduced appetite • Dry mouth • Enlarged (dilated) pupils • Higher blood pressure and faster heartbeat and breathing (after initial slowing) • Higher body temperature • Increased and sometimes unguarded sex drive • Unpredictable, violent or aggressive behaviour • Indifference to pain <p>Injecting cocaine and sharing needles may also cause transmission of blood borne disease and increase likelihood of overdose.</p> <p>Snorting cocaine regularly can also cause:</p> <ul style="list-style-type: none"> • Runny nose and nose bleeds • Infection of the nasal membranes • Perforation of the septum • Long term damage to the nasal cavity and sinuses 	<p>The following effects may begin within 15 to 20 minutes and may last for around 3 to 4 hours:</p> <ul style="list-style-type: none"> • Feelings of euphoria • Increased sex drive • Lowered inhibitions • Memory lapses • Drowsiness • Clumsiness • Dizziness or headache • Lowered temperature, heart rate • Tremors • Nausea • Diarrhoea • Urinary incontinence 	<p>The effects may be experienced within 30 seconds if injected, 5-10 minutes if snorted, and up to 20 minutes if swallowed. The effects of ketamine can last for approximately 45 to 90 minutes.</p> <ul style="list-style-type: none"> • Happiness, euphoria and/or relaxation • Feeling detached from your body ('falling into the zone or a 'k-hole') • Hallucinations • Confusion and clumsiness • Increased heart rate and blood pressure • Slurred speech and blurred vision • Anxiety, panic and violence • Vomiting • Lowered sensitivity to pain (due to the anaesthetic qualities)

Drug	Ecstasy/MDMA	Cocaine	GHB (gamma hydroxybutyrate)	Ketamine
Overdose	<p>If a large amount or a strong batch of ecstasy is consumed the user may experience:</p> <ul style="list-style-type: none"> • Floating sensations • Hallucinations • Out-of-character irrational behaviour • Anxiety • Irritability, paranoia and violence • Vomiting • High body temperature • Racing heart beat • Fitting 	<p>If a large amount or a strong batch of cocaine is consumed the user may experience:</p> <ul style="list-style-type: none"> • Nausea and vomiting • Extreme anxiety • Chest pains • Hallucinations • Breathing irregularities • Kidney failure • Heart problems • Stroke • Seizures • Coma • Death 	<p>Symptoms of a GHB overdose include:</p> <ul style="list-style-type: none"> • Vomiting • Sweating • Irregular or shallow breathing • Confusion, irritation and agitation • Hallucinations • Blackouts and memory loss • Unconsciousness that can last for 3 to 4 hours • Seizures • Death <p>The ADF states that the chemical composition of GHB is highly variable. As such it is very easy to take too much GHB: the difference between the amount needed to get high and the amount that causes an overdose can be hard to judge.</p>	<p>An overdose may result in:</p> <ul style="list-style-type: none"> • Inability to move, rigid muscles • High body temperature, fast heartbeat • Convulsions • Coma and 'near death' experiences • Death
Long-term effects	<ul style="list-style-type: none"> • Depression • Other mental health problems • Tolerance and dependence 	<p>High doses and frequent heavy use may cause 'cocaine psychosis', characterised by paranoid delusions, hallucinations and out of character aggressive behaviour. These symptoms usually disappear a few days after the person stops using cocaine. As with other forms of drug related psychoses, the extent to which this phenomenon is manifested by cocaine users and the exact relationship to the drug is uncertain.</p>	<p>The ADF and drug clinicians state that little is known about the long-term effects of GHB use. Nonetheless regular use can lead to tolerance and dependence, which means larger amounts of GHB are needed to get the same effect.</p>	<p>Regular use of ketamine may eventually cause:</p> <ul style="list-style-type: none"> • Headaches • Flashbacks • Mood and personality changes, depression • Poor memory, thinking and concentration • Ketamine bladder syndrome⁽⁹⁾ • Abdominal pain • Tolerance and dependence

Drug	Ecstasy/MDMA	Cocaine	GHB (gamma hydroxybutyrate)	Ketamine
Withdrawal	<ul style="list-style-type: none"> Restless sleep and exhaustion Anxiety, irritability and depression Difficulty concentrating Cravings for ecstasy Aches and pains 	<p>Withdrawal symptoms usually start around 1-2 days after last use and can last for approximately 10 weeks – with days 4 to 7 being particularly difficult.</p> <p>Withdrawal usually happens in 3 phases:</p> <ol style="list-style-type: none"> Crash – agitation, depression or anxiety, intense hunger, cocaine cravings, restless sleep, extreme tiredness (experienced in the first few days). Withdrawal – cocaine cravings, lack of energy, anxiety, angry outbursts and an inability to feel pleasure (can last for up to 10 weeks). Extinction – intermittent cravings for cocaine (ongoing) (Alcohol and Drug Foundation 2016). 		<p>Withdrawal symptoms for ketamine are similar to those for other party drugs discussed.</p>
Poly-drug use	<p>Ecstasy/MDMA and alcohol: increased risk of dehydration and consequently drinking too much water. In such cases a stimulant drug is counteracting with a depressant drug.</p> <p>Ecstasy/MDMA and ice or speed: increased risk of anxiety and reduced brain functioning due to dopamine depletion. Enormous strain on the heart and other parts of the body, which can lead to stroke.</p> <p>Ecstasy/MDMA and antidepressants: Drowsiness, clumsiness, restlessness and feeling drunk and dizzy.</p>	<p>As per ecstasy.</p>	<p>GHB and alcohol or benzodiazepines: the chance of overdose is greatly increased.</p> <p>GHB and amphetamines or ecstasy: the risk of seizures and organ malfunction.</p>	<p>Ketamine and alcohol/opiates: slows respiratory system; coma and overdose.</p>

(a) The ADF states that large, repeated doses of ketamine may eventually cause 'ketamine bladder syndrome', a painful condition needing ongoing treatment. Symptoms include difficulty holding in urine, and incontinence, which can cause ulceration in the bladder.

A5.3 Depressant drugs

Drug	Cannabis	Heroin
Appearance	<p>Comes in 3 different forms:</p> <ul style="list-style-type: none"> • Marijuana – the dried plant that is smoked in a joint or a bong. This is the most common form. • Hashish – the dried plant resin that is usually mixed with tobacco and smoked or added to foods and baked, such as biscuits and cakes • Oil – liquid that is usually added to an inhaler or the tip of a cigarette and smoked. A highly refined and concentrated form of hash oil is known as BHO (Butane Hash Oil) 	<p>Heroin is derived from the opium poppy and comes in different forms:</p> <ul style="list-style-type: none"> • Fine white powder • Coarse off-white granules • Tiny pieces of light brown 'rock'
Street name/s	Yarndi/yandi; pot, weed, hash, dope, gunja/ganja, joint, stick, cone, choof and many others.	Smack, gear, hammer, the dragon, H, dope, junk, harry, horse, black tar, white dynamite, homebake, china white, Chinese H, poison, Dr Harry
Mode of administration	<p>Cannabis is usually smoked or eaten.</p> <p>The effects of smoking/inhaling cannabis are fairly instantaneous. However, it takes about an hour to feel the effects of eating cannabis, which can lead to overconsumption when it is thought the drug has not taken effect.</p> <p>Cannabis can also come in synthetic form such as 'kronk'. Some commentators believe its synthetic derivatives may be more harmful than 'real' cannabis (Alcohol and Drug Foundation).</p>	<p>Heroin is usually injected into a vein, but it's also smoked ('chasing the dragon'), and added to cigarettes and cannabis. The effects are usually felt immediately. Sometimes heroin is snorted – the effects take around 10 to 15 minutes to feel if used in this way.</p>

Drug	Cannabis	Heroin
Effects	<p>Whether a person experiences such conditions after ingesting cannabis will depend on a number of factors including:</p> <ul style="list-style-type: none"> • The person's size, weight and health • Whether the person is used to taking it • Whether it is taken in conjunction with other drugs • The amount taken • The strength, purity or potency of the drug <p>The effects of cannabis may include:</p> <ul style="list-style-type: none"> • Pain relief • Feeling relaxed and sleepy • Spontaneous laughter and excitement • Increased appetite • Dry mouth • Quiet and reflective mood (a 'chilled' or 'mellow' state of being) 	<p>The following effects may be experienced and last approximately for 3 to 5 hours:</p> <ul style="list-style-type: none"> • Intense pleasure, euphoria and/or pain relief • Relaxation, drowsiness and clumsiness • Confusion • Slurred and slow speech • Slow breathing and heartbeat • Dry mouth • Tiny pupils • Reduced appetite and vomiting • Decreased sex drive • Trouble concentrating • Falling asleep ('on the nod') • Inability or problems relating to urination <p>As with other injectable drugs, injecting heroin and particularly sharing needles may also result in the transmission of:</p> <ul style="list-style-type: none"> • Tetanus • Hepatitis B • Hepatitis C • HIV and AIDS <p>Another danger associated with injectable heroin in particular is that it may have been adulterated/contaminated with foreign substances such as baking powder or talcum powder which can result in blood clotting and other dangerous complications.</p>
Overdose	<p>A large amount or particularly potent batch of cannabis may result in:</p> <ul style="list-style-type: none"> • Inability to concentrate • Blurred vision • Clumsiness • Slower reflexes • Bloodshot eyes • Increased heart rate • Low blood pressure • Mild anxiety and paranoia 	<p>If a large amount or a strong batch of heroin is consumed, the following may be experienced:</p> <ul style="list-style-type: none"> • Irregular heartbeat • Cold, clammy skin • Slow breathing, blue lips and fingertips • Passing out • Death

Drug	Cannabis	Heroin
Long-term effects	<p>With regular and sustained use, individuals may experience:</p> <ul style="list-style-type: none"> • Memory loss • Learning difficulties • Mood swings • Regular colds or flu • Asthma • Bronchitis • Cancer (if smoked with tobacco) • Reduced libido • Difficulty having children (low fertility in males and females) • Tolerance and dependence <p>The extent to which cannabis may cause as opposed to contribute to or exacerbate these conditions is unclear.</p>	<p>Regular use of heroin may eventually cause:</p> <ul style="list-style-type: none"> • Intense depression • Irritability and mood swings • Irregular periods and fertility problems (females) • Reduced libido/ sex drive (males) • Constipation • Damaged heart, lungs, liver and brain • Vein damage and skin, heart and lung infections from injecting • Needing to increase dosage to get the same effect (tolerance) • Tolerance and dependence
Withdrawal	<p>Withdrawal symptoms after heavy, sustained and regular use can include:</p> <ul style="list-style-type: none"> • Anxiety • Irritability • Aggressive and angry behaviour • Cravings for cannabis • Loss of appetite and upset stomach • Sweating, chills and tremors • Restless sleep and nightmares <p>Arguably, not everyone will experience all or any of these symptoms, particularly if use is light and/or intermittent.</p>	<p>Withdrawing from heroin after long time use is very difficult. Withdrawal symptoms usually start within 6 to 24 hours after the last dose and can last for about a week – with days 1 to 3 being most difficult. Withdrawal symptoms can include:</p> <ul style="list-style-type: none"> • Cravings for heroin • Restlessness and irritability • Depression • Diarrhoea • Restless sleep • Stomach and leg cramps • Nausea, vomiting and lack of appetite • Runny nose • Fast and/or irregular heartbeat
Poly-drug use	<p>The use of any one drug in combination with one or more other drugs, especially alcohol, is potentially dangerous. Cannabis is sometimes used to lessen the 'come down' effects of stimulant drugs, such as ice, speed and ecstasy. However, doing this can cause a number of physical and mental health problems and in some cases result in dependency on both drugs.</p>	<p>The effects of taking heroin with other drugs – including over-the-counter or prescribed medications – can be unpredictable and dangerous. Heroin used in conjunction with stimulant drugs (such as ice) can result in heart and kidney damage and the possibility of stroke. Heroin used with other depressant drugs (such as alcohol or cannabis) can result in the respiratory system slowing down or stopping altogether.</p>

A5.4 Pharmaceutical drugs

		Benzodiazepines	
Drug	Opioids		
Appearance	Fentanyl	Oxycodone	Codeine
	<p>Fentanyl comes in a number of different forms and strengths including:</p> <ul style="list-style-type: none"> • Transdermal patches (Durogesic® and generic versions) • Lozenges/lollipop (Actiq®) • IV injections (Sublimaze®) 	<p>Oxycodone comes in a number of forms including capsules, tablets, liquid and suppositories. It also comes in a variety of strengths.</p>	<p>Comes in different forms, including:</p> <ul style="list-style-type: none"> • Tablets • Capsules • Suppositories • Soluble powders and tablets • Liquids
		Hillbilly heroin ^(a) , oxy, OC and O.	Benzos, tranx, sleepers, downers, pills, xannies, serras (Serepax®), moggies (Mogadon®), normies (Normison®).
Street name/s			
Mode of administration	<p>The transdermal patch is applied to the skin and provides strong and consistent pain relief at an even rate over a 72 hour period. The patch is the most commonly used form of fentanyl.</p> <p>The lozenges are dissolved in the mouth and are used for pain relief in patients already taking regular opiates for severe pain.</p> <p>The IV solution is injected for pain relief and sedation during surgery and it's duration of action is short.</p> <p>Some people use fentanyl illegally to become intoxicated by extracting the fentanyl from the patch and injecting it. As the ADF comments this is extremely dangerous as there is little difference between the amount needed to get 'high' and the amount that causes overdose. It is also extremely hard to judge a 'correct' dose size.</p>	<p>Oxycodone is usually swallowed but is sometimes injected or used as a suppository. To prevent OxyContin® tablets being injected by people who misuse them they were reformulated on 1 April 2014. The tablets are now resistant to crushing and become a thick gel when added to water. They also have controlled release properties, even as a gel.</p>	<p>Codeine is usually swallowed.</p> <p>A highly dangerous mode of administration is to inject ground codeine.</p>

Drug	Opioids	Fentanyl	Oxycodone	Codeine	Benzodiazepines
Effects	The short and long term effects of fentanyl use are similar to heroin. As with heroin, naloxone can reverse the effects of this type of opioid. Fentanyl is increasingly being diverted for illicit purposes.	Oxycodone affects everyone differently particularly given the context in which it is used (legitimate pain relief versus recreational use), but the short and long term effects of the drug are generally similar to those of heroin and other opioids. As with most drugs that are injected, injecting oxycodone when misusing the drug may also cause: <ul style="list-style-type: none"> • Vein damage and scarring • Infection including tetanus, hepatitis B, hepatitis C, HIV/AIDS • Deep vein thrombosis and clots causing loss of limbs, damage to organs, stroke and possibly death 	The most common side effects, both short and long term of codeine including overdose are similar to those of other opioid drugs.	Benzodiazepines affect everyone differently depending on age, weight, gender, general health etc, but the short to medium term effects may include: <ul style="list-style-type: none"> • Depression • Confusion • Feelings of isolation or euphoria • Impaired thinking and memory loss • Headache • Drowsiness, sleepiness and fatigue • Dry mouth • Slurred speech or stuttering • Double or blurred vision • Impaired coordination, dizziness and tremors • Nausea and loss of appetite • Diarrhoea or constipation Injecting benzodiazepines may also cause: <ul style="list-style-type: none"> • Vein damage and scarring • Infection, including hepatitis B, hepatitis C, HIV and AIDS • Deep vein thrombosis and clots causing loss of limbs, damage to organs, stroke and possibly death 	
Overdose	As per heroin.	As per heroin.	Overdose may be characterised by: <ul style="list-style-type: none"> • Obstructed bowel and constipation • Agitation • Slow, shallow breaths • Hallucinations • Severe cases – coma and death 	If an excessive amount of the drug is taken, the following may also be experienced: <ul style="list-style-type: none"> • Over-sedation or sleep • Jitteriness and excitability • Mood swings and aggression • Slow, shallow breathing • Unconsciousness or coma • Death (more likely when taken with another drug such as alcohol) 	

Drug	Opioids	Fentanyl	Oxycodone	Codeine	Benzodiazepines
Long-term effects	The short and long term effects of fentanyl use are similar to heroin.		<p>Regular use of oxycodone may cause:</p> <ul style="list-style-type: none"> • Dental problems • Swelling in the arms and legs • Mood swings • Reduced sex drive and decreased level of testosterone (males) and menstrual problems (females) • Tolerance to the drug • Financial, work or social problems 	<ul style="list-style-type: none"> • Constipation • Reduced libido • Irregular menstruation • Muscle tension • Tolerance and dependence 	<p>Regular use of benzodiazepines may cause:</p> <ul style="list-style-type: none"> • Impaired thinking or memory loss • Anxiety and depression • Irritability, paranoia and aggression • Personality change • Weakness, lethargy and lack of motivation • Drowsiness, sleepiness and fatigue • Difficulty sleeping or disturbing dreams • Headaches • Nausea • Skin rashes and weight gain • Addiction
Withdrawal	Withdrawal symptoms are also similar to those of heroin.	Withdrawal symptoms are similar to those of heroin. Like other opioids regular use of oxycodone in non-controlled or medically unsupervised circumstances can lead to tolerance of the drug and eventual dependence.	Withdrawal symptoms are similar to those of heroin.	Withdrawal symptoms vary from person to person and are different depending on the type of benzodiazepine being taken. Symptoms can last from a few weeks to a year and can include:	<ul style="list-style-type: none"> • Headaches • Aching or twitching muscles • Dizziness and tremors • Nausea, vomiting, stomach pains • Bizarre dreams, difficulty sleeping, fatigue • Poor concentration • Anxiety and irritability • Altered perception, heightening of senses • Delusions, hallucinations and paranoia • Seizures

Drug	Opioids	Fentanyl	Oxycodone	Codeine	Benzodiazepines
Poly-drug use	Fentanyl and alcohol: may increase risk of respiratory problems.	Fentanyl and benzodiazepines: may increase sedative effects and also result in breaths/respiratory problems.	As with other forms of opioids, using oxycodone in conjunction with other licit or illicit drugs can result in serious complications including death.	The effects of taking codeine with other drugs, including alcohol, prescription medications and other over-the-counter medicines, are often unpredictable. In particular, the not uncommon practice of taking codeine with alcohol can cause slowed responses and vagueness, reduced coordination and respiration problems.	Benzodiazepines used in conjunction with alcohol and/or opiates can result in an increased risk of overdose and death. The use of benzodiazepines to help with the 'come down' effects of stimulant drugs (such as amphetamines or ecstasy) may result in a cycle of dependence on both types of drugs.

(a) Generally referring to the regions of the USA where it is most popular.

Appendix 6

Ice Action Plan membership

Premier's Ice Action Taskforce	
The Hon Daniel Andrews MP	Premier
The Hon Jill Hennessy MP	Minister for Health
Martin Foley MP	Minister for Mental Health
Gavin Jennings MLC	Special Minister of State
The Hon Lisa Neville MP	Minister for Police
The Hon Martin Pakula MP	Attorney-General
Ro Allen	Gender and Sexuality Commissioner
Deputy Commissioner Andrew Crisp	Deputy Commissioner, Victoria Police
Magistrate Anthony Parsons	Presiding Magistrate, Drug Court of Victoria
Professor Patrick McGorry AO	Director, Orygen Youth Health and Orygen Youth Health Research Centre
Sam Biondo	Executive Officer, Victorian Alcohol and Drug Association
Melanie Raymond	Chair, Youth Projects
Major Brendan Nottle	Salvation Army
Serina McDuff	Executive Officer, Federation of Community Legal Centres
John Ryan	Chief Executive Officer, Penington Institute
Professor Dan Lubman	Director, Turning Point Alcohol and Drug Centre
Jill Gallagher	Chief Executive Officer, Victorian Aboriginal Community Controlled Health Organisation
Specialist Workforce Advisory Group	
Bella Anderson	Branch Committee of Management, Health and Community Services Union
Lorraine Baker	President, Australian Medical Association Victoria
Karen Batt	State Secretary, Community and Public Sector Union Victoria
Pip Carew	Assistant Secretary, Australian Nursing and Midwifery Federation Victorian Branch
Wayne Gatt	Secretary, The Police Association
Steve McGhie	General Secretary, Ambulance Employees Australia of Victoria
Meredith Peace	President, Australian Education Union Victoria
To be advised	Bendigo Community Health Services

Appendix 7

Advisory Council recommendations

Recommendation three is the establishment of a new governance structure to oversee and monitor the four pillars drug strategy. This comprises:

- Ministerial Council on Drugs Policy – comprising relevant Victorian Ministers responsible for the portfolios of health, mental health, police, education, early childhood education, road safety, corrections, multicultural affairs, and families and children
- Advisory Council on Drugs Policy – comprising experts to advise the Victorian Government on drug-related issues and research in Victoria, in addition to individuals (current users, recovering users, affected families) who actively work with and support people affected by substance use.

Throughout the report, the Committee then refers a number of recommendations to the proposed Advisory Council on Drugs Policy for action, as outlined below. If the Victorian Government does not support the establishment of the new governance structure, the Committee trusts that the Government will redirect these recommendations to appropriate agencies for implementation.

RECOMMENDATION 20: The Victorian Advisory Council on Drugs Policy should investigate the role of general practitioners in providing access to medicinal cannabis, and consider how they can be best supported in this area.

RECOMMENDATION 23: The Advisory Council on Drugs Policy investigate international developments in the regulated supply of cannabis for adult use, and advise the Victorian Government on policy outcomes in areas, such as prevalence rates, public safety, and reducing the scale and scope of the illicit drug market.

RECOMMENDATION 24: The proposed Advisory Council on Drugs Policy investigate the current drug driving laws and procedures to determine their effect on road crashes and as a deterrent strategy. The Council should also explore:

- alternative drug driving regimes that use impairment limits/thresholds, and their potential applicability in Victoria
- options for expanding the types of drugs captured under the regime
- likely changes to drug driving laws resulting from medicinal cannabis use in Victoria.

RECOMMENDATION 42: The proposed Advisory Council on Drugs Policy review harms arising from current laws that prohibit non-injecting routes of drug administration (smoking paraphernalia), such as increased injecting use of methamphetamines and other drugs, and make recommendations to the Government accordingly.

RECOMMENDATION 49: The Victorian Government refer to the proposed Advisory Council on Drugs Policy the issue of drug checking services, and request that it monitor overseas and domestic models to obtain relevant evidence to inform consideration of a trial in Victoria. If appropriate, the Council should develop guidelines for such a trial (and include appropriate messaging e.g. not condoning drug use nor indicating that drug use is safe, appropriate technology, data collection and clear liability safeguards). The Council should also consider an evaluation framework to measure the future trial's effectiveness in minimising drug-related harms.

Extract of proceedings

The Committee divided on the following questions during consideration of this report. Questions agreed to without division are not recorded in these extracts.

Committee meeting - 15 March 2018

Report adoption

That all paragraphs of the draft report stand, together with the correction of any typographical or grammatical errors, as the report into the Inquiry into Drug Law Reform of the Committee, and the report be ordered to be printed.

The Committee divided.

Ayes 4	Noes 1
Mr Howard	Mr Thompson
Mr Dixon	
Ms Patten	
Ms Suleyman	

Carried.

Minority Report

Minority Report

There would be few families in Victoria who have not been impacted directly or indirectly by drug addiction, or drug related death.

How does a civil society balance the recreational use of licit and illicit drugs supported by the notion of individual liberty as against the potential obligation on the part of the State to pay the medical costs of rehabilitation or supply drugs, as part of a treatment program?

I hold the personal view that a healthier society is one which has a reduced reliance on drugs.

Excessive use of drugs or drug addiction impacts not only the drug user but also family, friends, neighbours, the wider community and oftentimes succeeding generations.

Dalrymple¹ notes that "the consumption of drugs has the effect of reducing men's freedom by circumscribing the range of their interests. It impairs their ability to pursue more important human aims, such as raising a family and fulfilling civic obligations. Very often it impairs their ability to pursue gainful employment and promotes"... (reliance upon others). "One of the most striking characteristics of drug takers is their intense and tedious self-absorption; and their journeys into inner space are generally forays into inner vacuums. Drug taking is a lazy (persons) way of pursuing happiness and wisdom, and the shortcut turns out to be the deadest of dead ends. We lose remarkably little by not being permitted to take drugs."²

When the casino and gaming machines were introduced into Victoria, it was argued that dangers could be managed. Natasha Robertson, journalist reported the words of a County Court judge Mr Roland Williams in The Australian newspaper dated 8 December 2006.

"I feel constrained to remark how sad a situation this is. Sad that the availability of gambling in this state is such that you found it so easy to turn to as your outlet, and once started you so readily became trapped by the gimmicky enticements and rewards which seemed to be accepted as part of the regime.

"How a so-called civilised society can allow and offer the mindless operation of poker machines to witless members of the public under the euphemism of gaming and entertainment is no doubt a question for the sociologists of this world."

Extrapolating from this example, albeit in a different context, I raise concerns regarding the trend towards a greater legislative tolerance towards illicit drug taking.

On the other hand I encourage the implementation of initiatives which will improve the wellbeing of addicts and enable them to live lives free from addiction. The evidence presented to the inquiry suggests there is a lack of access to residential drug recovery treatment programs.

¹ Theodore Dalrymple is the pseudonym used for Anthony Malcolm Daniels, Author, journalist, doctor and psychiatrist born 1949.

² Dalrymple, Theodore. City Journal Magazine 'Don't Legalize Drugs' Spring 1997

Dalrymple stated that once a prohibition has been removed, it is hard to restore.

Danger of Cannabis

Mr THOMPSON — I just note at page 36 of the Australia21 report there is a suggestion from a participant as to how the sales supply of cannabis might take effect and among the matters it suggests would have labels like, "Smoking this could give you schizophrenia," and it would have help seeking information at such-and-such a number if you feel you can't stop. I just note that there was a Dr Arieti from New York who once noted that no war, no disease, no famine had exacted such a great toll on human life or caused so much suffering as schizophrenia. In the drug debates there is a discussion regarding the correlation between the ingestion of marijuana and schizophrenia and I'm just wondering if there was such a harm as to be suggested, that has such a great impact upon human life and suffering, why would we sanction the sale of the product?

Dr WODAK — Well, there is still an academic debate about whether cannabis does in fact cause schizophrenia and there are reputable researchers on both sides of that debate. I think it's fair to say that the majority view is that there is a relationship between cannabis use and schizophrenia but it's been observed in a number of countries that the prevalence of cannabis use has increased dramatically from the 1960s, from close to zero to much higher levels that we see today and that the prevalence of schizophrenia has remained the same or gone down, if anything, and that the schizophrenia we see in 2017 is not as severe as the schizophrenia we saw 50 years or so ago.

So that doesn't sit comfortably with the theory that cannabis is a potent cause of schizophrenia. My view is that the benefit of doubt should go to schizophrenia and that until we know for certain we should assume cannabis does cause schizophrenia but when - importantly, when people have tried to estimate how much schizophrenia is caused by cannabis it turns out that the estimates are very low. If cannabis does cause schizophrenia, it causes very few cases. Some estimates are that we would have to reduce cannabis use by 20,000 people to have one fewer case of schizophrenia. So that is all in terms of the cost-benefit analysis but the other part of this is that the cannabis provided by Al Capone is presumably just as much at risk, if not more, of producing schizophrenia than the cannabis that is produced under the authority of her Majesty's government.

If anything, the risk will be less when we have a regulated product which is produced in a very consistent way. So there are a lot of uncertainties about this and in terms of the medicinal use, looking at that briefly, I think it's fair to say that a lot of the medications that doctors prescribe do have some unfortunate, severe side effects and some even produce fatalities now and then. So if we're prescribing medicinal cannabis for medicinal purposes, the occasional case of schizophrenia shouldn't - certainly shouldn't please us but it certainly shouldn't stop us from using it as an option when other conventional medicines have been tried in particularly carefully-selected cases.

When it is used recreationally, we know we can't stop cannabis use. Something like 2 million Australians use cannabis every year. The prevalence of schizophrenia is about 1 per cent of

the population so that means there are about roughly speaking 200,000 Australians who have schizophrenia now. Every case of schizophrenia that can be prevented I would certainly welcome but I don't think reducing cannabis use is going to achieve much in terms of reducing schizophrenia because the risk is fairly small, if it is a risk at all. I'm sorry that's a convoluted kind of an answer but I'm trying to summarise a lot of research in a practical way."

Dr Sherman gave evidence in the following terms:-

"If I can make one point about cannabis – and I used to treat cannabis - dependents until I found that my results were so poor that I got out of the game – it will not cause schizophrenia but it will trigger schizophrenia. If you have got the hereditary genetic make-up to get that illness, like asthma or diabetes, it will trigger it . If you want to find out whether you have got that genetic predisposition, go and smoke cannabis because soon after you will go psychotic.

The CHAIR — That is not a very good way of testing then, is it?

Dr SHERMAN — No.

Mr THOMPSON — It is not a good recommendation for my colleagues either.

Dr SHERMAN — The other thing is if you wish to have treatment and to be brought into remission with psychiatric antipsychotic drugs, they will not work because you will continue to smoke cannabis, which seems to be something about schizophrenia with smoking, with alcohol, with nicotine. So unfortunately it is a tragic state when a young man comes in who is psychotic and then you realise this is going to go on."

During my time as a lawyer and Member of Parliament I have seen firsthand the adverse impact of cannabis use on individuals. The use of cannabis can cause serious harm. It can be argued that increased use of cannabis will cause greater harm in the circumstances outlined above. Reducing the deterrent effect of the law may lead to the unintended consequence of increasing drug use.

Portugal

Portugal was described as a reform model. .

I note the response of the Office of National Drug Control Policy, Obama White House in 2009:-

"The Cato Institute report does not present sufficient evidence to support claims regarding causal effects of Portugal's drug policy on usage rates. More data are required before drawing any firm conclusions, and ultimately these conclusions may only apply to Portugal and its unique circumstances, such as its history of disproportionately high rates of heroin use. However, it is safe to say that claims by drug legalization advocates regarding the impact of Portugal's drug policy exceed the existing scientific basis."

In my view, further data analysis is required on the Portugal model. According to the Portugal Country Drug Report 2017 from European Monitoring Centre for Drug and Drug Addiction there

were 40 overdose deaths in Portugal for 2015, a significant reduction in HIV diagnoses attributed to injecting and a total of 17,011 people on opioid substitution treatment. Cannabis use in young adults 15-34 years was measured at 5.1% yet there was a reported 31,858 high risk opioid users against a population of an estimated 10.3 million. The Portugal model represents a case study for ongoing review.

As a general principal, rather than being 'an early adopter' of major reform, in my view it is preferable for Victoria to be 'a wise follower' once the evidence is conclusive. The harms associated with the use of cannabis and high risk opioid use in my view warrant further analysis.

The War on Drugs

Numbers of witnesses including highly respected law enforcement officers stated that the war on drugs was lost.

Theodore Dalrymple commented in an article that this argument is essentially flawed

"In claiming that prohibition, not the drugs themselves, is the problem, Nadelmann and many others—even policemen—have said that "the war on drugs is lost." But to demand a yes or no answer to the question "Is the war against drugs being won?" is like demanding a yes or no answer to the question "Have you stopped beating your wife yet?" Never can an unimaginative and fundamentally stupid metaphor have exerted a more baleful effect upon proper thought.

Let us ask whether medicine is winning the war against death. The answer is obviously no, it isn't winning: the one fundamental rule of human existence remains, unfortunately, one man one death. And this is despite the fact that 14 percent of the gross domestic product of the United States (to say nothing of the efforts of other countries) goes into the fight against death. Was ever a war more expensively lost? Let us then abolish medical schools, hospitals, and departments of public health. If every man has to die, it doesn't matter very much when he does so.

If the war against drugs is lost, then so are the wars against theft, speeding, incest, fraud, rape, murder, arson, and illegal parking. Few, if any, such wars are winnable. So let us all do anything we choose."...

..."The present situation is bad, undoubtedly; but few are the situations so bad that they cannot be made worse by a wrong policy decision.

The extreme intellectual elegance of the proposal to legalize the distribution and consumption of drugs, touted as the solution to so many problems at once (AIDS, crime, overcrowding in the prisons, and even the attractiveness of drugs to foolish young people) should give rise to skepticism. Social problems are not usually like that. Analogies with the Prohibition era, often drawn by those who would legalize drugs, are false and inexact: it is one thing to attempt to ban a substance that has been in customary use for centuries by at least nine-tenths of the adult population, and quite another to retain a ban on substances that are still not in customary use, in an attempt to ensure that they never do become customary."

Pill Testing

Mr THOMPSON — Just finally, there are a number of social determinants of health alluded to on page 12 of your submission, and you say that people who experience a severe difficulty or trauma in their life may be most at risk of problematic drug use. Then there is

a list of four bullet points, where circumstances are defined where people who might be disengaged from society through employment or mental health, disengaged from the school system, lacking role models or who grow up with drug use in their family. Is there a correlation between that cohort of people that might be drug reliant and those that might seek to use a tablet at a rave party, or is it a different social grouping where people might seek to mask their pain and trauma?

Mr ROGERSON — It is different but it is not different. Some of the people at a rave party are going to self-medicate because that is the way they cope with life — so life could be due to trauma or it could be socio-economic issues — but the majority of people at rave parties are having fun, they are wanting to have a good time, they are wanting to enhance their experience. That is part of the point I was making right at the start. If you look at why people use drugs, 60 per cent of people using drugs at the moment are using them to enhance their experience. They are using them to have a good time. Only 10 per cent of people are using drugs because they are dependent.³

The Report refers to the role of DanceWize.

“DanceWize (formerly known as RaveSafe) is a program that utilises a peer education model to reduce drug and alcohol related harm at Victorian dance parties, festivals and nightclubs.

Our Key Peer Educators [KPEs] attend from 15 up to 26 events per year: hosting a chill-out space for festival goers; providing a quiet, low stimuli, relaxation space where patrons can take time out, discuss safer drug use with peers and receive or be referred to different health resources.

The DanceWize goal is to provide our peers with accurate, credible information through face-to-face discussion or through the provision of resources (which always include information about the harms associated with illicit and licit drug use).

Our KPEs are recruited from the dance party, festival and nightclub communities and are trained by experts in the field to equip them with the knowledge and skills they need to answer questions or to refer peers to other services where appropriate.

The DanceWize chill-out space is not a first-aid facility. We use this area to engage our peers and to look after patrons who might be a little confused or freaking out. DanceWize KPEs use their experience and knowledge to talk them through their moments of confusion. Anyone needing medical attention is referred to First Aid which we work closely with.”⁴

As a member of the community I am concerned that DanceWize KPEs are required to help patrons who might be “a little confused or freaking out”.

Freedom

Dalrymple argued “And we even recognise the apparent paradox that some limitations to our freedoms have the consequence of making us freer overall. The freest man is not the

³ John Rogerson, Chief Executive Officer, Alcohol and Drug Foundation, Transcript of evidence, 19 June 2017

⁴ <https://www.hrvic.org/dancewize>

one who slavishly follows his appetites and desires throughout his life –as all too many of my patients have discovered to their cost.”

How do we build a better community in which all our citizens have hope for a better future, and being able to engage productively in the daily life of our nation?

In the last parliament I spoke at the launch of the opening of a street pastor network in the City of Yarra. It was not far from where indigenous pastor Sir Doug Nicholls was first employed as a drug and alcohol worker on the streets of Fitzroy in the 1930’s.

Sir Doug Nicholls was a sportsman, youth worker, Church of Christ minister, field officer for the Aborigines Advancement League, activist for indigenous recognition in 1967 and Governor of South Australia.

He worked “as a social worker in the Fitzroy Aboriginal community. He cared for his community and helped many aboriginals to stop taking drugs and gambling.”⁵

In 2007 I attended the unveiling of a statue of Sir Doug Nicholls in the Parliament gardens on the corner of Albert St and Spring St.

The Age newspaper reported that Pastor Neville Lilley read a favourite passage that Sir Doug had written on the cover of a small Bible, Philippians 3 13-14.

Part of the text reads

“... but this one thing I do, forgetting those things which are behind, and reaching forth unto those things which are before.

I press toward the mark for the prize of the high calling of God in Christ Jesus.”⁶

It is perhaps salutary to try to discern the undergirding factors which enabled Sir Doug Nicholls to be such a force for good in the wider Australian community.

I also add the comment of a former prisoner of war and School Principal who once noted that freedom is best exercised in community. He wrote “ But I look for a community in which personhood is given high value, in which our relationships with others are undergirded by a care about them and for them, and a hope for them that does not easily tire and that makes us willing to suffer some inconvenience and even hurt for their sake...

I myself have not been able to find the inspiration or the motivation for his kind of living except in the person, the example and the teaching of Christ and his new Testament followers... It was in His society that a person could belong and yet be free, could lose his isolation yet find true identity...”⁷

⁵ Fitzroy Trail, Pastor Sir Douglas Nicholls <http://simonfrankland.edublogs.org/fitzroy-trail/>

⁶ King James Bible. Philippians Chapter 3 Verses 13-14.

⁷ Webber, Horace “Years may pass on... Caulfield Grammar School 1881 – 1981” 1981 P189

I support legal measures which serve to dissuade illicit drug use rather than entrench it and also enable people to live fulfilling lives as contributing members of the Victorian community.

A handwritten signature in black ink that reads "Murray Thompson". The signature is written in a cursive style with a large, prominent 'M' and 'T'.

Murray Thompson MP
Member for Sandringham

