# SELECT COMMITTEE INTO ALTERNATE APPROACHES TO REDUCING ILLICIT DRUG USE AND ITS EFFECTS ON THE COMMUNITY

## INQUIRY INTO ALTERNATE APPROACHES TO REDUCING ILLICIT DRUG USE AND ITS EFFECTS ON THE COMMUNITY

**TRANSCRIPT OF EVIDENCE**
**TAKEN AT PERTH**
**MONDAY, 17 JUNE 2019**

**SESSION ONE**

**Members**

**Hon Alison Xamon (Chair)**
**Hon Samantha Rowe (Deputy Chair)**
**Hon Aaron Stonehouse**
**Hon Michael Mischin**
**Hon Colin de Grussa**

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**Hearing commenced at 9.33 am**

**Dr STEPHEN BRIGHT**
**Senior Lecturer, Edith Cowan University, sworn and examined:**

**The CHAIR**: On behalf of the committee I would like to welcome you to the hearing. Before we move onto the broadcast, can I please introduce you to my parliamentary colleagues and who it is you are meeting with. This is Hon Colin de Grussa; this is Hon Michael Mischin; this is Hon Samantha Rowe, who is also the Deputy chair Of the committee; this is Hon Aaron Stonehouse; and of course you know me, Hon Alison Xamon. I am the Chair of this inquiry. Today's hearing will be broadcast, so before we go live I would just like to remind you that if you have any private documents with you, make sure you keep them flat on the desk so you avoid the cameras. Do not do exactly what I am doing! Please begin the broadcast.

Before we begin, can you please state your full name and the capacity in which appear before the committee.

**Dr Bright**: I am senior lecturer in addiction at Edith Cowan University and today I am representing the Public Health Association of Australia, of which Edith Cowan University is a member.

**The CHAIR**: I now require you to take the affirmation.

[Witness took the affirmation.]

**The CHAIR**: You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

**Dr Bright**: I have read and understood that document.

**The CHAIR**: These proceedings are being recorded by Hansard and broadcast on the internet. Please note that this broadcast will also be available for viewing online after this hearing, so please advise the committee if you object to the broadcast being made available in this way. A transcript of your evidence will be provided to you. To assist the committee and Hansard, could you please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones and try to talk into them and ensure that you do not cover them with papers or make noise near them.

I remind you that your transcript will be made public. If you wish to provide the committee with details of any personal experiences during today's proceedings, you should request that the evidence be taken in private session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

We have of course received a submission from you. Would you like to make an opening statement to the committee?

**Dr Bright**: The Public Health Association of Australia provided a submission to this parliamentary inquiry that recommended that drug use be considered a health issue rather than a criminal justice issue, because there is little evidence that criminal penalties reduce the incidence of drug use. Rather, both international and local evidence suggests that criminal sanctions increase drug-related harms. We know that the prevalence of harm from illegal drugs is highest among socially

disadvantaged groups, and people from these groups tend to experience mental health conditions at a higher rate compared with other groups in our community, and often they will use drugs to self-medicate. Criminal penalties further marginalise these individuals through reducing their capacity to engage in employment opportunities, and through further iatrogenic effects that potentially perpetuate a cycle of drug use and crime.

Increasingly, the war on drugs is being viewed as a war on humanity. Earlier this year, the United Nations adopted a new position on drugs that supports the development and implementation of policies that put people, health and human rights at the centre. They promote a rebalancing of drug policies and interventions towards public health approaches. In reviewing WA's current drug policies the committee should consider the government's obligations as a member of the international community. By considering drug use as a health issue, the focus of drug policy should be on implementing evidence-based strategies that reduce the amount of harm experienced by the WA community through prevention, early intervention and treatment. Although the provision of quality treatment services can reduce the demand and use of illicit drugs, the Public Health Association of Australia gives primacy to primary prevention interventions. These aim to reduce the demand for drugs prior to people requiring treatment. Such interventions are most effective when holistic approaches are used that aim to increase social inclusion. A lot of the mass media campaigns that have been used to date to reduce the demand for illicit drugs tend to focus on low-incidence, high-severity harms, and these are found not only to be ineffective in reducing drug-related harm and use, but they normalise drug use, reduce the credibility of drug education and create further social division that increases stigma and reduces the likelihood that people will engage in treatment services.

Drug-related harm can also be reduced through the provision of harm reduction strategies, and these aim to reduce the adverse consequences of drugs without necessarily requiring a reduction in the consumption of illegal drugs. In this respect, harm reduction can be considered similar to sex education or ways in which we try to reduce the road toll. Motor vehicle accidents cause a number of deaths in Australia each year, but we do not ban cars; we educate drivers and we try to make cars safer and we make the roads safer. When seatbelts were first put into cars, there was concern that people would drive recklessly as a result. We see this as being quite silly now, but in many respects many of the harm-reduction interventions that are being suggested are seen as similar in that it is suspected they may lead to increased drug use. There is no evidence that any harm-reduction strategies have led to increased drug use. If anything, they lead to decreased drug use through people being able to engage in education and being referred to healthcare services. There is also evidence that harm reduction strategies provide economic savings. Australian research found that for every dollar spent on our needle-and-syringe programs we save $20 in healthcare services.

My favourite example of a harm reduction strategy came about 30 years ago following concerns about the increasing numbers of Australians experiencing alcohol-related brain injury through Wernicke's encephalopathy and Korsakoff syndrome. Rather than tell Australians to drink less alcohol, we mandated that bread products contain thiamine, because it was known that a deficiency of thiamine was mediating or moderating alcohol-related brain injury.

[9.40 am]

It has been tremendously successful in reducing alcohol-related brain injury in Australia, and similar innovations using harm reduction interventions need to be considered to reduce the harms from illegal drugs. We have more than 20 years of international evidence on pill testing suggesting that it can achieve similar reductions in healthcare costs, with a UK study published this year in the

*International Journal of Drug Policy* showing a 95 per cent reduction in hospital admissions following the implementation of a pill-testing service in the UK.

Government spending on drug policy indicates that current approaches to reducing the harms from illegal drugs favour policing over health. Nationally, two-thirds of funding to reduce drug-related harm is being spent on law enforcement activities. Meanwhile, 21 per cent is spent on treatment and less than nine per cent is spent on prevention and three per cent on harm reduction. In order for drug use to be considered a health issue, there needs to be a more equal distribution of funding. As noted by the United Nations earlier, there needs to be a rebalancing of drug policies and interventions towards public health approaches. The WA Cannabis Control Act 2003 is an example of local policy designed to rebalance WA's approach to cannabis. It decriminalised the possession of less than 30 grams of cannabis. It is important to recognise that decriminalisation is different from legalisation. Under that act, cannabis remained an illegal substance and it was treated in the same way as a speeding fine or as a traffic offence. In decriminalising the personal possession of cannabis, the WA Cannabis Control Act aimed to increase the number of people accessing treatment services and decrease the impact that exposure to the criminal justice system was having on WA citizens who were caught with small amounts of cannabis. To this end, the legislation was a success. However, despite no evidence of increased use of cannabis, this policy was repealed by the WA government in 2011.

Finally, the Public Health Association of Australia's submission noted that most drug-related harms experienced by the WA community are due to alcohol and tobacco. This is important to acknowledge, given the disproportionate amount of reporting by the WA media on the harms of illegal drugs. My PhD demonstrated how such reporting sets the policy agenda. There is little evidence to support the notion that there is a methamphetamine epidemic. Rates of methamphetamine use in WA have remained relatively stable. However, increased purity of the drug and more frequent use of the drug by those who are using it have led to increased harms. I like to use the metaphor of an iceberg. If the iceberg represents the amount of people who are using methamphetamine, the size of the iceberg has not actually changed. However, the salinity of the water has changed such that the iceberg is lifted higher out of the water, and we are seeing more harms associated with methamphetamine due to more of it sticking out of the water.

However, by focusing on what is sticking out of the water and that part of the iceberg, we are failing to recognise the many harms that are occurring underneath the water from alcohol and other drugs, including prescription drugs. There are more overdose deaths in Western Australia from prescription medications than from illegal drugs, alcohol and tobacco combined. Meanwhile, most drug-related violence in Western Australia is caused by alcohol. Health minister Neal Blewett advised Prime Minister Bob Hawke in 1984 that drug policy that aims to reduce harms to the community must also include alcohol. The Public Health Association of Australia hopes that the committee heeds this advice and also considers ways of reducing harms experienced by the WA community from tobacco, alcohol and prescription drugs. Thank you.

**The CHAIR**: Thank you very much, Dr Bright. I will ask some questions pertaining to the comments you have just made. This committee has been taking a lot of evidence that has been talking about removing criminal penalties around the issue of illicit drug use. However, the committee has also heard that there are concerns about how to treat particular types of drugs. For example, marijuana may seem to be not quite so dangerous as others, but there has been considerable concern around meth. One of the questions I have for you is—it sounds as though the answer is yes, but I am going to check with you—would you also suggest that criminal penalties should be removed for people who are using meth?

**Dr Bright**: I think the use of any substance should be considered a health issue and not a criminal justice issue. There is no evidence that making it a criminal issue leads to decreased incidence of use. However, it is likely to increase harm, as people are exposed to the criminal justice system. That has a significant impact on their developmental trajectory in terms of their ability to engage in employment, and also from interacting with other people who are deemed to be criminals, which potentially leads them to engage in other criminal behaviour.

**The CHAIR**: But what would you say to concerns within the community that by effectively removing criminal penalties, that is almost sending a message to people that it is okay to be undertaking drug use?

**Dr Bright**: I would say that it would be no different to saying that driving over the speed limit is okay. Driving over the speed limit is illegal. By decriminalising something, the behaviour is still illegal; it is just provided with civil sanctions, rather than criminal sanctions. To say that taking away the criminal sanctions and replacing them with civil sanctions is saying that it is okay for people to use illegal drugs is no different from saying that it is okay to speed, because that involves a criminal sanction as well.

**Hon MICHAEL MISCHIN**: I would like to understand this, if I may, because this is very important. We keep hearing about how decriminalisation is one of the answers to somehow reducing the harm. I do not understand the speeding analogy, I am afraid. There are sanctions. You get demerit points. You can lose your licence. What are the sanctions that you would say ought to be attached to the use of psychotropic substances that will affect your judgement, that may cause you to be a risk to others as well as to yourself? How does that work by taking it out of the criminal justice system and having some kind of civil sanctions? What do you mean by civil sanctions?

**Dr Bright**: Civil sanctions would include things likes fines. If you are caught speeding, you are fined. You have done something illegal and you are fined for that. With the case of drugs, rather than just fining somebody for being in possession of illegal drugs, ensuring that there are pathways to treatment services would be particularly important as well. I think in doing so, it is important to look at overseas evidence—for example, in Portugal—where people are assessed when they are going through the system to determine whether or not they actually do have a problem with their alcohol and other drug use. It may be that they have been caught with a small amount of drugs but they are not dependent on the drugs, and it may be a waste of time spending treatment money on those individuals. So, simply giving them a fine and maybe giving them some harm reduction and education may be more effective than providing them with a criminal charge, which stays on their record and potentially impacts their ability to engage in employment.

**The CHAIR**: In relation to the various civil sanction regimes—and you have mentioned Portugal in particular—what would be your thinking around how civil sanctions would work for somebody who is also deemed to have a drug problem? So they have been caught using or with a small amount of whatever drug—we are not talking about enough for dealing or distribution; we are talking purely for personal use. If they refuse to engage in any sanction that might be imposed, whether it be some sort of referral to treatment services or anything like that, what would you deem would be an effective follow-up to that failure to engage within a civil framework?

**Dr Bright**: That is a really difficult question, because —

**The CHAIR**: It is the sort of question we have to deal with.

**Hon MICHAEL MISCHIN**: It sure is. It is fundamental to this, actually.

**Dr Bright**: One of the issues is, I think the easy answer, which is not the correct answer—the easy answer is that you provide them with a fine, but providing somebody from a marginalised

population with a fine is unlikely to be paid, and it is probably then going to lead them to having a criminal conviction for not paying their fine, in the same way that if you do not pay a traffic fine you end up going to court and getting a criminal conviction. I am not sure I have a good answer to that.

[9.50 am]

**Hon MICHAEL MISCHIN**: That is the same problem we have. What happens in Portugal is that if you go to one of their committees and are provided with a treatment program, and you decline or do not complete it, you can be the subject of penalties—as you say, a fine and the like—and if you fail to pay that fine, you go to jail in default. The current policy, the current trend, it seems is that people who cannot pay or refuse to pay their fines should not go to jail, so we get back to it. If you take that standard out of society so that kids and others say, "It's not illegal to use this stuff. I'm not going to suffer any penalty from it. I'm going to go to a criminal and buy my meth and use it, and I'm not doing anything wrong, and if I simply decline to undertake treatment if I happen to be caught, so what?"

**Dr Bright**: The first thing I picked up on there is the young person believing it is not illegal if it is decriminalised. It is still illegal, so they would still be engaging in an illegal activity, and I think something that Portugal has done really well is education in the context of decriminalisation, so the young people in Portugal know that it is still illegal. I think going back to the original question of what you do with people who are unwilling to engage in treatment despite being assessed that they would benefit from treatment services is ensuring that there is a scaffolded system so that there are multiple opportunities for the person to engage in treatment to avoid criminal sanctions, to avoid being required to pay a fine, so that we do not end up with a situation like we have at the moment, where a lot of people from marginalised groups are given fines, are unable to pay the fines and end up receiving criminal penalties as a consequence.

**The CHAIR**: Dr Bright, I am sure you understand that one of the things that the committee has to grapple with is that, whilst the Australian community as a whole might have a fair bit of sympathy to treat people with drug addiction from a health perspective, the Australian community probably also expects that we would continue to condemn drug use, and to ensure that in no way is it supported or endorsed or promoted or even just dismissed in a cavalier fashion. This is why unpicking how you achieve that balancing act is a particular challenge.

**Dr Bright**: One of the advantages of decriminalisation in terms of a law enforcement perspective, and I have to say that I do not come from a law enforcement perspective, but from my perspective one of the advantages are that you are no longer focusing on the low-hanging fruit. You are no longer focusing on the low-level individuals who are using substances, and the time that is saved by policing services by actually be spent focusing on higher level drug dealing operations, and the money would be far more effectively spent focusing on that higher echelon.

**Hon MICHAEL MISCHIN**: Just on that, I am not sure that the police actually focus on simple use. The evidence that we have had so far is that, if they happen to find some drugs on someone in the course of their investigations for something else, then of course they will charge, but it is not as though they are investigating whether you happen to be using cannabis at home. They are looking at trafficable quantities.

**Dr Bright**: I would say, yes, that is true. They are not doing big police investigations to try to prosecute somebody for personal use of cannabis. However, given the current laws it is really discretionary in terms of what police do. I do not think good law allows for discretionary behaviour. It should be quite black and white in terms of what police do, and in addition to that, while I do not come from a law enforcement perspective, people such as Mike Palmer, ex-head of the Australian Federal Police, have repeatedly said that law enforcement often focuses on the low-hanging fruit,

particularly through the ongoing activities of policing. That is just part and parcel that you end up focusing on the low-hanging fruit, because it is easier than the larger police investigations that are required to be able to take out large drug dealer syndicates.

**The CHAIR**: Can I just ask a question about your statement? You said —

> Mass media campaigns that focus on the low incidence/high severity harms have not only been found to be ineffective in reducing the use of drugs, but normalise drug use and reduce the credibility of drug education.

I have two questions about that. Firstly, what do you mean by it normalising drug use? Secondly, you are talking about education programs. What education programs work, then, because we hear all sorts of evidence about going into schools and all sorts of things, but if these ones are not working, what does, and what do you mean by normalising drug use?

**Dr Bright**: This has come from research that was conducted in Western Australia but looked at a campaign in Montana—the "Faces of Meth" campaign. Some people might be familiar with this. It has pictures of people's faces before and after their experience —

**The CHAIR**: Yes, I am aware of that. It is awful.

**Dr Bright**: What they found was that when they looked at the data from before the campaign was introduced to after the campaign, young people who were surveyed actually believed that the rate of methamphetamine use had increased post the intervention. What I mean by normalising it is that it increases people's perception that methamphetamine use is a normal behaviour when you use demand reduction strategies that are quite sensationalist like that. What I mean by it reducing the credibility of drug education is, because they are low-incidence events that are usually promoted in our national demand reduction campaigns, it means that, if I have been given drug education at school, and I am told that drugs are bad, do not do drugs, these are all the harmful effects of drugs, and then I am out and about and somebody in my peer group uses methamphetamine and they have a great time, they are not experiencing any of those low-incidence, high-severity harms, it discredits all the information that has already been provided with regards to drug education in schools, because Johnny and his friends are having a great time on meth. They are not experiencing those harms. So what would be more effective then is focusing on high-incidence harms—things that are actually relevant to young people. In the area of tobacco demand reduction, we have done really well targeting adolescents. Young people do not care about getting lung cancer from smoking, but they do care about smelling of tobacco smoke, kissing a girlfriend or boyfriend and being pushed away because they taste of tobacco. Those are the things that resonate with young people.

Demand reduction campaigns that are effective for reducing use in young people need to focus on those things that are relevant to young people, that are meaningful to them, and it needs to be balanced—so not just focusing on the negative effects of drugs, but also focusing on the positives as well in being able to provide a balanced approach to education. I have done a lot of drug education in universities for first-year students coming into universities, and what I have found to be particularly effective is providing a balanced approach, and in doing so providing harm reduction. When I do that the students like it because I am treating them like adults. I am telling them about drug use and I am treating them like adults. The staff at universities like it as well, because the way in which I do it is to say that I do not think that everybody here is going to use drugs, but some people might, and this information that I am providing might not be relevant to you, but it might be relevant to a person who is close to you—one of your friends—and knowing how to help out one of your friends if they are experiencing some harms from drugs. That is a good way of inoculating a large group of people and reducing harm.

**The CHAIR**: Your submission talks about interventions with doubtful effectiveness or adverse side effects needing to be reviewed. Which current interventions do you think should be reviewed on that basis?

**Dr Bright**: I think the example I have just given is one. We spend a lot of money on these mass media campaigns, and I think they give the broader public the sense that the government is doing something about the drug problem, but in terms of their actual efficacy, it is not actually doing much in terms of reducing drug use. I think school education—I think we are getting better and we are doing a much better job with school drug education than we were 20 years ago, but in moving forward we need to continue to look at the evidence of what works and what does not work, and perhaps even looking at what we call evidence of success. Is evidence of success prevention of drug use or is evidence of success prevention of drug harm? If it is the latter, then the way in which we are providing drug education should probably be slightly different.

[10.00 am]

**The CHAIR**: One of the things that the committee has been looking at has been the issue of cannabis use. I am curious to know—what is the public health perspective on a fully commercialised cannabis model, such as the model which is operating currently in Colorado?

**Dr Bright**: What I am saying now is my personal opinion. I step back from representing PHAA. My perspective is that the commercialisation can be an effective way of reducing harm, not only from cannabis and criminal issues associated with the use of cannabis, but it could have flow-on effects. They have seen reductions in prescription drug overdoses. They have seen reductions in the amount of fatalities from car crashes. There have been more car crashes in Colorado subsequent to the implementation of the regulatory framework. There are more car crashes, but they are less fatal because people are often driving under the influence of cannabis rather than alcohol. I think that —

**Hon SAMANTHA ROWE**: Why would that make them less fatal?

**Dr Bright**: Because when people are intoxicated on cannabis, they tend to drive slower. They are aware of their impairment. When people are driving intoxicated from alcohol, they are less aware that they are impaired. They tended to drive faster. However, mixing both alcohol and cannabis is a real recipe for disaster because there is increased impairment and less judgement—less insight into the fact that the person is impaired. I personally have problems with the way in which the Colorado model has been implemented because it has come from a very capitalistic viewpoint. I think if you are going to regulate a substance, you need to put the regulations at volume 10 at the start because you can always dial down the amount of regulation. It is easier to dial down regulation than turn it up. We know that from tobacco and the amount of effort it has taken for Australia to increase the amount of regulation over tobacco. If there were regulation over cannabis, I think that it would be important to start with something that had a lot more controls over advertising, product availability, where it can be sold—all of those things could be regulated much better than they are currently being regulated in Colorado. I think Washington is probably a better example. There is Uruguay, in which the government is actually in control of the regulation of cannabis. It is sold from pharmacies in Uruguay. I think there are a lot of different models and it is important to look at those other models. I think Colorado has got a lot of media attention because it was one of the first states to go live, but I do not think it is necessarily the best model.

**The CHAIR**: To what end do you look at regulation for marijuana? Because, certainly the evidence we have received is that even with regulated models you never get rid of the criminal element and the illegal supply of marijuana. What really is the point of a regulated market?

**Dr Bright**: You may never get rid of the criminal element, but it still reduces—it certainly significantly reduces the criminal element. If we look at tobacco as a comparison, with increasing regulation over tobacco we have seen increasing black-market tobacco to be able to undercut the current costs and taxation that is put on tobacco. I think by regulating it, though, it gives you a lot more control. It gives you control over the cannabis products that are available. Interestingly, the reason that cannabis was regulated in Washington—in Colorado it was regulated because the argument was that cannabis is less harmful than alcohol so we should regulate it. In Washington, it was the CWA that regulated cannabis.

**Hon MICHAEL MISCHIN**: The CWA?

**Dr Bright**: The country women's association. They were concerned about young people were accessing cannabis on the black market and would be exposed therefore to other illegal drugs. They argued that by regulating it, by having it for sale from sanctioned distributors then it would mean that young people were no longer being exposed to other illegal drugs through accessing it through those means. As a consequence, the Washington model is much different to the Colorado model. There is a lot less advertising. There are fewer dispensaries and those dispensaries that are available are far more regulated.

**The CHAIR**: Is there any distinct advantage over the sort of regulated model that you have just described in Washington and simply enabling people to grow it themselves similar to the regime we had prior to 2011?

**Dr Bright**: I guess one of the key advantages from a government perspective is the additional revenue that is made through the taxation of the product. I am in favour of both models in terms of the cannabis growing club–type model like they have got in Spain or regulated access. I think it is really dependent on a number of factors, including cultural factors, as to which model would work best in any given country. However, one of the key things that makes a difference in terms of a regulated model where licences are being issued to be able to distribute cannabis, is that there is taxation on those licences. There is taxation on the product that is being sold. The money that is being generated through that revenue can be spent on health, education and other social policies, ideally to reduce some of the harms associated with cannabis use. Personally, I do not think that the regulation of cannabis in Australia would lead to significant increases in cannabis use, given that already nearly 40 per cent of Australians have smoked pot at some point in their lives, and around 14 per cent used it in the past 12 months.

**Hon AARON STONEHOUSE**: You talked about some of the drawbacks of the commercial model. You talked about what level of regulation might be appropriate and where to step back when a commercial model is implemented. Do you think, however, that a commercial model such as Colorado's has reduced harm overall, despite its possible drawbacks, compared to a Washington model or a Uruguay or Spanish model? Has it reduced harm overall? Would it be a net positive from a public health perspective?

**Dr Bright**: Yes. I think overall it has reduced harm. It has reduced harm through reducing motor vehicle fatalities. This is all correlation. You cannot say that it caused the reduction in harms, but subsequent to it being regulated in Colorado, there has been a decrease in the number of motor vehicle fatalities and there has been a decrease in the number of prescription opioid deaths. It was already fairly regulated there prior, so they were not experiencing a lot of young people being engaged with the criminal justice system in the way we see in Australia, for example. But I think those two markers on their own are quite significant. Underneath that, there is some evidence of a reduction in alcohol use. As I said in the statement, alcohol is something that we do not talk about. Alcohol is a type 1 carcinogen. Personally, I do not drink because I do not want to expose myself to

a type 1 carcinogen. That is my choice. It is nice that I can make that choice when it comes to alcohol, but I cannot make the choice to smoke cannabis instead because that would be breaking the law. If people are reducing the amount of alcohol they are consuming, that could reduce, in the long-term, and we will not see this for a long time, the number of cancers and a range of illnesses that are associated with only low levels of alcohol consumption. Our national guidelines state that we should not drink more than 20 grams of ethanol on any given occasion. If you have two glasses of wine, that is over that limit. If people are drinking less alcohol, and exposing themselves less to that carcinogen, I would say that is a positive as well. That is sort of reading between the lines and is not something that is evident at the moment.

**Hon AARON STONEHOUSE**: One of the criticisms of a regulated market for cannabis is that cannabis consumption would increase as a result. You do not think that would be the case here in Australia. Has that been the case in jurisdictions that have gone down that route?

**Dr Bright**: Yes. There is evidence that in a lot of states where cannabis has been regulated, there has been a small increase in consumption. Usually, though, if you look at the states and countries that have regulated cannabis, they have already had medical cannabis in place prior to that. There has only been a small increase following the regulation because already people are accessing medical cannabis through doctors for a range of reasons. It has been quite broadly prescribed. In Australia we do technically have medical cannabis, though it can be very difficult for people to access. There are not a lot of Australians currently receiving medical cannabis. I still do not believe that we would see a significant increase in cannabis use in Australia should such regulations be put into place.

We already have one of the highest rates of cannabis use in the world and so it is unlikely that that is going to increase significantly from where it is at the moment. Even while we continue to have criminal sanctions on cannabis, we still remain a larger consumer of cannabis than many of the states and countries that have introduced regulated cannabis.

[10.10 am]

**Hon AARON STONEHOUSE**: I have long suspected that a lot of current cannabis users are using it for self-medicating purposes. They are self-medicating some kind of disorder or illness. Maybe I could get your thoughts on this. If that is the case, you have a medical cannabis regime and most of those people are using medical cannabis legally through a prescription or some kind of model like that, then you are left with only a small cohort that is using it for recreational purposes exclusively. Then if you regulate recreational cannabis, you are going to get only a slight increase in cannabis-use rates as a result of people moving into a regulated market and out of a black market.

**Dr Bright**: Correct. Talking to that point, the largest increase in cannabis use, the largest cohort, is in people 60 and over. There has been 208 per cent increase in cannabis use among people aged 60 and over. It is likely that many of those individuals are using it illicitly at the moment for medical reasons, but we do not have good evidence to indicate that is why they are using it. We actually do not know why there has been this massive increase among that cohort, but it may be for medicinal use. Should medical cannabis be easier to access, then some of those individuals may be able to then access cannabis more easily through medical routes. As you say, many individuals, if they were able to access medicinal cannabis, there would probably be a very small proportion who are using it purely for recreational purposes. They are already using cannabis anyway for recreational purposes, so if you regulate cannabis, what you get is those individuals continuing to use cannabis but doing so through a regulated supply. The revenue goes to the community, to businesses legitimately and it goes to tax as well, rather than going to criminals in the black market. There would be a small proportion of people who had never tried cannabis before because it is illegal—they are a small proportion—and some of those people would try cannabis given a regulated model.

They might try it once and go, "That's not for me" or they might have tried it a few times, but it is a very small number of people who have never smoked cannabis before who would take up cannabis smoking following regulation.

**Hon AARON STONEHOUSE**: I have one more question on this matter and then I will let someone else ask a question. One of the concerns about a regulated cannabis model is the proliferation of cannabis use, or the wider availability of cannabis, and then cannabis working as a gateway drug. I think you mentioned earlier the concerns that people who start smoking cannabis and move to other substances. You also said that in Colorado opiate use decreased at the same time that cannabis was regulated. It seems to me that when accessing cannabis through a black market, you are exposed to other illicit substances because a drug dealer may sell those other illicit substances; whereas, if you access it through a regulated market, there is less exposure to those other illicit substances, because you are buying it through a licenced dispensary. Is their data from the jurisdictions that have regulated cannabis to show how the use of other illicit substances has changed or remained the same as a result of the legalisation of cannabis? You mentioned opiates in Colorado; is there any other data around?

**Dr Bright**: I am only familiar with the use of prescription drugs in terms of those jurisdictions overseas and the impact that cannabis regulation has had on other drug use. I am not aware that it has had any significant impact on decreasing or increasing; I think rates have remained relatively stable when it comes to other drugs. When you are talking about the gateway effect, it is important to recognise that a large reason that cannabis is seen as a gateway drug is due to its availability. It is one of the most widely available drugs in Australia, and so it is reasonable to assume that if people are going to access heroin, they have to have accessed cannabis and other drugs first to have been able to access a drug that is not widely available. We know that the availability of a drug significantly correlates with the use of a drug, and cannabis is the most widely available and most widely used illicit drug in Australia.

**Hon AARON STONEHOUSE**: It is not necessarily that people are moving from cannabis to another substance like heroin. If they are using illicit drugs, they likely would have used cannabis merely because of its wide availability.

**Dr Bright**: Correct. As you say, if they are accessing cannabis from the illicit market, the person selling cannabis may also be selling other illicit drugs that people are then exposed to. Ideally, in a regulated system, that reduces people's exposure to those other illicit substances.

**Hon MICHAEL MISCHIN**: Basically, the gateway is the gateway to someone who can supply illicit drugs.

**Dr Bright**: Correct. That is a much better way of putting it. It is not a gateway drug; it is a gateway into people who supply.

**The CHAIR**: The access.

**Hon SAMANTHA ROWE**: Dr Bright, recently there has been a lot of media attention around ecstasy-related deaths, particularly over east. Does the Public Health Association have any recommendations to the committee around pill testing or drug checking, particularly at music festivals that young people are going to?

**Dr Bright**: Absolutely. The evidence internationally is that pill-testing services, provided they are not a delicatessen service, where people get the drugs checked and they get a result. They need to be integrated with harm-reduction brief intervention. It is that brief intervention that is the integral component to—the actual drug testing is a bait to get people in to provide them with harm-reduction information and education. Having personally worked as a harm-reduction volunteer over

east, if you do not have that bait, it can be difficult to get people in to have a chat around their drug use.

**Hon SAMANTHA ROWE**: You have seen it firsthand?

**Dr Bright**: I have seen it firsthand. I have also seen it firsthand in an unsanctioned manner as well. I was at a festival in Victoria with a group of academics. We brought basic reagent drug testing kit equipment with us, which was completely legal. About every 20 minutes, people would come up to us asking if we wanted to buy some drugs, and we said, "Can we test them first?" After 24 hours, we identified the deadly adulterant PMA. We went to the festival organisers and said, "Look, this is what we've found." They said to start doing rudimentary pill testing, not to advertise it, but to get it out by word of mouth. The harm reduction service there was able to—the influx of people was massive. People wanted to know not only what was in their drugs, but also whether that adulterant was in their drugs as well. We did not have access to the internet, but we had a pretty good idea of what was coming up. We would tell people, "We're were not 100 per cent certain; we think that is what it is." Most people just simply threw their drugs in the bin. Those who did not, stuck around for another 10 or 15 minutes of engagement and we provided them with information around taking less of the drug and how to reduce some of the harms that they might experience.

**Hon SAMANTHA ROWE**: If we were to go down the path of a pill-testing trial, what do you think we need to do to make sure it is safe and effective?

**Dr Bright**: I think the first thing that the WA government needs to do is to develop a peer-based harm reduction service. Something I have really recognised having come back to Perth, having been away for some time over east, is that WA is really lacking a peer-based harm reduction service for those sorts of festivals. Yes, we have a harm reduction service that is peer based that primarily focuses on the provision of needles and syringes —

**The CHAIR**: They do an excellent job.

**Dr Bright**: They do an excellent job. They provide naloxone training and treatment for hepatitis C. They are doing a fantastic job, but the one bit that they are not funded to do is to provide peer-based harm reduction at festival environments. It was a service like that which I was volunteering for in Victoria. That service in Victoria has been involved in the two trials in the ACT. I think it is tremendously effective to have peers providing the education and harm reduction, because it increases the credibility of the information provided—the person is seen as a more trustworthy source. In addition to that, having done some research at WA festivals, two things have become really clear. One is that compared with our eastern states counterparts, people going to WA festivals have a much lower level of education when it comes to drug use in terms of how to reduce drug-related harms. I was really surprised by the lower level of information and education that they had. The other thing is that people are really suspect of the government going into the festival setting to provide pill-testing services. I think another thing that has to happen, in addition to developing peer-based harm reduction services for festivals is for them to first go in and develop good relationships with people in the festival settings, because, at the moment, I do not know if we set up a pill testing service whether anyone would use it.

Perth is a small place; people are worried about what other people are seeing and how they are being perceived, so I think we need to first go into the festival settings and develop trust with the people who are attending the festivals before pill testing can be successful. It is pointless to run a trial of pill testing services if it is not going to be used.

[10.20 am]

**The CHAIR**: What do you think of the use of sniffer dogs?

**Dr Bright**: I think sniffer dogs have a place in law enforcement. They have a place in assisting to detect large quantities of drugs. I think police sniffer dogs have low efficacy when it comes to identifying personal quantities on people. It has been shown that they have very high false positives, so the likelihood that they get it right is about the same as flipping a coin, so it is not particularly effective. A lot of the policing that uses sniffer dogs, targets particular individuals based on the way that they look rather than randomly checking individuals in a crowd. In addition, they are extremely costly—I think it is about $30 000 an hour to run a sniffer dog, when you consider all the training that takes place as well; that is based on information provided by the New South Wales Parliament. So it is a very costly way of identifying individuals who are carrying personal quantities of drugs. What is the point of detecting small quantities of drugs on individuals in the first place? If I go back to the conversation we were having around focusing on the low hanging fruit, sniffer dogs are a great way of focusing on the low hanging fruit because they are more likely to pick up small quantities of drugs. People who are carrying around large quantities of drugs are probably going to have them on their person in such a way that the sniffer dogs are not going to pick up on it. In addition, given the death of Gemma Thoms in Western Australia, when she saw sniffer dogs, I think we need to be really concerned about the way in which they are used in a public environment, because it can lead to people panicking and taking the drugs that they have on them, leading to a fatal overdose.

**Hon MICHAEL MISCHIN**: Is not the point of sniffer dogs not so much to effect and arrest as to deter people from taking the drugs in in the first place?

**Dr Bright**: That is the point; there is no evidence that that works at all. A number of surveys have been conducted that show that people knowing that sniffer dogs are going to be on site does not decrease the amount of drugs or whether or not they are going to take drugs into a festival. While it is seen to be a deterrent, there is no evidence to indicate that it is effective as a deterrent.

**Hon COLIN de GRUSSA**: I want to go back to your example of that festival you attended over east. My question is around the presence of law enforcement at that festival: was it there in significant numbers?

**Dr Bright**: Yes, law enforcement were there. I do not know if they were aware of what was going on, but they were certainly very tolerant of drug use at the festival. You could smell cannabis and dimethyltryptamine in the air, and police were there for the safety of people at the festival. I was not aware of anybody who was arrested at the festival for personal use.

**Hon COLIN de GRUSSA**: So you do not necessarily think that the deterrent effect was useful at that festival?

**Dr Bright**: I do not want to name the festival, but I think this particular one has had a very good relationship with law enforcement. The police are there and they are seen as not there to charge people for drug use, but looking after the individuals who are at the festival—the police are seen as a safety mechanism. People would feel comfortable going up to one of the officers if they had experienced sexual assault or something like that, so they are seen as a safety mechanism rather than as somebody who is going to be punitive.

**Hon COLIN de GRUSSA**: In terms of the drug-use angle, they are not going to approach the police and say there are issues around here; it is more likely they are going to approach the peer-based service you talked about?

**Dr Bright**: Correct.

**Hon COLIN de GRUSSA**: Were there dogs at that festival as well?

**Dr Bright**: No, there were no dogs.

**Hon COLIN de GRUSSA**: Have you attended festivals at which there have been both? Clearly you have attended one without dogs.

**Dr Bright**: I have not been to a festival where there have been dogs, in the past 20 years.

**Hon MICHAEL MISCHIN**: You had a bit to say about harm reduction regimes with a view to dealing with people who wish to use drugs and the like, and the safe way that they can do that and reducing harm to them personally. Do you have observations about rehabilitation regimes? Plainly, the use of drugs can lead, and in many cases does lead, to degradation of a person's lifestyle, all the problems with addiction—loss of jobs, loss of family, isolation socially through addictions and the like. In rehabilitation regimes, we have had a couple that we have seen or know of, for example, Hope Springs and Shalom House, and there are no doubt others. If you have any observations about how those ought to be constructed and, importantly, how to encourage people to go into those regimes, I would be interested to know that.

**Dr Bright**: I have worked in alcohol and other drug treatment services for over 20 years now. My observations have been that oftentimes people who are mandated to seek services see it as an opportunity to change—not all do—and some just come, attend, get the tick and leave. But others do see it as an opportunity to do something about their lives. I think what makes the difference between somebody who gets something out of it and actually changes their behaviour is they make lifestyle change. I think that is the most important thing. For somebody whom you have just described, experiencing all those things, they need to actually make a lifestyle change, which might include a geographical shift so they are no longer around the people they were with, who often are using drugs as well. It requires them to find purpose and meaning, often through some sort of employment where they feel useful as an individual, because often when they have hit that point they do not feel that they are a useful member of society. That comes from within the person. You cannot make people engage in lifestyle change. They have to want to do that. I think that is one of the reasons why mandated treatment does not work if it is truly mandated. Sure, some people will get mandated treatment, use it as an opportunity and make lifestyle change, but not everybody will. When people voluntarily access services, they have realised that something is not right with their current situation and they really want to change it; they want to make that lifestyle change. It is everything from getting rid of their phones so they have a new phone with none of the contacts in it anymore—an absolute change of lifestyle is required. For people to be able to access services, one reason they do not is they may not be aware of how; they may be under the impression, not necessarily that they are ineffective, but the perception of what treatment services look like and what they are, are often incongruent.

**Hon MICHAEL MISCHIN**: That is the value of these peer support groups that you talk about where there are people who can exchange ideas.

**Dr Bright**: And to talk about their own personal experience in accessing services and the different services that are out there. I think it is great that WA has myriad different services that are very different in the way that they provide treatment and rehabilitation, because different things work for different people. There should be a platter of options for individuals because different things will work for different people.

**Hon MICHAEL MISCHIN**: On that point if I may, I am interested in some of the things you said there, but one of them being the change of lifestyle. What is it that can encourage or trigger people to go into these things? Okay, mandated treatment might and might not work; court orders might and might not work. I suppose there is the value of a criminal sanction because it makes people realise, "Hey, you're really in trouble. You need to think about your life, and here's an opportunity." Without all that, what are the things that will encourage people to move from the start of an addiction or

into trying to take themselves and get out of that before it is too late, or do they have to wait until they have hit despair and have very few options?

[10.30 am]

**Dr Bright**: There has to be some experience; the person has to experience something that makes them want to do something differently. They have to experience something that challenges their current way of seeing their life so they are motivated to do something different about that.

When I teach my students about the idea of a coerced client—in other words, a mandated client—I often say that no client is not coerced; they are always coerced in some way, shape or form. It may be that their wife is wanting to leave them; it may be that there is a threat that their kids are going to be taken away or they are going to lose their job. There is always some sort of a threat there. Nobody comes into a treatment service saying, "I just want to give up the drugs." There is always going to be something about drugs that they like, or they would not have been using them in the first place, so in many respects, everybody is coerced into treatment in some way, shape or form. There are so many different reasons why a person will want to come and access treatment, but they need to experience that for themselves.

**The CHAIR**: One of the things that the committee has also been unpicking is the idea of compulsory detox, particularly for people who are on meth, as opposed to compulsory treatment. The evidence that has been received is that compulsory detox may need to be up to 12 to 14 days in order to even have effect. Do you have any thoughts, from a public health perspective, as to whether that is something that should be further investigated?

**Dr Bright**: In Victoria, a couple of years ago they introduced the opportunity to mandate someone to receive detox from alcohol, where it was deemed that they did not have the capacity to make a reasoned choice about whether or not they should receive detox services. The initial findings from that are that it has not been used very frequently; it has been very infrequently used, but when it has been used, it has been a good opportunity, for their physical health, to give the person a bit of a break from the alcohol, which is helpful. It is a bit of a moment to allow them to reassess, when they are not under the effect of alcohol, what is going on for them, and do they want to do something differently about it. I think if you give an individual an opportunity to cease using a substance, if they are particularly really heavily using that substance, it may provide them with an opportunity to see their situation from a different perspective and make their own choice from there on in whether or not they do something about it. If they make their own choice to do something about it at that point, they are going to be far more likely to be successful. When we own our choices, we are more successful in what we do.

**The CHAIR**: Just to be clear, are you saying that there is a particular piece of research around that trial?

**Dr Bright**: I am not sure; I am basing it purely on my anecdotal experience as a clinician in Victoria.

**The CHAIR**: Okay. As a further line of questioning, which I will deem 1A, I will write to you further to seek more information about that particular trial, if that is okay. I am happy to take that on notice.

**Dr Bright**: Sure.

**The CHAIR**: I am conscious of the time and that we have run out of time.

**Hon MICHAEL MISCHIN**: Do you have a problem if we write to you with a few more questions on various issues that occur to us?

**Dr Bright**: No, I welcome that. Thank you for having me today.

**The CHAIR**: That would be great. The committee really does appreciate your time today, and thank you for attending. A transcript of this hearing will be forwarded to you for correction. If you believe that any corrections should be made because of typographical or transcription errors, please indicate these corrections on the transcript. Errors of fact or substance must be corrected in a formal letter to the committee. When you receive your transcript of evidence, the committee will also advise you when to provide your answers to questions taken on notice. If you want to provide additional information or elaborate on particular points—often when you go through the transcript, it will trigger your memory and you may think, "I should have supplied that"—you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. Thank you so much for your time today. That was really helpful.

**Dr Bright**: I appreciate you allowing me the opportunity to come in today.

**Hearing concluded at 10.33 am**