



Public Health Association
AUSTRALIA

Supplementary submission to the WA Parliament Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community

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Illicit Drug Use and its Effects on the Community

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Contents

Introduction	3
General policies on prevention and harm reduction	3
Ecstasy-related harms	4
Pill testing	5
Supervised injecting centres	6
Syringe exchange in prisons	7
Experience from other jurisdictions and nations	8
Effectiveness of compulsory detoxification	8

Introduction

In January 2019 PHAA made a written submission to the Inquiry into alternate approaches to reducing illicit drug use and its effects on the community in Western Australia.

On 17 June 2019 Dr Stephen Bright, senior lecturer in addiction at Edith Cowan University, appeared as a witness before the Committee. The University is an organisational affiliate of PHAA and Dr Bright appeared on our behalf.

During Dr Bright's appearance one question was taken on notice, and the committee secretariat later forwarded an additional 16 questions seeking further information. This **supplementary submission** addresses those questions.

General policies on prevention and harm reduction

Question 1: I refer to the PHAA submission to this inquiry. The submission points out that the majority of funding currently goes toward supply reduction. What would a realistic proportion of funding for demand harm reduction be?

We know that Australia's health system devotes a strikingly low level of expenditure to preventive activities and services compared to most OECD nations. Only around 1.6% of total public and private expenditure on health in Australia is directed to preventive measures, whereas most OECD nations have a proportion in the range 2-4%, and the world leaders Canada, New Zealand and the UK have a proportion of around 5-6%.

However at a micro level approaching the policy design for particular categories of health services through the lens of resource dedication targets, or proportions between categories, may not be particularly helpful. PHAA does not propose any specific target proportion for use as a metric in policy balancing.

That said, PHAA would take the view that there is a strong case to devote more resources to harm reduction.

On the other side of the ledger, the cost-benefit value of current expenditure on supply reduction measures may well be poor, and where such returns are poor there will be a case for saving public resources. PHAA does not put forward evidence for the particular cost-benefit value of supply reduction programs – although we would certainly urge governments to acquire such evidence and review the value of all policies.

The price of drugs in Australia is higher than any other developed nation.¹ Given an ongoing high demand for drugs in the country, there is a lucrative black market that criminal syndicates will continue to engage with given the high profit margins. Supply control measures do not decrease demand and even if successful at reducing supply, the price of illegal drugs increases, further consolidating the lucrative black market

¹ Global Drug Survey. (2015). *The Global Drug Survey findings*. <https://www.globaldrugsurvey.com/the-global-drug-survey-2015-findings/>

Supplementary submission to the WA Parliament Inquiry into Alternate Approaches to reducing Illicit Drug Use and its Effects on the Community

Reducing the demand for drugs in Australia would reduce these profit margins. One suggestion in PHAA's initial submission was to consider decriminalisation measures. When the possession of personal quantities of drugs was decriminalised in Portugal, the funding that was being used for this aspect of supply control was used to fund demand reduction.

Question 2: Prevention is a key public health strategy. To what extent are prevention activities coordinated and evaluated in WA and Australia more generally?

National

PHAA's view is that prevention activities are not adequately coordinated across Australia. In 2011 the Australian National Preventive Health Agency was established at Commonwealth level, but regrettably this agency was defunded by the Commonwealth Government in 2014.

PHAA also supports the existing *National Drug Strategy*.

PHAA has a detailed policy statement on [Health Promotion and Illness Prevention](#), developed through extensive consultation among our expert members and released in late 2018. The policy is supported by a detailed [Background Paper](#).

Western Australia

In Western Australia, prevention is recognised as a priority in a number of key policies:

- The WA [Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025](#) provides an overview of recommended programs, strategies and initiatives to prevent and reduce drug use in WA. Identified strategies within the Prevention Plan include supporting key harm reduction measures to reduce alcohol and other drug-related harm, such as overdose prevention programs and needle and syringe programs. This Prevention Plan was developed as an action out of the *WA Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025*.
- The WA [Alcohol and Drug Interagency Strategy 2018 – 2022](#) also identifies prevention as a key strategic area.

In addition the recent WA Sustainable Health Review included the recommendation (which has been accepted by government) to “Increase and sustain focus and investment in public health, with prevention rising to at least five per cent of total health expenditure by July 2029”.² PHAA strongly endorses this high-level goal.

However, as with national policies, at state level there is also much that could be done to improve coordination across all illness prevention policies.

Ecstasy-related harms

Question 3: There has been a lot of attention on ecstasy-related deaths over east. What sort of ecstasy related harms are we seeing in WA?

WA has the highest prevalence of ecstasy use compared to any other Australian state or territory.³ Given this situation it is fortunate there have been no recent ecstasy-related deaths in WA. This

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<https://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Sustainable%20Health%20Review/Final%20report/sustainable-health-review-final-report.pdf>

³ Australian Institute of Health and Welfare. (2018). *National drug strategy household survey 2016: Detailed findings*. Canberra, Australia: Australian Institute of Health and Welfare.

absence of recent deaths in WA is likely due to our smaller population, with yet-to-be-published research conducted at WA music festivals this year by Dr Bright finding the level of knowledge about how to reduce harms from ecstasy to be lower among people in WA that use ecstasy compared to people over east. This is likely due to WA not having peer harm reduction services similar to those funded by Victorian and NSW governments that aim to educate people through engaging with them at festivals. Should there be no efforts to increase harm reduction knowledge among people who use ecstasy then an ecstasy-related death in WA is imminent.

However, death is the least common harm experienced by people who use ecstasy. Harms that are more common arise from the toxicity of adulterants contained in ecstasy. When used in clinical setting 3,4-Methylendioxmethamphetamine (MDMA) has not been found to cause adverse effects.⁴ MDMA is the chemical that is commonly referred to as ecstasy, however ecstasy does not necessarily contain MDMA given there is not quality control within black-markets. Rather, ecstasy often contains dangerous adulterants such as 25-C-Nbome, which has led to numerous hospitalisations across Australia.⁵ There is evidence that WA ecstasy has contained Nbome drugs, though the amount ecstasy-related harms experienced by the WA community is not clear.⁶ Unlike Victoria, where data on drug-related ambulance call outs, hospital admissions and access to treatment services is publically available via <https://aodstats.org.au/>, information on indicators of harm in WA are more difficult to obtain.

To be able to determine the degree to which drug-related harms are experienced by the WA community more accurately, it is recommended that WA establish a similar data monitoring system to <https://aodstats.org.au/>. Further, while there have been efforts by Royal Perth Hospital to establish a surveillance system to detect the emergence of novel psychoactive substances such as Nbome⁷, it is recommended that this data be used to develop an early warning system that can alert people who use ecstasy to reduce harm. Finally, to prevent ecstasy-related harms, including deaths, it is recommended that the WA government fund peer-based harm reduction services.

Pill testing

Question 4: The Committee has heard concerns about the at-home pill testing kits. Can you comment on the safety and effectiveness of these?

At-home pill testing kits contain reagent chemicals that react to certain chemical by changing colour. The most well known reagents are marquis, mandelin and mecke. Reagent chemicals are caustic and should be handled with care. Further, some at-home pill testing kits are not well labelled. For

⁴ Bright, S. & Williams, M. (2018). Should Australian Psychology Consider Enhancing Psychotherapeutic Interventions with Psychedelic Drugs? A Call for Research. *Australian Psychologist*, 53(6), 467-476.

⁵ Connaughton, M. (2017). Leaked police memo reveals what was in Melbourne's deadly batch of MDMA. *Vice* https://www.vice.com/en_au/article/3dp5pk/leaked-police-memo-reveals-what-was-in-melbournes-deadly-batch-of-mdma

⁶ Edmunds, R., Donovan, R., & Reynolds, D. (2018). The analysis of illicit 25X-NBOME seizures in Western Australia. *Drug Testing and Analysis*, 10, 786-790.

⁷ McCutcheon, D., Raghavan, M., Soderstrom, J., Oosthuizen, F., Douglas, B., MacDonald, E., & Fatovich, D. (2018). An early warning system for emerging drugs of concern in the emergency department: Protocol for the Western Australian Illicit Substance Evaluation (WISE) study. *Emergency Medicine Australasia*. [Early Online]

example, one of the most common ketamine test kits contains the mandolin reagent, which is not good at identifying ketamine due to the adulterants in ketamine, though is useful in identifying MDMA and adulterants contained in ecstasy.

Using reagent chemical to determine the contents of drugs is rudimentary at best; however, in the absence of sanctioned pill testing, reagent testing can provide people who use ecstasy with important information about dangerous adulterants contained in their drugs. In this respect, negative results (i.e., those that indicate the presence of an adulterant) are more useful than positive results (i.e., indicating the presence of MDMA). However, given the limited effectiveness of any one reagent to detect an adulterant, it has been recommended that people use more than one reagent to test their drugs.⁸ The effectiveness of using multiple reagents to detect dangerous adulterants was demonstrated during unsanctioned pill testing at a Victorian music festival where 25-C-Nbome was detected in a number of samples.⁹ Most people who were told that their sample contained 25-C-Nbome discarded their drugs. Some Australian universities are providing their students with free reagent testing kits and providing them with education on how to best use them and their limitations. The effectiveness of reagent testing can be improved through such education.

Question 5: Are many people using at-home pill testing kits?

A survey of 851 Australians who use ecstasy found that one in four had used an at-home pill testing kit or sent a sample of drugs to a laboratory overseas for analysis.¹⁰ Preliminary analysis of yet-to-be-published research conducted at WA music festivals this year by Dr Bright found significantly less people who reported using ecstasy had used at-home pill testing kits, with most participants unaware of such kits being available.

Supervised injecting centres

Question 6: The Committee has heard about the potential benefits of Medically Supervised Injection Centres.

Question 7: The Kings Cross Centre has been evaluated a number of times. Is there any emerging evidence about the Richmond Centre?

Question 8: To what degree is methamphetamine used at the Richmond Centre?

Question 9: Do either of these Centres have the facility for supervised inhalation? If not, would this be valuable?

PHAA's policy position is that harm minimisation should provide the framing for drug policy, and PHAA certainly supports the existence and ongoing development of the Richmond centre. We

⁸ Bright, S. J. (2019). While law makers squabble over pill testing, people should test their drugs at home. *The Conversation*. <https://theconversation.com/while-law-makers-squabble-over-pill-testing-people-should-test-their-drugs-at-home-109421>

⁹ Zimmerman, J. (November 2017). Ecstasy pill tests 'will save lives', says Perth researcher. *The Sunday Times*. <https://www.perthnow.com.au/news/wa/ecstasy-pill-tests-will-save-lives-says-perth-researcher-ng-209ae9ed38dd41c1fa2f4038f7e10e81>

¹⁰ Barratt, M. J., Bruno, R., Ezard, N., & Ritter, A. (2018). Pill testing or drug checking in Australia: Acceptability of service design features. *Drug and Alcohol Review*, 37, 226-236.

Supplementary submission to the WA Parliament Inquiry into Alternate Approaches to reducing Illicit Drug Use and its Effects on the Community

understand anecdotally that Richmond presents a complex local environment in which the centre is operating.

PHAA suggests that the Committee seek information on actual practices and (to the extent yet available) outcomes directly from the Richmond Centre and from Victorian health authorities.

Question 10: Are you aware if there is a particular part of Perth that might benefit from a Centre, due to a high concentration of injecting drug users?

Unlike Melbourne and Sydney, there are few geographic areas in Perth with high concentrations of people who inject drugs. Rather, people who inject drugs are dispersed across the metropolitan region. The area in which a MISC would be most utilised would likely be near the Mclver train station, where Peer-Based Harm Reduction WA are currently located who provide needle and syringe exchange services to over 18,000 people per year. However, rather than establishing a MISC in Perth, the WA government might get a better return on investment from increasing the availability of home and outreach needle and syringe exchange services and naloxone distribution.

Syringe exchange in prisons

Question 12: “The Committee understands that a number of countries operate needle and syringe programs in prisons.”

The following countries have needle and syringe exchange programs in prisons: Tajikistan, Germany, Spain, Switzerland, Luxembourg & Armenia.

Question 12: Could you summarise how these programs operate?

A range of methods are used to needle and syringe exchange programs in prisons, including “automatic dispensing machines; hand-to-hand distribution by prison physicians/health-care staff or by external community health workers; and programs using prisoners trained as peer outreach workers”.¹¹

Question 13: There is a lot of concern about safety risks. How are these managed overseas?

The Australian Capital Territory government has attempted to implement needle and syringe programs in its prisons on two occasions. These efforts have been unsuccessful due to concerns expressed by prison workers about increased risks of being exposed to needle stick injuries. However, the Australian Medical Association note that prison-based needle and syringe programs “have been shown to reduce the risk of needle-stick injuries to staff, and increase the number of detainees accessing drug treatment, while showing no adverse effect on illicit drug use or overall prison security”.¹² Given that 6% of WA prisoners admit to injecting drugs while in prison,¹³ there are already needle and syringes in WA prisons that could be used as weapons.

¹¹ Stöver, H., & Hariga, F. (2016). Prison-based needle and syringe programmes (PNSP)—still highly controversial after all these years. *Drugs: Education, Prevention and Policy*, 23(2), 103-112.

¹² Australian Medical Association. (2019). *Needle and syringe programs needed in prisons*. <https://ama.com.au/media/needle-and-syringe-programs-needed-prisons>

¹³ Rodas, A., Bode, A., & Dolan, K. (2012). Supply, Demand and Harm Reduction Strategies in Australian Prisons: An Update. Retrieved from http://www.atoda.org.au/wp-content/uploads/rp23_australian_prisons.pdf

Question 14: Are you aware of whether there is a problem with the transmission of blood borne viruses in WA prisons?

Despite the WA Department Corrective Services having a zero-tolerance approach to drug use in prison, at least 6% of WA prisoners use drugs by injection.¹⁴ These prisoners share injecting equipment, increasing the likelihood of blood borne virus transmission. Fortunately, the prevalence of Hepatitis C Virus is lower among people entering WA prisons compared to NSW, Queensland and Tasmania.¹⁵ However, the prevalence of Hepatitis C Virus is significantly higher among WA prisoners than in the WA community, and recently released prisoners infected with the Hepatitis C Virus place members of the community at increased risk of infection. While rates of HIV infection are relatively low among Australian prisoners, if there were to be an outbreak of this virus, the most likely source of the outbreak would be prisons.

Experience from other jurisdictions and nations

Question 15: The submission refers to international mechanisms including Swiss Heroin Assisted Treatment, Portuguese dissuasion commission and New Zealand's New Psychoactive Substances regulation. Do you have any views on whether these mechanisms could be applicable in the WA context?

The Portuguese dissuasion commission is relevant to the challenges being faced by WA, with the caveat that WA does not have particularly high rates of heroin use. Fully pursuing the Portuguese approach would first require the decriminalisation of drugs for personal use.

Given the 2015 changes to the WA Misuse of Drugs Act the current WA regime resembles the NZ Psychoactive Substance Act. However WA does not have the capacity to register a product for distribution as is happening in NZ.

Question 16: Can you tell us about any other demand or harm reduction trials occurring across Australia that we may not be aware of?

The Committee has already heard discussion about pill testing, which we believe has substantial potential to reduce both demand for drugs and in particular harms from drug use.

Effectiveness of compulsory detoxification

What evidence is there for the effectiveness of compulsory detoxification? (Question taken on notice)

The Victorian *Severe Substance Dependence Treatment Act 2010* allows people with severe substance dependence to be detained and provided with a compulsory detoxification for up to 14 days. The Act is based on similar premises that allow people with mental illness who are at-risk to

¹⁴ Rodas, A., Bode, A., & Dolan, K. (2012). Supply, Demand and Harm Reduction Strategies in Australian Prisons: An Update. Retrieved from http://www.atoda.org.au/wp-content/uploads/rp23_australian_prisons.pdf

¹⁵ Reekie, J. M., Levy, M. H., Richards, A. H., Wake, C. J., Siddall, D. A., Beasley, H. M., ... & Butler, T. G. (2014). Trends in HIV, hepatitis B and hepatitis C prevalence among Australian prisoners-2004, 2007, 2010. *Medical Journal of Australia*, 200(5), 277-280.

themselves or others who are deemed incapable of making an informed decision to be provided with mandatory treatment. The Act is intended as “a last resort treatment option for a small group of people who, without this life-saving intervention, would most likely become permanently disabled or die” and not individuals “who are capable of making choices about their substance use, including refusing treatment”.¹⁶

Consistent with this intention, between March 2011 and February 2015 only 23 people were detained under the Act.¹⁷ 28% of these individuals were either abstinent or had reduced their use at a 6-month follow up. It is important to note that while the United Nations advises that short periods of mandated treatment, such as those provided for people under the Act, there is little evidence that longer term compulsory treatment has efficacy in reducing alcohol and other drug-related harms and could be a breach of international human rights charters.¹⁸

Conclusion

PHAA hopes this additional information of useful to the Committee. Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

PHAA would like to acknowledge the contribution of Dr Stephen Bright in preparing this supplementary submission, and also acknowledge other members of PHAA who contributed and commented on drafts.



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¹⁶ Victorian Department of Health. (2015). About the Severe Substance Dependence Treatment Act 2010. <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-policy-research-legislation/aod-legislation/severe-substance-treatment-act-ssdta/about-the-severe-substance-dependence-treatment-act-2010>

¹⁷ DLA Piper. (2015). Final report on the review of the Severe Substance Dependence Treatment Act 2010. <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/final-report-on-the-review-of-the-severe-substance-dependence-treatment-act-2010-vol1>

¹⁸ Lander, F., Gray, D., & Wilkes, E. (2015). The Alcohol Mandatory Treatment Act: evidence, ethics and the law. *Medical Journal of Australia*, 203, 47-50.