HELP, NOT HANDCUFFS: EVIDENCE-BASED APPROACHES TO REDUCING HARM FROM ILLICIT DRUG USE

Final Report of the Select Committee into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community

Presented by
Hon Alison Xamon MLC (Chair)
November 2019
Select Committee into alternate approaches to reducing illicit drug use and its effects on the community

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**Government response**

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Where a report recommends action by, or seeks a response from, the Government, the responsible Minister or Leader of the House shall provide its response to the Council within not more than 2 months or at the earliest opportunity after that time if the Council is adjourned or in recess.

The two-month period commences on the date of tabling.
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EXECUTIVE SUMMARY

1 The Legislative Council established the Select Committee into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community (Committee) on 17 October 2018. The Committee inquired into approaches to reducing harm from illicit drug use in other jurisdictions and compared their effectiveness to the approaches currently used in Western Australia (WA).

2 The inquiry is specifically about illicit drugs, although the Committee heard about the high levels of harm associated with alcohol and prescription drugs. Importantly, the inquiry is concerned with drug users, and not people involved in the drug trade. The Committee inquired into approaches to addressing the use and possession for personal use of drugs, and not possession with intent to sell or supply, or the distribution of drugs.

3 People always have, and always will, use drugs. Prohibition has not stopped this. In 2016, 43% of Australians had illicitly used a drug at some point in their lives. There is a growing recognition across the world that drug prohibition has increased the harms associated with drug use. Under prohibition, black markets have thrived, prisons have filled with drug users and those committing drug-related offences, and stigma is experienced by people who use drugs.

4 The Committee has distinguished between non-problem and problem drug use. Most people who use drugs do so in an occasional, recreational way that does not adversely affect their lives or the community. The minority suffer from drug use disorder, and require treatment or support. Some people are more likely to develop drug problems than others. Factors including childhood trauma, economic disadvantage, unemployment, unstable housing and mental health issues are linked to problematic drug use. People living in regional and remote areas, and particularly Aboriginal Australians, are at greater risk of experiencing drug-related harm.

5 Drug use is associated with health, social and economic harms to the people who use drugs, their family and friends, and the wider community. Drug use itself causes some of these harms, such as death, disease and drug-fuelled violence. Other harms are caused by the criminalisation of drug use or possession for personal use. A criminal record can affect employment, housing and educational opportunities. Prohibition also increases stigma, as people are less likely to seek help when they fear criminal action. These impacts can compound existing social disadvantage. The Committee found that all of these harms are present in WA, particularly given our high rates of problematic methamphetamine (meth) use.

Current approaches in Western Australia

6 The Committee first examined current approaches to drug use in WA. Drug use and the possession of drugs for personal use are simple offences under the Misuse of Drugs Act 1981, and can attract a criminal record, a fine and/or imprisonment. Drug policy in WA and Australia more broadly is based on the three pillars of supply reduction, demand reduction and harm reduction. The Committee heard that demand and harm reduction are not receiving sufficient priority. Over two-thirds of drug-related government spending goes towards law enforcement efforts to target drug supply. Yet illicit drugs remain widespread, relatively cheap and easy to obtain.

7 People who use drugs may avoid criminal penalties through the WA Police Force Drug Diversion Program, which diverts low-level offenders to drug education sessions. Drug diversion is a cost-effective option for reducing imprisonment and increasing treatment uptake. Strict eligibility criteria and other limitations mean the Program is not diverting as
many people as it could. As a result, Western Australians are the least likely in the country to be diverted from prosecution for minor drug offences.

8 Over two-thirds of WA prisoners have a drug problem. The community expects that prisoners will receive treatment for their drug addiction while in custody. However, the Committee heard that this opportunity is often not available. Promising initiatives such as the Perth Drug Court and Wandoo Rehabilitation Prison help a small number of people to address their drug issues through the justice system. Yet prisoners risk being released without having their drug issues addressed, as many cannot access the single drug treatment program currently delivered in prison.

9 While a range of treatment, support and harm reduction services are available in WA, the Committee identified a number of barriers. These include a shortfall of treatment services to meet demand, no medical treatment for meth dependency, insufficient treatment options in the regions and a limited number of addiction specialists in the public health system.

A health-based approach

10 The Committee heard that drug use should be treated primarily as a health and social issue rather than a criminal justice issue. This view is gaining acceptance around the world. The Committee has found that in practice, as long as drug use is a punishable offence that attracts criminal penalties, it will predominantly be treated as a criminal justice issue instead of a health issue.

11 Portugal adopted a health-based approach to drug use in response to a heroin epidemic in the late 1990s/early 2000s. Reforms included:

- shifting responsibility for drug issues from the justice system to the health system
- increasing funding for treatment services
- adopting harm reduction measures
- replacing the criminal penalties associated with drug use and possession for personal use with administrative responses. People apprehended by police appear before an expert panel, who may refer the user to treatment, suspend proceedings, or issue a non-criminal penalty (such as community service or a fine).

12 Far from being lenient or ‘legalising’ drugs, the Committee found the Portuguese response to drug use to be comprehensive. Drug-related harms fell significantly after the reforms and, today, drug use in Portugal is lower than the European Union average. The Committee is of the view that a health-based approach could only work in WA if treatment and support services were sufficient to meet demand.

13 The Committee devised two potential options for adopting a health-based approach in WA:

- expand and improve the WA Police Force Drug Diversion Program
- establish a separate administrative body and process for dealing with drug use and possession for personal use.

Regulatory approaches to cannabis

14 The Committee heard that cannabis is different to other illicit drugs. It is more widely used, and many people told the Committee that they lead functioning lives after using cannabis for many years. The Committee inquired into cannabis-specific regulatory regimes that are operating around the world, including commercial legalisation (Colorado), Cannabis Social Clubs (Spain) and decriminalisation (South Australia and the Australian Capital Territory). As cannabis use is associated with significant risks, the Committee is of the view that its proposed health-based approaches are appropriate.
A zero-tolerance approach

15 The Committee inquired into the Swedish zero-tolerance approach. Some suggest that strict approaches can reduce harm by preventing the uptake of drug use. In Sweden:

- drug users cannot be diverted from court
- police may issue blood and urine tests to prove that drug use has occurred
- harm reduction is not a focus.

16 However, drug use is increasing over time, and Sweden has the second highest rate of drug-induced deaths in the European Union. In light of this, the long-held vision of a drug-free society is beginning to waver, and many suggest that it is time to reconsider strict prohibition. Notwithstanding this, the Committee considers the Swedish commitment to prevention and education to be valuable.

Harm reduction

17 The Swiss ‘four pillars’ policy, often cited as a model of global best practice, gives priority to public health and harm reduction over prohibition. Drug policy reforms were enacted incrementally throughout the 1990s and 2000s, based on evidence built over time through pioneering a range of harm reduction initiatives. The reforms led to significant declines in overdose deaths, property crime and HIV. Lessons from the Swiss experience include fostering genuine partnerships between law enforcement and health agencies and creating a policy setting focussed on harm reduction.

18 The Committee explored a range of harm reduction measures, which aim to reduce harms for those people who are unwilling or unable to stop using drugs. Harm reduction initiatives that the Committee considered include:

- Drug Consumption Rooms (also known as Medically Supervised Injection Centres)
- Heroin Assisted Treatment
- Needle and Syringe Programs in prisons.

19 Most Australians attending music festivals will take drugs. The Committee heard that the current strategy of using sniffer dogs has little effect on detecting or deterring drugs at these events. Drug checking services, also known as pill testing, are a means of avoiding drug-related deaths at music festivals. Drug checking can improve safety by facilitating early warnings about dangerous substances, and provides a vital opportunity for peer workers to engage with people who intend to take drugs. Such services have operated in Europe for over 20 years and have recently been trialled in the Australian Capital Territory. The Committee recommends that the WA Government consider piloting such a service.

Meth in emergency departments

20 Meth-induced psychosis causes chaos in WA hospital emergency departments. Healthcare workers experience violence, the cost to the taxpayer is high and admission does not necessarily lead to addressing drug problems. The Committee investigated a dedicated alcohol and other drug emergency department in Sweden. The Committee heard about new and promising WA approaches, which include the:

- WA Police Force Mental Health Co-Response Program
- Urgent Care Clinic at Royal Perth Hospital.

Alternative approaches to treatment

21 Compulsory treatment requires a legal order to detain a person for a specified period to receive drug treatment. This is not available in WA, but debate has ignited in recent years in
light of the meth problem. The Committee heard that for some WA families, compulsory treatment may seem like the only way to rescue their loved ones from a constant cycle of prison stays, criminal charges and drug relapses. The Committee explored Swedish and Australian models of compulsory treatment, but ultimately found that there is insufficient evidence about their effectiveness to recommend its introduction.

22 Although WA does not have compulsory drug treatment, the Mental Health Act 2014 (Mental Health Act) provides for the temporary detention of people with mental illness. The Committee heard that psychiatrists sometimes use the Mental Health Act to detain meth-affected patients for a day or so, but there is legal uncertainty around their power to do so. The Committee recommends that the Mental Health Commission clarify the position through its review of the Mental Health Act.

23 It can take up to two weeks to detoxify (detox) from meth. Given the questions about detaining meth-affected people under the Mental Health Act, the Committee considered whether compulsory detox would be a suitable short-term option for people who pose a threat to themselves or others. Given that approximately two-thirds of Perth police lock-up detainees are on meth, there may be a need for an alternative form of crisis intervention. If such an intervention can help people to make clear-headed, informed decisions about seeking further treatment, as well as protect the community from meth-related violence, the Committee found it would be worth trialling.

24 It can take longer to recover from meth dependency than other drugs. This is due to a lack of proven medical treatment for meth dependency, and the brain damage associated with meth use. The Committee explored the San Patrignano model, a therapeutic community located on a cooperative farm, running a three to four year residential rehabilitation. Similar programs are already operating in WA, although the Committee heard that government procurement processes make funding for longer-term treatment options difficult. The Committee also considered the need for all treatment service providers, including private providers, to meet quality standards.

A way forward

25 In conclusion, the Committee found that a number of approaches used within Australia and internationally have successfully reduced drug-related harms by shifting policy priorities from prohibition towards health, prevention and harm reduction.

26 The approaches proposed in this Report call for a refocussing away from a criminal justice approach and towards a health-based approach. In summary, the Committee recommends that:

• the protection of individuals and the community from drug-related harms remain a priority
• drug use is treated primarily as a health issue
• criminal penalties for the use and possession of drugs for personal use are replaced with administrative penalties
• current practices are reviewed and continually improved in line with contemporary evidence
• people who need help for drug-related issues, including those in regional areas or in prison, are able to access that help
• there be measures in place to reduce harms for those who are unwilling or unable to stop using drugs.
Findings and recommendations

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<td>A substantial amount of drug-related harm in Australia is attributable to alcohol and prescription drugs.</td>
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<td>A governmental or parliamentary inquiry be established to examine and report on the harms associated with prescription drug misuse in Western Australia.</td>
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<td>People across the world have used mind-altering substances for thousands of years, for a variety of reasons.</td>
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<td>The United Nations Conventions have provided the traditional framework for drug illegality and criminalisation across the world.</td>
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<td>The Western Australian Government review the <em>Misuse of Drugs Act 1981</em>, and as part of that overall review consider including a statement of its objectives.</td>
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<td>Most methamphetamine is imported into Australia from overseas and is of higher purity than five years ago.</td>
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<td>Western Australia faces unique geographical challenges to restricting the importation of drugs.</td>
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<td>Supply reduction strategies are an important part of reducing drug-related harms, but have limited capacity to influence drug use without comprehensive demand and harm reduction strategies.</td>
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The Committee received a level of support for considering alternative responses to dealing with harms arising from illicit drug use.

The current approach to prohibiting drug use is not having the intended effect of stopping people from taking drugs.

Social factors like trauma, homelessness and disadvantage are often predictors of problematic drug use.

The social predictors of problematic drug use may be more apparent in regional and remote areas.

Aboriginal Australians are more likely to experience serious drug-related harms.

On any given day, hundreds of millions of people around the world use drugs, and global drug use continues to increase.

Drug use in Western Australia has decreased slightly since 2010, but problems associated with drug use are increasing.

The final report of the Methamphetamine Action Plan Taskforce provides a good foundation for reducing methamphetamine use in Western Australia.

The harms associated with drugs prohibited under the *Misuse of Drugs Act 1981* vary widely, but the drugs are equally unlawful.
Recommendation 3
Should the Western Australian Government review the *Misuse of Drugs Act 1981*, as part of the review it also consider if the Acts provisions, operations and punishments are proportionate to the relative harms associated with specific drugs.

Finding 16
A significant proportion of people with problematic drug use also have co-occurring mental health issues.

Finding 17
The prevalence of methamphetamine in Western Australia has resulted in an increase in the number of people with comorbid mental illness and problematic drug use.

Finding 18
Illicit drug offences are the most common offences in Western Australia, and have increased over the past decade.

Finding 19
The true extent of drug-related offending in Western Australia is not known or measured.

Recommendation 4
The Department of Justice and the Western Australia Police Force develop mechanisms for identifying and recording drug-related offending.

Finding 20
Stigma around drug use may prevent people from seeking assistance.

Recommendation 5
The Department of Justice, in its review of the *Criminal Property Confiscation Act 2000*, consider the appropriateness or otherwise of confiscating assets that are not proceeds of crime.

Finding 21
Current threshold limits in the *Misuse of Drugs Act 1981* may not align with contemporary evidence on use and possession practices.
In reviewing the *Misuse of Drugs Act 1981*, the Western Australia Police Force consult the Mental Health Commission and examine contemporary evidence to review the current threshold limits giving rise to intent to supply.

**FINDING 22**
Strict eligibility requirements and barriers to access limit the utility of the Police Drug Diversion Program.

**FINDING 23**
The Other Drug Intervention Requirement Scheme diverts fewer drug use and possession offenders from court than the Cannabis Intervention Requirement Scheme.

**FINDING 24**
The Perth Drug Court is a valuable diversionary option for complex, drug dependent offenders. Additional and more current data would be helpful to measure its ongoing effectiveness.

**RECOMMENDATION 7**
The Department of Justice collect information on Drug Court completion rates, recidivism rates and cost.

**RECOMMENDATION 8**
The Department of Justice review the processes, procedures and eligibility criteria in the Perth Drug Court Guidelines with a view to expanding the criteria, enabling a greater range of individuals to access the Drug Court.

**RECOMMENDATION 9**
The Western Australian Government examine extending the operations of the Drug Court into regional Western Australia.

**FINDING 25**
A backlog of incomplete Individual Management Plans for prisoners is a barrier to accessing programs in prison.

**FINDING 26**
Prisoners with sentences of less than six months do not receive Individual Management Plans, meaning they leave prison without completing any drug treatment programs.
FINDING 27
Prisoners on remand cannot access drug treatment services in prison.

FINDING 28
Many prisoners in WA cannot access drug treatment opportunities while in prison.

RECOMMENDATION 10
The Department of Justice proceeds with implementing recommendations 38, 39 and 40 of the Methamphetamine Action Plan Taskforce as a matter of urgency.

RECOMMENDATION 11
The Department of Justice ensure that all sentenced prisoners, including prisoners on short-term sentences, receive an Individual Management Plan in adequate time to complete their assigned programs prior to their earliest release date.

FINDING 29
Early results suggest that the Wandoo Rehabilitation Prison for Women presents a valuable opportunity to address drug issues in prison.

RECOMMENDATION 12
The Department of Justice continues to establish and deliver drug rehabilitation prisons while maintaining a strong focus on addressing drug problems in mainstream prisons.

FINDING 30
There remains a shortfall of drug treatment and support services in Western Australia to meet current demand.

FINDING 31
Regional and remote Western Australians may face increased risk of problematic drug use, and face additional difficulties accessing services.

FINDING 32
Clinical trials are ongoing, but there is currently no proven pharmacotherapy to treat methamphetamine dependence.
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<td>People seeking help for drug problems must be able to access services as needed and in a timely manner.</td>
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<td>There are only 7.3 addiction physician full time equivalent positions in Western Australia, and none work in public hospitals.</td>
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<td>The Department of Health immediately review the number of addiction physicians in the WA public hospital system and compare it to other Australian jurisdictions.</td>
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<td>There are no addiction psychiatrists in the Western Australian public health system.</td>
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<th>RECOMMENDATION 14</th>
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<tr>
<td>The Department of Health immediately review the number of addiction psychiatrists in the WA public hospital system and compare it to other Australian jurisdictions.</td>
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<th>RECOMMENDATION 15</th>
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<td>Once the optimal number of addiction specialists is identified, the Department of Health address the shortfall.</td>
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<th>FINDING 36</th>
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<td>Many people suffering from problematic drug use concurrently require assistance for mental illness, homelessness, poverty and social isolation.</td>
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<th>FINDING 37</th>
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<td>Needle and syringe programs in Western Australia have averted thousands of blood borne infections and saved over a hundred million dollars in healthcare costs.</td>
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<th>FINDING 38</th>
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<tr>
<td>Some groups, such as fly-in fly-out workers, may experience barriers to accessing opioid substitution therapy.</td>
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The Department of Health investigate how to address barriers to opioid substitution therapy, including for fly-in fly-out workers.

Decriminalisation is distinct from legalisation. Under decriminalisation, drug use and possession for personal use may attract a civil rather than a criminal penalty.

Demand and supply reduction strategies to reduce alcohol-related harms are founded in public health and differentiate between problem and non-problem drinking. This is possible because alcohol possession and use is not criminalised.

New Zealand has amended drug laws to provide police the discretion to prosecute for drug use and possession, and require that they first consider whether a health-based approach would be more beneficial.

Drug use and possession for personal use should be treated primarily as a health issue.

Drug use and possession for personal use should be treated primarily as a health issue.

A significant number of international jurisdictions use administrative responses to drug use and possession for personal use.

The Western Australian Government commits to defining and treating drug use as a health and social issue rather than a criminal justice issue.

Drug use and possession in Portugal remain illegal and are administrative offences, while supply, trafficking and production remain criminal offences.
FINDING 46
Overdose deaths and new HIV diagnoses attributed to injecting drugs fell significantly in Portugal in the last 10 years.

FINDING 47
Recent drug use in Portugal is lower than the European average.

FINDING 48
Decriminalisation in Portugal is just one element of an integrated, multi-faceted and comprehensive health-based approach to drug use.

RECOMMENDATION 18
The Mental Health Commission launch a public campaign to frame drug use as a health and social issue rather than a criminal justice issue.

RECOMMENDATION 19
The Western Australian Government increase funding for drug services in line with the demand projected by the Mental Health, Alcohol and Other Drugs Services Plan 2015-2025.

FINDING 49
The primary objective of drug regulation should be to address the health and social issues associated with problem drug use.

RECOMMENDATION 20
In order to adopt a health-based approach to drug use and possession in practice, the Mental Health Commission and Western Australia Police Force work together to investigate, develop and implement either:
- Option 1—an expanded Police Drug Diversion Program
- Option 2—an administrative decision-making body and associated process for dealing with drug use and possession. That the Mental Health Commission and Western Australia Police Force give particular consideration to ensuring that people in regional and remote areas can receive equitable access.

FINDING 50
Community attitudes towards cannabis are becoming increasingly tolerant, and there is a degree of public support for cannabis decriminalisation or even legalisation.
**FINDING 51**  
Cannabis use may impair ability to operate machinery or a motor vehicle and result in adverse long-term health effects.

**FINDING 52**  
The potency of Australian cannabis has increased.

**FINDING 53**  
Regular cannabis use may increase the likelihood of psychotic symptoms or worsen symptoms in people who are predisposed to, or already experiencing, psychotic mental illness.

**FINDING 54**  
Early evidence emerging from Colorado points to increased harms following the legalisation of cannabis, including increases in traffic deaths, cannabis-related emergency department visits, recent cannabis use and black market activity.

**FINDING 55**  
There is currently insufficient evidence available from other countries to support a commercial model of cannabis legalisation.

**FINDING 56**  
Cannabis Social Clubs are a non-profit means of producing cannabis for personal use for members, but are best suited to jurisdictions where the personal use and possession of cannabis has been decriminalised.

**FINDING 57**  
The South Australian Cannabis Expiation Notice Scheme diverts minor cannabis offenders from the criminal justice system, but does not direct users to education or treatment.

**FINDING 58**  
The Australian Capital Territory has adopted a model of cannabis decriminalisation, not legalisation.

**RECOMMENDATION 21**  
A health-based response to the use and possession of drugs makes provision for the cultivation of cannabis for personal use.
Sweden places a high priority on delivering drug prevention initiatives to a range of target audiences.

Sweden has the second highest rate of drug-induced deaths in the European Union.

Attitudes towards the success of the prohibitionist approach to drug use in Sweden are beginning to change.

A zero-tolerance approach to drug use is incompatible with harm reduction.

Recent drug use (past 12 months) in Sweden is below the European Union average for cannabis and slightly higher than the European Union average for other illicit drugs.

People charged with drug use or possession in Sweden may experience consequences for their housing, welfare and interaction with child protection services, which they might regard as being even more punitive than the criminal penalties.

The Western Australian Government fund and continuously evaluate prevention and education activities in line with the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

Ongoing trials of harm reduction measures in Switzerland built a body of evidence about their effectiveness.

The Mental Health Commission increase funding for drug harm reduction in line with forecast demand.
**FINDING 66**  
There is no harm reduction strategy that has been developed specific to Western Australia.

**RECOMMENDATION 24**  
The Department of Health and the Mental Health Commission develop a Harm Reduction Strategy for Western Australia.

**FINDING 67**  
Pure MDMA has been proven safe when used in controlled clinical trials.

**FINDING 68**  
Australian illicit drug market ecstasy is often dangerous due to contamination and strength, which can result in harms including seizures, hyponatremia, poisoning and death.

**FINDING 69**  
Drug detection dogs are an unreliable means of detecting drugs at music festivals.

**FINDING 70**  
Research suggests that sniffer dogs deter very few people from taking drugs at music festivals.

**RECOMMENDATION 25**  
The Western Australian Government commission an independent evaluation into the efficacy and cost-effectiveness of using drug detection dogs at music festivals in Western Australia.

**FINDING 71**  
The presence of sniffer dogs at music festivals may prompt patrons to engage in risky drug taking behaviour.

**RECOMMENDATION 26**  
If the Western Australia Police Force continue to use drug detection dogs, that they develop policies and procedures around their use at festivals to reduce the risk to festival patrons.

**RECOMMENDATION 27**  
The Western Australia Police Force develop, publish and communicate clearly defined objectives for the use of drug detection dogs at music festivals.
FINDING 72
Drug checking services have been operating in Europe for over 20 years, and evidence suggests that drug checking services do not increase ecstasy use or uptake.

FINDING 73
The Australian Capital Territory has trialled drug checking for two consecutive years and evaluation of the second year trial is pending.

FINDING 74
The drug checking trials in the Australian Capital Territory are intended to minimise harm and are not intended to condone drug use.

FINDING 75
Many Western Australians who take ecstasy use online pill testing kits, word of mouth or online pill reports to learn about the safety of their drugs.

FINDING 76
Online pill testing kits may be unreliable and dangerous, and miss a vital opportunity for people who intend to take drugs to engage with service and peer support workers.

RECOMMENDATION 28
The Mental Health Commission fund a peer-based harm reduction organisation to deliver peer-based harm reduction services in music festival settings.

FINDING 77
A range of mobile drug checking analysis techniques are now available, but concerns remain about their ability to detect new psychoactive substances.

FINDING 78
Drug checking results can be used to monitor drug use trends and emerging substances of concern in real time.

RECOMMENDATION 29
The Western Australian Government establish a working group with representation from the Mental Health Commission, the Western Australia Police Force, the Department of Health, the alcohol and other drug services sector and the peer/consumer sector to consider strategies for optimising safety at music festivals.
RECOMMENDATION 30

The working group consider strategies for optimising safety at music festivals, including:
- trialling a drug checking service
- appropriate drug checking analysis methods
- establishing an early warning system to alert people who use ecstasy about new or dangerous substances.

FINDING 79

Despite the initial concerns of the local community, the drug consumption room in Lausanne has not led to increased crime.

FINDING 80

Apart from reducing overdoses and the transmission of blood-borne viruses, Drug Consumption Rooms provide a key point of interaction and referral for marginalised people who may not otherwise be accessing services.

FINDING 81

Drug Consumption Rooms may be cost-effective harm reduction strategies, but demand for such a facility in Perth has not yet been established.

RECOMMENDATION 31

The Department of Health and the Mental Health Commission consult with service providers and people who use drugs to ascertain the demand for a Drug Consumption Room in Perth.

RECOMMENDATION 32

The Western Australian Government fund harm reduction activities in line with the demand forecasted in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

FINDING 82

The need for Heroin Assisted Treatment in Western Australia has not been established. Ensuring equitable access to opioid substitution therapy should be prioritised.

FINDING 83

Needle and syringe programs can assist to reduce drug-related harms in prisons and are delivered in prisons in 13 countries.
<p>| FINDING 84 | Other prisoners and prison staff may have realistic safety concerns about the introduction of needle and syringe programs in prisons. |
| RECOMMENDATION 33 | The Western Australian Government investigate the viability of needle and syringe programs in prisons. |
| FINDING 85 | Peer workers play an important role in delivering treatment and harm reduction initiatives. |
| RECOMMENDATION 34 | The Mental Health Commission finalise and implement the Workforce Strategic Framework for peer workers, in co-design with the alcohol and other drug sector. |
| FINDING 86 | Royal Perth Hospital deals with a disproportionately high amount of meth-related emergency presentations. |
| RECOMMENDATION 35 | The Western Australian Government’s recently announced measures to combat drug-related violence in hospitals are extended to regional hospitals. |
| FINDING 87 | Methamphetamine-affected patients contribute to disruption and risk in WA hospital emergency rooms. |
| FINDING 88 | The benefits of a dedicated alcohol and drug emergency ward include increased throughcare to outpatient treatment, staff with alcohol and other drug experience and specialty, and decreased stigma for patients. |
| FINDING 89 | The Western Australia Police Force Mental Health Co-Response program is an effective and cost-effective way of diverting people from emergency departments. |</p>
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<tr>
<th>RECOMMENDATION 36</th>
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<tr>
<td>The Western Australia Police Force and Mental Health Commission proceed with plans to expand the Police Mental Health Co-Response Program to include support for drug issues.</td>
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<tr>
<td>The Western Australia Police Force and Mental Health Commission proceed with plans to expand the Police Mental Health Co-Response program to regional areas.</td>
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<th>FINDING 90</th>
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<tr>
<td>The Urgent Care Clinic at Royal Perth Hospital is a promising alternative for dealing with drug-affected patients in emergency situations.</td>
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<th>RECOMMENDATION 38</th>
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<tr>
<td>The Mental Health Commission and the Department of Health consider options for creating direct treatment pathways from the Urgent Care Clinic at Royal Perth Hospital, including co-locating or involving an alcohol and other drug service.</td>
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<th>RECOMMENDATION 39</th>
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<td>In future reviews of the Urgent Care Clinic, the Department of Health measure stigma experienced by patients and referrals to ongoing alcohol and drug treatment.</td>
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<th>FINDING 91</th>
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<td>Families of people with severe addiction may see compulsory treatment as the only way to help their loved ones.</td>
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<th>FINDING 92</th>
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<td>There is insufficient evidence to support introducing compulsory drug treatment in Western Australia.</td>
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<th>RECOMMENDATION 40</th>
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<td>The Western Australian Government meet voluntary treatment needs and demand before any consideration is given to compulsory treatment.</td>
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<th>FINDING 93</th>
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<tr>
<td>Psychiatrists are interpreting the Mental Health Act 2014 differently, and there is a lack of clarity around how these provisions should apply to people experiencing drug-induced psychosis.</td>
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RECOMMENDATION 41
The Mental Health Commission clarify through the statutory review of the Mental Health Act 2014 how and when the Act can be used to detain people experiencing drug-induced psychosis who may not also be mentally ill.

FINDING 94
Compulsory detox can be a crisis intervention for people dependent on methamphetamine, and an alternative to an emergency department, police lock-up or prison.

FINDING 95
Compulsory detoxification in Victoria has achieved some reduction in dependency in a small group of people with very complex needs, albeit predominantly alcohol dependent.

RECOMMENDATION 42
The Western Australian Government proceed with plans to trial compulsory crisis detoxification for people addicted to methamphetamine or other drugs.

RECOMMENDATION 43
The Mental Health Commission fund supervised detoxification programs in line with the demand forecast in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

RECOMMENDATION 44
The Mental Health Commission review whether current procurement processes are appropriate for funding longer-term alcohol and other drug services.

FINDING 96
Privately funded alcohol and other drug services in Western Australia are not required to be certified under a recognised accreditation standard.

RECOMMENDATION 45
The Western Australia Government consider introducing mechanisms to ensure the quality of private alcohol and other drug service providers.
RECOMMENDATION 46

The next iteration of the Western Australian Alcohol and Drug Interagency Strategy:

- is a 10-year strategy
- aims to reduce the harms associated with drug use to individuals and the community
- addresses the priorities and recommendations put forward by this Committee
- incorporates learnings from other Australian and international jurisdictions
- is evaluated every two years.
CHAPTER 1
Introduction

About the Committee

1.1 The Legislative Council established the Select Committee into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community (Committee) on 17 October 2018. The Committee is to inquire into and report on:

(a) other Australian state jurisdictions and international approaches (including Portugal) to reducing harm from illicit drug use, including the relative weighting given to enforcement, health and social interventions;

(b) a comparison of effectiveness and cost to the community of drug related laws between Western Australia and other jurisdictions;

(c) the applicability of alternate approaches to minimising harms from illicit drug use from other jurisdictions to the Western Australian context; and

(d) consider any other relevant matter.

1.2 The Committee was to report no later than 12 months after establishment. On 4 September 2019, the Legislative Council granted an extension of time to report by 5 December 2019. The Committee will dissolve upon its final report to the Legislative Council.

About the Report

1.3 Most parts of the world have prohibited the use of certain drugs for over half a century. However, in recent decades a new body of evidence has emerged about the social determinants of poor life and health outcomes. In 2019, we know that factors such as trauma, abuse, unemployment, homelessness, mental illness and drug abuse are often inextricably linked. These factors then make a person more likely to come into contact with the criminal justice system, exacerbating existing disadvantage.

1.4 This has prompted decision-makers to consider different approaches to addressing drug use and addiction. For some years now, politicians, media outlets and experts across the world have come to understand drug use as a health issue. The Committee has found that in practice, as long as drug use is a punishable offence that attracts criminal penalties, it will primarily be treated as a criminal justice issue instead of a health issue.

1.5 The Committee heard repeatedly throughout this inquiry that the current approach to drug use is not having the effect of stopping drug use or reducing the harm from drugs. This report will consider the current objectives of our drug policies and their effectiveness. The new body of evidence about addiction and the factors that drive it, coupled with the emergence of innovative new approaches from across Australia and the world, mean that this is an opportune time to consider a new approach for Western Australia (WA).

1.6 This report provides a practical blueprint for reducing drug-related harms by shifting the focus from a criminal justice response to a health-based response within WA.

• Chapter 2 briefly summarises the context of drug prohibition, including the history of drug control and existing global and domestic legal and policy frameworks.

• Chapter 3 details the persistent drug-related harms in WA. These include primary harms associated with drug use, such as morbidity and mortality, and the structural systemic

1 Standing Orders of the Legislative Council, Schedule 3.
harm associated with drug prohibition, such as stigma and the impact of receiving a criminal record for drug use. These harms establish the case for considering alternative approaches.

- **Chapters 4 and 5** set out the current responses to drug use in WA and their limitations, costs and effectiveness. These include criminal justice system responses, treatment, social supports, harm reduction, education and prevention.

- **Chapter 6** establishes why drug use is a health issue. Informed by the Portuguese drug policy model, this Chapter proposes a system of health-based responses to the offences of drug use and possession. This is the flagship component of the proposed new approach.

- **Chapter 7** examines a range of alternative approaches to regulating cannabis, including decriminalisation, legalisation and Cannabis Social Clubs.

- **Chapters 8 and 9** detail the Committee’s findings about the drug policy models of Sweden and Switzerland.

- **Chapter 10** outlines a number of harm reduction initiatives used in other jurisdictions, including drug checking and medically supervised injection centres.

- **Chapter 11** considers ways of responding to methamphetamine (meth) users in hospital emergency departments, including a dedicated alcohol and other drug emergency ward and the new Urgent Care Clinic at Royal Perth Hospital.

- **Chapter 12** considers the roles of compulsory treatment and compulsory detoxification in reducing drug-related harms.

- **Chapter 13** ties the distinct proposals together to frame a potential new overarching approach to illicit drugs for WA.

### Terms and acronyms used in this report are explained in the glossary.

**Inquiry scope**

**1.8** The Committee undertook a scoping process to set parameters around which drugs, approaches and jurisdictions it wished to focus the inquiry on. The Committee inquired into:

- illicit drugs, meaning those drugs that are prohibited by law in WA
- drug use, as opposed to manufacturing, sale and supply
- drug policy, including laws, regulation, courses of action and funding.

**1.9** Given the emphasis on ‘harm’ in the inquiry terms of reference, the Committee decided to focus on drugs that are associated with high levels of harm. The Committee considered drug harm ranking studies and indicators like drug-induced deaths and decided to focus on the following drugs, which are currently illegal in WA and associated with relatively high levels of use, harm or both:

- methamphetamine and other amphetamines
- heroin
- cannabis
- cocaine
- ecstasy.
1.10 Other illicit drugs that are associated with lower levels of use and harm, such as hallucinogens, are not the focus of the inquiry but are included in the inquiry scope.

1.11 The Committee was interested in considering alternative approaches with proven results, which WA could plausibly replicate.

- The Committee inquired into current approaches in WA and how they can be improved.
- The Committee inquired into alternative approaches from other Australian jurisdictions, including the Cannabis Expiation Notice Scheme in South Australia, the drug checking trial in the Australian Capital Territory and the Medically Supervised Injection Centres in New South Wales and Victoria.
- After conducting desktop research that benchmarked and compared the results of drug-related policies in eight European countries, and in response to submissions, the Committee investigated the drug policies of Portugal, Sweden and Switzerland.

**Problem and non-problem drug use**

1.12 The Committee is interested in distinguishing problem and non-problem drug use:

Using drugs does not necessarily result in high levels of harm or problematic behaviour. Given this, there needs to be a clear understanding of the risk factors associated with drug use, which are different to the risk factors associated with harmful or problematic drug use.  

1.13 The United Nations Office on Drugs and Crime (UNODC) defines problem drug use as regular or long-term use, particularly that resulting in dependency. Of the 271 million people in the world who used drugs in 2017, an estimated 13% (35 million) suffer from drug use disorder, meaning that they are dependent and/or require treatment. Non-problem drug use then means other drug use, including occasional, recreational use that does not negatively affect a person’s life.

1.14 Major questions for the Committee include:

- With regard to problem drug use, is it helpful or effective to criminalise people who may be suffering from a disorder and in need of treatment?
- With regard to non-problem drug use, is it appropriate to criminalise people for an activity that may harm their health, but does not harm others?

**Alcohol and prescription drugs**

1.15 The Committee heard that alcohol remains the single most harmful drug in Australia to individual users and the community. The Committee did not inquire into alcohol, as it is legal.

1.16 Through research and submissions, the Committee heard about the increasing harms associated with prescription drugs in Australia, specifically opioids and benzodiazepines. Benzodiazepines and opioids other than heroin, such as fentanyl, oxycodone and codeine,

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3 Submission 25 from Hope Community Services, 26 November 2018, p 1.
5 ibid., p 23.
7 Submission 20 from Department of Health WA, 19 November 2018, p 2.
were the cause of 67% of drug-induced deaths in Australia in 2016. Increasing misuse of fentanyl is of concern, given its fatal strength and role in the United States’ opioid epidemic. Prescription opioids are now responsible for more overdose deaths and hospitalisations in Australia than heroin.

**FINDING 1**
A substantial amount of drug-related harm in Australia is attributable to alcohol and prescription drugs.

1.17 The Committee resolved that prescription drug use is not within the inquiry terms of reference. Inclusion would imply that Western Australians are using prescription drugs illegally, and it is unclear to what degree this is true. The Committee notes that harms from prescription drug use are increasing and worthy of further investigation.

**RECOMMENDATION 1**
A governmental or parliamentary inquiry be established to examine and report on the harms associated with prescription drug misuse in Western Australia.

**Recent Australian inquiries**
1.18 The following Australian Committees and Taskforces have recently conducted relevant inquiries:

- WA Government Methamphetamine Action Plan Taskforce – final report, August 2018
- Parliament of Australia Joint Committee on Law Enforcement – inquiry into crystal methamphetamine (ice), March 2018
- Parliament of Victoria Joint Committee on Law Reform, Road and Community Safety – inquiry into drug law reform, March 2018

1.19 The Committee notes that in November 2018, the WA Government Methamphetamine Action Plan Taskforce (Meth Taskforce) recommended that a bipartisan parliamentary Committee inquire into and report on alternative models for drug regulation, regulatory systems and controls in other jurisdictions:

The Taskforce is of the view that there needs to be a comprehensive public consideration of the ways we treat currently illegal drugs in our community which recognises the limitations of criminalisation and imprisonment of drug users and considers alternative non-prohibition models for drugs including those which are being trialled and implemented in other countries.

**Committee procedure**
1.20 The Committee heard from stakeholders and the community through written submissions, site visits and hearings. The Committee invited 113 stakeholders to submit, received 77

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submissions and held 22 hearings. Public hearings and submissions are available on the Committee’s webpage.\textsuperscript{13}

1.21 The Committee received a wide variety of submissions. Some included extensive evidence and research, while others outlined entrenched opinions supported by little or no evidence.

1.22 People with personal experiences of drug use submitted to the inquiry. The Committee wished to provide the opportunity for people to tell their stories, but was also conscious of potential risks that may arise to submitters and third parties as a result. In redacting submissions, the Committee considered whether submissions contained personal or defamatory information about submitters or third parties and balanced this against the need to ensure the Committee’s transparency.

1.23 The Committee visited the Perth Drug Court and Wandoor Rehabilitation Prison for Women in Perth. The Committee travelled to Sweden, Switzerland and Portugal to observe and understand three alternative international models for reducing drug use and harms. The Committee also travelled to Geraldton and held regional-specific hearings with stakeholders in Bunbury to learn about the specific challenges facing regional Western Australians. The local, regional and international meetings and site visits have been integral for the Committee to draw comparisons and ascertain whether alternate models, or elements of alternate models, could be effective in WA.

1.24 The Committee extends its sincere thanks to all those who submitted, appeared before the Committee and generously provided their time and expertise during the international, regional and Perth-based site visits. See Appendix 1 for details of stakeholders contacted, submissions received, hearings held and sites visited during this inquiry.

\textsuperscript{13} \url{www.parliament.wa.gov.au/alt}
CHAPTER 2
Drug control – the existing framework

A brief history of drug use and control

2.1 People have used mind-altering substances, including opium, peyote and cannabis, for thousands of years and for a variety of social, cultural and medicinal reasons. Psychoactive substances have only been illegal for a relatively short time. In 19th century Australia, opium was widely available and easy to obtain. People typically took drugs such as opiates to self-medicate, and little was known about addiction issues.

2.2 Attitudes toward drug use began to change toward the end of the 19th century. Recreational opium smoking, which was popular among Chinese immigrants, became associated with immorality and criminal behaviour. The United States (US) played a driving role in combating the use and trade of opium across the world in the early 20th century, and the International Opium Convention 1912 became the world’s first multilateral drug control treaty. Controls on cocaine and cannabis soon followed suit. Today, commentators suggest that drug control policy in its early stages was motivated by a range of external factors, including global trade concerns, commercial interests, racism, foreign policy and arms control.

FINDING 2
People across the world have used mind-altering substances for thousands of years, for a variety of reasons.

Overarching framework

United Nations Conventions

2.3 Following World War 2, international drug control became the remit of the United Nations. Australia, along with most of the world, is signatory to three United Nations Conventions which establish the international drug control framework:

- The Single Convention on Narcotic Drugs 1961 consolidates nine multilateral treaties ratified between 1912 and 1953. The effect of the 1961 Convention is to prohibit the production and supply of narcotic drugs, including cannabis, cocaine and opiates, except for approved drugs used for medical or research purposes.
- The Convention on Psychotropic Substances 1971 extended these controls to psychoactive drugs such as amphetamines and psychedelics.
- The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 combats drug manufacturing and distribution through legal mechanisms such as extradition, and extended the drug control regime to chemical precursors required to

produce synthetic drugs, such as ephedrine, which is used in the production of amphetamines.\textsuperscript{19}

2.4 Collectively known as ‘the Conventions’, these three documents form the overarching structure of drug prohibition and criminalisation, overseen by the United Nations Commission on Narcotic Drugs.\textsuperscript{20} The effect of the Conventions is to require member states to adopt domestic measures to make drug possession a ‘punishable offence’, although alternatives to punishment may be appropriate where the accused is an ‘abuser of drugs’.\textsuperscript{21}

2.5 In 1971, US President Richard Nixon declared drug abuse to be ‘public enemy number one’. In order to fight and defeat this enemy, he declared ‘it is necessary to wage a new, all-out offensive’.\textsuperscript{22} In 1990, the United Nations General Assembly held its first Special Session on Drug Abuse, where Member States pledged to secure a ‘drug free world’ by 2008.

**FINDING 3**
The United Nations Conventions have provided the traditional framework for drug illegality and criminalisation across the world.

**Drugs in domestic legislation**

2.6 Australia, along with most of the world, proceeded to implement the Conventions by passing legislation to establish offences and penalties for the use, possession, manufacturing and sale of drugs. The Australian Government has jurisdiction over border control and drug importation and maintains the federal Poisons Standard, which reflects decisions regarding the classification of medicines and chemicals.\textsuperscript{23} However, drug control is primarily a state and territory responsibility.

2.7 The Misuse of Drugs Act 1981 (Act) provides that it is illegal to possess, use, manufacture, cultivate or supply an illicit drug. Penalties include diversion opportunities, fines, imprisonment and a criminal record. Like other state and territory drug legislation, the Act reflects Schedule 9 of the federal Poisons Standard. The Committee notes that the Act does not state any objectives. The Act has not been comprehensively reviewed since it came into effect.\textsuperscript{24}

**RECOMMENDATION 2**
The Western Australian Government review the Misuse of Drugs Act 1981, and as part of that overall review consider including a statement of its objectives.

**Three pillars of harm reduction**

2.8 The Ministerial Drug and Alcohol Forum oversees the National Drug Strategy 2017-2026. Now in its seventh iteration, the Strategy provides the overarching framework for minimising the harms associated with alcohol, tobacco, pharmaceutical and illicit drugs in Australia. The

\textsuperscript{19} Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988.


\textsuperscript{21} Single Convention on Narcotic Drugs 1961, article 36(1)(a).


\textsuperscript{23} Poisons Standard February 2019.

\textsuperscript{24} Department of Justice, Answer to question on notice 1 asked at hearing held 18 March 2019, dated 19 April 2019, p 1.
Strategy aims for a balanced approach across the three pillars of harm minimisation, which are:

- Supply reduction – preventing, stopping, disrupting and reducing drug production and supply.
- Demand reduction – preventing the uptake and delaying the onset of drug use, reducing drug misuse and supporting people to recover.
- Harm reduction – reducing the adverse consequences of drug use for people who use drugs, their families and the community.

2.9 At the state level, strategic direction for the delivery of services and funding is set by the WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

Objectives

2.10 The Committee is of the view that the general objectives of drug policy and legislation in WA, when taken together, include to:

- prevent, stop or minimise illicit drug use
- prevent, stop or minimise criminal activity related to illicit drugs
- prevent the uptake of illicit drugs
- support people to recover
- reduce harm to individuals, families and the community resulting from illicit drug use.

The limitations of supply reduction

2.11 Supply-side measures are those strategies aimed at restricting illicit drug availability, primarily through policing and border patrol. The Committee notes the pivotal role of supply reduction in drug control policy, but recognises its limitations.

2.12 In ‘The Abject Failure of Drug Prohibition’, Dr Alex Wodak, President of the Australian Drug Law Reform Foundation, states that there is little evidence to suggest that supply reduction measures have been effective.25 World production of opium and cocaine are currently at record levels.26 Approximately two-thirds of drug-related spending in Australia goes towards law enforcement efforts, yet illicit drugs remain easy to obtain.27

2.13 The Committee is aware that drugs are readily available in WA. The Meth Taskforce considered this matter in detail:

The so-called war on drugs has been an absolute failure, because drugs, and particularly meth, are now far more readily available than they were 10 years ago and they are 50% cheaper.

When I sat in rehab with people that had been using, many times over they said, “Ron, come for a walk with me and I’ll find you three shots in 15 minutes, just walking”. 28

27 The 2018 results of the Illicit Drugs Reporting System in WA show that 98% of respondents (heavy users of illicit drugs) described heroin as ‘easy’ or ‘very easy’ to obtain.
2.14 Until 2009, most meth in Australia was produced domestically. Today, most meth is imported from overseas, particularly from China.\(^{29}\) Most seizures are from international mail, but the bulk of the drug arrives by sea cargo.\(^ {30}\) This shift in the market has seen the number of domestic clandestine laboratories decrease dramatically in recent years: \(^ {31}\)

That is also demonstrated by the vast reduction in the numbers of illicit clandestine drug laboratories. That in Western Australia alone is under 20 per annum, whereas we were getting hundreds of them before; I think at one point it was over 700 found in a single calendar year.

The amount of drugs that are cooked, if I can put it that way, in very small inside houses and cars in the bush has reduced dramatically.\(^ {32}\)

2.15 This shift from domestic to international production has resulted in stronger and more dangerous drugs. Meth was 10% more pure in 2018 than in 2014.\(^ {33}\)

2.16 The Committee acknowledges the important work carried out by state and federal police, evidenced by seizures of massive quantities of meth in recent years.\(^ {34}\) Law enforcement plays a central role in prevention, and protects the community from ‘social disorder that can flow from the use of prohibited drugs’.\(^ {35}\) However, limiting the supply of drugs into the state is extremely hard to do. WA Police Commissioner Chris Dawson explained in a hearing with the Committee:

I am not confident that we can adequately patrol all our borders...We have an extensive coastline in Western Australia. There is a very great shortage of maritime and aviation assets to patrol our borders.\(^ {36}\)

2.17 Despite record seizures in recent years, the price of meth continues to decrease and it is cheaper than ever.\(^ {37}\)

**FINDING 4**

Most methamphetamine is imported into Australia from overseas and is of higher purity than five years ago.

**FINDING 5**

Western Australia faces unique geographical challenges to restricting the importation of drugs.

2.18 In 2017-18, the WA Police Force seized more than 1400 kilograms of meth, which is double the amount seized in 2016-17. Despite this, Commissioner Dawson revealed in early 2019 that Western Australians now consume between 27 and 30 kilograms of meth each week.\(^ {38}\)

\(^{29}\) Department of Defence, *Ice dragon: a proposal to target the supply of methamphetamine from China to Australia*, report prepared by Commander Nigel Ryan, Vice Chief of the Defence Force, Canberra, February 2017, p 2.


\(^{31}\) ibid., p 15.


\(^{35}\) Submission 41 from National Drug Research Institute, 30 November 2019, p 4.


FINDING 6
Supply reduction strategies are an important part of reducing drug-related harms, but have limited capacity to influence drug use without comprehensive demand and harm reduction strategies.
CHAPTER 3
The case for considering alternative approaches

Introduction

3.1 This chapter will establish the stagnant or worsening state of drug use and drug-related harms to individuals and communities under prohibition, which makes a compelling case for why WA should consider alternative approaches for tackling drug abuse. It will show that:

- problem drug use is often socially determined
- many people still use drugs despite prohibition
- drug use is linked to harms including morbidity, mortality and drug-fuelled violence
- the prohibition of drugs is linked to harms including stigma, prison overcrowding and the impacts of criminalisation on a person’s life outcomes.

A changing landscape

3.2 A central message the Committee heard throughout the inquiry is that what we are doing now is not working. There is a growing recognition that many people always have, and always will, use drugs, regardless of their illegality. In 2016, at least one in three Australians had used illicit drugs at some point in their lives.39

3.3 Professor Neil Morgan, the then-Inspector of Custodial Services, pointed out that many submissions to this inquiry contained a common starting point—there is a need to think about doing things differently.40 The Committee heard that:

  We have been losing the war on drugs since we began it.41
  An attempt to end the use of illicit drugs is a well-meaning but ultimately futile measure. The goal should be to reduce the harm that substances bring.42
  It is important to note that the balance of funding across the three pillars is significantly out of kilter and imbalanced, with supply reduction receiving about 65 per cent of the funding, treatment about 30 per cent and harm reduction...about two per cent.43

FINDING 7

The Committee received a level of support for considering alternative responses to dealing with harms arising from illicit drug use.

3.4 Some argue the opposite, suggesting that drug use and harm arising from it have increased not because of prohibition, but due to the relaxation of community attitudes and the introduction of harm minimisation measures (such as Medically Supervised Injecting Centres)

41 Submission 3 from Tom Marwick, 6 November 2018, p 1.
42 Submission 6 from Kelan Wood, 9 November 2018, p 1.
43 Jill Rundle, Chief Executive Officer, Western Australian Network of Alcohol and Other Drug Agencies, Transcript of evidence, 15 April 2019, p 2.
in preference to traditional policing and enforcement. This is not supported by the evidence received by the Committee.

3.5 Service providers, private citizens and people impacted by illicit drugs supported the Committee’s inquiry on the basis that:

What has been missing from the dialogue in recent years, however, is a mature and responsible debate and analysis of the overall approach to illicit drug use.

Good work is being done, however, a cold-eyed analysis as to whether our legislative and law enforcement elements are best practice is long overdue.

3.6 These calls for change broadly echo the views of an increasing number of world experts and leaders regarding the failure of drug prohibition. In 2011, 19 former heads of state and world leaders came together to establish the Global Commission on Drug Policy, based on the premise that the global war on drugs has failed with devastating consequences. In 2014, the Commission set out five pathways to drug policies that work:

- put people's health and safety first
- ensure access to essential medicines and pain control
- end the criminalisation and incarceration of people who use drugs
- refocus enforcement responses on drug trafficking and organised crime
- regulate drug markets to put governments in control.

3.7 Dr Alex Wodak has explained that for over 50 years, Australian drug policy has been heavily based on law enforcement. Yet during this time, drug markets have expanded while death, disease and violent crime also have increased.

3.8 According to Dr Wodak, the academic debate about drug policy is now largely over. The Global Commission on Drug Policy points out that across the world, local and national governments are trialling different approaches to the legal regulation of drugs, and harm minimisation measures are scaling up:

What we are witnessing is drug policy reform in action.

3.9 In 2016, Kofi Annan, former Secretary General of the United Nations said that prohibition has had little impact on drug supply, demand and use:

The widespread criminalisation and punishment of people who use drugs, the over-crowded prisons, mean that the war on drugs is, to a significant degree, a war on drug users – a war on people.

3.10 It follows that if we continue to do only what we have been doing, we will achieve similar results. Thirty years ago, the Australian Parliamentary Joint Committee on the National

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44 Submission 22 from D Hartley, 26 November 2018, p 2.
45 Submission 75 from Alcohol and Other Drug Consumer & Community Coalition, 28 February 2019, p 1.
46 Submission 60 from Cyrenian House, 17 January 2019, p 1.
52 Professor Steve Allsop, private citizen, Transcript of evidence, 14 May 2019, p 2.
Crime Authority concluded that drug prohibition in Australia had failed. At the time, there was no consensus on what policy should replace it. The significant shift in global drug policy over the last 10 years means that this Committee has access to much more evidence to make an assessment.

**FINDING 8**
The current approach to prohibiting drug use is not having the intended effect of stopping people from taking drugs.

**Social determinants of drug use**

3.11 One in three Australians will use illicit drugs at some point in their lives. However, some people are more likely to develop drug problems than others. Factors including childhood trauma, low socio-economic status, unemployment, unstable housing, health and mental health issues are all linked to problematic drug use:

Repeatedly throughout the task force, we heard all about the social determinants of health that drives drug use through the community. It is a social disease; it is not the disease of an individual’s choice.55

3.12 Social disconnection, family breakdown and loss of community are increasingly attributed to drug-related harms. People living in remote areas, particularly Aboriginal Australians, experience higher levels of drug-related harm:

We would typically see alcohol and other drug use...and high levels of mental distress co-occurring. But they do not occur in isolation. Those would occur while people, as I said, are managing difficult housing, and they may be managing parenting stresses. There is a range of other life stresses and financial problems that they could also be dealing with.56

3.13 These factors are known as the ‘social determinants of drug use’, and they tend to mimic the social determinants of health:

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.58

3.14 The National Drug Research Institute (NDRI) notes that groups who are most at risk of problem drug use also tend to be over-represented in social disadvantage and general ill health statistics.59 These correlations are not limited to Australia—the UNODC has noted that

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59 Submission 41 from National Drug Research Institute, 30 November 2018, p 3.
many of the world’s prisoners incarcerated for drug offences are from economically disadvantaged backgrounds:

There is now growing recognition among researchers and practitioners that illicit drug use and misuse can be socially determined. This approach recognises that a variety of individual, social and environmental factors contribute to drug use and harm, and problem outcomes.

These factors include social disadvantage and exclusion, poor educational and employment outcomes, financial distress, insecure housing, family and neighbourhood dysfunction, and violence against women.60

3.15 The Committee notes that the social determinants of drug use may be especially apparent in the regions. The Mid-West branch of the Aboriginal Legal Service of WA told the Committee that none of their clients simply has a drug issue. Lack of housing, trauma and unemployment are usually also present.61

3.16 The Aboriginal Health Council of WA told the Committee that Aboriginal people are more susceptible to developing drug dependence for a range of reasons, including a long history of socio-economic disadvantage, family dysfunction and adverse childhood experiences:

It is important to acknowledge that alcohol and other drug use among Aboriginal people is both a symptom of disadvantage and suffering, but also a cause of serious health and social problems. As such, Aboriginal people who are dependent on alcohol and illicit drugs present with a range of complex needs.62

FINDING 9
Social factors like trauma, homelessness and disadvantage are often predictors of problematic drug use.

FINDING 10
The social predictors of problematic drug use may be more apparent in regional and remote areas.

FINDING 11
Aboriginal Australians are more likely to experience serious drug-related harms.

Drug use trends

Global drug use trends

3.17 Drug use has always been a reality. Hundreds of millions of people around the world use illicit drugs each day, despite the information available about the risks.63 Some of the reasons that people use illicit drugs include to socialise, relax, relieve pain, for traditional or cultural reasons, as a coping mechanism or to self-medicate.64

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61 Kate Turtley-Chappel, Managing Lawyer, Mid-West Office, Aboriginal Legal Service of WA, email, 2 August 2019.
62 Submission 52 from Aboriginal Health Council of Western Australia, 4 December 2018, p 2.
64 Submission 49 from Mercurio Cicchini, 4 December 2018, p 1.
3.18 Between 2009 and 2017, the estimated number of people in the world who used any drug in the past 12 months increased by 30%, partly because of global population growth.\textsuperscript{65} Cannabis remains by far the most commonly used illicit drug and opioids such as heroin and fentanyl are responsible for the greatest health harms to users. The use of meth is increasing in North America, Asia, and Australia.

**FINDING 12**
On any given day, hundreds of millions of people around the world use drugs, and global drug use continues to increase.

**Australian drug use trends**

3.19 According to the 2016 National Drug Strategy Household Survey, 8.5 million Australians (43%) had used a drug illicitly. One in six had done so in the past year and 8.6% had used an illicit drug in the last month. These proportions have remained relatively stable since 2004.\textsuperscript{66}

Table 1. *Past year use of distinct illicit drugs by Australians aged 14+*

<table>
<thead>
<tr>
<th>Illicit drug</th>
<th>Used in the past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>10.4%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2.5%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>2.2%</td>
</tr>
<tr>
<td>Meth/amphetamines</td>
<td>1.4%</td>
</tr>
</tbody>
</table>


3.20 While the majority of cocaine and ecstasy users only use once or twice a year, cannabis and meth use is more likely to be frequent. Heroin use in Australia has remained low since 2001, but half of all heroin users take it at least weekly. The use of hallucinogens, ketamine and gamma hydroxybutyrate (GHB) are also low.

**Western Australian drug use trends**

3.21 In WA, the rate of use of any illicit drug has remained stable over time at about 16.6%. This is slightly higher than the national average of 15.6%. WA has the highest rates of meth and ecstasy use in the country, and regional WA had Australia’s third highest rate of drug use in the past 12 months at 22.3%.\textsuperscript{67} Meth use is particularly high in regional WA, with use also on the rise in remote areas.\textsuperscript{68} Conversely, the use of cocaine is lower than in any other state or territory.


\textsuperscript{67} ibid., p 94.

Table 2. *Estimated consumption by kilogram*\(^{69}\)

<table>
<thead>
<tr>
<th>Illicit drug</th>
<th>Kilograms consumed in WA, August 2017 – August 2018</th>
<th>Kilograms consumed, national average, August 2017 – August 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meth</td>
<td>1416.8 kg</td>
<td>1230.9 kg</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>74.9 kg</td>
<td>145.3 kg</td>
</tr>
<tr>
<td>Cocaine</td>
<td>67.9 kg</td>
<td>514.4 kg</td>
</tr>
<tr>
<td>Heroin</td>
<td>46.8 kg</td>
<td>93.8 kg</td>
</tr>
</tbody>
</table>


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\(^{69}\) The National Wastewater Drug Monitoring System has not yet been able to test for cannabis.
Figure 1. Estimated consumption, Western Australia
Source: Australian Criminal Intelligence Commission, National Wastewater Drug Monitoring Program 2019.
Chapter 3 The case for considering alternative approaches

3.22 Palmerston Association see the prevalence of meth reflected in treatment settings:

During the financial year 2017-18, Palmerston Therapeutic Community in Perth supported 209 residents. Sixty five percent of residents claimed meth was their primary drug of concern, compared to 25% of residents reporting alcohol.

However, when we look at the younger population (under 25 years of age), we see a much larger take up of meth. In this cohort, 77% under the age of 25 identified meth as their primary drug of concern.70

3.23 Statistics show that the percentage of people using drugs in WA decreased slightly between 2010 and 2016, including for meth.71 Professor Simon Lenton of NDRI told the Committee that drug problems are increasing, rather than the number of users:

We are not seeing increasing rates of number of methamphetamine users, but what we are seeing is increasing rates of problems, so people who are using tend to be more likely to be dependent and experiencing significant problems.72

FINDING 13

Drug use in Western Australia has decreased slightly since 2010, but problems associated with drug use are increasing.

Drug-related harms

3.24 Drug use is associated with health, social and economic harms to people who consume drugs, their family and friends and the wider community. It accounts for 2.3% of the total burden of disease in Australia, which includes the health impact of the associated diseases, conditions and injuries, at an annual cost to the economy of approximately $8.2 billion.73

3.25 This section will outline the primary and secondary harms arising from drug use, with ‘harm’ broadly meaning any type of damage. This includes primary harms such as hospital costs, the transmission of blood-borne viruses, drug-related deaths, and drug-fuelled violence. Potentially more extensive are the secondary systemic harms arising from drug use, which often relate to the criminalisation of drugs. These include stigma, homelessness, the impact of a criminal record and other factors that can compound existing social disadvantage.

Primary harms: death, disease, addiction, psychosis—the impact of meth

3.26 Meth is causing more damage than any other illicit drug to Western Australian people and communities. Meth is the second most harmful illicit drug to users (after heroin) and the most harmful to other people.74 Its high levels of harm in addition to its prevalence in WA make for a dangerous combination.

3.27 In 2018, the Meth Taskforce conducted widespread community consultation and detailed the impact of meth on WA in its final report. The Committee agrees with Professor Neil Morgan’s submission to this inquiry, which states that the final report of the Meth Taskforce provides a solid foundation for reducing meth use in WA, and that many of the recommendations could

70 Submission 57 from Palmerston Association, 9 January 2019, p 6.
72 Professor Simon Lenton, Director, National Drug Research Institute, Transcript of evidence, 10 June 2019, p 3.
also apply to other illicit drugs. The Committee does not intend to revisit the work of the Meth Taskforce, and encourages readers to refer to the report.

**FINDING 14**

The final report of the Methamphetamine Action Plan Taskforce provides a good foundation for reducing methamphetamine use in Western Australia.

3.28 In Australia, an estimated 160,000 people are dependent meth users, 108,000 are regular, non-dependent users and 250,000 are occasional users. Users commonly smoke meth, but it can also be injected, snorted or taken in pill form. Associated health harms include:
- death resulting from drug or poly-drug toxicity, disease, suicide and accident
- transmission of blood borne viruses
- emergency presentations resulting from meth-induced psychosis—see Chapter 11 for more detail.

3.29 In 2016, WA had the highest rate of drug-induced deaths in Australia at 9.9 deaths per 100,000. That year, there were 252 drug-induced deaths in WA, including 197 from greater Perth and 52 from the rest of the state. Although a high percentage is attributable to prescription drugs, as referred to in the introduction, deaths attributable to meth are increasing. Across Australia in 2013–14, at least 170 people died from meth-related drug toxicity.

3.30 According to Professor Steve Allsop, meth-related deaths occur for a variety of reasons:

It may well be related to suicide, for example. It may well be related to vehicular accidents, both in terms of the intoxication and/or the fatigue that may come after long-term stimulant use. It may actually be, for example, if somebody has got a vulnerability to cardiovascular problems... or it may well be other organ problems that can arise. For example, a small proportion of strokes are caused by methamphetamine.

3.31 Long-term, high-dose meth use can change the structure and function of the brain. These changes have been linked to poor self-control, decision-making and adaptive thinking. Other effects relating to brain changes include cognitive decline, violence, hallucinations, delusions and depression.

3.32 The Committee heard that meth is a widely available and dangerously addictive substance. While many people can and do use meth intermittently, some people can spiral into a pattern of meth use within a week. Furthermore, meth-related harms are not confined to one socio-economic group:

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81 Cracks in the Ice, *The Effects of Crystal Methamphetamine on the Brain*, report prepared by Australian Government Department of Health and the University of Sydney, Canberra.
83 Janelle Scutt, Magistrate, Perth Drug Court, email, 10 June 2019.
Meth is such a crude substance – it blasts right through different groups.\(^{84}\)

3.33 The Committee heard that regional and remote WA is suffering the most:

Meth is a scourge...in the country, it is everywhere.\(^{85}\)

When we first had increases in methamphetamine use in the early 2000s, it was largely in the metropolitan areas. Now we are seeing methamphetamine use appearing in our remote and rural communities, where people may already have significant disadvantage and challenges.\(^{86}\)

When I spoke to the people from the Royal Flying Doctor Service, they said that, at any given time, up to four of their 16 aircraft are out of action flying in people who are high on meth.\(^{87}\)

3.34 The Aboriginal Health Council of WA told the Committee that meth has become a key concern for Aboriginal people. Their members said that meth use is:

- inflicting terrible hardship on families and users
- increasing anti-social behaviour, particularly domestic violence
- compounding mental health issues, particularly in young people
- desensitising young people to its effects through parental use
- increasing theft and violence, leading to family breakdowns
- creating social dysfunction, leading to a loss of respect and destruction of values and identity.\(^{88}\)

3.35 Meth in Australia continues to become purer and more potent.\(^{89}\) A major harm related to heavy methamphetamine use is psychotic symptoms, brought on by lack of sleep. This can result in erratic behaviour, self-harm, aggression and violence:

Even the most psychologically robust of us, if we use enough methamphetamine, may well experience psychotic symptoms.\(^{90}\)

**Primary harms from other illicit drugs**

3.36 The Australian Drug Harms Ranking Study ranks licit and illicit drugs in order of most to least harmful. The study demonstrates that heroin is the most harmful illicit drug to individual users and crystal meth is the most harmful to other people.\(^{91}\)

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\(^{84}\) ibid.

\(^{85}\) ibid.

\(^{86}\) Professor Steve Allsop, private citizen, Transcript of evidence, 14 May 2019, p 9.

\(^{87}\) Ron Alexander, Former Chair, Methamphetamine Action Plan Taskforce, Transcript of evidence, 15 April 2019, p 12.

\(^{88}\) Submission 52 from Aboriginal Health Council of WA, 4 December 2018, p 13.


\(^{90}\) Professor Steve Allsop, private citizen, Transcript of evidence, 19 May 2019, p 13.

The major risks of heroin to users are dependence, fatal overdose and human immunodeficiency virus (HIV) transmission. These risks may be managed through the availability of harm reduction mechanisms such as naloxone (a drug which can temporarily reverse opioid overdose) and needle and syringe exchange programs. In a study of 100 drug users in Perth in 2018, seven reported overdosing on heroin. Of the seven, four reported being attended by an ambulance and four reported receiving the overdose reversal medication naloxone.\(^2\)

Heroin use has remained relatively stable in WA since global supply was interrupted in 2001. However, Peer Based Harm Reduction contend that heroin-related harms have been increasing in WA since about 2009.\(^3\) The Committee is aware that availability has increased in recent years, including in regional areas:\(^4\)

It is increasing in Bunbury. We are seeing more cocaine use and we are definitely seeing more heroin use.\(^5\)

Emergency physician Dr Jessamine Soderstrom told the Committee that cocaine-related emergency admissions at Royal Perth Hospital are rare:

The CHAIR: Do you have many presentations of cocaine overdose?

Dr Soderstrom: Very occasionally; maybe one or two a year, if that.\(^6\)

The potential harms associated with cannabis and ecstasy are discussed in more detail in Chapters 7 and 10, but empirical evidence in Australia (see Figure 2. Harm to user vs harm to others) suggests that these drugs, along with cocaine, are less harmful overall compared to

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\(^3\) Paul Dessauer, Outreach Coordinator, Peer Based Harm Reduction, *Transcript of evidence*, 14 May 2019, p 4.

\(^4\) National Drug and Alcohol Research Centre, *Indicators of an increase in heroin availability in Western Australia*, report prepared by J Fetherston and S Lenton, National Drug Research Institute, Sydney, December 2015.


heroin, crystal meth, alcohol, tobacco or prescription opioids. Hallucinogenic drugs like LSD and psilocybin mushrooms are associated with relatively low levels of harm and increasingly recognised for their therapeutic value. Western Australia’s Misuse of Drugs Act 1981 does not discriminate in its treatment of these drugs based on harm.

**FINDING 15**
The harms associated with drugs prohibited under the Misuse of Drugs Act 1981 vary widely, but the drugs are equally unlawful.

**RECOMMENDATION 3**
Should the Western Australian Government review the Misuse of Drugs Act 1981, as part of the review it also consider if the Acts provisions, operations and punishments are proportionate to the relative harms associated with specific drugs.

**Co-occurring mental illness**

3.41 A drug-related harm common to all prohibited drugs is co-occurring mental illness or mental health issues. In 2018, 47% of respondents in the Illicit Drug Reporting System reported having a mental health issue. Drug and alcohol service provider Cyrenian House told the Committee that it was the norm for their clients to suffer from a mental health issue such as anxiety or depression:

*The CHAIR: Can I ask, in your experience, for the people that are presenting with comorbidity, how often would people have gone down the drug path, effectively, because they are self-medicating for underlying mental health issues?*

*Ms DAWNS: I think that is a fairly common presentation.*

3.42 The Committee has heard that since crystal meth became prevalent in WA, the increase in mental health comorbidity has been ‘astounding’. The evidence shows that co-occurring mental health and alcohol and other drug use is the expectation when people present to services, rather than the exception, and should be approached as such.

**FINDING 16**
A significant proportion of people with problematic drug use also have co-occurring mental health issues.

**FINDING 17**
The prevalence of methamphetamine in Western Australia has resulted in an increase in the number of people with comorbid mental illness and problematic drug use.

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101 Janelle Scutt, Magistrate, Perth Drug Court, email, 10 June 2019.

Drug-related offending and incarceration

3.43 The Committee considers it important to distinguish between:

- ‘Illicit drug offending’, which includes:
  - using or possessing an illicit drug for personal use
  - possessing an illicit drug with intent to sell or supply
  - selling or supplying illicit drugs
  - manufacturing, preparation or cultivation of illicit drugs.

- ‘Drug-related offending’, which is other offending that arises from or is connected to a person’s drug use. This may include property crime to feed drug addiction, driving under the influence of drugs and antisocial or violent crimes committed while under the influence of drugs.

3.44 Available data on illicit drug offending does not differentiate between offences of possession with ‘intent to sell or supply’ and offences of possession for ‘personal use’, the latter of which are one of the foci of this report. In addition, whether offending is drug-related is not specifically measured at all. Noting these limitations, the purpose of this section is to demonstrate the disproportionately large role that drugs play in crime and incarceration in WA.

3.45 The UNODC has attributed prison overcrowding in many countries to the global mass incarceration of drug offenders. In 2016, 18% of the world’s prisoners were incarcerated for illicit drug offences.

3.46 The problem of prison overcrowding is pertinent to WA. The prison population of WA has increased by 36.8% between 2013-14 and 2018-19, far outstripping the general population growth of Perth.

3.47 Illicit drug offences have been the most common principal offence in WA since 2013-14. Some 60% of offenders had a principal offence of use or possession (which may include possession with intent to supply).

3.48 Illicit drug offending has been at least partially driving the increasing WA prison population over the past decade. Between 2012-13 and 2016-17, the number of illicit drug charges lodged increased by 124%.

3.49 In 2017-18, 41% of WA prisoners received into custody had an illicit drug offence. However, the number of prisoners who have drug-related offences is expected to be much higher.

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105 The United Nations Office on Drugs and Crime uses different definitions – for example, ‘drug-related offending’ has a similar meaning to what the Committee calls ‘illicit drug offending’. The Committee has chosen to use its own terms in this section.
108 Submission 40 from Department of Justice, 29 November 2018, p 8. Refers to individual charges, which means there may be other charges involved in the same case.
3.50 As previously mentioned, the Department of Justice (Justice) does not collect data on drug-related offending:

The CHAIR: How does the department account for the true extent of drug-related offending?

Mr JOHNSON: Again, when I ask the questions, I ask: what seems to be the reasons in your area for why some of the offences are being committed? Invariably, it comes back to drugs – to fund their drug habit.

Hon AARON STONEHOUSE: We cannot quantify that, though – it is merely feedback you are receiving from the clerks.

Mr JOHNSON: Yes.\(^\text{109}\)

3.51 Justice also confirmed that the Prisoners Review Board does not keep data on the number of offenders applying for parole who have a drug problem.\(^\text{110}\) However, the Inspector of Custodial Services estimated that it could be upwards of 90%:

A very, very large number of people who are in prison for offences like burglary are committing those offences because of drug issues.

Actually nailing the proportion of people and what substances are at issue is extremely difficult, but speaking from experience in this job, on the parole board and on the basis of research, I remember that when I was on the parole board it seemed to me that upwards of 90 per cent of people coming before us had an alcohol or drug problem.\(^\text{111}\)

3.52 The illicit nature of the drug market appears to drive much of the associated criminal behaviour:

We heard a range of stories of people who got into debt, were threatened, and then got into prostitution, burglaries and assaults. I am sure you are aware of the stat that 85% of assaults and burglaries in Western Australia are alcohol and drug-related.\(^\text{112}\)

3.53 The Committee heard from other relevant stakeholders about the link between drugs and offending in WA. Legal Aid WA said that illicit drug use is often a factor in the criminal law, child protection and family law cases that they deal with, and decisions to take children into state care.\(^\text{113}\) Alcohol and other drug service provider Cyrenian House told the Committee that:

Most people in prison in WA have problems with alcohol and/or illicit drugs. Further, much of the crime committed that results in imprisonment is either directly or indirectly drug related.\(^\text{114}\)

3.54 The difficulty with measuring drug-related imprisonment stems from the way crimes are recorded. For example, it is likely that meth has driven at least some of the recent increases in family related offences, including assault and threatening behaviour. The fact that two-

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\(^{109}\) Michael Johnson, Acting Executive Director, Court and Tribunal Services, Department of Justice, Transcript of evidence, 18 March 2019, p 9.

\(^{110}\) Department of Justice, Answer to question on notice 13 asked at hearing held 18 March 2019, dated 3 April 2019, p 5.


\(^{112}\) Ron Alexander, Former Chair, Methamphetamine Action Plan Taskforce, Transcript of evidence, 15 April 2019, p 5.

\(^{113}\) Submission 39 from Legal Aid Western Australia, 29 November 2019, p 3.

\(^{114}\) Submission 60 from Cyrenian House, 19 November 2019, p 3.
thirds of Perth watch-house detainees test positive for meth indicates a link with much of the violence and aggression in the area.\textsuperscript{115}  

3.55 The Committee considers it important for the WA State Government to have a clear picture of the true extent of drug related offending and imprisonment in order to develop adequate policy responses.

**FINDING 18**

Illicit drug offences are the most common offences in Western Australia, and have increased over the past decade.

**FINDING 19**

The true extent of drug-related offending in Western Australia is not known or measured.

**RECOMMENDATION 4**

The Department of Justice and the Western Australia Police Force develop mechanisms for identifying and recording drug-related offending.

**The impacts of criminalisation**

3.56 The Committee heard that a major drug-related harm is the impact that criminalisation has on the lives of drug users. This section refers to the criminalisation of drug use and possession, not other drug-related offending.

3.57 Penalties aside, a criminal record can present problems on its own. A criminal record can have a range of consequences on employment, housing and education opportunities.\textsuperscript{116} For example, people in public housing or rentals risk eviction if drugs are detected on the premises, which increases the risk of homelessness and poverty.\textsuperscript{117}

> The adverse consequences of a criminal conviction are substantial for people, in terms of their future employment prospects, their ability to get accommodation, becoming more identified as part of the criminal justice system...travel, and all the things that occur as a result of a criminal record.\textsuperscript{118}

3.58 Several private citizens told the Committee about the impact that prohibition has had on their lives:

> My police record means that my employment chances are decreased and my opportunity to become the best person I can is stifled beyond repair.

> The court appearances, the urinating in a jar, the visits to the probation officer were all expensive for the state and to no avail. I still consume cannabis and I still suffer the discrimination and I feel nothing but hatred for a system that has expelled me and made my life extremely difficult.\textsuperscript{119}

3.59 According to Hope Community Services, scheduling a drug as illegal will not eliminate its use. However, it may entrench the disadvantage experienced by those who use it.\textsuperscript{120}

\textsuperscript{115} Phil Hickey, ‘Almost two-thirds of Perth lockup detainees are on meth’, WA Today, 17 April 2019.

\textsuperscript{116} Gabriel Chin, ‘Race, the war on drugs, and the collateral consequences of criminal conviction’, *Journal of Gender, Race and Justice*, 2002, vol. 6, p 253.

\textsuperscript{117} Associate Professor Kate Seear, Associate Professor in Law, Monash University, Transcript of evidence, 17 June 2019, p 11.

\textsuperscript{118} Professor Simon Lenton, Director, National Drug Research Institute, Transcript of evidence, 10 June 2019, p 5.

\textsuperscript{119} Submission 23 from a private citizen, 26 November 2018, p 1.

\textsuperscript{120} Submission 25 from Hope Community Services, 26 November 2019, p 2.
Committee heard that those people most likely to suffer the consequences of the criminalisation of drug use and possession are already struggling with unemployment, mental health issues and unstable housing. For example, Aboriginal people are more likely to go to jail for failing to pay fines, especially in remote areas where community development alternatives are not available.\textsuperscript{121}

3.60 The Committee heard that Western Australians do not typically go to jail for drug possession alone. The Mid West branch of the Aboriginal Legal Service WA told the Committee that for their clients, drug use and possession are typically contributing charges. Police often find drugs when they encounter people for another reason, such as family violence. Drug possession can lead to imprisonment where possession or use is a breach of parole, bail or a suspended sentence.\textsuperscript{122} Despite making up only 3.1\% of the population, 38\% of Western Australians in prison are Aboriginal.\textsuperscript{123}

3.61 The Global Commission on Drug Policy links drug criminalisation with negative public health outcomes, including a global pandemic of HIV and hepatitis C.\textsuperscript{124} Interacting with the black market can also produce harms, as illicit products are not subject to quality control or safety standards. The Commission states that for these reasons, and the others outlined in this section, repressive drug policies create far more harm than the drugs themselves.\textsuperscript{125}

3.62 There is some argument about the effectiveness of criminalising drug use and possession. Proponents of criminalisation say that it protects people from the harmful effects of drugs.\textsuperscript{126} Laws have a role in shaping community values and opinions. The prohibition of drugs can send a message that the substance is so harmful that society cannot sanction its use under any circumstances. The Committee heard that for this reason, prohibition should be reserved for the most harmful drugs.\textsuperscript{127}

3.63 In Australia, 31\% of people surveyed cite illegality as one of their reasons for not trying illicit drugs, although ‘not interested’ (73\%) and ‘health concerns’ (43\%) were cited more frequently.\textsuperscript{128} However, research suggests that peer influences have a more powerful impact on young people than the law.\textsuperscript{129} The Alcohol and Other Drug Community and Consumer Coalition told the Committee that illegality might not be a strong motivator to prevent young people from trying drugs:

\textbf{Hon MICHAEL MISCHIN:} How will they see discouraging young people – their kids, for example – from taking up drug use and experimentation?

\textbf{Ms KOEIJERS:} … It is funny that the criminalisation of drugs was seen to be enticing to some, and that particularly young people are seeking to engage in risky

\textsuperscript{121} Kate Turtley-Chappel, Managing Lawyer, Mid-West Office, Aboriginal Legal Service of WA, email, 2 August 2019.

\textsuperscript{122} ibid.


\textsuperscript{127} Submission 60 from Cyrenian House, 17 January 2019, p 2.


\textsuperscript{129} Submission 41 from National Drug Research Centre, 30 November 2018, p 4.
behaviour. And actually, having it not deemed so bad...essentially was taking it off their radar.\textsuperscript{130}

3.64 Studies including a 2008 review of World Health Organisation data have failed to establish a link between harsh drug laws and drug use:

Globally, drug use is not distributed evenly and is not simply related to drug policy, since countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones.\textsuperscript{131}

3.65 The WA Bar Association expressed their concern about the effectiveness of criminal penalties as a tool to reduce drug use:

The experience of most of our members is that most people charged with drug offences have little knowledge of the applicable penalties and the message behind the principle of general deterrence in sentencing rarely reaches its intended audience.

The WA Bar Association is also concerned as to the public cost of investigating, prosecuting and administering justice relating to drug use, in circumstances when those public funds could be used in different and better ways to address the problem.\textsuperscript{132}

**Stigma**

3.66 Closely associated with the effects of criminalisation is the issue of stigma. Stigma refers to the negative attitudes and community perceptions that people who use drugs face, which decreases their likelihood of seeking treatment,\textsuperscript{133} and contributes to social isolation and exclusion.\textsuperscript{134}

3.67 The Committee received evidence that the prohibition of drugs increases stigma.\textsuperscript{135} People are less likely to access support or services to address their illicit drug use due to fear of criminal action. According to Hope Community Services, the ‘moral panic’ around drug use drives negative community perceptions and judgement.\textsuperscript{136} While people with mental illness or alcohol problems also experience stigma, studies have found illicit drug users to be the most stigmatised group because of the criminal connotations.\textsuperscript{137}

3.68 Mental Health Matters 2, a community advocacy group that represents people with mental illness, told the Committee that drug and alcohol patients feel stigmatised by health professionals, which can affect their healthcare outcomes. This type of stigma is institutionally entrenched, not just the result of individual negative perceptions.\textsuperscript{138}

\begin{itemize}
\item [\textsuperscript{130}] Juanita Koeijers, Project Lead, Alcohol and Other Drug Consumer and Community Coalition, *Transcript of evidence*, 17 June 2019, p 8.
\item [\textsuperscript{132}] Submission 56 from WA Bar Association, 21 November 2018, p 2.
\item [\textsuperscript{133}] Submission 41 from National Drug Research Centre, 30 November 2018, p 6.
\item [\textsuperscript{134}] Caroline Waddington, Steering Group Committee Member, Mental Health Matters 2, *Transcript of evidence*, 18 March 2019, p 7.
\item [\textsuperscript{135}] Submission 25 from Hope Community Services, 26 November 2018, p 5.
\item [\textsuperscript{136}] ibid., p 2.
\item [\textsuperscript{138}] Submission 41 from National Drug Research Centre, 30 November 2018, p 6.
\end{itemize}
The Committee agrees that reducing stigma around drug addiction could encourage people to seek help. If there was less stigma, people may seek support earlier, rather than avoiding the problem out of fear or shame.

**FINDING 20**
Stigma around drug use may prevent people from seeking assistance.

**Conclusion**

Drugs result in individual and community-wide social, health and economic harms. These harms result from both drug use and drug prohibition. While drug-related harms affect all levels of society to some degree, the people likely to experience those harms most deeply are those who are subject to the social determinants of drug use—social disadvantage, mental illness, trauma and poor health. For these people, drug-related harms such as experiencing stigma and receiving a criminal record can compound existing disadvantage and make it more difficult to achieve good life outcomes.

Given the understanding of what drives drug abuse and the fact that drug-related harms are not being reduced under the existing framework, the Committee is of the view that now is an opportune time to examine alternative approaches to reducing drug-related harms in WA.
CHAPTER 4
Current approaches through the Western Australian criminal justice system

Introduction

4.1 The Committee required a thorough understanding of current approaches before it could examine alternatives. The Committee heard evidence from the WA Police Force, Justice, the Inspector of Custodial Services and drug service providers about the criminal justice responses to drug use and possession in WA.

4.2 The legislative basis of prohibition in WA means that drug use is primarily treated as a criminal justice issue. As drug use and possession are criminal offences under law, criminal justice responses are not optional. Conversely, there is no legislative requirement to deliver a treatment program or service to someone with a drug issue.

4.3 This chapter will demonstrate that the criminal justice system incorporates treatment and services in its responses to people who use drugs, although sometimes in a peripheral way. This chapter considers the operation and effectiveness of:

- the WA Police Force Drug Diversion Program
- the Perth Drug Court
- drug programs in prisons, including the Pathways Program and the new Wandoo Rehabilitation Program for Women.

Penalties for drug use and possession

4.4 Section 6(2) of the Act establishes that it is a simple offence for a person to have in their possession, or use, a prohibited drug. This offence is liable to a fine of up to $2000, imprisonment for up to two years, or both. Unless diverted, offenders will also receive a criminal record.

4.5 The Committee is primarily interested in offences concerning less than the amounts prescribed in Schedule 5 of the Act, which gives rise to a presumption of intent to supply. Lesser amounts are considered to be for personal use.

Penalties for drug sale and supply

4.6 The Committee heard that the current penalties should continue to apply to drug manufacturing, trafficking or dealing.

4.7 However, the Committee heard that criminal confiscation laws in WA relating to drug dealing might operate in a manner that is disproportionately punitive. The Criminal Property Confiscation Act 2000 enables the State to apply to have all assets of a convicted drug trafficker seized regardless of whether he or she obtained the assets lawfully.

4.8 The Committee heard that in some cases, the State can freeze the assets of people who are charged but have not yet been found guilty. Drug and alcohol services provider Cyrenian House told the Committee about a young man who was charged with possessing 10 grams of meth, a trafficable amount, which he claimed was for personal use. The young man had a payout from his fly-in, fly-out job frozen during court proceedings. As a result, he has been

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139 Misuse of Drugs Act 1981 s 34(1)(e).
140 Submission 1 from Gary Brennan, Mayor of Bunbury, 1 November 2018, p 2.
unable to pay his mortgage during this time and his houses were seized. Regarding this example, Cyrenian House explained:

He was purchasing methamphetamine for his own use. He had a house, which he had purchased... There is a young woman, who is having a baby, who is his partner—he cannot provide for his family.

I do not understand the value in seizing that man’s assets when it is pretty clear that the assets have not come from the proceeds of crime. They are pretty clearly assets that he owns. Why should they be taken from him?

4.9 The Criminal Property Confiscation Act 2000 is currently under review.

RECOMMENDATION 5

The Department of Justice, in its review of the Criminal Property Confiscation Act 2000, consider the appropriateness or otherwise of confiscating assets that are not proceeds of crime.

Threshold limits giving rise to intent to supply

4.10 The evidence in the above section raises a question about threshold amounts. Currently, possessing over two grams of most illicit drugs gives rise to a statutory presumption of intent to sell or supply.

4.11 However, the Committee heard that the prescribed amounts are ‘out of touch’. The Committee heard that today, someone possessing two grams of meth could be a heavy user rather than a supplier.

4.12 In 2014, the National Drug and Alcohol Research Centre (NDARC) studied the quantities of different illicit drugs typically used in each state and found that for some drugs, the maximum amount used in a single heavy session in WA constituted an amount that gives rise to a presumption to supply.

Table 3. Western Australian threshold amounts vs maximum used in heavy session

<table>
<thead>
<tr>
<th>Illicit drug</th>
<th>Threshold amount WA (trafficking)</th>
<th>Maximum used in heavy session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meth (any form)</td>
<td>2 grams</td>
<td>2 grams</td>
</tr>
<tr>
<td>Speed</td>
<td>2 grams</td>
<td>4 grams</td>
</tr>
<tr>
<td>Heroin</td>
<td>2 grams</td>
<td>2 grams</td>
</tr>
<tr>
<td>MDMA</td>
<td>2 grams</td>
<td>3.5 grams</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2 grams</td>
<td>4 grams</td>
</tr>
<tr>
<td>Cannabis</td>
<td>100 grams</td>
<td>27 grams</td>
</tr>
</tbody>
</table>


4.13 The results indicate that the current threshold limits accurately reflect the amount of heroin or meth that could be used in a single heavy session. However, users of ecstasy, cocaine and speed may be at an increased risk of prosecution for possessing a trafficable amount.

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141 Carol Daws, Chief Executive Officer, Cyrenian House, Transcript of evidence, 11 May 2019, p 15.
142 Hon John Quigley MLA, Attorney General, Former Chief Justice to undertake review of WA’s asset seizure laws, Media statement, Department of the Attorney General, Perth, 19 September 2018.
143 Janelle Scutt, Magistrate, Perth Drug Court, email, 10 June 2019.
FINDING 21
Current threshold limits in the *Misuse of Drugs Act 1981* may not align with contemporary evidence on use and possession practices.

RECOMMENDATION 6
In reviewing the *Misuse of Drugs Act 1981*, the Western Australia Police Force consult the Mental Health Commission and examine contemporary evidence to review the current threshold limits giving rise to intent to supply.

**Drug diversion**

4.14 Diversion aims to redirect low-level offenders away from certain criminal justice processes. Once considered controversial, today all Australian states and territories employ some form of diversionary response for drug possession and/or drug related offending. Most states operate five or six different programs.\(^{144}\)

4.15 The National Drug Strategy identifies diversion away from the criminal justice system into health interventions as an evidence-based approach to reducing the adverse health, social and economic consequences associated with drug use.\(^{145}\)

4.16 Common forms include police diversion and court diversion. Police drug diversion occurs at the point of police apprehension as an alternative to prosecution, and may involve imposing a civil penalty or diverting the person to some form of therapeutic intervention.

4.17 Court drug intervention typically occurs following conviction at the pre-sentencing stage, and may involve ongoing requirements to undertake a treatment program and abstain from drug use.

4.18 The Committee received evidence in support of drug diversion.\(^{146}\) Australian evaluations show benefits including:

- cost effectiveness
- reduced burden on criminal justice systems
- increased treatment referrals and uptake
- decreased likelihood of imprisonment
- improved social outcomes.\(^{147}\)

4.19 In 2015, the National Ice Taskforce found that diversion programs can increase the efficiency of the criminal justice system by reducing costs. The Taskforce recommended that state and territory governments review diversionary programs to determine best practice approaches, and consider options for improving and expanding existing arrangements.\(^{148}\)


\(^{146}\) For example, submission 73 from Western Australia Police Force, 21 January 2019, p 5.


\(^{148}\) National Ice Taskforce, *Final Report of the National Ice Taskforce*, Department of the Prime Minister and Cabinet, Canberra, 2015, p 146.
4.20 Potential negative outcomes of diversion include net-widening and unequal access.¹⁴⁹ Net-widening occurs when more people rather than less are processed by police following the introduction of a diversionary scheme. Unequal access results from structural barriers, such as a lack of treatment options in regional and remote areas, which may deny access to diversionary schemes.

4.21 WA currently has two drug diversion programs, the:
- WA Police Force Drug Diversion Program
- Perth Drug Court.

**Western Australia Police Force Drug Diversion Program**

4.22 The WA Police Force Drug Diversion Program comprises the:
- Cannabis Intervention Requirement Scheme (CIRS)
- Other Drug Intervention Requirement Scheme (ODIRS).

4.23 Key elements of the two schemes are set out in Table 4.

<table>
<thead>
<tr>
<th></th>
<th>CIRS</th>
<th>ODIRS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduce</strong></td>
<td>2010</td>
<td>2004 (use expanded in 2015)</td>
</tr>
<tr>
<td><strong>Established by</strong></td>
<td>Part 3 of the <em>Misuse of Drugs Act 1981</em></td>
<td>Policy (non-legislative)</td>
</tr>
<tr>
<td><strong>Requirements</strong></td>
<td>A police officer may give a Cannabis Intervention Requirement (CIR) to a person believed to have committed a minor cannabis related offence. The alleged offender may avoid prosecution by completing a Cannabis Intervention Session (CIS) within 28 days.</td>
<td>A police officer may give an Other Drug Intervention Requirement (ODIR) to a person believed to have committed a simple drug offence in relation to a drug other than cannabis (but including cannabis resin, oils and synthetic cannabinoids). The alleged offender may avoid prosecution by completing three Other Drug Intervention Sessions (ODIS) within 42 days.</td>
</tr>
</tbody>
</table>

### Eligibility

<table>
<thead>
<tr>
<th>CIRS</th>
<th>ODIRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- No prior CIR as an adult</td>
<td>- Adult</td>
</tr>
<tr>
<td>- No prior cannabis related offence as an adult</td>
<td>- No prior drug offences (excluding CIR)</td>
</tr>
<tr>
<td>- Young people under the age of 18 may be issued a CIR if they have one prior CIR</td>
<td>- No prior ODIR</td>
</tr>
<tr>
<td>Possession of less than 10 grams.</td>
<td>- No convictions for violent or other serious specified offences</td>
</tr>
<tr>
<td></td>
<td>Possession of less than 25% of deemed weight for possession with intent – 0.5 grams for heroin, methamphetamine and cocaine.</td>
</tr>
</tbody>
</table>

[Source: *Misuse of Drugs Act 1981*, Western Australia Police Force presentation - Early Intervention for Simple Illicit Drug Related Offences: Diversion to Treatment.]

4.24 In summary, eligible offenders have the option of attending one to three education sessions within 28-42 days to avoid prosecution for drug possession. The 90-minute sessions aim to inform participants about drug-related laws, the adverse health and social consequences of drug use and effective strategies to address drug use.\(^{150}\)

4.25 The Mental Health Commission has responsibility for these sessions, which it procures from non-government organisations. Community Alcohol and Drug Services deliver the sessions in regional areas.

### Operation and effectiveness

4.26 In May 2019, NDARC released a study on the reach of Australian drug diversion programs.\(^ {151}\) Across the country, the proportion of offenders apprehended for drug use or possession and diverted away from court by police declined between 2010-11 and 2014-15. This means that more offenders were prosecuted and punished for drug use or possession alone. Reasons for the decline may include changes in drug and policing trends, narrow eligibility criteria and a lack of access to treatment.

4.27 Western Australians are the least likely in the country to be diverted by police. The incidence of police diversion ranged from 32.4% in WA to 98% in South Australia, meaning people in South Australia were more than three times more likely to be diverted than people in WA (see Figure 3).

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\(^{150}\) *Misuse of Drugs Act 1981* s 8J.

Figure 3. Proportion of offenders with a principal offence of use/possession given a drug diversion, 2010-11 to 2014-15, by state

4.28 According to NDARC:

The low rates of diversion in Western Australia were more of a surprise given police diversion programs operated for use and possession of both cannabis and other illicit drugs.

Nevertheless, low rates of diversion in Western Australia were attributed to three main factors: first, that Western Australia switched from a cannabis infringement scheme to a therapeutic cannabis diversion scheme during the first year of analysis, stopping or limiting access during the transition period; second, strict eligibility factors; and finally, implementation issues which made it easier for police to charge than divert offenders (due to both a lack of a 24-hour diversion line and a requirement that police schedule diversion appointments).

A still further factor highlighted as affecting all three ‘low diversion states’ is geography. Here it was noted that access to drug diversion is more restricted in rural/regional Australia, due to the lack of availability of alcohol and drug treatment services and structural barriers to offenders accessing services.\(^\text{152}\)

4.29 NDARC also identify low threshold limits as being a barrier to diversion. The threshold amounts for other illicit drugs tend to be low in comparison to cannabis,\(^\text{153}\) meaning heroin, meth and ecstasy users may miss out on diversion, assessment and treatment opportunities.

4.30 Although low in comparison to other states, between 2014 and 2018 the number of police diversions in WA increased by 53%.\(^\text{154}\) Data to compare the current rate of diversion in WA to other states is not available.

4.31 The increase is likely due in part to the policy decision to expand ODIRS use in 2015.\(^\text{155}\) However, only a quarter of total intervention requirements issued relate to drugs other than cannabis, suggesting that the ODIRS is underutilised in comparison to the CIRS. In addition,
people referred to the ODIRS are less likely to successfully complete it than those referred to the CIRS, which results in prosecution proceedings. The WA Police Force believe this is because:

The ODIR requires booking and completion of three 90-minute treatment sessions over 42 days. This is more arduous than the CIR, which requires completion of one 90-minute treatment session, and this contributes to slightly lower compliance with the ODIR.

The recipients of the ODIR are users of methamphetamine, heroin, MDMA etc. They generally have more entrenched patterns of drug use, more chaotic and dysfunctional lifestyles and are therefore less likely to adhere to a treatment schedule (three sessions) than cannabis users.\(^{156}\)

4.32 The Committee questioned the rationale for requiring attendance at only one education session for possessing cannabis, and three sessions for possessing any other illicit drug. The Mental Health Commission advised that it is likely that the longer intervention for other drug possession was based on the presenting needs of people with amphetamine and opioid use being more complex.\(^{157}\)

4.33 One of the concerns often raised about police discretion is that it has the potential to lead to the underrepresentation of certain groups, including Aboriginal people and people living regionally and remotely.\(^{158}\)

4.34 The Committee asked the WA Police Force for a breakdown of the number of drug diversions issued to Aboriginal people in 2017 and 2018. The WA Police Force provided the following results:

Table 5. Number of intervention sessions issued, 2017 and 2018

<table>
<thead>
<tr>
<th>Year</th>
<th>Total issued</th>
<th>Number issued to Indigenous Australians</th>
<th>% Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cannabis Intervention Requirement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>2316</td>
<td>296</td>
<td>12%</td>
</tr>
<tr>
<td>2018</td>
<td>2047</td>
<td>271</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Other Drug Intervention Requirement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>457</td>
<td>36</td>
<td>8%</td>
</tr>
<tr>
<td>2018</td>
<td>449</td>
<td>26</td>
<td>6%</td>
</tr>
</tbody>
</table>


\(^{156}\) Western Australia Police Force, Answer to question on notice A1 asked at hearing held 15 April 2019, dated 2 May 2019, p 2.

\(^{157}\) Mental Health Commission, Answer to question on notice 7 asked at hearing held 17 June 2019, dated 5 August 2019, p 10.

Chapter 4 Current approaches through the WA criminal justice system

4.35 Aboriginal people make up 31% of people appearing before the Magistrates Court, but only 6-13% of drug diversions.\textsuperscript{159} The Committee also notes that the operation of the ODIRS in regional areas is limited compared to the metropolitan area.\textsuperscript{160}

4.36 The WA Police Force told the Committee that apart from the current policy, there is no real barrier to expanding the ODIRS for drugs like meth.\textsuperscript{161}

4.37 The Committee sought to understand whether the actual sessions (CIS and ODIS) present therapeutic value to participants or simply act as a box-ticking exercise. The Mental Health Commission told the Committee that CIS and ODIS treatment providers offer the opportunity for the participant to engage in further treatment:

\textbf{Dr O’REAGAN}: It very much depends on what the person wants. Some people will come without any particular problems and they have been made to do this and they do not really want to do it and they will come along so they avoid further penalty, whereas some people come along and that will be, if you like a stepping stone into a more significant engagement with us.

\textbf{Mr KIRBY}: In the case of the CIR that we are talking about, it brings people in contact with the treatment service that they might not otherwise have done. For some, they will simply expiate and that will be the end of it, but for others...it can be the gateway for them into the treatment service that they might not have otherwise attended.

\textbf{The CHAIR}: Which is effectively the Portuguese model, but it is civilly constructed, not via criminal penalty.\textsuperscript{162}

4.38 People who attend a CIS are offered a voluntary feedback survey. Between the commencement of the CIRS in August 2011 and 31 July 2018:\textsuperscript{163}

- 82.6% of respondents indicated that they thought a little or a lot about cutting down their cannabis use following their CIS
- 73.5% of respondents indicated they thought a little or a lot about not using cannabis anymore.

4.39 There is no dedicated feedback survey for the ODIRS. However, routine pre- and post-ODIS data for participants from 2016-17 and 2017-18 indicates that for those who completed the evaluation:

- 26% stated that they had reduced use of the primary drug of concern
- 37.5% stated they had improved mental health
- 35% stated that they had increased confidence to stop or reduce alcohol and/or other drug use.

4.40 The WA Police Force also use reoffending, that is, people who go on to be apprehended again for drug possession, as a measure of success. Data suggests that 28% of participants who completed their CIS did not reoffend, as opposed to 49% of people who did not

\textsuperscript{159} Department of Justice, Answer to question on notice 18 asked at hearing held 18 March 2019, dated 3 April 2019, p 14.

\textsuperscript{160} Western Australia Police Force, \textit{Early intervention for simply illicit drug related offences: diversion to treatment, Alcohol, Tobacco and Other Drugs Council of Tasmania Conference, May 2016.}


\textsuperscript{162} Dr Richard O’Reagan, Director, Clinical Services, Next Step and Gary Kirby, Director, Prevention Services, Mental Health Commission, \textit{Transcript of evidence}, 17 June 2019, p 7.

\textsuperscript{163} Mental Health Commission, Answer to question on notice 5 asked at hearing held 17 June 2019, dated 5 August 2019, p 2.
complete a CIS. From a June 2018 sample of people who completed a CIS, 27% were apprehended with cannabis for a second time and dealt with through the courts.\textsuperscript{164} Police Commissioner Chris Dawson acknowledged:

\begin{quote}
It is fair to say we have been diverting more by way of policy for cannabis than we have for other drugs.\textsuperscript{165}
\end{quote}

\textbf{4.41} Although the Police Drug Diversion Program provides an avenue for achieving health and social outcomes, barriers to access mean that it more closely reflects the philosophy of the criminal justice model – ‘punish once, and, if that does not work, punish harder’.\textsuperscript{166}

\begin{aspenbox}{FINDING 22}
Strict eligibility requirements and barriers to access limit the utility of the Police Drug Diversion Program.
\end{aspenbox}

\begin{aspenbox}{FINDING 23}
The Other Drug Intervention Requirement Scheme diverts fewer drug use and possession offenders from court than the Cannabis Intervention Requirement Scheme.
\end{aspenbox}

\section*{Strengthening police diversion}

\textbf{4.42} The WA Police Force submitted that improving the existing Police Drug Diversion Program would be preferable to relaxing criminal penalties for drug users:

\begin{quote}
The WA Police Force could increase utilisation of Drug Diversion through the removal of existing legislative barriers and through policy adjustments. This is the preferred way forward as opposed to a relaxation of existing illicit drug laws. A relaxation of existing drug laws would have significant detrimental impacts on the community.\textsuperscript{167}
\end{quote}

\textbf{4.43} The WA Police Force suggest the following options for enhancing the use of drug diversion by broadening eligibility criteria:\textsuperscript{168}

\begin{itemize}
\item Legislative change:
  \begin{itemize}
  \item Expand access to the CIRS by removing the provision in the \textit{Misuse of Drugs Act 1981} that precludes persons from eligibility if they have ever had a previous minor cannabis-related conviction.
  \item Consider incorporating the policy-based ODIRS into the \textit{Misuse of Drugs Act 1981}. This could enhance the validity of the ODIR in the eyes of offenders and issuing officers.
  \item In doing so, enable people under the age of 18 to be eligible for an ODIR. While making consequential amendments to the \textit{Young Offenders Act 1994}, replace the term ‘infringement’ with ‘intervention’ for both CIRS and ODIRS.
  \end{itemize}
\end{itemize}

\begin{footnotes}
\item[164] Western Australia Police Force, Answer to question on notice A2 asked at hearing held 15 April 2019, dated 2 May 2019, p 2.
\item[166] Brendan Hughes, Principal Scientist, European Monitoring Centre for Drugs and Drug Addiction, \textit{Transcript of evidence}, 17 June 2019, p 7.
\item[167] Submission 73 from Western Australia Police Force, 21 January 2019.
\item[168] ibid., p 11.
\end{footnotes}
Consider moving the eligibility criteria for the CIR and ODIRS into the Misuse of Drugs Regulations 1982 so that the laws are agile enough to adapt to emerging drug type and usage trends.

Policy change:
- Review the current policy-based criteria that precludes a person that has ever been convicted of a serious violent or serious drug-related offence. Access to the CIR and ODIRS options could be expanded if a three or five-year conviction lifespan is applied to the precluding convictions.

4.44 The Committee notes the suggestions but reserves its recommendations in light of relevant alternate approaches outlined later in this report.

**Perth Drug Court**

4.45 Drug Courts can divert drug-dependent offenders away from prison. The Drug Court model emerged in America in the 1980s in response to rapidly rising incarceration rates among drug offenders. The model is based on the idea that combining the coercive power of the criminal justice system with drug treatment may be effective in reducing substance abuse and offending among low level, non-violent repeat offenders.

4.46 Drug Courts have since gained international popularity and operate in five Australian states. The Perth Drug Court first convened in 2000 with the goal of breaking the cycle of substance misuse and offending by facilitating treatment for people with significant drug use.

4.47 Justice administers the Perth Drug Court, and the Mental Health Commission coordinates its drug treatment services. Treatment options include detoxification, pharmacotherapy, non-residential and residential treatment.

**Operation**

4.48 The Drug Court operates in the Perth Magistrates Court and accepts referrals from the District and Supreme Courts and regional Magistrates Courts. It also operates under a separate process in the Perth Children’s Court.

4.49 The Perth Drug Court Team includes a dedicated Magistrate who leads a multi-disciplinary team and works with participants in a primarily non-adversarial setting.

**Table 6. Perth Drug Court Team**

<table>
<thead>
<tr>
<th>Team member/s</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Court Magistrate</td>
<td>• decides if participant can be assessed for a Drug Court treatment program</td>
</tr>
<tr>
<td></td>
<td>• sets bail conditions</td>
</tr>
<tr>
<td></td>
<td>• makes decisions about the participant’s progress through the program.</td>
</tr>
<tr>
<td>WA Police Force Prosecutor</td>
<td>Represents the interests of the community.</td>
</tr>
<tr>
<td>Drug Court Lawyer (Legal Aid)</td>
<td>Interviews and represents the participant in court.</td>
</tr>
</tbody>
</table>

---


### Team member/s

<table>
<thead>
<tr>
<th>Team member/s</th>
<th>Role</th>
</tr>
</thead>
</table>
| Court Assessment & Treatment Service (CATS) Officer | • conducts assessment of participant’s risks and criminogenic needs  
• accesses and links participant with appropriate treatment (counselling, detox, residential treatment) and support services (housing, education)  
• monitors treatment and compliance  
• prepares reports and recommendations for Magistrate. |
| Treatment agencies                     | Engage with participants to provide treatment and support services for offenders through a variety of modalities.                      |

Source: Perth Drug Court Guidelines.

#### 4.50

The Drug Court deals with complex offenders who would otherwise be facing imprisonment. Participants may have committed illicit drug offences or other types of offences, but must have a drug issue that has contributed to their offending behaviour.

**Table 7. Participant criteria**

<table>
<thead>
<tr>
<th>Criteria offender must meet</th>
<th>Criteria that may exclude offender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facing charges in court</td>
<td>Offences involve actual violence</td>
</tr>
<tr>
<td>Request a referral from Magistrate or Judge</td>
<td>Offences are sex offences</td>
</tr>
<tr>
<td>Plead guilty</td>
<td>Offences involve manufacture of drugs</td>
</tr>
<tr>
<td>Have a demonstrable drug problem</td>
<td>Offences are of a sophisticated drug trafficking nature</td>
</tr>
<tr>
<td>Willing and able to participate</td>
<td>Offences relate to armed robbery</td>
</tr>
<tr>
<td>Willing and able to live in or move to Perth</td>
<td>Offences relate to stealing a motor vehicle</td>
</tr>
<tr>
<td>All outstanding legal issues resolved</td>
<td>Offender has outstanding legal matters that are subject to a not guilty plea</td>
</tr>
<tr>
<td></td>
<td>Facing mandatory imprisonment</td>
</tr>
</tbody>
</table>

Source: Perth Drug Court Guidelines.

#### 4.51

Once the participant has been assessed by the Court Assessment and Treatment Service and accepted to a Drug Court program by the Magistrate, the participant is placed on a treatment program and case managed for up to 24 months. Four programs are available, depending on the accused person’s offending severity and history. Programs vary in intensity, and the program imposed depends on the offender and the nature of the offending.
Table 8. Perth Drug Court programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervised Treatment Intervention Regime (STIR)</td>
<td>A pre-sentence program for people who are facing less serious charges, are unlikely to be imprisoned and may have support from friends and family. It is the least intensive program and includes a signed contract for up to six months, court appearances, random urine testing, attendance at counselling sessions and compliance with the directions of the Drug Court Team.</td>
</tr>
<tr>
<td>Conditional Drug Court Regime (DCR)</td>
<td>A pre-sentence program for offenders who are not suitable for a Pre-Sentence Order but are facing more serious charges, have a criminal history or a history of drug problems and may require more intensive support and monitoring. Offenders undertake this program while on conditional bail for a period of up to six months after entering a plea of guilty. The program includes the same elements as STIR with increased frequency and the requirement to abide by strict bail conditions.</td>
</tr>
<tr>
<td>Pre-Sentence Order</td>
<td>A pre-sentence program for participants who would otherwise be facing an immediate and substantial prison sentence. The program is generally 12 months long, with strict bail conditions that decrease in frequency over time.</td>
</tr>
<tr>
<td>Conditional Suspended Imprisonment Order</td>
<td>A post-sentence program for offenders who committed the referral offences while on parole or a suspended sentence of imprisonment.</td>
</tr>
</tbody>
</table>

Source: Perth Drug Court Guidelines.

4.52 Each program is separated into stages, which may begin with a residential rehabilitation placement. Honesty is a key tenet of the Drug Court, and while the Drug Court Team does not expect perfect performance from people dealing with addiction, they do not tolerate lying or cheating:

   In most cases, there will be lapses.\textsuperscript{171}

4.53 The sentencing judge will take into account Drug Court completion at final sentencing, which may result in a reduced sentence.

**Effectiveness**

4.54 The Committee heard support for the Drug Court from a number of stakeholders.\textsuperscript{172} National and international evidence demonstrates that drug court programs reduce drug use and reoffending.\textsuperscript{173} A 2006 review of the Perth Drug Court found that the program reduced reoffending and was more cost-effective than prison and community correction supervision.\textsuperscript{174}

\textsuperscript{171} Janelle Scutt, Magistrate, Perth Drug Court, email, 10 June 2019.

\textsuperscript{172} Including the WA Bar Association, the Alcohol and Other Drug Consumer & Community Coalition and Mission Australia.


Bearing in mind the high level (and high cost) of imprisonment in Western Australia, drug courts provide an effective and strictly monitored alternative for drug-dependent offenders.\textsuperscript{175}

4.55 Justice has not evaluated or reviewed the Perth Drug Court since 2006. The Committee found it difficult to obtain information about cost or effectiveness, but heard that:

- In 2017-18, the Drug Court referred 205 diversion treatment episodes.\textsuperscript{176}
- Aboriginal representation in the Perth Drug Court is in line with Aboriginal representation in the Magistrate's Court generally, at 30.9%.\textsuperscript{177}

4.56 Justice advised of the annual cost of the dedicated Magistrate and Judicial Officer, but does not have access to the other associated costs, including the rest of the team and the treatment services.\textsuperscript{178}

4.57 Justice does not record successful completion rates for Drug Court participants.\textsuperscript{179} Justice does not have information on recidivism (reoffending) rates for Drug Courts, or courts in general, because there is no accepted definition of what constitutes recidivist behaviour. Work is due to commence next year on planning to build the capacity to measure 'return to court'.\textsuperscript{180} The Committee notes that the 2006 internal review of the Perth Drug Court also recommended that the Department improve the collection of effectiveness data.

**FINDING 24**

The Perth Drug Court is a valuable diversionary option for complex, drug dependent offenders. Additional and more current data would be helpful to measure its ongoing effectiveness.

4.58 Given that Justice was unable to provide the Committee with relevant supporting data, the Committee met with the Drug Court Team to obtain anecdotal evidence about its operations and effectiveness.

\textsuperscript{175} Law Reform Commission of Western Australia, *Court Intervention Programs – Final Report*, Perth, June 2009, p 52.

\textsuperscript{176} These numbers represent the number of treatment episodes, i.e. closed episodes from the Drug Court for alcohol and other drug treatment. This includes the Children's Court Drug Court.

\textsuperscript{177} Department of Justice, Answer to question on notice 18 asked at hearing held 18 March 2019, dated 3 April 2019, p 14.

\textsuperscript{178} Department of Justice, Answer to question on notice 15 asked at hearing held 18 March 2019, dated 3 April 2019, p 6.

\textsuperscript{179} Department of Justice, Answer to question on notice 14 asked at hearing held 18 March 2019, dated 3 April 2019, p 5.

\textsuperscript{180} Department of Justice, Answer to question on notice 16 asked at hearing held 18 March 2019, dated 3 April 2019, pp 6-7.
Chapter 4 Current approaches through the WA criminal justice system

4.59 The Drug Court Team told the Committee that many participants find the structured program to be a valuable opportunity to address their drug addiction. The Committee heard from a Drug Court graduate who told the Committee that in order for the Drug Court to work, he needed to be in the right frame of mind. Today, he has been clean from drugs for years and has a managerial job:

I would be dead without the Drug Court.  

4.60 The Committee heard that there is strong demand for the Drug Court, which is often operating at its capacity of 90 participants. There are usually between 10 and 20 people awaiting a vacancy in the Drug Court while remanded in custody. According to the Drug Court Team, a barrier to expanding the Drug Court is low availability of residential rehabilitation beds for the first stage of the program.

4.61 The Drug Court Team estimate that 30% of Drug Court participants have committed illicit drug offences, such as dealing, and 70% have committed drug-related violence and property offences. The Drug Court Team told the Committee that they have seen an increase in violent offenders coming through the Drug Court in the past five years, driven by the increasing prevalence and strength of meth. Burglaries and violence are particularly common among meth users. The increase in violent offenders in the Drug Court presents a treatment

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181 Janelle Scutt, Magistrate, Perth Drug Court, email, 10 June 2019.
182 ibid.
challenge, as violence can affect a person’s chances of being accepted into residential rehabilitation.

Regional access

4.62 Drug Courts do not currently operate in regional WA. Although regional participants have occasionally moved to Perth to complete a Drug Court program, people from the regions do not generally have the financial or other support to come to Perth. While the Drug Court Team supports the expansion of the Drug Court into the regions, the limited treatment options and residential rehabilitation beds in these areas could be barriers to successful program completion.\textsuperscript{183}

4.63 In 2009, the WA Law Reform Commission concluded that it would not be cost effective to establish separate specialist drug programs in all regional courts, and instead urged the Government to develop a ‘flexible and inclusive general court intervention’.\textsuperscript{184}

4.64 The Committee heard that one such example, the Barndimalgu Family Violence Court in Geraldton, fills the role of the Drug Court in the Mid-West and has had success dealing with drug issues. The Mid-West branch of the Aboriginal Legal Service of WA told the Committee that Barndimalgu is a good example of a multilayered, wrap-around program including housing, counselling and urinalysis.\textsuperscript{185}

Legislation

4.65 The Committee also heard about the lack of legislative foundation for the Drug Court. The WA Law Reform Commission recommended that a new pre-sentence Drug Treatment Order could remedy this. The Drug Court Team also supports a legislative basis for the Perth Drug Court.\textsuperscript{186}

4.66 However, the Committee is aware that legislating for the Drug Court could limit its flexibility and adaptability. Instead of creating the Drug Court in legislation, the Committee is of the view that Justice should regularly review the Drug Court Guidelines to ensure that the processes, procedures and eligibility criteria are contemporary, evidence-based and fit for purpose.

4.67 The Committee notes that the lack of data on cost and effectiveness make the Drug Court vulnerable. Without this information it would be difficult to make a case for expanding the Drug Court.

RECOMMENDATION 7

The Department of Justice collect information on Drug Court completion rates, recidivism rates and cost.

RECOMMENDATION 8

The Department of Justice review the processes, procedures and eligibility criteria in the Perth Drug Court Guidelines with a view to expanding the criteria, enabling a greater range of individuals to access the Drug Court.

\textsuperscript{183} ibid.

\textsuperscript{184} Law Reform Commission of Western Australia, \textit{Court Intervention Programs – Final Report}, Perth, June 2009, p 70.

\textsuperscript{185} Janelle Scutt, Magistrate, Perth Drug Court, email, 10 June 2019.

\textsuperscript{186} ibid.
RECOMMENDATION 9

The Western Australian Government examine extending the operations of the Drug Court into regional Western Australia.

Justice Health

4.68 The concept of Justice Health includes the range of strategies, policies and services available to address health, mental health, dental and alcohol and other drug issues.

4.69 The Justice Health Project was a collaboration between Justice, the Department of Health and the Mental Health Commission to examine issues and consider options for the optimal management and commissioning of prison health services, including mental health and alcohol and other drug services.\(^{187}\)

4.70 The Committee received evidence from the Commissioner of Corrective Services that a working group was formed in 2017, and its report is ‘currently up with both Ministers’.\(^{188}\) The Commissioner also told the Committee that work so far progressed included a review of prison health infrastructure and a network design, which involved ‘looking at what programs and health services were available in all the prisons in the state’.\(^{189}\)

4.71 The Justice Health Project also involves considering who will deliver prison health services in the future. The Committee asked if Justice is likely to retain prison health services, or if health services will be taken over by the Department of Health. Justice was unable to answer this question:

> The Report regarding the proposal to transfer the delivery of prison health services to the Department of Health is being considered by Government and is subject to Cabinet in Confidence.\(^{190}\)

4.72 The Committee is concerned that this proposal may have stalled, and sought further detail on reports informing the Cabinet proposal and its submission date. The Commissioner was unable to provide further detail.\(^{191}\) The Committee is disappointed that it was unable to receive any information about this important issue.

Drug programs in prisons

4.73 Drug use is an issue for a significant proportion of the growing WA prison population. A 2013 survey of prisoners who had recently arrived in a WA prison found that 74% of women and 77% of men fulfilled the criteria for a clinically diagnosable alcohol and/or drug disorder.\(^{192}\)

4.74 Chapter 3 acknowledged that although it is difficult to quantify, most people in prison are there directly or indirectly because of drugs.\(^{193}\) WA prisons effectively have a ‘captive...

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\(^{188}\) Tony Hassall, Commissioner of Corrective Services, Department of Justice, *Transcript of evidence*, 18 March 2019, p 4.

\(^{189}\) ibid., p 3.

\(^{190}\) Department of Justice, Answer to question on notice 3 asked at hearing held 18 March 2019, dated 3 April 2019, p 1.

\(^{191}\) Tony Hassall, Commissioner of Corrective Services, Department of Justice, Letter, 11 September 2019.


audience’ of approximately 5200 people who could potentially benefit from some form of substance use treatment or intervention.\textsuperscript{194} Prison therefore provides an important opportunity to address drug addiction.

4.75 The Inspector of Custodial Services confirmed that prison should be used as an opportunity to provide programs and other interventions to reduce the chance of returning to prison. However, accessing treatment programs in prison is difficult.\textsuperscript{195}

4.76 Cyrenian House, Justice’s contracted alcohol and other drug service provider, submitted that:

\begin{quote}
Prison is a very good place for treatment to be delivered, but at present, such treatment is inadequate and very poorly resourced in WA.\textsuperscript{196}
\end{quote}

4.77 Advocacy group Mental Health Matters 2 pointed out that the community assumes drug treatment in prisons already happens:

\begin{quote}
New family members and supporters often share with us that “at least now the person is in the justice system, they’ll get the help they need”. This appears to be the weak ray of light in an otherwise distressing situation. Unfortunately, this is too often not the case...\textsuperscript{197}
\end{quote}

The Pathways Program

4.78 The WA Auditor General found in 2017 that the number of programs available to treat offenders with substance use problems had decreased from four to one since 2010. Specific options for women and Aboriginal prisoners ceased in 2010 and 2015 respectively, despite Aboriginal people making up 38% of the prison population.\textsuperscript{198}

4.79 Today, Justice delivers a single alcohol and other drug program across all prisons and prisoner cohorts.\textsuperscript{199} The Pathways Program is a voluntary 100-hour structured psychoeducational, cognitive behavioural skills program, which treats offenders with a history of problematic substance use.\textsuperscript{200} Prisoners who have drug use issues which are linked to their offending behaviour may be suitable for the Pathways Program, even if they have not committed illicit drug offences.

4.80 The following concerns with the Pathways Program have been raised by the Auditor General, the Meth Taskforce, Cyrenian House and the Inspector of Custodial Services:

\begin{itemize}
  \item failure to meet the needs of a diverse prison population and cater to individual needs
  \item requires a level of literacy that most prisoners do not have
  \item poorly integrated with other prison and community-based services, meaning prisoners are not accessing adequate substance use support when they leave prison
  \item has not been evaluated since 2013.
\end{itemize}

Access to programs and services

4.81 Perhaps the most significant problem with the Pathways Program is the ability to access it. As per Table 9, in April 2019, only 10.7% of prisoners discharged from a drug

\textsuperscript{194} Based on adult prison population of 6935, supplied by the Inspector of Custodial Service on 11 March 2019.
\textsuperscript{195} Submission 66 from Inspector of Custodial Services, 18 November 2018, p 1.
\textsuperscript{196} Submission 60 from Cyrenian House, 19 November 2018, p 3.
\textsuperscript{197} Submission 37 from Mental Health Matters 2, 29 November 2018, p 3.
\textsuperscript{198} Western Australian Auditor General, \textit{Minimising Drugs and Alcohol in Prisons}, Perth, 2017.
\textsuperscript{199} With the exception of Wandoo Rehabilitation Prison for Women, which will be discussed later in this Chapter.
\textsuperscript{200} Submission 40 from Department of Justice, 29 November 2018, p 4.
possession-related sentence had completed a program. In 2017, approximately 65% of prisoners could not access the Pathways Program due to being remanded in custody, or serving a sentence of six months or less.

4.82 Reasons for low rates of program participation include backlogs in assessing prisoners, prison resourcing and staffing levels and the fact that the Pathways Program is not available to prisoners on remand. The Committee also heard that prisoners with co-occurring mental illness are typically not assessed as being suitable for group programs like Pathways:

For people who have longer sentences, what we have found, again from anecdotal evidence, is that people with diagnoses of serious mental illness do not get to access those programs in prison because they are basically run in group sessions and they may not be assessed as suitable.

4.83 A nurse-led comorbidity team with in-reach psychiatric help cares for prisoners with serious mental illness. Justice, rather than the Mental Health Commission, is currently responsible for contracting all services in prisons. This is different to the Police Drug Diversion Program and the Perth Drug Court, where the Mental Health Commission plays a central role in planning and purchasing services.

Table 9. Discharges by program completion for persons with any sentenced offence relating to ‘illicit drug offence’ 2018-19 year to March 2019

<table>
<thead>
<tr>
<th>Offence type</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultivate illicit drugs</td>
<td>51</td>
<td>2</td>
</tr>
<tr>
<td>Deal or traffic in illicit drugs – commercial quantity</td>
<td>455</td>
<td>112</td>
</tr>
<tr>
<td>Deal or traffic in illicit drugs – non-commercial quantity</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Import illicit drugs</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Manufacture illicit drugs</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Other illicit drug offences</td>
<td>202</td>
<td>21</td>
</tr>
<tr>
<td><strong>Possess illicit drugs</strong></td>
<td><strong>1117</strong></td>
<td><strong>134</strong></td>
</tr>
<tr>
<td>Use illicit drugs</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Justice, questions taken on notice at hearing on 18 March 2019.

4.84 Chapter 3 acknowledged the link between unstable housing and drug abuse. The Committee heard support for transitional programs that assist people leaving prison to access suitable accommodation.

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201 Department of Justice, Answer to question on notice 19 asked at hearing held 18 March 2019, dated 3 April 2019, p 18.


204 ibid., p 9.

205 Not including people who are awaiting program placement or have started but not completed a program.

206 Discharges where the individual had any sentenced offence relating to illicit drug offences. However, it should also be noted that there will be cases where individuals have illicit drug use co-occurring with their offending, but for which they are not charged or sentenced.

207 Completion of addictions offending programs do not include cases where an addictions offending need is addressed as part of another program.

208 Submission 37 from Mental Health Matters 2, 29 November 2018, p 4.
Individual Management Plan backlog

4.85 Individual Management Plans (IMP) ensure prisoners receive targeted programs, services and exit planning based on their individual needs. People in custody must be both a sentenced prisoner and assessed as part of the IMP process before they are assigned to a treatment program. The assessment should occur within 28 days of a sentenced prisoner arriving in the prison.209

4.86 In recent years, Justice has not kept up with assessments.210 On 11 March 2019, there were 1020 prisoners either overdue for an initial IMP or excluded from the IMP process.211 Due to this backlog, prisoners with short sentences no longer receive IMPs. This results in people leaving prison before they have had the opportunity to complete any programs, meaning drug issues remain untreated:

Mr HASSALL: At the moment, prisoners who are serving less than six months do not get an IMP; that is correct.

The CHAIR: They are presumably doing their time and then coming out into the community, not having had the opportunity to access any drug services during the time they have been incarcerated.

Mr HASSALL: At this moment in time, that would be correct.212

4.87 Justice has identified a number of reasons for the outstanding IMPs, including time and resource constraints and issues with system integration and processes.213 The full list of reasons is included at Appendix 2. The Committee notes that the introduction of a new assessment tool may also have contributed to the delay:

In January 2015, the Department implemented a new Treatment Assessment Tool to assess a prisoners treatment needs. Whilst the new tool is more comprehensive it does take approximately 50% longer to complete the assessment compared to the previous method, resulting in delays in completion of IMPs.214

4.88 Cyrenian House, who deliver the Pathways Program, told the Committee that group sessions were often not full as a result:

The front end is struggling to assess enough people for the programs that we run. We would like to deliver more services under that contract than we are currently delivering.215

4.89 Cyrenian House have suggested to Justice that another way around this issue would be for service providers to conduct initial assessments for drug and alcohol needs, streamlining the currently ‘clunky’ process and facilitating quicker access to the Pathways Program.216

209 Submission 66 from Inspector of Custodial Services, 18 November 2018, p 4.
210 ibid., p 3.
212 Tony Hassall, Commissioner of Corrective Service, Department of Justice, Transcript of evidence, 18 March 2019, p 6.
213 Department of Justice, Answer to question on notice 7 asked at hearing held 18 March 2019, dated 3 April 2019, p 12.
214 Department of Justice, Answer to question on notice 12 asked at hearing held 18 March 2019, dated 3 April 2019, p 7.
216 ibid., p 15.
Justice advised the Committee of its plan to address the backlog. Most of the prisoners awaiting assessment are at Acacia Prison. Acacia is not resourced to conduct assessments. Justice has agreed to fund Serco, the private provider operating Acacia, to address the backlog of 764 overdue initial IMPs for six to 12 months. New staff will be recruited and trained. Serco should address the backlog within six months of commencing work in July 2019.

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>Initial IMP's Approved In the Month of February</th>
<th>Sentenced Prisoners with an effective term greater than 6 months</th>
<th>Sentenced Prisoners with an approved Initial IMP</th>
<th>*Sentenced Prisoners with Initial IMP dispensation</th>
<th>Exempt from Initial IMP process as per COB 12/18 **</th>
<th>Sentenced Prisoners who require an Initial IMP within 28 days</th>
<th>Sentenced Prisoners who have an outstanding Initial IMP Outside 28 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACACIA</td>
<td>1</td>
<td>1386</td>
<td>758</td>
<td>130</td>
<td>108</td>
<td>28</td>
<td>362</td>
</tr>
<tr>
<td>ALBANY</td>
<td>35</td>
<td>334</td>
<td>229</td>
<td>24</td>
<td>7</td>
<td>15</td>
<td>59</td>
</tr>
<tr>
<td>BANDYUP</td>
<td>12</td>
<td>205</td>
<td>112</td>
<td>22</td>
<td>2</td>
<td>9</td>
<td>60</td>
</tr>
<tr>
<td>BORONIA</td>
<td>3</td>
<td>69</td>
<td>64</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>BROOME</td>
<td>2</td>
<td>43</td>
<td>33</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>BUNBURY</td>
<td>3</td>
<td>263</td>
<td>233</td>
<td>7</td>
<td>2</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>CASUARINA</td>
<td>1</td>
<td>508</td>
<td>299</td>
<td>29</td>
<td>19</td>
<td>39</td>
<td>122</td>
</tr>
<tr>
<td>EGIP</td>
<td>57</td>
<td>176</td>
<td>116</td>
<td>25</td>
<td>3</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>GREENOUGH</td>
<td>5</td>
<td>86</td>
<td>70</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>HAKEA</td>
<td>63</td>
<td>122</td>
<td>35</td>
<td>15</td>
<td>9</td>
<td>38</td>
<td>25</td>
</tr>
<tr>
<td>KARNET</td>
<td>0</td>
<td>342</td>
<td>281</td>
<td>6</td>
<td>20</td>
<td>3</td>
<td>32</td>
</tr>
<tr>
<td>MELALEUCA</td>
<td>4</td>
<td>32</td>
<td>6</td>
<td>14</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>PARDELUP</td>
<td>0</td>
<td>87</td>
<td>82</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>ROEBOURNE</td>
<td>9</td>
<td>110</td>
<td>66</td>
<td>14</td>
<td>6</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>WANDOO</td>
<td>4</td>
<td>63</td>
<td>54</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
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<td>81</td>
<td>11</td>
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<tr>
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<td>242</td>
<td>29</td>
<td>39</td>
<td>3</td>
<td>31</td>
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<td>4284</td>
<td>2761</td>
<td>340</td>
<td>225</td>
<td>194</td>
<td>764</td>
</tr>
</tbody>
</table>

Figure 5. Breakdown of outstanding Individual Management Plans by facility
Source: Department of Justice, Answer to questions on notice 8 and 21 asked at hearing held on 18 March 2019, p 13.

**FINDING 25**
A backlog of incomplete Individual Management Plans for prisoners is a barrier to accessing programs in prison.

**FINDING 26**
Prisoners with sentences of less than six months do not receive Individual Management Plans, meaning they leave prison without completing any drug treatment programs.

**Lack of access for prisoners on remand**

Prisoners may be remanded in custody pending bail, trial or sentencing. Over the past ten years, the proportion of prisoners on remand has increased from approximately 17% to 30% of the total prison population. Remand rates across Australia broadly reflect this sharp increase.

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218 Department of Justice, Answer to questions on notice 9 and 10 asked at hearing held 18 March 2019, dated 3 April 2019, p 2.

increase. Approximately 55% of people on remand are held for less than a month, and the median length of time on remand was 19 days for women and 26 days for men.\textsuperscript{220}

4.92 Justice told the Committee that services for prisoners on remand are limited and resources go toward convicted prisoners.\textsuperscript{221} When asked what happens to ensure remand prisoners can access substance use services when they leave custody, Justice provided the following answer:

There are limited resources to ensure remand prisoners receive access to appropriate AOD [alcohol and other drug] services when they exit custody. Remand prisoners are not assessed and are only referred to reintegration providers if an area of concern is identified at intake stage. Upon release remand prisoners are not provided information regarding AOD services in the community.

This has been identified as an area for improvement and a release website has been developed to provide information to prisoners regarding help and support in the community upon release, this is due to go live imminently.\textsuperscript{222}

4.93 Prison rehabilitation programs are intended for sentenced prisoners. People on remand pending conviction and sentence are presumed innocent until proven guilty, and as such, cannot be legally required to complete a criminogenic program such as the Pathways Program. Professor Neil Morgan adds:

That is the technical legal impediment...but what I have found is that certainly when it comes to drugs and alcohol, I think every prisoner I have ever spoken to has wanted to deal with it.\textsuperscript{223}

4.94 The Committee is of the view that treatment and support for drug issues are not necessarily linked to offending in the same way as violence or sex offending treatment programs:

Someone who is remanded in custody or serving a prison sentence for burglary might be saying, "I didn’t do that burglary. I’m legally innocent, but I do actually have a drug problem."\textsuperscript{224}

4.95 Ensuring broader access to drug support and treatment in custody means accepting that different groups have different requirements. While approximately 50% of prisoners on remand exit within the first month, some people will be on remand for six to 12 months.\textsuperscript{225} Margaret Doherty of Mental Health Matters 2 told the Committee that people on remand do not even receive information about getting help on release from prison:

But you are not going to get anything comprehensive and, more importantly, you do not seem to be getting the information that says, "if you get out of here next week and you really want to do something about your drug and alcohol abuse that may have contributed to you being here" – even if the only motivator is to be seen to be doing it for a court appearance, it is still a motivator – “here’s some

\begin{footnotesize}
\textsuperscript{220} Office of the Inspector of Custodial Services, \textit{Western Australia’s rapidly increasing remand population}, Perth, October 2015, p 9.
\textsuperscript{221} Tony Hassall, Commissioner of Corrective Services, Department of Justice, \textit{Transcript of evidence}, 18 March 2019, p 5.
\textsuperscript{222} Department of Justice, Answer to question on notice 5 asked at hearing held 18 March 2019, dated 3 April 2019, p 2.
\textsuperscript{224} ibid., p 6.
\textsuperscript{225} ibid., p 5.
\end{footnotesize}
information about services that are available in your area.” That would be really helpful.\footnote{Margaret Doherty, Convenor, Mental Health Matters 2, \textit{Transcript of evidence}, 18 March 2019, p 9.}

4.96 Different remand cohorts need different options if they have a drug problem. For example, people who spend only a few weeks in custody may benefit from brief interventions or referrals to appropriate services in their community. Those who spend longer periods on remand should be able to access a drug treatment program whilst in custody.

**FINDING 27**

Prisoners on remand cannot access drug treatment services in prison.

**FINDING 28**

Many prisoners in WA cannot access drug treatment opportunities while in prison.

**Drugs in prison**

4.97 Notwithstanding their illegality, drugs are available in prisons. The Committee has heard that illicit drugs seem to be reasonably accessible in WA prisons, although the extent of the problem is unknown.\footnote{Professor Neil Morgan, Inspector of Custodial Services, Office of the Inspector of Custodial Services, \textit{Transcript of evidence}, 11 March 2019, p 11.} The Committee did not investigate this further as it is beyond the scope of the inquiry, but believes that it adds weight to the need to provide effective and accessible drug treatment services in prisons.

**Implications for parole**

4.98 One consequence of such a low rate of program completion is its impact on parole. Although Justice does not keep data on reasons for parole denial, the Committee has heard the Prisoners Review Board places a ‘good deal of weight on program completion’ in its decision making.\footnote{ibid., p 9.}

4.99 Failure to access and complete the Pathways Program prior to one’s parole eligibility date could result in parole being denied. As keeping a person in prison costs an average of $299 per day, providing the capacity for program completion in time for release on parole is arguably the more cost effective approach.\footnote{Department of Justice, \textit{Annual Report 2017/18}, Perth, 19 September 2018, p 150.}

**Conclusions**

4.100 The Committee broadly agrees with the Meth Taskforce’s recommendations on this topic, including those in Table 10. The Committee also agrees with the Inspector of Custodial Services that the recommendations of the Taskforce, as they relate to justice populations, can apply to all illicit drugs. Relevant recommendations of the Taskforce include:
**Table 10. Relevant recommendations of the Methamphetamine Action Plan Taskforce**

<table>
<thead>
<tr>
<th>#</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>The Department of Justice expands drug and alcohol through-care services to ensure that prisoners on remand who are released from custody are effectively connected to support and treatment services in the community.</td>
</tr>
<tr>
<td>39</td>
<td>The Department of Justice ensures that all persons in custody, including remanded and sentenced offenders, are assessed for alcohol and other drug use, including methamphetamine, and are provided with intervention and treatment to meet the needs identified.</td>
</tr>
<tr>
<td>40</td>
<td>The Department of Justice expands drug and alcohol through-care services to sentenced prisoners in regional prisons.</td>
</tr>
</tbody>
</table>

Source: Final Report of the Methamphetamine Action Plan Taskforce

4.101 The WA Government has supported these recommendations, noting that recommendation 39 is ‘addressed by all prisoners being assessed by a nurse within 24 hours’. The Committee notes that assessment by a nurse on entry is not the same as an IMP process assessment, which enables prisoners to access programs.

**RECOMMENDATION 10**

The Department of Justice proceeds with implementing recommendations 38, 39 and 40 of the Methamphetamine Action Plan Taskforce as a matter of urgency.

**RECOMMENDATION 11**

The Department of Justice ensure that all sentenced prisoners, including prisoners on short-term sentences, receive an Individual Management Plan in adequate time to complete their assigned programs prior to their earliest release date.

**Drug rehabilitation prisons**

4.102 In August 2018, the state’s first dedicated alcohol and drug rehabilitation prison opened. Wandoo Rehabilitation Prison for Women (Wandoo) is a 77-bed minimum-security facility. Planning for a second rehabilitation facility for men at Casuarina prison is underway, with the facility due to open mid-2020.

4.103 The Committee has heard evidence about promise and early indications of success from Justice, the Inspector of Custodial Services and Cyrenian House, as well as support from the Alcohol and Other Drug Consumer and Community Coalition. The Committee visited Wandoo in June 2019 to learn more about how the model operates.

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Cyrenian House deliver a psychoeducational Moral Reconciliation Therapy program in a modified therapeutic community setting at Wandoo, funded by Justice. In a therapeutic community, the community itself plays a role in the treatment of drug addiction. Residents and staff participate in the management and operation of the facility and community, creating a safe learning environment to facilitate personal change. A major advantage of residential therapeutic communities is the ability to treat on a 24/7 basis, through pro-social interaction as well as structured interventions.

Typically used in community-based residential settings, evidence for the operation of therapeutic communities in prison settings has been gathering in the United States, United Kingdom and New Zealand for some years. Studies show that prison-based therapeutic communities result in modest but consistent reductions in both reoffending and drug relapse. It has been found that counselling alone only reduces reoffending and opioid maintenance programs alone only reduce drug relapse. Cyrenian House believes that it is ‘truly amazing’ to see this type of model operate in a prison:

By creating an environment where people feel safe, where people feel secure to be able to speak their mind about what is really going on, it allows them to speak up and address the behaviour and it allows people to take responsibility.

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231 Submission 40 from Department of Justice, 29 November 2019, p 4.
232 Presentation to Select Committee from Cyrenian House, Wandoo Therapeutic Community Women’s Rehabilitation Prison, 24 June 2019.
233 ibid.
The therapeutic community at Wandoo was developed in accordance with emerging evidence and the Australasian Therapeutic Communities Association Standard.\textsuperscript{236} Key principles and elements of the program include:\textsuperscript{237}

- minimum six month program participation
- trauma-informed staff and services
- individual treatment plans, multidisciplinary case management, individual counselling and group work
- staged treatment over four stages
- the use of agreements to keep residents accountable for their behaviour
- strict drug-free environment, with rigorous monitoring
- exit planning, through-care and continuity of service on release. One graduate has gone directly from Wandoo to one of Cyrenian House’s community-based therapeutic communities, and other residents have expressed interest in doing the same.

Justice selects residents carefully, using a mobile triage unit to conduct comprehensive assessments. Residents must be sentenced prisoners with at least six months left to serve and genuinely motivated to address their drug problems.

The Committee had the opportunity to meet with residents on their tour of the facility, who were optimistic about the program.

The program is amazing – it opens your eyes and makes you reach out for support.\textsuperscript{238}

Justice will evaluate Wandoo in 2020. However, early results are promising. In June 2019, 15 residents had completed the program and the dropout rate has been very low.\textsuperscript{239} Despite rigorous testing, there has not been a positive drug test at Wandoo in its first year of operation.\textsuperscript{240}

**FINDING 29**

Early results suggest that the Wandoo Rehabilitation Prison for Women presents a valuable opportunity to address drug issues in prison.

Cyrenian House, Justice and the Inspector of Custodial Services all believe that the partnership between the prison and the service provider, and the corresponding ability to continue delivering support on release, were the keys to its success.\textsuperscript{241}

The Committee is conscious that even when the planned facility at Casuarina is open, the drug rehabilitation prisons will serve approximately 200 prisoners out of almost 7000. For

\textsuperscript{236} Presentation to Select Committee from Department of Justice, Wandoo Rehabilitation Prison: Triage, Enhanced Case Management and Model of Care, 24 June 2019.

\textsuperscript{237} ibid.

\textsuperscript{238} Susan Rowley, Superintendent, Wandoo Rehabilitation Prison for Women, Department of Justice, email, 26 July 2019.

\textsuperscript{239} Tony Hassall, Commissioner of Corrective Services, Department of Justice, *Transcript of evidence*, 18 March 2019, p 15.

\textsuperscript{240} Susan Rowley, Superintendent, Wandoo Rehabilitation Prison for Women, Department of Justice, email, 26 July 2019.

this reason, the Committee encourages Justice to maintain focus on delivering programs and supports to address drug problems in mainstream prisons.

**RECOMMENDATION 12**

The Department of Justice continues to establish and deliver drug rehabilitation prisons while maintaining a strong focus on addressing drug problems in mainstream prisons.

**Conclusion**

4.112 People caught with drugs will often be subject to a criminal justice response. Mechanisms are in place to minimise the impact of that response (police drug diversion) or ensure that some people receive help for their drug problems (the Perth Drug Court, Wandoo Rehabilitation Prison). However, the existing mechanisms within prison, or access to them, are limited in their ability to effectively deal with drug issues.
CHAPTER 5
Current access to services in Western Australia

Introduction

5.1 This chapter will provide an overview of the current access in WA to:
- drug treatment services
- social supports and services
- harm reduction
- prevention and education.

5.2 The level and type of available services, and the ability to have access to them, will be relevant to how any new approaches can be delivered. This Chapter identifies a range of issues with, and barriers to, current drug treatment in WA, including:
- a shortfall of treatment services to meet demand
- no medical way to treat meth dependence
- insufficient treatment options in the regions
- a limited number of addiction specialists
- siloed service delivery.

Drug treatment services

5.3 The value of drug treatment is well established. Treatment is more cost-effective than no treatment or imprisonment, and Deloitte Access Economics estimates that diverting non-violent offenders to residential rehabilitation could save over $100,000 per offender as well as improve health and mortality.242

5.4 Drug treatment services assist people to address their drug use. Objectives can include reducing or ceasing drug use and improving functioning in other areas of life. Treatment services are delivered in residential and non-residential settings and include:243
- detoxification (withdrawal management and support)
- rehabilitation
- counselling (group or individual)
- pharmacotherapy (for example, the relapse prevention medication naltrexone).

5.5 Following its amalgamation with the former WA Drug and Alcohol Office, the WA Mental Health Commission is responsible for planning, purchasing and overseeing the delivery of drug treatment and services. The Mental Health, Alcohol and Other Drugs Services Plan 2015-2025 sets the parameters for this work, outlining the optimal mix and level of service required.

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242 Deloitte Access Economics, An economic analysis for Aboriginal and Torres Strait Islander offenders, prison vs residential treatment, August 2012.
Shortfall of services

5.6 The Committee heard that the alcohol and other drug (AOD) sector in WA provides a range of different treatment options, recognising that different things work for different people. WA has a professional and balanced drug treatment sector, but services are not currently sufficient to meet community need. While stakeholders recognise the value of law enforcement efforts, the Committee heard the balance of resourcing between law enforcement and treatment is currently out of kilter.

5.7 The WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025 identified that in 2014, demand for AOD services far outstripped the actual services delivered.

Figure 7. Current alcohol and other drug services as a proportion of 2014 demand
Source: Mental Health Commission, Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

5.8 The Mental Health Commission has since revised the original estimates. Estimated community support hours, community treatment hours and hospital beds have decreased. Estimated community beds have increased slightly. Figure 8 displays 2017 services as a proportion of the revised 2025 optimal levels. The Mental Health Commission acknowledges that substantial growth is still required in prevention, community support hours and community treatment services.

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244 Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association Australia, Transcript of evidence, 17 June 2019, p 14.
245 Submission 60 from Cyrenian House, 17 January 2019, p 3.
246 Submission 62 from Ruah Community Services, 17 January 2019, p 5.
5.9 The overall demand for specialist AOD services remains high. In 2017-18, 18,589 people sought treatment at 96 specialist AOD services in WA.248

**FINDING 30**

There remains a shortfall of drug treatment and support services in Western Australia to meet current demand.

**Treatment availability in regional WA**

5.10 Regional and remote Western Australians may face increased risk of problematic drug use.249 Access to timely and appropriate treatment and services is also much more difficult in the country. The Committee heard that, in Bunbury, people could wait up to six weeks for an appointment with a drug and alcohol counsellor:250

Drug and alcohol issues are exacerbated by geographic isolation, the heightened stigma that can occur in smaller communities, longer distances from services and limited transport options.251

To have people who are on meth having to catch a bus to get to somewhere 100 kilometres away to seek some treatment is difficult.252

Many people in rural and remote areas do not have access to appropriate alcohol and drug related services that address mental health and alcohol and drug issues in a holistic manner. Thus, people in rural and remote areas must travel to regional towns or metropolitan areas to access these services.253

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249 Submission 41 from National Drug Research Institute, 30 November 2018, p 3.
251 Tabled by Ron Alexander, Methamphetamine Action Plan Taskforce during hearing held 15 April 2019, p 1.
253 Submission 42 from Mission Australia, 30 November 2019, p 18.
5.11 The Committee received evidence that regional Western Australians have a more limited range of treatment options, and distance can make these services harder to access.254

5.12 There are no detoxification (detox) services in regional WA. Because detox is often a prerequisite for residential rehabilitation, people who are addicted to drugs must first travel to Perth to detox. According to the Alcohol and Other Drug Consumer and Community Coalition, a backlog at Perth's only dedicated detox facility can cause a bottleneck for people trying to get into residential rehabilitation.255

**FINDING 31**

Regional and remote Western Australians may face increased risk of problematic drug use, and face additional difficulties accessing services.

### Treating meth dependency

5.13 Relapse prevention medications such as naltrexone, when used in combination with psychological interventions, can be effective in dealing with drug issues.

5.14 The Committee notes that a concern for service providers, users and families is that, unlike some other drugs, there is currently no proven pharmacotherapy to treat meth dependence.

Working with people with meth problems is very challenging and doing so without any pharmacological tools in the toolbox makes it even harder.256

5.15 Various treatment options have been clinically trialled across the world in the hope of finding new methods of treating meth addiction. Agonist therapy uses a replacement drug to mimic the biological processes and chemical effects of a drug. However, unlike for heroin and its pharmacotherapy, methadone, there is currently no effective replacement drug to manage cravings and reduce withdrawal symptoms for meth.257

5.16 Drugs trialled include, but are not limited to; bupropion, naloxone, N-acetylcysteine (NAC) and modafinil. Clinical trials continue to produce mixed results, with no single replacement drug therapy emerging as a leader to combat dependency. This has prevented replacement therapy from gaining classification as an official treatment option.

5.17 The Committee heard from Associate Professor Rebecca McKetin, who is leading a program of research into pharmacotherapy for meth dependency at NDARC. The N-ICE Trial is currently underway to confirm whether daily oral NAC will have a clinically relevant benefit on meth use when compared to a placebo. As the trial is currently underway, results cannot be shared at this time.258 An Australian trial is also underway into whether lisdexamfetamine, a long acting amphetamine, can be used for maintenance therapy in meth dependent people.

5.18 Associate Professor McKetin also told the Committee that the evidence supporting the effectiveness of any other medical response for meth dependence is very weak. Past trials around alternative stimulants like dexamphetamine and methylphenidate have been plagued with issues. These include small trial groups, poor adherence to medication and the abuse

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255 Shannon Dixon, Chair, Alcohol and Other Drug Consumer and Community Coalition, *Transcript of evidence*, 17 June 2019, p 11.
256 Submission 60 from Cyrenian House, 17 January 2019, p 4.
258 Associate Professor Rebecca McKetin, National Drug and Alcohol Research Centre, Letter, 26 August 2019, p 3.
potential of the trial drugs. The trials were only suitable for daily or almost daily users. The need for regular face-to-face contact has made it difficult to recruit suitable participants.

5.19 The Committee heard that service providers primarily use non-pharmacological interventions to treat meth dependency. Longer treatment periods may also be required:

In terms of improving the quality of life, you are probably talking about short-term support over a period of up to six months, maybe a year. That does not necessarily mean inpatient care.

5.20 Behavioural interventions are currently the standard in treating meth addiction issues, and trials suggest that meth use is responsive to such therapies. Behavioural interventions, such as Cognitive Behaviour Therapy (CBT), are useful in treating a range of issues relating to trauma, stress and mental health. CBT helps the participant to recognise problematic thinking patterns, environmental stressors and environmental risks, and uses monetary incentives such as vouchers to encourage positive behaviour.

5.21 Community-based residential rehabilitation has been shown to have a time-limited effect, increasing abstinence from meth use one year after treatment. This can be improved by providing individualised counselling after leaving rehabilitation, and ensuring longer stays for those who inject the drug. However, detox alone does not reduce meth use.

5.22 The life-long cognitive impairment and neurotoxic effect that can occur from meth abuse means that cognitive therapies lose efficacy on people with long-term addictions. This is why it can take years for a person to recover from meth dependency. It is also important to recognise that the prevalence of mental health comorbidity and poly-drug use aggravates addiction issues and reinforces barriers to treatment, preventing positive outcomes. For these reasons, prevention and early intervention is vital.

FINDING 32
Clinical trials are ongoing, but there is currently no proven pharmacotherapy to treat methamphetamine dependence.

Timeliness of treatment

5.23 The Committee heard that drug treatment services must be timely. When a person with drug issues asks for assistance, the window of opportunity to provide help is narrow:

Once someone has taken the step towards accessing services, they need to be assisted quickly. The longer people have to wait to access services, the more likely

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259 Professor Simon Lenton, Director, National Drug Research Institute, Transcript of evidence, 10 June 2019, pp 4-5.
260 Professor Steve Allsop, private citizen, Transcript of evidence, 14 May 2019, p 12.
265 Professor Daniel Fatovich, Former Deputy Chair, Methamphetamine Action Plan Taskforce, Transcript of evidence, 15 April 2019, p 11.
5.24 The Mental Health Commission told the Committee that ‘instant access’ is not always appropriate in the context of detox and residential rehabilitation. They have to be ready to want to go as well. Usually, that means they have engaged with the community drug service team. They have had counselling. They have seen a doctor. They are starting to be prepped and be psychologically ready to enter detox.

Sometimes, if people are not psychologically ready to go through that procedure, they end up just leaving. There will be a self-discharge because they are not prepped and ready for that.268

5.25 Professor Steve Allsop told the Committee that the ‘immediate’ response should be coming from a variety of settings, including primary healthcare. General Practitioners, nurses and pharmacists are well placed to support people with drug problems by identifying issues, providing brief interventions and timely referrals.269 However, the Committee also heard that the most marginalised people struggle to access primary health for the reasons discussed in Chapter 3 – stigma, social isolation and disadvantage.270

5.26 Mental Health Matters 2 told the Committee that, in reality, practical considerations can prevent people accessing services in a timely way:

I know there is a concept in the sector called “no wrong door”, but our experience is that that no wrong door is firmly shut at four o’clock on a Friday afternoon and does not open again until Monday morning.

An example I can think of most recently is someone who got discharged on a Friday afternoon from a public mental health locked ward to homelessness and was not getting paid until Monday. They ended up in remand nine days later.271

5.27 People may also find the drug treatment system complex and difficult to navigate:272

The system here in Western Australia is a bit of a minefield, which puts up all sorts of restrictions when it comes to trying to get an addict into treatment.273

**FINDING 33**

People seeking help for drug problems must be able to access services as needed and in a timely manner.

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267 Submission 25 from Hope Community Services, 26 November 2019, p 3.
268 Sue Jones, Assistant Commissioner, Alcohol, Other Drugs and Prevention Services, Mental Health Commission, Transcript of evidence, 17 June 2019, p 13.
269 Submission 61 from WA Primary Health Alliance, 18 January 2019, p 3.
271 Margaret Doherty, Convenor, Mental Health Matters 2, Transcript of evidence, 18 March 2019, p 4.
273 Submission 53 from Murray Kinnane, 6 December 2018, p 1.
Addiction specialists

5.28 Addiction specialists include addiction physicians and addiction psychiatrists. Addiction specialists can recognise and treat the psychiatric and physical complications of addiction, as well as providing prevention, screening, intervention and treatment.\(^{274}\)

5.29 The disparity between Perth and regional WA is especially evident in the number of addiction physicians. There are only 7.3 addiction physician full time equivalent positions in WA. All of these specialists work at Next Step Drug and Alcohol Services in Perth. None work in public hospitals.\(^{275}\)

5.30 Dr Richard O’Regan, Director of Clinical Services at Next Step, told the Committee that WA is far behind the rest of Australia in this regard, and the current system is not set up to train new doctors:

> I have just had a doctor complete training who did not have a position to go to who is now going to leave the state. Half the people who work as addiction specialists in WA are over 60. They will be retired in the next three to five years and I have 1.6 training at the moment.

The sums are that the minimal specialists that we have in Western Australia are dwindling and the replacement is not catching up with the already low amounts that we have.\(^{276}\)

**FINDING 34**

There are only 7.3 addiction physician full time equivalent positions in Western Australia, and none work in public hospitals.

**RECOMMENDATION 13**

The Department of Health immediately review the number of addiction physicians in the WA public hospital system and compare it to other Australian jurisdictions.

5.31 A similar issue applies to addiction psychiatrists. Addiction psychiatrists manage mental illness with a specialty in dealing with addiction. There are no addiction psychiatrist positions in the WA health system. In comparison, there are at least 34 addiction psychiatrists in New South Wales and 12 in Victorian hospitals. Psychiatrists must travel to the eastern states to train as addiction specialists.

> A lot of our psychiatrists are dealing with methamphetamine-induced psychosis and other meth-related—it is not just methamphetamine psychosis that is a problem; it is depression, it is suicide, anxiety disorders, bipolar disorders as well, probably more so than psychosis in some instances. They need the expert experience and training as well.\(^{277}\)

**FINDING 35**

There are no addiction psychiatrists in the Western Australian public health system.

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\(^{275}\) Dr Richard O’Regan, Director, Clinical Services, Next Step, *Transcript of evidence*, 17 June 2019, p 14.

\(^{276}\) ibid., p 22.

\(^{277}\) Associate Professor Mathew Coleman, WA Representative of Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists, *Transcript of evidence*, 5 August 2019, p 8.
RECOMMENDATION 14

The Department of Health immediately review the number of addiction psychiatrists in the WA public hospital system and compare it to other Australian jurisdictions.

RECOMMENDATION 15

Once the optimal number of addiction specialists is identified, the Department of Health address the shortfall.

Co-occurring mental illness and substance use disorder

5.32 As previously mentioned, many people with substance use disorder also suffer from mental illness or mental health problems. To look at the situation in reverse, in 2011 approximately half of all people with severe mental illness (such as schizophrenia, bipolar disorder and major depression) had a history a drug abuse or dependence.\(^{278}\) Evidence suggests that these figures are worse among Aboriginal people.\(^{279}\)

5.33 People with comorbid severe mental illness and substance use disorders have greater difficulties with:

- engaging with treatment
- adhering to medication
- homelessness
- increased risk of suicide
- increased risk of contact with the criminal justice system.

5.34 The Committee has heard that the treatment and care of this group is one of the biggest challenges facing mental health services in WA.\(^{280}\) Evidence suggests that integrated treatment models with the capacity to address both mental illness and drug dependence are feasible and effective.\(^{281}\) Psychiatric or addiction focussed treatments alone have been found not to sufficiently manage comorbid mental health and substance use problems.

5.35 Integrating AOD services with mental health services is a priority of the WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025. However, the Committee heard that attempts to deliver integrated services have so far been ‘disappointing’. The Chief Psychiatrist of WA told the Committee that different cultures and philosophies underpin the AOD and mental health treatment sectors. Because of this, the Mental Health Commission’s attempts at better integration have not yet produced results at a clinical level:

Service users are frequently refused entry by mental health or AOD services and advised to seek treatment with the other service, without adequate recognition of the mutual influence that each condition has in maintaining or exacerbating the other.\(^{282}\)

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\(^{280}\) Submission 46 from Chief Psychiatrist, 30 November 2018, p 2.

\(^{281}\) Submission 42 from Mission Australia, 30 November 2018, p 14.

\(^{282}\) Submission 46 from Chief Psychiatrist, 30 November 2018, p 3.
5.36 The Mental Health Commission is aware of the cultural barriers to integration. The Commission is working with the sectors to address these barriers through initiatives such as:
- training courses to address both mental health and AOD
- developing a shared Outcomes Framework across the mental health and AOD sectors
- co-location of Whealtbelt Community Alcohol and Drug Service and Wheatbelt Mental Health Service
- developing state-wide strategic documents such as the Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2019-2025
- the One-Stop Shop project, which will produce a complementary online service directory of AOD and mental health services across WA, making it easier for individuals and families to find help.

Social supports and services

5.37 Many people suffering from substance use disorder, and particularly those with comorbid mental health issues, also need assistance for social problems. As noted at paragraph 3.11, drug abuse is linked to homelessness, financial stress and social isolation. People with comorbid substance use disorder and mental illness often struggle to get access to housing or maintain their accommodation.

5.38 Treatment alone is rarely enough to address the complex needs of drug users. A holistic, wrap-around approach that addresses fundamental human needs is required to break the cycle of disadvantage.

The most effective responses to preventing AOD use and harm should include a wide range of interventions that acknowledge the social origins of poor health, and the role social determinants play in AOD use.

5.39 Ruah Community Services contend that providing basic human needs, such as housing, to people struggling with addiction can have a flow-on effect in improving community safety and achieving health and criminal justice cost savings. However, the Alcohol and Other Drug Consumer and Community Coalition submitted that current social interventions, particularly transitional housing for people leaving rehabilitation, are insufficient.

Mr Dixon: ...I think there is something like five or six agencies with transitional houses and probably 100 or so beds. In terms of beds in residential facilities and transitional housing, there is a massive difference.

The Chair: Okay, so people are leaving residential facilities without simply being able to access that particular program. So one of the things you are saying is: it needs to be expanded.

Mr Dixon: Correct, yes.

5.40 The Committee heard that agencies often only focus on one part of the ‘problem’. For this reason, Mission Australia submit that it is important to support and fully resource the WA

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283 Mental Health Commission, Answer to question on notice 6 asked at hearing held 17 June 2019, dated 5 August 2019, p 6.
284 ibid., p 3.
286 Submission 41 from National Drug Research Institute, 30 November 2018, p 3.
287 Debra Zanella, Chief Executive Officer, Ruah Community Services, Transcript of evidence, 8 April 2019, p 16.
288 Shannon Dixon, Chair, Alcohol and Other Drug Consumer and Community Coalition, Transcript of evidence, 17 June 2019, p 7.
Alcohol and Drug Interagency Strategy 2018-2021, which aims to break down service delivery silos.\textsuperscript{289}

**FINDING 36**
Many people suffering from problematic drug use concurrently require assistance for mental illness, homelessness, poverty and social isolation.

**Harm reduction**

5.41 Harm reduction refers to public health policies and practices that aim to reduce the harms associated with drug use for those people who are unable or unwilling to stop.\textsuperscript{290} The focus is on reducing drug-related harm rather than reducing drug use.

5.42 The following evidence-based harm reduction initiatives operate in WA, mostly to respond to the overdose and disease risks associated with heroin or other injecting drug use.

- Needle and syringe programs (NSPs), which supply free sterile needles and syringes, conditional on the return of used items.
- Naloxone, an opioid overdose reversal drug, is distributed to drug users, friends, families and frontline AOD workers along with training on overdose recognition and response.
- Opioid substitution therapy, which replaces heroin with a longer acting but less euphoric opioid, such as methadone or buprenorphine.\textsuperscript{291}

5.43 The Mental Health Commission is the agency primarily responsible for harm reduction. Although there is no specific harm reduction strategy for WA, the Commission’s AOD strategies align with the harm minimisation framework of the National Drug Strategy. Recent harm reduction activities which the Commission is undertaking include:\textsuperscript{292}

- planning and implementing take-home naloxone projects in Perth and the South West
- facilitating WA’s involvement in a pilot of Pharmaceutical Benefits Scheme subsidised take-home naloxone, which will commence in December 2019 and expand access to free naloxone
- in collaboration with the WA AIDS Council, the Methamphetamine Peer Education Project, aimed at increasing the capacity of peer educators (who have lived experience of drug use) to effectively provide early intervention and harm reduction education to people who use meth
- the Drug Aware pilot program ‘Medix’ campaign, which provided harm reduction information to patrons at music festivals who were planning to use drugs.

5.44 The Committee heard strong support for harm reduction initiatives, which are relatively inexpensive and easy to implement.\textsuperscript{293} According to the Australian Institute of Health and Welfare, nearly two thirds of Western Australians support initiatives like NSPs and opioid substitution therapy.\textsuperscript{294}


\textsuperscript{291} A Manhapra, R Rosenheck and D Fiellin, ‘Opioid substitution treatment is linked to reduced risk of death in opioid use disorder’, *BMJ*, 2017, vol. 357.

\textsuperscript{292} Jennifer McGrath, Acting Commissioner, Mental Health Commission, Letter, 22 October 2019.

\textsuperscript{293} Submission 42 from Mission Australia, 30 November 2018, p 3.

\textsuperscript{294} Submission 35 from Australian Institute of Health and Welfare, 28 November 2018, p 4.
Injecting drug use is a major risk factor for transmitting bloodborne viruses, including HIV, hepatitis B and hepatitis C. Needle and syringe sharing among people who inject drugs is partly responsible for transmitting infection among drug users, although unsafe sexual behaviours also play a role.\textsuperscript{295}

For those who continue to use drugs, public health approaches are needed to mitigate the impacts on individuals, families and communities. For example, emerging evidence suggests making naloxone more available to heroin users, their peers and families can reduce deaths from overdose.\textsuperscript{296}

Harm reduction strategies are a useful complementary approach to reduce injury or death from drug use, in the hope that the individual will seek treatment and other support at a later stage.\textsuperscript{297}

NSPs in Australia have been the most cost-effective program in reducing drug related harms among communities and people who inject drugs.\textsuperscript{298}

5.45 The Department of Health delivers NSPs in WA. The programs have saved significant healthcare costs and averted thousands of blood-borne infections. Dr Andrew Robertson, Assistant Director General of Public and Aboriginal Health, told the Committee about how the program is delivered and its resultant benefits:

There are needle and syringe exchange programs at fixed sites. There are some outreach and mobile services and they are primarily one-for-one transfer. There are pharmacy-based needle and syringe programs. They are primarily on a commercial basis so people can get them from pharmacies.

Health services will provide them, particularly in regional hospitals through public health units and community health centres. Then there are needle and syringe vending and dispensing machines. They are either very low cost or free.

To give you an idea of the scale of that, between 2000 and 2009, we invested $12.9 million into those, which is believed to have resulted in a saving of approximately $124 million in healthcare costs.

Over that period, it is estimated—I am only talking across Australia now—that the NSP has probably averted around 32 000 new HIV infections and approximately 96,000 new hep C infections across Australia over a 10-year period.\textsuperscript{299}

**FINDING 37**

Needle and syringe programs in Western Australia have averted thousands of blood borne infections and saved over a hundred million dollars in healthcare costs.

5.46 People in the regions are more likely to have drug use issues, and have more difficulty accessing drug treatment (see paragraph 5.11). The Committee heard that harm reduction services are less accessible in regional areas.\textsuperscript{300}

5.47 Peer Based Harm Reduction delivers non-judgemental peer based support and services in WA. Outreach Coordinator Paul Dessauer gave evidence reflecting on the disparities between metropolitan and regional areas in accessing harm reduction services:


\textsuperscript{296} Submission 41 from National Drug Research Institute, 30 November 2018, p 4.

\textsuperscript{297} Submission 42 from Mission Australia, 30 November 2018, p 3.

\textsuperscript{298} Submission 47 from Australian Public Health Association, 3 December 2019, p 3.

\textsuperscript{299} Dr Andrew Robertson, Chief Health Officer, Assistant Director General, Public and Aboriginal Health, Department of Health, *Transcript of evidence*, 15 April 2019, p 14.

\textsuperscript{300} Paul Dessauer, Outreach Coordinator, Peer Based Harm Reduction, *Transcript of evidence*, 13 May 2019, p 2.
Mr DESSAUER: We are largely funded to operate within the Perth metropolitan area. We also have a site in Bunbury. We have a van that goes into towns in the south west region. A couple of our outreach workers are attached to that Bunbury site, so they can go to people’s homes in the south west region. Apart from that, we are not really funded to work outside of those areas.

The CHAIR: So, of course, you are recognised as being pretty much the main organisation in Western Australia delivering those sorts of peer-based services. Is anyone delivering those services in the Kimberley, the Pilbara, the Gascoyne or the Kalgoorlie region?

Mr DESSAUER: Not the sort of work that we do, no. We do occasionally do workforce development, training and education or consultancy for other agencies in the regions. We are not actually funded to do that, so we actually have to ask those agencies to pay the cost of us delivering that education or training, if we do it.\textsuperscript{301}

The Committee heard that due to strict daily supervised reporting requirements, some fly-in, fly-out workers may struggle to get access to opioid substitution therapy:

They are not as accessible as they could be. We have quite restrictive policies around how these medications are provided to people. You have to present for daily supervised dosing. Even if you are stable in the program for several years, you can never get more than three takeaway doses per week, and no more than two on consecutive days.

This means that if you are a fly in, fly out worker, you cannot access this treatment at all, for instance. For people in remote or regional areas, access is very, very difficult because of the necessity for presenting to dose every day.\textsuperscript{302}

FINDING 38

Some groups, such as fly-in fly-out workers, may experience barriers to accessing opioid substitution therapy.

RECOMMENDATION 16

The Department of Health investigate how to address barriers to opioid substitution therapy, including for fly-in fly-out workers.

Only two percent of drug-related expenditure in Australia goes toward harm reduction. The Committee heard that this does not reflect the ‘balanced’ approach that the ‘three pillars of harm minimisation’ under the National Drug Strategy aims to achieve.\textsuperscript{303}

As harm reduction is inexpensive relative to criminal justice responses, a modest investment in harm reduction may go a long way. Harm Reduction International estimate that redirecting 10% of drug control funding towards harm reduction and public health would cover harm reduction needs in the community.\textsuperscript{304}

Prevention and education

Prevention and education are demand reduction strategies that aim to delay or prevent people from starting to use drugs, protect against risk and reduce drug-related harms. The

\textsuperscript{301} ibid., p 3.

\textsuperscript{302} ibid., p 7.

\textsuperscript{303} Submission 52 from Aboriginal Health Council of Western Australia, 4 December 2018, p 23.

\textsuperscript{304} Harm Reduction International, See: \url{https://www.hri.global/10by20}. Viewed 14 August 2019.
WA Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 establishes prevention as a key strategic priority.

5.52 Prevention initiatives can be targeted at a whole population or specific priority target groups. Examples of prevention activities in WA include mass reach public campaigns like ‘Drug Aware’ and community development initiatives that support drug-free environments and activities.

5.53 In response to the Final Report of the Meth Taskforce, the WA Government has advised that it has committed additional funding to ensure the continuation of school and public education programs to reduce the uptake of meth.305

5.54 In 2013-14, the former WA Drug and Alcohol Office spent 12.9% of its annual budget on alcohol and drug prevention. An expert reference group estimated that about 10% of the alcohol and other drug budget should be spent on prevention.

5.55 The Public Health Association of Australia suggest that prevention and education activities are inadequately resourced:

We know that Australia’s health system devotes a strikingly low level of expenditure to preventive activities and services compared to most OECD [Organisation for Economic Cooperation and Development] 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%.306

Conclusion

5.56 Drug treatment, social services, harm reduction, prevention and education initiatives are all integral to responding to drug use. While WA has a range of excellent services and initiatives on offer, they are also limited in a number of ways. Examples include insufficient treatment services to meet demand, regional disparity in access, siloed service delivery and a lack of integration between mental health and AOD services.

306 Public Health Association of Australia, Answer to question on notice 1, asked at hearing on 17 June 2019, dated 10 July 2019, p 3.
CHAPTER 6
Alternative approach – a health-based response

Introduction

6.1 An alternative to drug prohibition is a health-based approach to address drug use. This chapter will outline:

- the difference between a health-based approach and a prohibitionist approach
- the arguments for and against treating drug use as a health issue
- how health-based approaches have developed
- administrative, as opposed to criminal, responses to drug use and possession for personal use
- Portugal’s health-based drug policy
- how WA could implement a health-based response to drug use and possession.

6.2 A health-based approach to drug use may include a range of strategies that seek to shift the focus away from criminal justice responses and towards treatment and support. This Chapter deals primarily with a central component of a health-based approach - the non-criminal response to personal drug use and possession. Additional strategies that can contribute to a health-based approach are covered in the remainder of this report.

6.3 Some drug-related matters are very clearly criminal justice issues and must remain so. These include the dealing in, trafficking of and manufacturing of drugs, and crimes related to supporting or resulting from drug use, such as burglaries and assaults. The Committee wishes to emphasise that this Chapter is specifically about personal drug use and possession for personal consumption, and the penalties attached to those offences.

6.4 Readers will see the term ‘decriminalisation’ in this Chapter. Decriminalisation means that drugs are illegal, but offences concerning drug use and possession for personal use do not attract a criminal penalty. For convenience and unless the context otherwise requires, in this Chapter a reference to ‘possession’ will mean possession for personal use.

6.5 The Committee has found that ‘decriminalisation’ means different things to different people, and some assume it means ‘legalisation’. Where possible, the Committee will refer to ‘administrative responses’ and ‘removing criminal penalties’, which are clearer ways of conceptualising the ideas discussed in this Chapter.

FINDING 39
Decriminalisation is distinct from legalisation. Under decriminalisation, drug use and possession for personal use may attract a civil rather than a criminal penalty.

The difference between a health-based approach and a prohibitionist approach

6.6 The main difference between a health-based approach and a prohibitionist approach to drug use is where the emphasis lies. Under prohibition, the emphasis is on law enforcement with a view to punishment, and as both a general and specific deterrent. Under a health-based approach, the emphasis is on identifying the reasons people use and abuse drugs and addressing addiction and its consequences.
The two approaches are conflicting, primarily because they are driven by two different systems—justice and health—which have different objectives. For example, the only acceptable outcome for the criminal justice system is abstinence, because drug use is illegal. To the criminal justice system, a casual recreational user and a long-time addict who are caught with the same amount of an illicit drug may represent the same violation of the law. The health system, conversely, is likely to consider a reduction in problematic drug use or harm avoidance to be a good outcome, even if the individual is still using illicit drugs.

Each approach can include elements of the other, but one approach must be dominant. WA already has many elements of a health-based approach, including a well-resourced healthcare system, a variety of drug treatment services, some harm minimisation measures and some alternatives to punishment for drug possession for personal use, in limited circumstances. As the responsibility for responding to drug use and possession lies with the criminal justice system, WA is on the prohibitionist end of the spectrum.

**Treating drug use as a health issue**

The Committee heard that drug use is a health, social and community issue. This sentiment came from academics, service providers, health professionals and people affected by drug use. The Meth Taskforce said that this was the main message received during their extensive community consultation in 2017 and 2018. For example, the Committee heard:

- Treat drug addiction as a sickness, not a crime.

  While suppliers of illicit drugs such as methamphetamines should face the full force of robust drug laws, those with actual drug problems should be treated from a health perspective.

  We contend that alcohol and other drug dependency is a health issue, and primarily requires a health-focused response to address the needs of those people with complex needs.

It follows that the alternative approach raised most in this inquiry was to treat drug use as a health issue rather than a criminal justice issue. This means creating the legal and policy framework to ensure that health considerations are forefront:

- I think we have to start looking at much more emphasis on treating drug possession and use as a health issue and not as a criminal justice issue.

The Committee heard that a health-based approach could contribute to addressing the social determinants of disadvantage. As discussed in Chapter 3, factors such as homelessness, poverty, unstable housing and trauma are linked to problematic drug use. Criminal penalties, from fines to imprisonment, are unlikely to address these underlying factors which drive problematic drug use:

- The criminal justice system is a crude instrument to address the health and social repercussions of drug use.

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307 Professor Daniel Fatovich, Former Deputy Chair, Methamphetamine Action Plan Taskforce, Transcript of evidence, 15 April 2019, p 3.
308 Submission 3 from Tom Marwick, 6 November 2018, p 1.
309 Submission 60 from Cyrenian House, 17 January, p 3.
310 Submission 52 from Aboriginal Health Council of Western Australia, 4 December 2018, p 2.
311 Submission 47 from Australian Health Promotion Association, 3 December 2018, p 3.
312 Professor Steve Allsop, private citizen, Transcript of evidence, 13 May 2019, p 3.
313 Submission 56 from WA Bar Association, 21 December 2018, p 2.
Everyone says let us go hard on drugs. I argue we need to go hard on health.  

6.12 An analogous example is Australia's approach to alcohol. Although excess alcohol consumption is linked to undesirable personal and social consequences, including disease, addiction and death, its consumption is not a criminal offence. Demand reduction strategies to reduce the harmful use of alcohol come from public health and focus on prevention, education and treatment. Supply-side measures around price regulation and marketing restrictions are also driven by public health, so there is no conflict between the two.

6.13 The public health agencies responsible for alcohol policy also differentiate between problem and non-problem use. Some people drink and get violent or damage property, and these actions are rightfully treated as criminal offences. However, most do not. It is accepted that many people drink alcohol recreationally, and do not cause harm to themselves or others as a result. Many who drink to excess may nevertheless not commit criminal offences, and are functioning members of society. The ability to accept this fact is only possible because alcohol consumption is not a criminal offence.

FINDING 40

Demand and supply reduction strategies to reduce alcohol-related harms are founded in public health and differentiate between problem and non-problem drinking. This is possible because alcohol possession and use is not criminalised.

6.14 Drug research expert Professor Steve Allsop views a health-based approach as an appropriate way to deal with individual and systemic stigma. This is important, given the number of people who use drugs to deal with serious past trauma in their lives:

We should treat people affected by drug use the same way we treat anyone affected by any health problem.

Something like 70 per cent of the women in our treatment services have been sexually abused, and simply to say “stop doing it” is to fail to understand what is happening there. That does not mean that everybody who uses has been sexually abused, but those who are most disadvantaged do end up in our treatment services.

So if we do not address stigma, we will continue to have people not seeing themselves at risk, not putting up their hands and not getting optimum care when they do put their hands up, and we will see continued relatively poor funding going in this domain—you have brought it on yourself, why should we help you?

That is legitimate, because we do the same for people who eat too many pies, smoke cigarettes, drive their cars too fast, and climb mountains and need rescuing. It is a health condition that requires the same level of responsibility and dignity we give anyone else.

6.15 Advocates for prohibition argue that a slackening of community attitudes and enforcement efforts over the past few decades has led to increased drug use. Accordingly, they are concerned that a move away from strict prohibition could potentially normalise drugs and send a message of tolerance.

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314 Professor Daniel Fatovich, Former Deputy Chair, Methamphetamine Action Plan Taskforce, Transcript of evidence, 15 April 2019, p 16.
315 Professor Steve Allsop, private citizen, Transcript of evidence, 13 May 2019, p 15.
316 Submission 22 from D Hartley, 26 November 2018.
6.16 Some are concerned that a shift away from strict enforcement will increase drug use, which may lead to increases in certain drug related harms, such as road accidents. This position is supported by the WA Police Force, which contends that 31% of Australians who had decided never to use illicit drugs cited ‘reasons relating to the law’ as a factor influencing their decision.

Development

6.17 The concept of a health-based approach is far from new. In 2002, the Royal Australian and New Zealand College of Psychiatrists and the Royal Australasian College of Physicians adopted the joint position that governments must redefine illicit drug use primarily as a health and social issue, with funding for health and social interventions increased to the same level as law enforcement.

6.18 The position has gathered momentum over the past two decades. Last year, the Parliament of Victoria’s Law Reform, Road and Community Safety Committee recommended that:

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.

6.19 The Committee notes with interest that in August 2019, at the time of writing this report, the Parliament of New Zealand passed the Misuse of Drugs Amendment Act 2019 (NZ Act). The NZ Act came into effect on 13 August 2019. The explanatory note to the Bill for the NZ Act stated that ‘addressing drug-related harm requires a health-based response, rather than a punitive one, so that people can access the health and social support services they need.

6.20 The NZ Act affirms that Police have discretion regarding whether or not to prosecute when a person is apprehended for the use or possession of any illicit drug. When considering prosecuting for drug possession or use, police are now required to consider whether a health-centric or therapeutic approach would be more beneficial. The NZ Act intends to address drug-related harms by ensuring that legislation focuses on importers, producers and suppliers and not people who use drugs.

FINDING 41
New Zealand has amended drug laws to provide police the discretion to prosecute for drug use and possession, and require that they first consider whether a health-based approach would be more beneficial.

6.21 The most established and well-known example of a health-based approach is the Portuguese model of drug regulation. This chapter will outline in detail the Portuguese model and discuss whether a similar model could be applied successfully in WA.

319 ibid., p 8.
322 Misuse of Drugs Amendment Act 2019 (NZ).
324 ibid.
Administrative responses to drug use and possession

6.22 Taking a health-based approach can mean different things in practice, from rebalancing funding between health and law enforcement through to replacing criminal penalties for drug possession with health and social interventions.

6.23 One strategy associated with a health-based approach is replacing criminal penalties for personal drug use and possession with administrative penalties or responses. The Committee emphasises that ‘personal drug use and possession’ means an amount intended for personal use rather than sale or supply (see Table 3. Western Australian threshold amounts vs maximum used in heavy session).

FINDING 42

Drug use and possession for personal use should be treated primarily as a health issue.

6.24 The Committee heard support from a range of submitters, including the Chief Psychiatrist, the Meth Taskforce and the National Drug Research Institute for removing criminal penalties for drug use and possession in WA. Removing criminal penalties can reduce the harms resulting from drug prohibition.325 As outlined in Chapter 3, ‘Drug-related harms’, these include the adverse impacts that a criminal record can have on a person’s ability to secure a job or a rental property. Furthermore, the stigma associated with drug use because of prohibition can cause people to become socially isolated and refuse to seek help. These harms can compound existing social disadvantage and associated harm.

Drug dependence is not a crime. It is a treatable health problem frequently underpinned by social disadvantage and mental health issues.326 The decriminalisation of the possession of small quantities of any illicit drug for personal use would reduce the harms caused to individuals with severe mental illness by involvement in the criminal justice system.327

6.25 The Committee heard that removing criminal penalties could:

- enable families to seek early intervention without fear of triggering a police response328
- enable individuals to seek help with less fear of stigma or discrimination329
- facilitate open discussion and effective education about harms and risks – current education and community awareness campaigns have the least success for those who are at the greatest risk330
- allow drug use to be viewed as a health issue, leading to improved health outcomes over time
- reduce prison overcrowding331

325 Submission 41 from National Drug Research Institute, 30 November 2018, p 6.
327 Submission 46 from Chief Psychiatrist, 30 November 2018, p 4.
328 Submission 25 from Hope Community Services, 26 November 2018, p 5.
• allow police and justice agencies to focus on targeting drug manufacturing, dealing and trafficking.

6.26 The Committee heard that the people most likely to benefit from the removal of criminal penalties in WA are Aboriginal people.  

6.27 At least 25 countries across the world currently have some form of formal decriminalisation policy in place. This includes Australia, where some jurisdictions have decriminalised cannabis possession (see CHAPTER 7). For the first time ever, in 2018, the Chief Executive Board of United Nations committed to promoting alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use.

Table 11. Countries with decriminalisation policies

<table>
<thead>
<tr>
<th>Country</th>
<th>Year first introduced</th>
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</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>2009</td>
</tr>
<tr>
<td>Armenia</td>
<td>2008</td>
</tr>
<tr>
<td>Australia</td>
<td>1987</td>
</tr>
<tr>
<td>Belgium</td>
<td>2003</td>
</tr>
<tr>
<td>Chile</td>
<td>2005</td>
</tr>
<tr>
<td>Colombia</td>
<td>1994</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>1988</td>
</tr>
<tr>
<td>Croatia</td>
<td>2013</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1990</td>
</tr>
<tr>
<td>Ecuador</td>
<td>2013</td>
</tr>
<tr>
<td>Estonia</td>
<td>2002</td>
</tr>
<tr>
<td>Germany</td>
<td>1994</td>
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<tr>
<td>Italy</td>
<td>1975</td>
</tr>
<tr>
<td>Jamaica</td>
<td>2015</td>
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<tr>
<td>Mexico</td>
<td>2009</td>
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<tr>
<td>The Netherlands</td>
<td>1976</td>
</tr>
<tr>
<td>Paraguay</td>
<td>1988</td>
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<tr>
<td>Peru</td>
<td>1991</td>
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<tr>
<td>Poland</td>
<td>2011</td>
</tr>
<tr>
<td>Portugal</td>
<td>2001</td>
</tr>
<tr>
<td>The Russian Federation</td>
<td>2004</td>
</tr>
<tr>
<td>Spain</td>
<td>Possession of drugs for personal use has never been a criminal offence.</td>
</tr>
</tbody>
</table>

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332 Kate Turtley-Chappel, Managing Lawyer, Mid-West Office, Aboriginal Legal Service of WA, Email, 2 August 2019.


<table>
<thead>
<tr>
<th>Country</th>
<th>Year first introduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland</td>
<td>2013</td>
</tr>
<tr>
<td>United States of America</td>
<td>Simple cannabis possession was never a criminal offence in 13 states.</td>
</tr>
<tr>
<td>Uruguay</td>
<td>Possession of drugs for personal use has never been criminalised in Uruguay.</td>
</tr>
</tbody>
</table>


**FINDING 43**

Drug use and possession for personal use should be treated primarily as a health issue.

**FINDING 44**

A significant number of international jurisdictions use administrative responses to drug use and possession for personal use.

**RECOMMENDATION 17**

The Western Australian Government commits to defining and treating drug use as a health and social issue rather than a criminal justice issue.

**The Portuguese model**

6.28 The national drug policy of Portugal is the best-known example of a health-based approach. Since its implementation in the early 2000s, the policy has remained in the spotlight of media attention and public debate. The model attracted attention by:

- decriminalising the possession of drugs for personal use
- establishing dissuasion commissions
- shifting responsibility for drug issues from the Ministry of Justice to the Ministry of Health.

6.29 The Committee considered key indicators across eight European countries. The Committee decided to inquire into Portugal as it demonstrated relatively low rates of drug-related harms.

6.30 The Committee received support for its intention to consider the Portuguese model from stakeholders including the WA Bar Association, the Meth Taskforce, Ruah Community Services and the National Drug Research Centre:

An approach that warrants consideration is to address possession of small quantities of drugs as a health issue and an opportunity for intervention, not punishment, such as occurs in Portugal.

**Background and context**

6.31 Under an authoritarian regime throughout the mid-20th century, Portugal had limited exposure to the global cultural movements of the time. Access to drugs increased

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335 European Monitoring Centre for Drugs and Drug Addiction, Drug Policy Profiles, Lisbon, 2011.
336 Submission 56 from Western Australian Bar Association, 21 December 2018, p 2.
exponentially following the democratic revolution of 1974.\textsuperscript{337} With this came a sudden increase in problematic drug use, particularly heroin.

6.32 Throughout the 1990s, the Portuguese government worked to develop a clear and integrated drug strategy and expand treatment options. At that time, responsibility for drug treatment services belonged to the Department of Justice. Between 1995 and 1998, funding allocated to fighting drugs more than doubled.\textsuperscript{338}

6.33 Despite these efforts, by 1997 around 1\% of the Portuguese population were problematic drug users.\textsuperscript{339} By 1999, Portugal had some of the highest rates of drug-related AIDS and HIV in the European Union.\textsuperscript{340} Between 1997 and 1999, overdose deaths increased by 57\%.\textsuperscript{341} Drug use became Portugal's primary social issue. Director General of the General-Directorate for Intervention on Addictive Behaviours and Dependencies (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências - SICAD), Dr Joao Goulao, told the Committee that 'it spread across all social groups', and it was almost impossible to find a Portuguese family that did not have some sort of problem with drugs.\textsuperscript{342} It was because the crisis affected all levels of society and was so widespread, that people wanted to see change.

Reform and implementation

6.34 In response to the crisis, the government established the Commission for the National Strategy to Fight Drugs.\textsuperscript{343} The nine-member panel included five health and legal experts, in addition to political and public service representatives. The Commission had a broad mandate, with the only boundary being the limits defined by the United Nations Conventions.\textsuperscript{344} In 1999, the Commission’s report was approved by the Council of Ministers and became the first National Strategy for the Fight Against Drugs (National Strategy).

6.35 The National Strategy was based on eight structuring principles, including prevention and pragmatism (see Appendix 3). The six objectives (see Appendix 4) of the National Strategy included:\textsuperscript{345}

- reducing the use of drugs
- guaranteeing the necessary resources for drug treatment, including outpatient treatment, withdrawal treatment, therapeutic communities and methadone maintenance
- social reintegration of drug addicts, and protecting security and public health
- repressing illicit drug trafficking and money laundering.

\textsuperscript{337} General-Directorate for Intervention on Addictive Behaviours and Dependencies Portugal, Submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours, September 2018, p 1.

\textsuperscript{338} European Monitoring Centre for Drugs and Drug Addiction, Drug Policy Profiles, Lisbon, 2011.

\textsuperscript{339} General-Directorate for Intervention on Addictive Behaviours and Dependencies Portugal, Submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours, September 2018, p 2.


\textsuperscript{342} Elsa Maia, International Relations Division, General-Directorate for Intervention on Addictive Behaviours and Dependencies Portugal, Email, 19 July 2019.

\textsuperscript{343} European Monitoring Centre for Drugs and Drug Addiction, Drug Policy Profiles, Lisbon, 2011.

\textsuperscript{344} General-Directorate for Intervention on Addictive Behaviours and Dependencies Portugal Portugal, Submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours, September 2018, p 2.

The overarching goals of drug policy became to reduce the use of drugs among the population and their negative social and health consequences.\textsuperscript{346}

6.36 The National Strategy outlined 13 strategic options for achieving these objectives, which included:
- decriminalise the use of drugs, prohibiting them as a breach of administrative regulations
- redirect focus to primary prevention
- extend and improve the quality and response capacity of the healthcare network, to ensure access to treatment for all drug addicts who seek treatment
- extend harm reduction policies such as methadone and needle exchange to deliver good social and professional reintegration
- commit to combatting drug trafficking and money laundering.

6.37 In 2001, Law 30/2000 decriminalised the individual use and possession of all illicit drugs in Portugal, and created the corresponding administrative framework:

The consumption, acquisition and possession for own consumption of plants, substances or preparations listed...constitutes an administrative offence.\textsuperscript{347}

Offences shall be processed and the respective penalties applied by a commission referred to as “commission for the dissuasion of drug addiction”, especially created for this purpose, operating in the premises of the civil governments.\textsuperscript{348}

6.38 The new law maintained the illegality of drugs, but changed the offences from criminal to administrative. Trafficking, supply, cultivation and production remained criminal offences.

**FINDING 45**

Drug use and possession in Portugal remain illegal and are administrative offences, while supply, trafficking and production remain criminal offences.

6.39 The 2001 law reforms were accompanied by:
- increased funding for prevention activities delivered by the Institute for Drugs and Drug Addictions
- risk and harm reduction measures such as drug checking services, treatment and social reintegration programmes.

**Operation**

6.40 Law 30/2000 established a Commission for the Dissuasion of Drug Addiction (Comissão para a dissuasão da toxicodependência - CDT) in each of Portugal’s 18 regions. CDTs are three-person panels who meet with drug offenders, assess and evaluate their case and make a ruling. The primary aim of a CDT is to dissuade drug use and encourage problem users to seek treatment or education.

6.41 Each CDT is comprised of three government-appointed members. One member will be a legal expert and the other two will be doctors, psychologists, social workers or have other

\textsuperscript{346} C Hughes and A Stevens, ‘A resounding success or a disastrous failure: re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs?’, *Drug and Alcohol Review*, 2012, vol. 31(1).

\textsuperscript{347} Law 30/2000 (Portugal), article 2(1).

\textsuperscript{348} ibid., article 5(1).
professional expertise in addiction. A team of technical and administrative staff assists each CDT.

Table 12. Process summary Table 12 summarises how the process established by these reforms works in practice. Language in this table reflects the English translation used by Portuguese authorities.

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349 ibid., article 7.
Table 12. Process summary

<table>
<thead>
<tr>
<th>Action</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intersection</strong></td>
<td>Police intersect an individual in the possession of illicit drugs and seize the substance.</td>
</tr>
<tr>
<td><strong>Referral</strong></td>
<td>Police weigh the substance. If it is less than 10 daily doses (as prescribed in regulation), it is automatically considered to be an amount for personal use. Police prepare a report regarding the circumstances and refer the alleged offender to their local CDT within 72 hours.</td>
</tr>
<tr>
<td><strong>Consideration by CDT</strong></td>
<td>Offender presents at CDT and discusses with staff the motivations and circumstances around the drug use. Staff perform risk assessment screening and prepare technical advice for CDT to consider.</td>
</tr>
</tbody>
</table>
| **Decision of CDT**  | If the offender is not a dependent user and does not have a previous record, the CDT will order a provisional suspension of proceedings. If the offender is a dependent user, the provisional suspension of proceedings will only be ordered when the offender accepts treatment. Sanctions can only be applied if a non-dependent user has a previous record for the same reasons, or if a dependent user refuses treatment. Treatment is never mandated. CDTs may impose the following administrative sanctions: \(^{350}\)  
  - periodic presentation to staff of CDT (to improve motivation for treatment or deliver harm reduction practices)  
  - warning  
  - community service  
  - forbiddance from attending certain places or seeing certain people  
  - apprehension of objects  
  - forbiddance of international travel  
  - forbiddance of receiving welfare payments  
  - restriction of practicing certain professions or obtaining firearms  
  - fine of between 25 and 150 euros. A fine cannot, under any circumstances, be imposed on a person who the CDT considers to be a drug addict. Non-payment of fines may result in deductions from welfare payments. |

Source: Law 30/2000, the implementation of Portuguese drug policy: issues for CDTs, record of conversation with Dr Nuno Capaz.

A health-based philosophy

6.43 Key to the Portuguese model is that it embodies a health-based approach. A number of other countries across the world have decriminalised drug use and possession without taking a health-based approach. For example, Spain and Italy both have administrative penalty regimes in place for drug possession that operate more like road traffic penalties in Australia. In Spain, the penalty is a fine and in Italy, the penalty may be the suspension of drivers licence. In both countries, the offender may also be invited to attend counselling or treatment.  

6.44 In parallel with the legal reforms:  

The overall attitude towards the Portuguese drug problem shifted from a punitive approach to a new, comprehensive public health-oriented approach, where prevention and treatment are core concerns.  

6.45 The Commissioner of the Public Security Police in Lisbon told the Committee that the police have played a key role in developing and implementing the reforms at every stage. Today, their interactions with people who use drugs are more positive, as people feel less threatened by their presence.  

6.46 The direction of funding allocation shifted towards CDTs and the network of services they refer drug users to. SICAD is the government agency responsible for the planning, implementation and coordination of demand reduction strategies. Dr Joao Goulao, Director General of SICAD, told the Committee that since 2004, every person who has sought treatment has been able to access it immediately. Sometimes people may need to wait to access the specific service they want, but they will always be referred to another treatment service in the meantime.  

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353 Filipe Pinto da Silva, Commissioner, Portuguese Public Security Police, Email, 13 August 2019.  
355 Elsa Maia, International Relations Division, General-Directorate for Intervention on Addictive Behaviours and Dependencies Portugal, Email, 19 July 2019.
Dr Pedro Catita, Technical Coordinator of the East Lisbon Integrated Response Centre, told the Committee that during the reforms, treatment centres made a commitment to help every person on the same day they came seeking help. This was difficult at first, while treatment centres were expanding to meet the need. The need has settled over time. Many inpatient clinics have since closed down, replaced by less intensive outpatient clinics and longer-term therapeutic communities:

When the opportunity to provide help appears, you need to grab it with both hands and help the person now. If you tell them to come back next week, the window of opportunity will be closed.  

In conversation with the Committee, Dr Nuno Capaz, Vice President of the Lisbon CDT, explained that one of the main differences between a CDT and a Drug Court is the medical, as opposed to judicial, mindset. Drug court judges cannot abide any drug taking on their program, because it is illegal. Doctors with expertise in addiction, on the other hand, accept that simply reducing drug taking is a more realistic goal for some people.  

The Committee considered whether people would comply with referrals to treatment or support services without the looming threat of prosecution. The Committee asked Brendan Hughes, Principal Scientist at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) how the Portuguese respond if they refer someone to a treatment service and they refuse to comply. Mr Hughes said that they try again;  

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356 Dr Pedro Catita, Coordinator and Clinical Psychologist, Lisbon Oriental, Email, 21 August 2019.
357 Dr Nuno Capaz, Vice President of the Lisbon Commission for the Dissuasion of Drug Addiction, General-Directorate for Intervention on Addictive Behaviours and Dependencies Portugal, Email, 15 October 2019.
358 Brendan Hughes, Principal Scientist, Drug Legislation, European Monitoring Centre for Drugs and Drug Addiction, Transcript of evidence, 17 June 2019, p 8.
You do not go to a doctor a second time and say, "My knee still hurts" and the doctor says, 'You’ve already come once, go away'.  

6.50 When asked what the Portuguese do if they have referred a drug user to a health service and they fail to show up, Mr Hughes said that rather than punishing them, they try again. You need a system that is adapted for the complexity of drug addiction.

6.51 In short, as with any other health intervention, there may be lapses or failures on the road to recovery.

6.52 Most people referred to a CDT are not drug dependent. Today, most CDT decisions result in a suspension of proceedings without treatment. Alongside the comprehensive treatment system, Portugal maintains an ongoing commitment to harm reduction through needle and syringe programs, mobile methadone vans, peer educators and overdose response training.

Figure 10. Select Committee Members Hon Colin de Grussa MLC, Hon Samantha Rowe MLC, Hon Aaron Stonehouse MLC, Hon Michael Mischin MLC and Hon Alison Xamon MLC with team members from Ares do Pinhal at a Mobile Methadone Van in Lisbon
Source: Committee site visit, 30 April 2019.

Results

6.53 Early evidence about the model was somewhat mixed. A 2009 evaluation by the Cato Institute found decriminalisation to be a ‘resounding success’. The report revealed that critics worst fears, including that drug use would become rampant and that Portugal would become a drug tourism destination, had failed to emerge.

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359 ibid.
360 ibid., p 7.
The US Office of National Drug Control Policy stated that the Cato Institute report had failed to demonstrate a causal relationship between Portugal’s drug policy and its usage rates. The Association for a Drug Free Portugal then released a report drawing attention to increases in ‘lifetime use’ (i.e. have tried drugs at least once in their life) amongst certain age groups.\(^{363}\)

In 2012, Dr Caitlin Hughes and Professor Alex Stevens examined both sets of evidence and concluded that it is incorrect to refer to the Portuguese policy as either a ‘resounding success’ or a ‘disastrous failure’. An objective assessment of available data indicates that the following changes were observed following the reforms:

- reduced problematic drug use
- increased lifetime use (but still below European average)
- reduced burden of drug offenders on the criminal justice system
- increased uptake of drug treatment
- reduction in drug related deaths and infectious diseases.

In 2018, SICAD identified additional gains, including a decrease in drug use among adolescents, reduced stigmatisation of drug users and an increase in the amounts of drugs seized by police and customs.\(^{364}\)

Some of these changes have also been observed in neighbouring Spain and Italy, indicating regional trends. However, the reduced burden on the justice system and reduction in problem drug users are counter to regional trends, indicating a positive policy outcome.\(^{365}\)

Recent data from the EMCDDA demonstrates:\(^{366}\)

- Drug use: between 2007 and 2016, rates of recent use (in the past year) of most drugs declined. The number of people using cannabis has increased, but remains low by European standards. Drug use among 15 and 16 year old students was lower than the European average.
- Drug-related harms: the number of new HIV diagnoses attributed to injecting drugs fell by 94% from 500 in 2006 to 30 in 2016.
- Overdose deaths fell by 71% from 94 in 2008 to 27 in 2016.


Figure 11. Estimates of last-year drug use among young adults aged 15-34 in Portugal


**FINDING 46**

Overdose deaths and new HIV diagnoses attributed to injecting drugs fell significantly in Portugal in the last 10 years.

**FINDING 47**

Recent drug use in Portugal is lower than the European average.

6.59 Support from prominent global drug policy experts indicates a level of success, although these opinions do tend to focus on the decriminalisation element of the policy framework. The Global Commission on Drug Policy has found that decriminalisation does not result in significant increases in drug use, and that Portugal is currently the best example of a country using decriminalisation to achieve public health outcomes.\(^\text{367}\)

6.60 Overall, commentators have taken a positive view of the balance of the evidence from Portugal:

> In most respects, the law seems to have worked: serious drug use is down significantly, particularly among young people; the burden on the criminal justice

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system has eased; the number of people seeking treatment has grown; and the rates of drug-related deaths and cases of infectious diseases have fallen.\textsuperscript{368}

6.61 Brendan Hughes of the EMCDDA told the Committee that Portugal was a prime example of a country that is actually achieving its drug policy objectives:

\textbf{Hon MICHAEL MISCHIN:} Have you noticed any particular model in the European community that has clearly defined objectives that are being met and achieves what I would say is the ultimate sort of aim, which is to reduce drug dependency and the harm to both the person and the community from drug use or misuse?

\textbf{Mr HUGHES:} Certainly we describe the Portuguese model as being consistent and coherent for those similar reasons, in that they have managed to address all different types of drug users.\textsuperscript{369}

6.62 An unresolved criticism of the model is that it does not provide any legitimate means of supply. As discussed earlier in this report, engaging with a black market and consuming a black market product gives rise to risks and harms due to lack of quality control. According to the Global Commission on Drug Policy, while removing criminal penalties for drug use is a step in the right direction, it is just that – a step. Under this model, a society is still vulnerable to the negative effects of the illegal trade. According to the Commission, the only way to resolve this tension is for governments to regulate drugs, from production through to distribution.\textsuperscript{370}

6.63 Notwithstanding this, the Committee does not understand Portugal to be contemplating legalising the production or distribution of illicit drugs. It is the Committee’s understanding that the policy is to continue to regard such activity as unlawful.

\textbf{International model of best practice}

6.64 The United Nations has acknowledged that the Portuguese approach exists within the ambit of the international drug control requirements. President of the International Narcotics Control Board (INCB), Werner Sipp, explained in 2015 that although the Conventions state that the non-medical possession of drugs shall be a punishable offence, they explicitly allow alternatives to conviction or punishment in the case of drug abusers.

6.65 Today, Portuguese drug policy is the most prominent example of a health-based approach, with the President of the INCB stating that ‘the Portuguese approach can be considered as a model of best practices’.\textsuperscript{371}

\textbf{Misconceptions}

6.66 When visiting Portugal in April and May 2019, the Committee was keen to address some of the common community perceptions about the model. The Committee found that some of these perceptions are incorrect:

- **Portugal legalised drugs, or created a ‘window to legalisation’**: This is not the case. Illicit drug use, possession and all other drug related activity remain illegal. All that has

\textsuperscript{368} M Specter, ‘Getting a fix’ The New Yorker, 17 October 2011.

\textsuperscript{369} Brendan Hughes, Principal Scientist, Drug Legislation, European Monitoring Centre for Drugs and Drug Addiction, Transcript of evidence, 17 June 2019, p 3.

\textsuperscript{370} Global Commission on Drug Policy, Advancing drug policy reform: A new approach to decriminalisation, Geneva, 2016, 27.

\textsuperscript{371} United Nations International Narcotics Control Board, Statement of the President of the International Narcotics Control Board, Mr Werner Sipp, Vienna, 9 December 2015, p 5.
changed is that the response to drug use and possession for personal use attracts an administrative rather than criminal response.\textsuperscript{372}

- \textbf{Decriminalisation is the cornerstone of the model:} Media and public debate on the topic tends to hone in on the concept of decriminalisation. The Committee found that decriminalisation was only one part of a system-wide policy, legislative and funding reform across justice, health and social services agencies.

- \textbf{The Portuguese are lenient on drugs:} The response to personal use and possession of drugs is comprehensive and relatively resource-intensive compared to many countries. Even first-time cannabis offenders go through the CDT process.

- \textbf{There is a diminished role for police:} The Commissioner of the Public Security Police of Lisbon told the Committee that they work in much the same way as before, intercepting suspected drug criminals and using the same time and resources. The major change is only that police direct people possessing less than a certain amount of drugs to a dissuasion commission rather than a criminal court.\textsuperscript{373}

6.67 The Committee was curious as to how the police felt about the reforms:

The police officers reacted well to the reform, as they also realised that many of the citizens who were arrested for possessing narcotic drugs were not criminals, but drug addicts who required medical and social assistance in tackling their dependency.

Therefore, the changes in legislation were perceived as logical and beneficial by police officers, both for the judiciary system and drug users.\textsuperscript{374}

6.68 A key concern for the Committee is how to avoid sending the message that drug use is okay if drugs are decriminalised. According to Psychologist and Senior Lecturer Dr Stephen Bright, educating people about the fact that drugs are still illegal is key:

**Hon MICHAEL MISCHIN:** 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.\textsuperscript{375}

\begin{table}[h!]
\centering
\begin{tabular}{|l|}
\hline
\textbf{FINDING 48} \\
Decriminalisation in Portugal is just one element of an integrated, multi-faceted and comprehensive health-based approach to drug use. \\
\hline
\end{tabular}
\end{table}

\section*{Applicability}

6.69 Part of the purpose of the Committee’s travel to Portugal was to consider whether the approach, or any elements of the approach, could be suitable in the WA context. At the

\begin{footnotes}
\footnotetext{372}{ibid., p 4.}
\footnotetext{373}{Filipe Pinto da Silva, Commissioner, Portuguese Public Security Police, Email, 13 August 2019.}
\footnotetext{374}{ibid.}
\footnotetext{375}{Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, \textit{Transcript of evidence}, 17 June 2019, p 6.}
\end{footnotes}
outset, the Committee notes that in essence, the decriminalisation element of the policy is a form of police diversion. It is not so different to the Western Australian response, except that the police refer people to a different institution.

6.70 The Committee heard that WA requires much more in terms of treatment, support, prevention and harm reduction before implementing decriminalisation. However, the Committee considers that WA is ready to start this discussion. The most recent National Drug Strategy Household Survey demonstrated that more Western Australians than ever support non-criminal responses to people found in possession of small quantities of drugs.

RECOMMENDATION 18

The Mental Health Commission launch a public campaign to frame drug use as a health and social issue rather than a criminal justice issue.

6.71 A cornerstone of the Portuguese model is the commitment to an immediate response. This means some form of meaningful interaction occurs on the day a person comes looking for help. The Committee notes that the WA treatment and social support systems may not have the resources and capacity to facilitate this, particularly in regional and remote areas (see CHAPTER 5).

It is WANADA’s [Western Australian Network of Alcohol and other Drug Agencies] view that any alternative approaches to reducing illicit drug use must be considered within the context of there being insufficient alcohol and other drug services to meet existing and projected demand, as indicated in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

RECOMMENDATION 19

The Western Australian Government increase funding for drug services in line with the demand projected by the Mental Health, Alcohol and Other Drugs Services Plan 2015-2025.

6.72 The context and events leading up to the reforms are obviously unique to Portugal:

Efforts to replicate the successful approaches of other countries and jurisdictions needs to bear in mind that there are significant differences and potential limitations in the WA context. We note the Portuguese social environment that lead [led] to decriminalisation was unique, and in particular the attitude of the general public to drug users was and continues to be very different to that of Australia.

The key lesson that Portugal offers is that “while we can’t eradicate heroin, it’s possible to save the lives of drug users - if we’re willing to treat them not as criminals but as sick suffering human beings who need helping hands, not handcuffs”.

6.73 As the WA Police Force notes, the Portuguese reforms were in response to a heroin crisis. Australia also experienced problems with heroin around this time, but the crisis has not

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376 Jill Rundle, Chief Executive Officer, Western Australian Network of Alcohol and Other Drug Agencies, Transcript of evidence, 15 April 2019, p 8.
378 Western Australian Network of Alcohol and Other Drug Agencies, Answer to question on notice 3 asked at hearing held 15 April 2019, dated 3 May 2019, p 3.
re-emerged following the global heroin shortage of the early 2000s. Even today, the illicit drugs most likely to be used problematically across Europe are heroin, cocaine and crack cocaine. While meth use is increasing in some European countries, it is not widely used in most of mainland Europe.

The other thing was that their key problem was heroin, not meth. Heroin is a different drug, for which there is a substitution therapy available, so there are some medical components to treatment that are attainable, whereas methamphetamine does not have a substitution-therapy approach available.

This raises the question of whether such a model is easily transferable when meth is the primary drug of concern rather than heroin. The two drugs have different impacts on individuals and communities and different treatment modalities (see paragraphs 3.26 and 5.13). According to Professor Daniel Fatovich of the Meth Taskforce, while the two drugs are very different, the overriding principle that drug use is a health and social issue remains the same.

The Committee notes that the Australian Parliamentary Joint Committee on Law Enforcement investigated the Portuguese model in 2016 and acknowledged its positive results, but did not reach a definitive conclusion:

The committee has not reached a concluded view about the appropriateness of decriminalisation of methamphetamine or a broader range of illicit drugs in Australia.

The committee is cognisant of the jurisdictional challenges that arise in a federated system and the legal complexity and ambiguity that might be created if the Commonwealth and states and territories take different approaches.

The committee is also cautious about endorsing the Portuguese model for implementation in Australia: the Portuguese experts and agencies with which the committee met repeatedly emphasised that the Portuguese approach was one intended to address heroin use, and not methamphetamine, and that the availability of pharmacotherapy to treat heroin use makes treating that drug addiction a different proposition to methamphetamine.

The WA Police Force submit that the Police Drug Diversion Program already allows for a non-criminal penalty. The WA Police Force believe that WA Police Drug Diversion Program provides greater scope to divert more low-level drug users to treatment than the Portuguese model, because our threshold limits are higher. However, the Portuguese threshold limits are significantly higher than the WA thresholds, because police can divert people possessing up to 10 days worth of a reasonable daily quantity. Table 13. Threshold maximum quantities for diversion in Portugal and Western Australia outlines the amount of drugs a person can possess in Portugal and WA and be diverted.

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382 Professor Daniel Fatovich, Former Deputy Chair, Methamphetamine Action Plan Taskforce, Transcript of evidence, 15 April 2019, p 7.
383 ibid.
384 Parliament of Australia, Joint Committee on Law Enforcement, Inquiry into crystal methamphetamine (ice), 7 March 2018, p 166.
385 Submission 73 from Western Australia Police Force, 21 January 2019, p 3.
Table 13. *Threshold maximum quantities for diversion in Portugal and Western Australia*

<table>
<thead>
<tr>
<th>Illicit drug</th>
<th>Divertable quantity - Portugal</th>
<th>Divertable quantity - WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>1 gram</td>
<td>0.5 grams</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>1 gram</td>
<td>0.5 grams</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2 grams</td>
<td>0.5 grams</td>
</tr>
<tr>
<td>MDMA</td>
<td>1 gram</td>
<td>0.5 grams</td>
</tr>
<tr>
<td>Cannabis</td>
<td>25 grams</td>
<td>10 grams</td>
</tr>
</tbody>
</table>


6.77 The National Drug Research Institute submits that the Portuguese approach is different to most Australian police diversion schemes, including the WA scheme, because these are usually limited to first or second time offenders. 386

6.78 The Committee acknowledges that reforms such as those undertaken in Portugal could not happen overnight in WA. Although attitudes are changing over time, Australians still believe that people who possess harder drugs, such as heroin or meth, deserve punishment more than people who possess cannabis or ecstasy. 387

   We appreciate that there is considerable fear within the community and decriminalisation would be a big step for Australia. The community needs to be ready for this approach and for this reason leadership and a long-term, holistic view would be essential for success. 388

6.79 As mentioned, one of the most common arguments against moving from a criminal to administrative system is that it will increase drug use by sending the message that it is okay to use drugs. There is now sufficient evidence to demonstrate that removing criminal penalties in Portugal did not lead to major increases in drug use. 389 However, evidence suggests that it did lead to significant reductions in harms including overdose deaths and HIV.

**An administrative response model for Western Australia**

**The need for clear objectives**

6.80 The Committee considered what sort of non-criminal, administrative response regime could work in WA. The Committee spoke to Brendan Hughes of the EMCDDA and Associate Professor Kate Seear of Monash University, both of whom emphasised the importance of having clearly defined objectives before embarking on any new drug policy. Mr Hughes told the Committee that Portugal was a good example of a country that had clear objectives from the outset.

6.81 Well-intentioned drug policies across the world have fallen down because of bending to pressures and shifting objectives half way through. For example:

   In Italy, one of the objectives of the change of the Law 4912006 was to send a clear message that drugs were illegal and use would be punished...the law was

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386 Submission 41 from National Drug Research Institute, 30 November 2018, p 4.
388 Submission 25 from Hope Community Services, 26 November 2018, p 7.
changed to offer the treatment only after the punishment had been completed; and this resulted in a collapse in the take-up of treatment.  

6.82 A jurisdiction must identify whether its primary objective is to save money and reduce the burden on the criminal justice system, or address the health and social issues associated with drug use. The response will differ depending on the objective. If the primary objective is to reduce the burden on the criminal justice system, a response like the Cannabis Expiation Notice Scheme in South Australia may be most appropriate. Under this scheme, which is outlined in more detail in CHAPTER 7, all minor drug use and possession offences result in a fine and no further action.

6.83 The Committee is of the view that the primary objective of drug regulation should be to address the health and social issues associated with problem drug use. The Committee believes that treating addiction and addressing the underlying factors that drive it, such as poverty and trauma, will lead to improved community safety, reduced levels of drug use and reduced burdens on the criminal justice system.

**FINDING 49**

The primary objective of drug regulation should be to address the health and social issues associated with problem drug use.

**Accounting for different levels of need**

6.84 The Committee notes that it is possible to build a system with a scale of responses that are appropriate for differing levels of need. For example, the Committee is aware that the majority of people who use drugs do not have an addiction problem. Professor Steve Allsop explained that a good system would also include appropriate responses for those people who do not need treatment:

> While there are merits in what has happened in Portugal, the issue is that a lot of people who come to the attention of law enforcement are not severely dependent whereas a lot of the emphasis on the Portuguese model is about dealing with people who are severely dependent.

> You need to have a system that is cost-efficient and addresses the needs of people, including a large number of people who come to the attention of law enforcement once and have low-level problems to those who might come to the attention more frequently and have high-level problems.

> Both should be treated as a health issue but you need a graded approach so that you are not unnecessarily costing the health system, if you like, far more than is necessary.  

6.85 A scaled system can respond to the individual needs of different drug users:

> One of the main lessons that we have seen is that the response needs to be targeted to a particular offender. If you wish to divert only problematic users, then you design your program accordingly. If you wish to divert all users, you will need to have different responses from the occasional cannabis users to the serious problematic users.  

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390 Brendan Hughes, Principal Scientist, Drug Legislation, European Monitoring Centre for Drugs and Drug Addiction, *Answer to question on notice 2 asked at hearing held 17 June 2019, dated 10 July 2019*, p 1.


It is important that any administrative system has a suite of diversion options available in recognition of the fact that people use and possess drugs for a range of reasons, and that not all drug use takes the form of a medical problem.\(^{393}\)

6.86 A key objective would be to avoid the criminal consequences, and associated harms, that are presently attached to drug use and possession:

One of the objectives that can be met is that people who are diverted out of the criminal justice system will not attract some of those penalties, will not have those criminal obligations attached to their drug use or drug possession and, therefore, might not encounter obstacles like obstacles to employment or housing.

There is a whole range of priorities that can be addressed through moving away from a punitive scheme and towards a more administrative scheme.\(^{394}\)

6.87 The Committee is of the view that a health-based approach should aim to achieve the following objectives:

- reduce drug-related harms
- reduce drug use, particularly problem use
- ensure people who need help can access it
- ensure that people who have not engaged in offending behaviours are diverted away from the criminal justice system.

6.88 With the assistance of expert witnesses, the Committee has developed two options for pursuing these objectives.

**Option 1 – expand and improve police diversion to achieve a health-based response**

6.89 The WA Police Force Drug Diversion Program aims to divert people in possession of drugs for personal use away from court to a health intervention.

6.90 In summary, the WA Police Force Drug Diversion Program includes the legislated CIRS and the policy-based ODIRS. Under the CIRS, first-time offenders in possession of less than 10 grams of cannabis may avoid prosecution by attending an education session within 28 days. Under the ODIRS, first-time offenders in possession of less than 0.5 grams of most other illicit drugs may avoid prosecution by attending three education sessions within 42 days.

6.91 CHAPTER 4 outlines the limitations of the current WA Police Force Drug Diversion Program. It is a one-size-fits-all approach with strict eligibility requirements, including low threshold amounts. Police prosecute those who fail to attend the intervention session or offend for a second or third time. Because the ODIRS is not legislated, cannabis users are diverted far more often than other drug users.

6.92 The Committee is of the view that if these limitations were addressed, a health-based response system could exist within the framework of the WA Police Force Drug Diversion Program. If improved and expanded, police diversion could achieve the following:

- Remove criminal penalties for drug users: This could reduce the harms associated with drug criminalisation for personal use and possession, such as the impact of a criminal record and stigma. Apprehension with drugs for a second or third time would present additional opportunities to provide help, rather than prosecution.

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\(^{393}\) Associate Professor Kate Seear, Associate Professor in Law, Monash University, Answer to question on notice 2 asked at hearing held 17 June 2019, dated July 2019, p 2.

\(^{394}\) Associate Professor Kate Seear, Associate Professor in Law, Monash University, *Transcript of evidence*, 17 June 2019, p 5.
• Ensure that people have access to help for drug or related issues. For some people, help will not just mean drug services, but may also include homelessness, mental health, unemployment or medical services.

• Relieve pressure on the criminal justice system by issuing warnings to low-level, first-time offenders. Police will be saved the administrative burden of referring first timers through the intervention requirement process, and drug service delivery agencies can focus their attention on delivering services to people with greater need.

6.93 The Committee considers that the following policy and legislative changes are required to shift the focus of the WA Police Drug Diversion Program from criminal justice to health:

• Establish the ODIRS in the Misuse of Drugs Act 1981 (Act).

• Amend the Act to require police to divert people found with personal amounts of drugs. Currently, diversion is optional. Removing the discretionary element ensures that people in regional and remote areas have equitable access to diversion as people in metropolitan areas.

• Remove limitations on the number of times a person can be diverted.

• Amend the blanket requirement to attend three sessions (for drugs other than cannabis) to one.

• Enable the AOD service providers delivering the treatment to determine, in consultation with the attendee, what their ongoing treatment and support needs are.

• Remove the requirement that failure to attend an intervention session triggers prosecution. There should be consequences for failure to attend, but the system should try to avoid imposing consequences that result in a criminal record or potential imprisonment.

6.94 Some of these changes would simply bring WA into line with other Australian jurisdictions, like South Australia, while ensuring that the program maintains a focus on health responses.

6.95 The Committee also considers that a broader range of proportionate and graduated responses to drug users should be available under the scheme. For example, people apprehended with cannabis for the first time should receive a warning. Figure 12 sets out an example of scaled responses.
The WA Police Force has told the Committee that they support the expansion of the current Police Drug Diversion Program. To ensure that health objectives are at the forefront, cooperation and co-ownership of this approach between the WA Police Force and the Mental Health Commission is required from the outset. The Committee believes that the Mental Health Commission should play a key role in developing associated legislative and policy changes.

Anticipated outcomes would include court cost savings, a reduction in drug-related harms arising from criminalisation and stigma and increased opportunities to access treatment and supports.

**Option 2 – establishing an administrative body and process for dealing with drug use and possession**

The Committee spoke to Associate Professor Kate Seear about how to take Option 1 further by establishing an administrative system inspired by the Portuguese model of CDTs in WA. This would include establishing an expert decision-making body under either standalone legislation or the Mental Health Act 2014. Members would be government appointed experts with medical, psychiatric, community and legal backgrounds, similar to the Mental Health Tribunal:

The drug misuse Act, like other legislation, has a set of objectives that might differ from the objectives that you would want to govern that administrative decision-making body. I think

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395 Submission 73 from Western Australia Police Force, 21 January 2019, p 12.
396 Brendan Hughes, European Monitoring Centre for Drugs and Drug Addiction, Answer to question on notice 4 asked at hearing held 17 June 2019, dated 10 July 2019, p 1.
they should be clearly separated out so that it does not bear any of the remnants or legacies of a criminal model, if that is the direction you head in.\textsuperscript{397}

### 6.99 The model would involve:

- enabling legislation to establish Expert Tribunals in each region
- amending the \textit{Misuse of Drugs Act 1981} to require that police refer any person apprehended with less than the threshold amount directly to the Expert Tribunal
- the government appointing expert members with medical, community or legal backgrounds
- a scaled approach to respond to individual needs in each case, conducting risk and needs assessments and considering the person’s history
- capacity under enabling legislation for Expert Tribunals to impose a range of administrative responses, from a fine to a referral to treatment with reporting conditions
- Expert Tribunals having the responsibility to deal with failures to comply, and ability to follow up with people or instigate fine recovery.

**ROLE OF POLICE UNDER MISUSE OF DRUGS ACT**

- Found with illicit drugs
  - More than threshold amount: Prosecution proceedings
  - Less than threshold amount: Referred to Expert Tribunal

**ROLE OF EXPERT TRIBUNAL UNDER NEW LEGISLATION**

- Assessment of users needs and risks
  - Impose administrative response, including:
    - No response
    - Referral to treatment
    - Referral to social service
    - Civil fine
    - Conditions such as the need to report on progress, stay away from certain places etc.

If breached: in first instance, encourage the person to re-engage. In second instance, commence fine default proceedings.

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**Figure 13. Example administrative response process under Option 2**

Source: Select Committee into Alternate Approaches to Reducing Illicit Drug Use.

6.100 A court could still find that a person in possession of a quantity of drugs in excess of the threshold amount giving rise to the presumption of intent to sell or supply had those drugs for personal use and refer that person to the Expert Tribunal.

6.101 Option 2 is likely to be more involved and expensive to establish. However, it goes much further than Option 1 in terms of reflecting a health-based approach by officially putting

\textsuperscript{397} Associate Professor Kate Seear, Associate Professor in Law, Monash University, \textit{Transcript of evidence}, 17 June 2019, p 10.
decisions about people who use drugs in the hands of health and social experts rather than the police.

6.102 The Committee notes that any alternative approach needs to be accessible by all Western Australians, including those living in regional and remote areas.

**RECOMMENDATION 20**

In order to adopt a health-based approach to drug use and possession in practice, the Mental Health Commission and Western Australia Police Force work together to investigate, develop and implement either:

- Option 1—an expanded Police Drug Diversion Program
- Option 2—an administrative decision-making body and associated process for dealing with drug use and possession. That the Mental Health Commission and Western Australia Police Force give particular consideration to ensuring that people in regional and remote areas can receive equitable access.
CHAPTER 7
Alternative approaches to regulating cannabis

Introduction

7.1 This Chapter considers:

- why public attitudes about cannabis are different to other drugs
- alternative models to regulating cannabis from around the world, including:
  - legalisation
  - decriminalisation
  - Cannabis Social Clubs.

Why is cannabis different?

7.2 Attitudes toward cannabis tend to be different to other illicit drugs. The 2016 National Drug Strategy Household Survey showed that cannabis is the most used illicit drug in Australia. Over a third of Australians have used cannabis, and 10.4% used it in the last year. Community tolerance of medicinal and recreational cannabis use is increasing, and 35% of Australians support cannabis legalisation.398

7.3 WA legislation reflects the view that cannabis is different to other illicit drugs. A person can possess much more cannabis than other illicit drugs and still be eligible for diversion.399 A separate and less onerous police drug diversion program, the CIRS (see paragraph 4.22), only requires cannabis users to attend one intervention session, while users of other drugs must attend three. See Chapter 4 for the regulatory framework for cannabis use and possession in WA.

7.4 Many submissions from private citizens focused specifically on cannabis. People submitted that cannabis is less harmful than alcohol and tobacco400 and that legalisation will create revenue, disrupt the black market and make cannabis harder for minors to access.401

The perception in our society that ‘drugs are bad’ and that cannabis is somehow the same as ‘ice’ is also a problem. How can we educate our children if we are lying and continuing the situation that we have come to endure?402

7.5 A number of private citizens told the Committee about the benefits cannabis has had on their lives. Some have used it for pain relief over many years,403 and still use it today because of difficulties obtaining a medicinal cannabis prescription.404 Others claim that it helped them to reduce their dependency on alcohol.405 Some told the Committee that they use cannabis

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399 10 grams of cannabis, vs 0.5 grams of heroin, MDMA, cocaine or amphetamines – Misuse of Drugs Act 1981.
400 Submission 12 from Michael Fragomeni, 12 November 2019, p 1.
401 Submission 36 from private citizen, 29 November 2018.
402 Submission 23 from private citizen, 26 November 2018.
403 For example, submission 4 from private citizen, 7 November 2018, p 1.
404 Submission 13 from private citizen, 12 November 2018, p 1.
405 Submission 15 from private citizen, 19 November 2018, p 1.
regularly while maintaining employment, family relationships and community participation.\textsuperscript{406}

There is a misconception that people who use cannabis are no-hopers and lazy. This could not be further from the truth, when in fact many users are functioning so highly that you will not spot them, and they will not stand up for fear of being discriminated against.\textsuperscript{407}

For the last 14 years, we have run a family business, our son works with us. We pay our taxes, we donate to charity, I give to homeless...I am not a bad person by any means. I just like to smoke weed.\textsuperscript{408}

7.6 A major difference between cannabis and other illicit drugs is the ability to self-supply. Submitters who smoke cannabis would also like the option to grow a plant or two for their own use without facing criminal charges.\textsuperscript{409}

7.7 Others submitted that decriminalisation is not enough and the sale of cannabis should be legalised:

Legalise the personal use of marijuana. Provide a legal supply network for marijuana, perhaps similar to tobacco.\textsuperscript{410}

The sale of recreational amounts of cannabis and related products should be through authorised retailers. This removes the criminal element and possibly the temptation to try other illegal drugs the dealers might be pushing as well.\textsuperscript{411}

I believe the current cannabis laws are outdated and based on a lack of modern scientific evidence, which should be addressed.\textsuperscript{412}

**FINDING 50**

Community attitudes towards cannabis are becoming increasingly tolerant, and there is a degree of public support for cannabis decriminalisation or even legalisation.

**Cannabis-related harms**

7.8 Cannabis is associated with low levels of harm in relation to individuals and the community relative to meth, heroin and alcohol.\textsuperscript{413} A growing body of evidence shows that cannabis helps to deal with chronic pain and the symptoms of conditions like cancer and Parkinson’s disease.\textsuperscript{414} Students for Sensible Drug Policy submit that the harms associated with the criminalisation of cannabis are greater than the harms associated with the use of the drug.\textsuperscript{415}

7.9 The Committee heard anecdotal evidence that people with jobs where drug testing is common, such as fly-in fly-out workers, may choose to switch from cannabis to meth to

\textsuperscript{406} Submission 45 from Diana Marr, 26 November 2018.
\textsuperscript{407} Submission 23 from private citizen, 26 November 2018.
\textsuperscript{408} Submission 28 from private citizen, 23 November 2018, p 2.
\textsuperscript{409} Ibid.
\textsuperscript{410} Submission 3 from Tom Marwick, 6 November 2018.
\textsuperscript{411} Submission 1 from Gary Brennan, 1 November 2018, p 2.
\textsuperscript{412} Submission 31 from Lee Hollingsworth, 28 November 2018.
\textsuperscript{414} Australian Institute of Criminology, *Cannabis legalisation in the United States: an Australian perspective*, report prepared by P Homel and R Brown, Canberra, June 2017.
\textsuperscript{415} Submission 74 from Students for Sensible Drug Policy, 30 January 2019, p 6.
avoid detection. Cannabis is detectable in urine for up to seven days after use, where meth leaves the system within three days.417

Hon AARON STONEHOUSE: It has been put to me that some people may have used cannabis recreationally, but because that potentially stays in your system for weeks, it can easily be detected by drug tests. For somebody doing fly in, fly out work, where they are regularly subjected to drug tests by their employer, cannabis is no longer a way of unwinding and recreating during their time back in Perth. They switch to a different substance like meth, which may only be in their system for a few days. It may be clear from their system, at least at detectable levels, by the time they have to go back to work and are drug tested again. Is that true? Does that happen?

Prof. Fatovich: That is a scenario that has been explained to me, yes.

Hon AARON STONEHOUSE: Is it accurate to say that—hopefully I am not taking too much of a leap here—

Mr Alexander: No. You are absolutely right. When we went to areas like Kalgoorlie and those sorts of places it is the drug of choice, because it goes through the system so quickly.

7.10 The Committee is also aware of the physical and social risks of cannabis, including impaired driving.418 The long-term effects of cannabis use may include:419

- brain damage resulting in impaired concentration, memory and learning ability
- lung damage
- a lowered sex drive, irregular menstrual cycle and reduced sperm count
- immune system damage
- mental health issues.

FINDING 51

Cannabis use may impair ability to operate machinery or a motor vehicle and result in adverse long-term health effects.

7.11 Regular cannabis use may increase the likelihood of psychotic symptoms in people with a family history of psychotic mental illness. It may also make psychotic symptoms worse for people already experiencing them.420 Brendan Hughes of the EMCDDA told the Committee that because of these links, he would not consider cannabis ‘harmless’.421

7.12 James Hunter of Cyrenian House told the Committee that cannabis may exacerbate, but not necessarily cause, psychotic mental illness:

Mr HUNTER: The prevalence of schizophrenia has not necessarily massively increased in the last 50 years, and over that period, we have seen a massive

416 Professor Steve Allsop, Transcript of evidence, 13 May 2019, p 10.
419 Australian Institute of Criminology, Cannabis legalisation in the United States: an Australian perspective, report prepared by P Homel and R Brown, Canberra, June 2017, pp 12-3.
420 ibid.
expansion in the use of cannabis, a massive expansion in the potency of cannabis, yet we have not seen the needle really move on the number of people with severe schizophrenia.

Ms DAWSON: On the other hand, when people with schizophrenia smoke –

Mr HUNTER: It will make it much worse.

7.13 The Committee also heard that the potency of Australian cannabis has increased:

Cannabis has changed. From cannabis of old, when we were kids, and cannabis of now, the ratio of THC to cannabinoids has changed, so that the THC levels now, with their different breeding that they are doing, is much higher. I do not think it is safe, especially in the young adult group with a predisposition to psychosis.

**FINDING 52**
The potency of Australian cannabis has increased.

**FINDING 53**
Regular cannabis use may increase the likelihood of psychotic symptoms or worsen symptoms in people who are predisposed to, or already experiencing, psychotic mental illness.

**Global reforms**


7.15 Across the world, regulatory systems are changing rapidly to catch up with public attitudes. A global movement towards legalising medicinal cannabis has been underway since the 1990s. In 2013, Uruguay became the first country in the world to legalise the recreational use of cannabis. Since 2012, eight states of the US, including Washington, Colorado and California have voted to legalise recreational cannabis, which remains illegal at a federal level. In 2018, Canada legalised recreational cannabis and established a framework for controlling its production, distribution, sale and possession.

7.16 A lower-profile global movement towards non-profit regulation and decriminalisation is also occurring. European countries including Switzerland, the Netherlands, Belgium and Spain have adopted various approaches to tolerating or strictly regulating recreational cannabis use and distribution. In some Australian jurisdictions, use and possession of minor amounts of cannabis attracts a civil, rather than criminal, penalty. These approaches occupy the ‘middle ground’ between complete prohibition and complete legalisation.

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422 Dr Jessamine Soderstrom, Emergency Physician, Department of Health, Transcript of evidence, 15 April 2019, p 10.
424 Conrad Chahary, Global Commission on Drug Policy, Email, 14 October 2019.
425 Australian Institute of Criminology, Cannabis legalisation in the United States: an Australian perspective, report prepared by P Homel and R Brown, Canberra, June 2017.
Legalisation of cannabis

7.17 The approach to cannabis regulation that has attracted the most attention in recent years is legalisation. Cannabis legalisation means removing legal prohibitions on the production, distribution, sale, possession and use of cannabis. Legalisation is distinct from decriminalisation, where cannabis is still illegal but does not attract a criminal penalty.

7.18 There are two main models for legalising cannabis:426

- Non-commercial: government strictly controls the production, packaging, distribution, sale of and access to cannabis to pursue health and wellbeing objectives. In Uruguay, for example, cannabis production is government controlled and cannabis is only sold in pharmacies. Another example is medicinal cannabis in Australia.

- Commercial: retailers have more freedom to produce, brand and market a range of cannabis products with the goal of pursuing economic benefits.

7.19 Professor Simon Lenton explained the distinction:

Regulated supply through a pharmacy is not the same as commercial production.
You are not having marketing; you are not having a whole lot of players.
Lots of people would prefer to access their drugs from a legal supply network than a criminal supply network, and might be prepared to pay a price premium in order to do that, so it does not have to undercut the illegal market, because price is not the only thing that people consider when they think about where they get their drugs from.427

7.20 The main arguments for a commercial model of legalisation are based in economics and harm reduction. In theory, legalisation undercut the black market in cannabis and drives criminality out of production and sale. Revenue can go toward health care and law enforcement. Users can engage in a safe and legal market, reducing the harms associated with black market interaction.428 Supporters also suggest that legalisation separates the market between cannabis and more harmful illicit drugs.429

Colorado

7.21 The approach used in Colorado was raised six times in submissions to this inquiry. A number of private citizens support the legalisation of cannabis, three of whom specifically referred to Colorado.430 Other stakeholders warned the Committee against the Colorado model.431

7.22 Colorado is the most well-known example of a commercially legalised model. In November 2012, Colorado voted to legalise recreational cannabis for adults. This allowed for the operation of licenced cannabis retail stores, cultivation and manufacturing of edible products.432

7.23 The Colorado model is known as the ‘retail model’ because economic benefits are a primary objective. The reforms focused on commercial production, sale and supply. It is also referred to as the ‘alcohol model’ because it closely resembles the regulatory control system for

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427 Professor Simon Lenton, Director, National Drug Research Centre, Transcript of evidence, 10 June 2019, p 11.
428 Submission 74 from Students for Sensible Drug Policy, 30 January 2019, p 7.
429 Submission 43 from Jamnes Danenberg, 30 November 2018.
430 Submissions 9, 15 and 30.
431 Submissions 50, 65 and 73.
The world is watching Colorado with interest as a mixture of positive and negative results begin to emerge.

7.24 The WA Police Force advised the Committee that the harms associated with cannabis legalisation in Colorado had been significant. The Rocky Mountain High Intensity Drug Trafficking Area Project, established by the White House, found that since 2012 cannabis related traffic deaths and emergency department visits had increased, and cannabis had become stronger.

7.25 Doctors in Colorado have reported increasing occurrences of Cannabis Hyperemesis Syndrome, which causes extreme vomiting, nausea and abdominal pain. This, and the increase in emergency department presentations, has been attributed to the strength of commercialised cannabis. Current commercialised cannabis contains nearly 20% THC, compared to less than two per cent in the 1980s.

7.26 Cannabis use in the past month has increased since 2011, with the largest increases observed between 2012 and 2015.

Figure 14. Cannabis use in the past month in Colorado, by age group


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434 Submission 73 from WA Police Force, 21 January 2019, p 12.


436 N Lenihan, ‘Marijuana has been legal in Colorado for five years. Business is booming, but there’s a dark side’, ABC News, 2 June 2019.


438 ibid.
7.27 According to a study published in 2019, the adverse health consequences have been significant. Although the author of the study himself acknowledges the limitations of his review and the existing literature, he concludes that:

Cannabis legalization has led to significant health consequences, particularly to EDs [emergency departments] and hospitals in Colorado. The most concerning include psychosis, suicide, and other substance abuse. There are deleterious effects on the brain, and some of these may not be reversible with abstinence.

... Given these factors and the Colorado experience, other states should carefully evaluate whether and how to decriminalise or legalise non-medical cannabis use.\(^{439}\)

7.28 Furthermore, it appears that legalisation has not eliminated the black market for cannabis in Colorado. Part of the reason for this is likely to be that cannabis is still illegal in neighbouring states, creating an incentive for cross-border trafficking. Seizures of Colorado cannabis in the US mail system has increased 1042 percent from an average of 52 parcels (2009-2012) to an average of 594 parcels (2013-2017) since cannabis has been legalised:

There is evidence of cross-border sales and people whipping in to buy cannabis from Colorado and whipping back out of the state. If you look at the states around Colorado, there is evidence of that interstate trafficking or interstate supply; I do not think we know yet.\(^{440}\)

**FINDING 54**

Early evidence emerging from Colorado points to increased harms following the legalisation of cannabis, including increases in traffic deaths, cannabis-related emergency department visits, recent cannabis use and black market activity.

7.29 Dr Stephen Bright spoke to the Committee about this in his capacity as a private citizen:

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.\(^{441}\)

7.30 Although the regulatory costs of legal recreational cannabis are substantial, neighbouring Vermont (where cannabis is decriminalised) spends more on cannabis law enforcement. Over time, the regulatory costs are due to be more than offset by incoming revenue, suggesting that economic benefits will be achieved.\(^{442}\)

7.31 There are mixed results from North American jurisdictions which have recently legalised cannabis about effects on the workplace, mental health and drug use patterns. A 2017 summary of emerging evidence published by the Australian Institute of Criminology suggests that American models are too young to assess the impacts of recreational cannabis legalisation.

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\(^{439}\) ibid.

\(^{440}\) Professor Simon Lenton, Director, National Drug Research Centre, Transcript of evidence, 10 June 2019, p 11.

\(^{441}\) Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Transcript of evidence, 17 June 2019, p 8.

\(^{442}\) Australian Institute of Criminology, Cannabis legalisation in the United States: an Australian perspective, report prepared by P Homel and R Brown, Canberra, June 2017.
7.32 The Committee heard that from a public health standpoint, a commercial model is far from ideal.\textsuperscript{443} By their nature, commercially based models of sale encourage additional consumption, which may result in adverse health and mental health issues. Professor Steve Allsop said that previous experiences with regulating supply have not necessarily produced the best outcomes:

We have not done a very good job of managing supply mechanisms if you think about tobacco, pharmaceuticals and alcohol in terms of a legalisation approach.\textsuperscript{444}

7.33 Professor Allsop also told the Committee about the risk that stakeholders in legalised cannabis markets will focus on profits over health outcomes:

Certainly, for example, the Canadian model really has just been put into place now, but we are already beginning to see commercial interests move into the production and supply.

For me, personally, I would firstly be saying that we have to look at a system whereby people who are found with small amounts of a drug for personal use are directed to a health service. That is very different from legalisation.\textsuperscript{445}

7.34 The WA Police Force noted that because regulated cannabis is taxed and more expensive, organised crime networks will continue to sell cannabis at a cheaper price on the black market.\textsuperscript{446} The WA Police Force submitted that illicit tobacco, also known as chop-chop, demonstrates that legalisation does not necessarily take profit away from the black market:

A Western Australian example was in only November 2018, where one seed [sic – sea] container, which was interdicted by the Australian Border Force in Fremantle, was found to contain an estimated 9.5 million illicit tobacco cigarettes. That is estimated to have avoided tariffs – tax evasion – by one seed [sic – sea] container of this material, by up to $7.6 million. That is an example where I would contest the notion that in relation to cannabis that if it were legalised, organised criminals would simply pay their taxes. Organised criminals do not pay taxes.\textsuperscript{447}

7.35 However, the Committee notes that high tobacco excise may create greater opportunities for the illicit tobacco market. Australian tobacco is the most expensive in the Asia-Pacific region. A packet of Marlboro is approximately seven times more expensive in Australia than in China. KPMG suggest that this price difference creates an economic incentive for importing and selling illicit tobacco.\textsuperscript{448}

7.36 The Committee notes that legal commercialised recreational cannabis regimes are relatively new. Evidence is starting to emerge about the associated benefits and risks, but longitudinal data is required to fully understand the impacts. While emerging evidence points to economic benefits, whether or not commercial models reduce harm to the community is less clear.

7.37 The Committee did not receive sufficient evidence to support WA adopting commercial legalisation as yet, and was concerned at some of the emerging evidence about negative health consequences in Colorado.

7.38 Legalisation by an individual state may have unknown flow-on effects for neighbouring states and territories. In Colorado, evidence suggests that inter-jurisdictional black market

\textsuperscript{443} Submission 41 from National Drug Research Institute, 30 November 2018, p 5.

\textsuperscript{444} Professor Steve Allsop, Transcript of evidence, 13 May 2019, p 4.

\textsuperscript{445} ibid.

\textsuperscript{446} Submission 73 from WA Police Force, 21 January 2019, p 6.

\textsuperscript{447} Chris Dawson, Commissioner, Western Australia Police Force, Transcript of evidence, 15 April 2019, p 2.

\textsuperscript{448} KPMG, Illicit tobacco in Australia, London, 15 April 2016, p 47.
cannabis trafficking may be increasing. It is not inconceivable that the same issues could apply if WA adopted a commercially legalised model of cannabis production and sale. The Committee wishes to emphasise that these concerns apply to a commercially legalised model which allows for manufacture and sale, and not the model recently adopted by the Australian Capital Territory, which will be discussed later in this chapter.

FINDING 55
There is currently insufficient evidence available from other countries to support a commercial model of cannabis legalisation.

Middle ground options

7.39 A number of ‘middle ground’ options, which prioritise health over profit, are already operating internationally. Middle ground options are strictly regulated, non-commercial mechanisms for providing limited access to cannabis.

7.40 Researchers at the RAND Corporation have identified the following middle-ground approaches, some of which are currently in use:

- allowing adults to grow their own cannabis
- allowing distribution within small buyers’ clubs (Cannabis Social Clubs)
- tolerating local retail sale without legalising commercial production (for example, the Netherlands’ ‘coffee shop’ model)
- supply chain operated by government or public authority
- only allowing sale by non-profit organisations.

7.41 Professor Simon Lenton, Director of the NDRI, believes these options are worthy of attention:

> We think that the bottom of the harm curve...is actually in those middle ground options. Where you have strict criminal penalties and you do not have any legal supply, you get problems due to contamination and involving criminal organised gangs and all the problems due to criminalisation, so the currently illegal drugs. Where you have full commercial availability, you get problems associated with widespread use, you get promotion, you get excessive use and you get excessive harm in the community.

> We should be talking much more about the options in that mid-range that are likely to reduce harm at the bottom of the curve than we are about full legalisation or full criminalisation.

7.42 Figure 15 demonstrates that middle ground options, denoted by the orange highlight, result in lower health and social harms than complete prohibition or complete legalisation.


450 Professor Simon Lenton, Director, National Drug Research Institute, *Transcript of evidence*, 10 June 2019, p 7.
Cannabis Social Clubs

7.43 The Committee heard about Cannabis Social Clubs as a middle ground option. Cannabis Social Clubs are a non-profit means of cannabis production and distribution, which produce cannabis for the personal consumption of members.

7.44 Emerging in Spain in the mid-1990s, Cannabis Social Clubs now operate in Uruguay, Slovenia, Belgium, France, the United Kingdom and San Francisco. Although Clubs operate differently in every country, they have key features in common: ⁴⁵¹

- Cannabis Social Clubs are registered not-for profit organisations
- membership is typically limited to adult nationals, removing the risk of ‘drug tourism’
- members are vetted on signing up, and must enter into an agreement with the Club not to distribute cannabis to non-members
- members level of use will be assessed on entry, and they must demonstrate a willingness to receive advice about harm reduction
- strict health and safety licensing conditions are imposed and monitored by a regulatory body
- the number of members and plants per member is limited.

7.45 Cannabis Social Clubs can operate in countries where the possession and cultivation of small amounts of cannabis has been decriminalised. Alternatively, they can operate as an experiment while a government works towards decriminalisation.\textsuperscript{452}

7.46 Students for Sensible Drug Policy told the Committee that the benefit of Cannabis Social Clubs is two-fold:

On the one hand, it removes the need for people who use cannabis to approach the black market, crippling criminal syndicate revenue streams; and on the other hand, the nature of being a legal collective provides a sense of community involvement for people who use cannabis who previously have been ostracised from the larger populace.\textsuperscript{453}

7.47 Some countries do not have a formal regulatory approach and Cannabis Social Clubs are largely self-regulated. In Spain, a lack of regulation has led to excess and opportunism, where Cannabis Social Clubs are promoted to tourists.\textsuperscript{454} If the objective of introducing Cannabis Social Clubs is better public health outcomes, a thorough regulatory framework would likely be required.

7.48 In jurisdictions where cannabis is not decriminalised, such as WA, Cannabis Social Clubs seem to operate as a step towards decriminalisation rather than a long-term solution. If Cannabis Social Clubs are intended as an experiment or transitional measure, the question becomes whether it is worth establishing the regulatory framework.

7.49 The Committee is of the view that if cannabis is decriminalised in WA, Cannabis Social Clubs could be considered as an option for limited self-supply. However, WA is currently not an ideal location for Cannabis Social Clubs, as people can be prosecuted for possessing small amounts of cannabis.

**FINDING 56**

Cannabis Social Clubs are a non-profit means of producing cannabis for personal use for members, but are best suited to jurisdictions where the personal use and possession of cannabis has been decriminalised.

**Swiss model of legal low-THC cannabis**

7.50 In April 2019, the Committee visited Switzerland. During its visit, the Committee learned about the Swiss approach to strict cannabis regulation. The Swiss have been working towards a regulated market for cannabis since 2001. Minor cannabis use and possession has been decriminalised, and in most cantons (states) possession will not attract any penalty.

\textsuperscript{452} ibid.

\textsuperscript{453} Submission 74 from Students for Sensible Drug Policy, 30 January 2019, p 6.

Chapter 7 Alternative approaches to regulating cannabis

7.51 Cannabis with less than 1% THC is legal. Since 2017, low-THC cannabis has been sold in tobacco stores and taxed at the same rate as tobacco.\(^{455}\) THC is the main psychoactive compound in cannabis, meaning users of low THC cannabis will probably not experience the sensation of being ‘high’.

7.52 Chair of the Global Commission on Drug Policy, Madame Ruth Dreifuss, told the Committee that low-THC cannabis has been an economic success, particularly among older people who use cannabis for pain relief. Legal low-THC cannabis provides this group with safer, non-smoking methods for cannabis use and removes the need to interact with the black market. However, the availability of low-THC cannabis seems to have had little effect on the black market for illicit cannabis.\(^{456}\)

**Australian civil penalties models**

7.53 South Australia and the Northern Territory apply civil rather than criminal penalties for the possession of small amounts of cannabis or a single cannabis plant for personal use. Under these schemes, people apprehended with cannabis can choose to pay a cannabis expiation notice of between $100 and $300 to avoid a criminal conviction and the associated penalty.\(^{457}\)

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\(^{455}\) A Bella, ‘Court confirms legal weed should be taxed as tobacco’, *Swissinfo*, 13 March 2019.

\(^{456}\) Conrad Chahary, Global Commission on Drug Policy, Email, 14 October 2019.

7.54 As noted at paragraph 7.6, a key difference between cannabis and most other illicit drugs is that it can plausibly be grown at home by users. While the claim that cannabis acts as a ‘gateway’ to harder drugs remains unproven, it may act as an avenue to black market interactions. For many people, procuring cannabis will be their first interaction with the illicit drug trade, and may set the stage for future transactions in other drugs. Specific harms associated with buying from the black market include information asymmetry, where the buyer cannot be sure of the quality, safety or value of what they are buying, and potential exposure to other black market goods and activity.

7.55 For a civil penalties regime for cannabis to have utility and effectively reduce harms to cannabis users, it must also contemplate removing criminal penalties for some limited means of self-supply.

7.56 In 2004, WA became the fourth Australian jurisdiction to instate civil penalties for cannabis possession. The Cannabis Control Act 2003 established the Cannabis Infringement Notice (CIN) scheme. Under the CIN scheme, possession of up to 30 grams of cannabis attracted a $100 fine. Crucially, the CIN scheme also removed civil penalties for growing small amounts of cannabis for personal use. Cultivation of up to two plants attracted a $200 fine.

7.57 WA no longer has this civil penalty regime. The CIN scheme was repealed in 2011 and replaced with the CIRS (police diversion program) that Chapter 4 outlines.

7.58 Dr Stephen Bright spoke to the Committee about the operation of the CIN scheme:

The WA Cannabis Control Act 2003 is an example of a local policy designed to rebalance WA’s approach to cannabis. 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.

7.59 The CIN was a form of administrative penalty regime. Unlike the Portuguese model outlined in Chapter 6, or the WA CIRS, the response is a simple fine. Users are not required to appear before a commission or attend an education session. Expiation schemes focus on reducing interaction with, and costs to, the criminal justice system. According to Professor Steve Allsop, directing all minor cannabis users to treatment may not be the best use of our limited resources, and may limit access to treatment for those who voluntarily seek help.

7.60 As established in Chapter 4, between 2010 and 2015 South Australia diverted almost all minor drug possessors and users from the criminal justice system. WA only diverted 32%. In South Australia, it is illegal to keep, use, grow, sell or give away cannabis or related products, but minor offences relating to personal use or possession are dealt with by expiation. Expiation means a fine that does not attract a criminal conviction. South Australia is the only Australian jurisdiction to mandate police drug diversion in legislation, and prior offences do not preclude a person from future diversion.

**FINDING 57**

The South Australian Cannabis Expiation Notice Scheme diverts minor cannabis offenders from the criminal justice system, but does not direct users to education or treatment.

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459 Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, *Transcript of evidence*, 17 June 2019, p 3.

Australian Capital Territory

7.61 The Australian Capital Territory (ACT) adopted a civil penalty regime for minor cannabis possession and use in 1993. Offenders caught with up to two cannabis plants or 25 grams of cannabis receive an offence notice and have 60 days to pay a fine or elect to attend a treatment program.\textsuperscript{461}

7.62 In September 2019, the Legislative Assembly of the ACT passed the \textit{Drugs of Dependence (Personal Cannabis Use) Amendment Act 2019}. The Act amends the \textit{Drugs of Dependence Act 1989 (ACT)} to exempt people over the age of 18 in the ACT from offences relating to possession, use and cultivation of personal amounts of cannabis. The law will come into effect from January 2020.

7.63 Media outlets have described this legislation as ‘legalising cannabis’. However, the ACT Attorney General describes the law as ‘further decriminalising’ cannabis, as cannabis offences still exist in ACT law. In practice, people who use or possess small amounts of cannabis will not have committed an offence. This aims to avoid a situation where Commonwealth \textit{Criminal Code Act 1995} provisions regarding cannabis apply in the ACT as the cannabis law.

7.64 The ACT Attorney General has said that the reforms treat addiction as a health issue and may prevent individuals from unnecessarily coming into contact with the criminal justice system:

\begin{quote}
The ACT government is committed to a justice system that is restorative and rehabilitative. When it comes to people who face our courts primarily as a result of addiction, it is important to focus on the evidence that we have about their behaviour. The evidence is overwhelming that treating addiction as an issue of right and wrong is not only ineffective but also is not in accordance with what we know about the biology and psychology of drug use.\textsuperscript{462}
\end{quote}

7.65 Furthermore, there is no avenue for the sale and supply of cannabis under this model.

7.66 The Committee notes that the distinction between decriminalisation and legalisation is not always well defined, and there is a degree of confusion and differing interpretations in the community. The Committee is of the view that this model is an extended form of decriminalisation, and a middle ground option, as opposed to the full legalisation discussed earlier in this Chapter.

\begin{quote}
\textbf{FINDING 58}

The Australian Capital Territory has adopted a model of cannabis decriminalisation, not legalisation.
\end{quote}

Cannabis regulation for Western Australia

7.67 The Committee considered alternative approaches to regulating cannabis specifically, including legalisation, legal low-THC cannabis and Cannabis Social Clubs.

7.68 In summary, the Committee is of the view that cannabis is most appropriately dealt with by the health-based approach to drug use and possession proposed in \textit{CHAPTER 6}. This approach would see criminal penalties for cannabis possession and use replaced with administrative responses under an expanded police diversion scheme or a new administrative decision making process.

\textsuperscript{461} \textit{Drugs of Dependence Act 1989 (ACT)} s 171A.

\textsuperscript{462} Gordon Ramsey, Attorney General, Australian Capital Territory, Legislative Assembly, \textit{Parliamentary Debates (Hansard)}, 25 September 2019, p 3811.
The Committee considers that the main difference between cannabis and other illicit drugs in this context is the need to provide for a limited mode of self-supply. This may mean extending administrative responses to the cultivation of cannabis for personal use. The Committee notes that WA has done this before under the CIN scheme.

RECOMMENDATION 21

A health-based response to the use and possession of drugs makes provision for the cultivation of cannabis for personal use.
CHAPTER 8
Alternative approach – a zero tolerance stance

Introduction

8.1 The Committee received some evidence to suggest that it should consider models that prioritise harm prevention over harm minimisation. The Australian Family Association submitted that Iceland, Sweden, the United Kingdom and the US are examples of countries that have shifted the focus to preventing people from taking drugs in the first place.

8.2 In deciding which approaches to investigate, the Committee was open to considering any model that purported to produce good results.

8.3 With a consistently low rate of drug use in relation to the rest of Europe, Sweden appeared to be one such model. The United Nations and other commentators have referred to Swedish drug control as a model from which other countries may learn. This Chapter outlines the Committee’s learnings about the Swedish ‘zero tolerance’ approach to drugs.

The Icelandic model

8.4 Several stakeholders expressed support for the Icelandic model as an alternative to the Portuguese model. The key feature of the Icelandic approach is its strong focus on preventing young people from trying drugs. Elements of the policy include:

- extensive funding for young people to participate in extra-curricular activities like sport
- evening curfews for adolescents to promote spending time with family
- encouraging parental involvement at school
- a community-wide commitment to reducing the opportunities for young people to drink and use drugs.

8.5 Icelandic adolescents had the highest rate of substance use in Europe in 1998. By 2015, it was the lowest. Iceland has a population of only 340 000 people, and a key component of their approach to drug use is a mandatory curfew for young people. There is insufficient comparable data on key indicators to support in-depth consideration of this model. The Committee also did not believe that such an approach would be accepted or practical in an Australian context, and therefore chose not to further investigate this model.

The Swedish model

8.6 A few submissions supported the Swedish drug policy. The Family Council of WA contend that harm reduction measures have only accelerated the acceptance of drug use, and advocate for a return to prohibitionist policies, in line with the Swedish model.

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Failure to attain a 100 percent success rate should not be used as an excuse for a slackening of deterrent effort; or even worse, acceptance of that which was previously illegal.  

8.7 The Committee travelled to Sweden in April 2019 to investigate whether lower levels of overall drug use results in lower levels of drug-related harms. Unlike many other European countries, amphetamine use is a problem in Sweden.  

8.8 The Committee was interested in several parts of the Swedish approach, including their system of compulsory substance use disorder treatment and the dedicated drug and alcohol emergency department in Stockholm. Chapters 11 and 12 deal with those topics. This chapter focuses on the overarching approach to illicit drugs in Sweden, anchored in a zero-tolerance approach to drug use.  

Background and context

8.9 Until the 1960s, Sweden treated drug use as an individual medical problem. Sweden even trialled the legal prescription of certain illicit drugs to addicts, although the trial ended after two years following the death of a 17 year old girl who was given drugs by a trial participant.  

8.10 Since the 1970s, Sweden has pursued a relatively restrictive drug policy with the goal of achieving a drug-free society. This approach signalled a move away from the medicalisation of drug use to conceptualising it as a social issue affecting the whole community. The vision of a ‘drug free society’ has enjoyed relatively consistent cross-party support ever since.  

8.11 Drug consumption, distinct from drug possession, became a criminal offence in 1988. While consumption is an offence in many jurisdictions, including WA, it is difficult to prove and police more often charge people with possession. Since 1993, Swedish police have been authorised to issue blood and urine tests to prove that drug use has occurred. Penalties for use and possession include fines and imprisonment.  

8.12 The zero-tolerance approach does not provide for diversion from court. In 1980, the Swedish Prosecutor General issued a directive indicating that police and prosecutors could no longer issue waivers for possessing small amounts of illicit drugs.  

8.13 Cannabis is not treated differently or more leniently than other illicit drugs. Cannabis in Sweden is widely considered a gateway to more dangerous illicit drugs, and using cannabis is socially unacceptable. There is limited political discussion about cannabis liberalisation, despite the ongoing global movement towards alternative ways of regulating cannabis.  

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466 Submission 22 from D Hartley, 26 November 2018, p 1.  
469 Drug Policy Futures, Future of Drug Policy – Real Solutions Grounded in Global Evidence, Mexico, 2015, p 70.  
471 In 2018-19 (year to date until April) only two people discharged from prison had an offence of drug use, compared to 1117 who had an offence of drug possession. Source: Department of Justice, answer to question on notice 19 from hearing held on 18 March 2019, dated 3 April 2019.  
473 Anna Rune, Committee Secretary, Swedish Riksdag, Email, 11 July 2019.
is unclear whether Sweden will revisit this stance in light of the World Health Organization’s recent recommendation to reschedule cannabis.

**Operation and results**

8.14 The Committee heard that all sections of the community broadly share the goal of a drug free society. Cultural attitudes favour abstinence, and people generally do not consider recreational drug use to be socially acceptable:

According to surveys, it is not socially acceptable to use drugs in Sweden. This is an important aspect to prevent people from using drugs, or developing substance use disorders, and is therefore important to maintain.474

8.15 A major focus of the Swedish approach to drugs is prevention, particularly among school-aged children. Prevention activities are carried out in schools, clubs, social and medical services. Many school-based interventions include parents. Some involve social and emotional training, and others focus on providing alternative leisure activities in cooperation with local sport organisations.475 School-based education programs in Sweden are regularly evaluated and have been linked to lower overall drug use.476

8.16 Different audiences receive targeted prevention measures and messages. For example, programs such as EFFEKT, COPE and Komet target parents of children and adolescents. These programs aim to reduce substance use and other negative behaviours in young people by changing parental attitudes and increasing understanding.477

8.17 Staff at clubs and bars receive training so they may deny entry and refuse service to patrons who are under the influence of drugs.478 Because staff at licenced venues are more likely to use illicit drugs themselves than the general population, they have been identified as a key target group. The ‘Clubs against Drugs’ program is a community-based intervention targeting licenced premises in Stockholm. The program includes developing written policies, education, training, drug testing and rehabilitation. A study found that the use of illicit drugs amongst staff decreased following the introduction of Clubs against Drugs in 2001.479

**FINDING 59**

Sweden places a high priority on delivering drug prevention initiatives to a range of target audiences.

8.18 Harm reduction is not a core element of the Swedish drug policy, with the emphasis on preventing people from taking up drugs in the first place. Although Sweden was the first European country to make methadone maintenance treatment available, access to substitution therapy and needle and syringe programs are tightly restricted.

8.19 The number of people convicted of a drug offence has also increased in the last ten years. More than 80% of drug-related offences relate to simple use and possession. The Committee heard that penalties typically include a fine and a criminal record, and it is rare for people to

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478 Anna Rune, Committee Secretary, Swedish Riksdag, Email, 11 July 2019.
go to prison for drug use alone. Unlike Australia, people do not go to prison for failure to pay fines. Sweden also has a relatively low and declining rate of people in prison, even closing a number of prisons in recent years:

The legal consequences are not harsh, but they exist and are for real.

Figure 17. Members of the Select Committee with members of the Swedish Committee for Health and Welfare
Source: Committee site visit, 24 April 2019.

8.20 The Committee evaluated the Swedish approach to drugs by looking at the same indicators as it did for Portugal. Results of the Swedish approach include:

- The proportion of people who have used cannabis at least once in their lives (lifetime use) is relatively low. Reported lifetime use of cannabis is 15%, where the European Union average is 21.7%.
- Lifetime use of illicit drugs was low among 15 and 16-year-old school students in Sweden, and is less than half of other European countries.
- The proportion of people who have used drugs in the past year is average, and higher than in Portugal. Recent use of cannabis, cocaine and ecstasy is increasing over time.
- Overdose deaths have been increasing since the mid-2000s and are three times higher than the European average. In 2017, 626 people died of a drug overdose, a 166%

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480 Anna Rune, Committee Secretary, Swedish Riksdag, Email, 11 July 2019.
484 The European School Survey Project on Alcohol and Other Drugs, ESPAD 2015 report, Luxembourg, 2016, p 41.

Figure 18. \textit{Last-year drug use in Sweden among young adults aged 17-34 years}
Source: European Monitoring Centre for Drugs and Drug Addiction.

**FINDING 60**

Sweden has the second highest rate of drug-induced deaths in the European Union.

8.21 On visiting Sweden, the Committee heard that the long-held vision of a drug-free society may be starting to waver in response to high numbers of drug-related deaths. Niklas Eklund, Chairman of the Swedish Drug Users Association, told the Committee that the drug situation in Sweden is changing.\footnote{Niklas Eklund, Chair, Stockholm Users Association, Email, 26 August 2019.}

8.22 Members of the Parliamentary Committee for Health and Welfare acknowledged to the Committee that drug problems in Sweden are increasing, and they need to look at other ways of approaching the issue.\footnote{Anna Rune, Committee Secretary, Swedish Riksdag, Email, 11 July 2019.} The Swedish Association of Local Authorities and Regions (SKL) recently announced its support for re-visiting Swedish drug laws. Research conducted...
by the SKL found that the majority of political parties on the Committee for Health and Welfare also support a re-evaluation.  

### FINDING 61

Attitudes towards the success of the prohibitionist approach to drug use in Sweden are beginning to change.

8.23 Researchers at the Centre for Social Research on Alcohol and Drugs at Stockholm University told the Committee that the prohibitionist approach has not worked. One of the reasons cited is that the aim of a drug free society is so ‘black and white’. There is no opportunity for measures that could be seen as tolerating drug use:

> We painted ourselves into a corner by aiming for a drug free society – so any harm reduction measure is seen as drug liberalisation.

8.24 A zero-tolerance approach to drug use, by its nature, is inconsistent with harm reduction. Harm reduction fundamentally contradicts the basic philosophy of abstinence by accepting that some level of drug use does, and will continue to happen. Chair of the Stockholm Users Association, Niklas Eklund, sees the value in harm reduction:

> Harm reduction doesn’t mean that you’re positive on drugs. It means you want to save lives because dead people can’t change their minds.

### FINDING 62

A zero-tolerance approach to drug use is incompatible with harm reduction.

8.25 The Committee also heard that prohibition has led to increased stigma in Sweden, and impacts people’s willingness to seek assistance for drug problems. The harms arising from prohibition can serve to further marginalise people who are already struggling.

8.26 The Swedish Government has acknowledged that the increasing overdose deaths are of concern:

> Drug-related mortality has increased in Sweden since 2006, which is worrying, and the Government is working to produce more rapid reporting systems and attempting to identify the reasons for this trend. Common initiatives to prevent people dying due to substance use disorders include increasing access to substitution programmes.

> This trend also has its risks and in Sweden in 2014 more people died from poisoning by substitution drugs (methadone and Subutex) than from heroin. Most of the substances seem to derive from the illegal market and not from the opioid substitution treatment programs.

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489 Staff writers, 'Majority of parties support re-evaluating Sweden’s strict drug policies', The Local, 30 March 2019.

490 Associate Professor Jessica Storbjork, Head of Centre, Centre for Social Research on Alcohol and Drugs, Email, 26 August 2019.


492 Anna Rune, Committee Secretary, Swedish Riksdag, Email, 11 July 2019.

493 ibid.

494 Associate Professor Jessica Storbjork, Head of Centre, Centre for Social Research on Alcohol and Drugs, Email, 26 August 2019.

8.27 As in Australia, many overdose deaths involve prescription opioids and poly-drug use.\textsuperscript{496} The Government has worked to increase access to harm reduction measures like opioid substitution therapy and needle and syringe programmes to respond to the crisis, but Transform Drug Policy Foundation contend that it ‘is still not nearly enough’:

Political bureaucracy and the continued use of drug-free rhetoric remain a barrier to the comprehensive programmes needed, and have meant Sweden has been unwilling to support such programmes on the international stage.\textsuperscript{497}

8.28 Two indicators are commonly used in most parts of the world to measure drug use. The first is ‘lifetime’ drug use. This measures the number of people who have tried drugs at least once in their life. The second is ‘past year’ drug use. This measures people who have used drugs in the past 12 months, which is more likely to identify people who use drugs regularly.

8.29 Proponents of Swedish drug policy point to relatively low rates of lifetime drug use as an indicator of success. However, rates of recent drug use are fairly average, and higher than Portugal. Compared to European Union averages, recent use of cannabis is lower in Sweden but recent use of other illicit drugs is slightly higher (Table 14). This would suggest that while Sweden may be preventing some people from ever trying or experimenting with drugs, the proportion of Swedish people who use drugs on a regular basis is not particularly low.

Table 14. Recent (past 12 months) drug use as proportion of population aged 15/17-34\textsuperscript{498}

<table>
<thead>
<tr>
<th>Country</th>
<th>Cannabis</th>
<th>Cocaine</th>
<th>MDMA</th>
<th>Amphetamines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>9.6%</td>
<td>2.5%</td>
<td>2%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Portugal</td>
<td>8%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0%</td>
</tr>
<tr>
<td>Denmark</td>
<td>15.4%</td>
<td>3.9%</td>
<td>1.5%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Finland</td>
<td>13.5%</td>
<td>1%</td>
<td>2.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>EU average</td>
<td>14.4%</td>
<td>2.1%</td>
<td>1.7%</td>
<td>1%</td>
</tr>
</tbody>
</table>


**FINDING 63**

Recent drug use (past 12 months) in Sweden is below the European Union average for cannabis and slightly higher than the European Union average for other illicit drugs.

8.30 Data from the 2015 European School Survey Project on Alcohol and Other Drugs (ESPAD) shows that ‘lifetime’ cannabis and other illicit drug use among 15 and 16-year-old schoolchildren in Sweden is lower than the European average.\textsuperscript{499} Students complete the ESPAD survey in the classroom on a set day. The survey measures young people’s awareness of and experiences with various licit and illicit substances, as well as internet use, gaming and gambling.\textsuperscript{500}

8.31 The Committee heard that the surveys may not be the most reliable method of data collection. Chair of the Stockholm Users Association, Niklas Ekland, pointed out that children

\textsuperscript{496} Associate Professor Jessica Storbjork, Head of Centre, Centre for Social Research on Alcohol and Drugs, Email, 26 August 2019.


\textsuperscript{498} Portugal, Finland and Denmark data is for ages 15-34. Swedish data is for ages 17-34.


\textsuperscript{500} The European School Survey Project on Alcohol and Other Drugs, ESPAD 2015 report, Luxembourg, 2016.
are unlikely to be completely truthful about their drug use in a survey that they are handing in to their teacher, particularly when there is such strong disapproval of drug use in Sweden.

8.32 The Committee expected that the biggest impact on people who use drugs in Sweden would be from the criminal justice system. Instead, the Committee heard that the social services consequences of drug use, particularly in relation to child protection, affected people the most. The Committee heard that:

   It is not so much criminal penalties that prevent people seeking treatment, but the potential social services impacts – child protection, housing, welfare payments will be at risk.\textsuperscript{501}

**FINDING 64**

People charged with drug use or possession in Sweden may experience consequences for their housing, welfare and interaction with child protection services, which they might regard as being even more punitive than the criminal penalties.

**Applicability**

8.33 Given that drug use, HIV rates, overdose deaths and drug offences in Sweden are increasing over time, the Committee does not recommend the prohibitionist approach for WA. Based on the evidence received throughout this inquiry, the Committee believes that WA has moved past the point of believing a drug free society to be realistic or attainable, regardless of the policy used to pursue this goal.

8.34 Hope Community Services told the Committee that an underpinning principle of any new drug policy is the need to accept that a ‘drug free world’ is unrealistic and unachievable:

   Addressing the issue of drugs in the WA community needs to use a realistic and balanced approach, which accepts that drug use will be present in society but find a way to minimise its use and reduce harm.\textsuperscript{502}

8.35 Restrictive approaches tend to result in higher levels of drug-related harm and offending, but lower levels of overall drug use and an environment where less school-aged children use drugs. Approaches that focus on health, such as in Portugal, may result in a higher proportion of people who have ever used drugs, but lower levels of drug-related harms.

8.36 The Committee believes that WA could learn from the Swedish commitment to prevention. Prevention activities are adequately funded, subject to continuous evaluation and improvement and treated as a serious component of the overall approach to drug use. The Committee is of the view that pragmatic prevention messages can easily co-exist with harm reduction measures. Prevention and harm reduction should be connected and complementary components of a balanced drug policy.

**RECOMMENDATION 22**

The Western Australian Government fund and continuously evaluate prevention and education activities in line with the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

\textsuperscript{501} Associate Professor Jessica Storbjork, Head of Centre, Centre for Social Research on Alcohol and Drugs, Email, 26 August 2019.

\textsuperscript{502} Submission 25 from Hope Community Services, 26 November 2018, p 2.
CHAPTER 9
Alternative approach – the ‘four pillars’ policy

The Swiss model

9.1 As in Australia, Switzerland prohibits the use and possession of illicit drugs. However, the approach to illicit drug use and users is fundamentally different. The Swiss model, often cited as a global model of best practice, actively focusses on public health and harm reduction over enforcing prohibition. This requires a holistic approach and genuine cooperation across health and law enforcement agencies.

9.2 Switzerland famously pioneered many harm reduction measures, including drug checking (pill testing), drug consumption rooms and Heroin Assisted Treatment (HAT). This chapter will consider the legal and policy framework that allows public health to take centre stage. Chapter 10 will examine specific harm reduction measures of interest from Australia and other parts of the world.

9.3 The Committee was interested in Switzerland because it is a confederation made up of 26 separate federated states, known as cantons. As in Australia, each canton has its own constitution, parliament, government and judiciary. Switzerland is also traditionally quite conservative, and sweeping reforms are difficult to implement under its system of semi-direct democracy.503

Background and context

9.4 Until the 1980s, policing was the foundation of Swiss drug control. Switzerland first criminalised drug possession in 1969 in response to increasing and widespread drug use. In 1975, the Swiss Government softened drug laws to provide that people found guilty of drug use or possession would receive a fine, but not a criminal record. Treatment options at this time were exclusively based on abstinence.504

9.5 The heroin epidemic hit Switzerland hard in the 1980s. Drug overdose deaths, HIV, opioid disorders and drug-related offences soared. Open drug scenes exploded in major cities. By the early 1990s, 700 people were dying from drug related causes each year. 505 This crisis, and the settlement of heroin users in Zurich’s ‘needle park’, signalled the need for change.

9.6 Rather than focussing on stricter law enforcement, the Swiss began rethinking drug policy and practice more broadly.506 Local organisations started delivering harm reduction measures, such as opening the world’s first safe injection site in 1982. Health professionals began to recognise that total abstinence was not realistic for many patients and started adopting more pragmatic treatment approaches.507

503 Semi-direct democracy includes elements of direct democracy and representative democracy. The Swiss mechanisms for direct democracy include people’s initiative (changes to the constitution can be forced if 100,000 signatures are gathered within 18 months) and the optional referendum (a popular vote can be for ced on any law passed by Parliament if 50,000 signatures are gathered within 100 days).


Gradual and incremental reform

9.7 The Swiss system of semi-direct democracy tempers attempts at major reform. Under the Swiss constitution, citizens have the right to call a federal referendum to challenge any law passed by parliament. Citizens can also put a constitutional amendment to a national vote if 100 000 voters sign the proposed amendment within 18 months. Drug policy changes needed to be gradual to succeed in a system that favours careful, incremental change.

9.8 In 1994, the National Drug Strategy was revised to include a fourth pillar of harm reduction in addition to policing, treatment and prevention. This change acknowledged that prevention and education efforts do not stop everyone from using drugs. The new Strategy cleared the way for governments across the country to fund, initiate and expand on measures like low-threshold methadone, needle exchange programs and drug consumption rooms.

9.9 Throughout the 1990s, the Swiss pursued the goal of reducing drug-related harms. They focussed on innovation and building an evidence base for public health and harm reduction approaches. Needle and syringe exchange programs were introduced in Swiss prisons. Drug checking services began operating at parties, festivals and fixed sites in Zurich and Bern. Today, the Swiss experience is central to the body of literature evaluating the effectiveness of pill testing.508

9.10 In the 2000s, the federal government passed amendments to provide a legal basis for drug consumption rooms and HAT trials. HAT is a program pioneered in Switzerland that prescribes heroin to the small group of people with long-term heroin dependency who do not respond to low-threshold opioid substitution. The objectives of HAT are to stabilise users and reduce the risks of street use, which include overdose and the contraction of blood-borne viruses. The trials were widespread, rigorously evaluated, constantly improved on and shown to be feasible and cost-effective. Programs such as these attracted significant international criticism at the time.509

9.11 Health professionals and experts drove the reforms, as they believed that public health programs could control drug harms more effectively than policing. The reforms were characterised by a willingness to innovate and experiment at the edge of the law, evaluate rigorously and let science inform policy.510

9.12 By 2008, the evidence in favour of health-based approaches to drug use had convinced the Swiss public. After 15 years of incremental change, 68% of Swiss voted to provide a legislative basis for the four-pillars policy.511

Switzerland’s case demonstrates that in certain socio-political settings it is possible for an integrated drug policy centred on health to overcome the ideological imperatives previously motivating governing authorities to adopt a law enforcement-oriented approach.512


511 ibid., p 30.

FINDING 65
Ongoing trials of harm reduction measures in Switzerland built a body of evidence about their effectiveness.

Results
9.13 Today, the Swiss approach to dealing with problem opioid use is considered to be global best practice. Switzerland observes low levels of drug-related harms, including drug-related criminal activity and average levels of overall drug use by European standards. Key results include:

- during reform years (1990-2004), significant declines in drug-related deaths, HIV, new heroin users and property crime committed by drug users
- no deaths related to ecstasy or other stimulants since 2000
- average overall drug use by European standards
- relatively high cocaine use driven by party scenes in the big cities.

Figure 19. Deaths due to drug use in Switzerland from 1974 to 2004

Operation
9.14 The Committee visited the cantons of Geneva and Vaud while in Switzerland in April 2019. Drug laws are set at the federal level, but policies and policing strategies vary widely from canton to canton. The Committee was surprised to learn how practices could differ between Geneva and Lausanne, given that the two cities are only 45 minutes apart by train.

9.15 Key to the Swiss approach to drug policy is that police are not sidelined, but are seen as genuine partners. The reforms were not about eliminating policing, but shifting the focus of policing from repression and punishment towards ensuring public order. Police activity did

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516 Diego Esteban, Vice President, Judiciary Committee, Grand Council of Geneva, Email, 27 August 2019.
not decline, and the majority of drug policy funding continues to go towards law enforcement.\textsuperscript{517}

Figure 20. The Select Committee with representatives of Groupement Romand d'Etudes des Addictions, the City of Lausanne and Federal Public Health
Source: Committee site visit 26 April 2019.

9.16 In both Geneva and Lausanne, the Committee heard that cantonal police do not target individual users, but focus on dealers. A level of tolerance to individual users exists to provide amnesty to people attending drug consumption rooms:

Local police know that there is little to be gained from going after the little guys, so they are actively targeting the big fish.\textsuperscript{518}

9.17 Penalties for drug use and possession are restricted to fines. Although fines are a civil penalty, a criminal penalty such as prison time will apply when someone continues to refuse to pay a fine.\textsuperscript{519} The Committee considers that apart from the ability to elect to go to jail for fine default, this is otherwise a system of administrative penalties for drug use and possession.

9.18 The Committee heard that local police, health, social workers and harm reduction agencies in Switzerland work together closely, and this has been key to success.\textsuperscript{520} In Geneva, the Judiciary and Police Committee said that there is no police culture of being ‘tough on

\begin{footnotes}
\item[518] Diego Esteban, Vice President, Judiciary Committee, Grand Council of Geneva, Email, 27 August 2019.
\item[519] Conrad Chahary, Operations Officer, Global Commission on Drug Policy, Email, 14 October 2019.
\item[520] ibid.
\end{footnotes}
Police in Lausanne noted that it has been a cultural challenge to build these partnerships, and the police and health agencies do not always agree with each other.522

9.19 Madame Ruth Dreifuss, Chair of the Global Commission on Drug Policy and former President of Switzerland, played a key role in driving the drug reforms of the 1990s. In conversation with the Committee, Madame Dreifuss said that the first priority in Switzerland was to save lives and make sure no one is marginalised, while ensuring public safety. When asked about how the Swiss experience could apply to a meth problem, Madame Dreifuss said the most important thing is simply to connect with the people who have drug problems:

The biggest success of the Swiss policy was to rebuild contact with people in need who are marginalised.523

9.20 The Committee visited a hospital-based HAT Clinic in Lausanne. Clinicians told the Committee that patients must have tried and failed with low-threshold opioid substitution at least twice before admission to the program. Patients can attend for a maximum of 20 minutes, up to twice a day, seven days a week and take their prescribed drugs onsite. Approximately half inject and half take the heroin in tablet form. The Committee heard that a program like this would not be a suitable response to stimulant drugs, because long-term use of stimulants damages the brain.524

Application

9.21 As in Portugal, the Swiss drug reforms developed in response to a heroin crisis. Stakeholders in Switzerland acknowledge that a major reason for their success was the ability to respond

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521 Diego Esteban, Vice President, Judiciary Committee, Grand Council of Geneva, Email, 27 August 2019.
522 Jennifer Hasselgard-Rowe, Executive Coordinator, Groupement Romand d’Etudes des Addictions, Email, 31 October 2019.
523 Conrad Chahary, Operations Officer, Global Commission on Drug Policy, Email, 14 October 2019.
524 Jennifer Hasselgard-Rowe, Executive Coordinator, Groupement Romand d’Etudes des Addictions, Email, 31 October 2019.
medically to heroin addiction. The Committee notes that the use of heroin in Australia has also declined significantly because of the global heroin shortage of 2001.525

9.22 In Switzerland, as in Portugal, there is an acceptance that for some people, abstinence will never be a reality. The goal for that group of people becomes stabilising their use to a point where they can safely go about their life. The Committee is not clear that the goal of medical stabilisation could be suitable for people addicted to meth. As discussed at paragraphs 5.13-5.22, although clinical trials are underway to find an effective pharmacotherapy, there is currently no proven substitution therapy for meth. Use can escalate very quickly without the user realising it has become a problem.

9.23 However, the Committee is of the view that a number of lessons from the Swiss experience transcend the principal drug of concern.

• Drugs do not have to be legalised or even decriminalised in order to focus on health and harm reduction.
• Changes to drug laws and policies can be made incrementally.
• Evidence can build over time and inform policy.

9.24 The Committee considers that the Swiss model provides a framework for dealing with overarching, systemic discrimination towards people who use drugs:

Many reports identify the need to address stigma and discrimination. I think it is a shift away from the individual and more of a systems approach to addressing stigma and discrimination. I have seen research that says that the focus on the individual in regards to alcohol and other drugs only leads to further attitudes of stigma and discrimination.526

9.25 Harm reduction is already one of the three pillars of the Australian National Drug Strategy, although it is estimated that across Australia, only two percent of total drug spending goes toward harm reduction. The Committee notes that in WA, both the Department of Health and the Mental Health Commission fund and deliver harm reduction. Figure 22. Current and forecast alcohol and other drug harm reduction and personal support illustrates that current Mental Health Commission harm reduction services are equal to only a tiny proportion of the forecast demand for 2025. As mentioned at paragraph 5.43, there is currently no harm reduction strategy for WA.

526 Jill Rundle, Chief Executive Officer, Western Australian Network of Alcohol and other Drug Agencies, Transcript of evidence, 14 April 2019, p 4.
Figure 22. Current and forecast alcohol and other drug harm reduction and personal support
Source: Mental Health Commission.

**RECOMMENDATION 23**

The Mental Health Commission increase funding for drug harm reduction in line with forecast demand.

**FINDING 66**

There is no harm reduction strategy that has been developed specific to Western Australia.

**RECOMMENDATION 24**

The Department of Health and the Mental Health Commission develop a Harm Reduction Strategy for Western Australia.
CHAPTER 10
Alternative harm reduction initiatives

Introduction
10.1 Harm reduction refers to public health policies and practices that aim to reduce the harms associated with drug use for those people who are unable or unwilling to stop. The focus is on reducing drug-related harm rather than reducing drug use. As outlined in CHAPTER 5, harm reduction initiatives offered in WA include NSPs, naloxone, opioid substitution therapy and peer support.

10.2 This Chapter will examine alternative harm reduction measures from other jurisdictions, including:
- drug checking services (also known as pill testing)
- drug consumption rooms
- Heroin Assisted Treatment
- NSPs in prisons.

Drug checking services
10.3 This section will cover the Committee’s inquiry into ecstasy use and harms in WA, the current approaches to dealing with drugs at WA music festivals, evidence on drug checking services, the drug checking trial in the ACT and what a suitable drug checking model for WA might involve.

Ecstasy use and harms in WA
10.4 Young people have long been associated with distinct drug taking behaviours. Outdoor dance music festivals in particular are popular arenas for alcohol and other drug use. At least eight young Australians have died from drug-related reasons at music festivals between 2017 and 2019, including five people in New South Wales last summer.

10.5 The recent deaths in the eastern states have led to escalating calls for Australian governments to consider operating pill testing, or drug checking services. The Committee has chosen to use the term ‘drug checking’ instead of ‘pill testing’, as it has heard that people often ingest ecstasy in crystal rather than pill form.

10.6 Western Australians are more likely than the average Australian to have used ecstasy in the past year. Users are typically people in their 20s who only take ecstasy once or twice a year. Of those users, only 1.7% say that they would struggle to stop or cut down their use.

10.7 Ecstasy is the street name for MDMA. According to the Australian Drug Harms Ranking Study, MDMA poses a low level of harm to users and society relative to alcohol, meth, heroin

528 Submission 41 from National Drug Research Centre, 30 November 2018, p 6.
530 Professor Simon Lenton, Director, National Drug Research Institute, Transcript of evidence, 10 June 2019, p 13.
532 ibid., p 60.
and fentanyl. The use of MDMA in clinical settings does not cause adverse effects, and may even have therapeutic value in appropriate doses. Countries including the US and Canada are conducting clinical trials of MDMA-assisted psychotherapy for the treatment of post-traumatic stress disorder.

**FINDING 67**

Pure MDMA has been proven safe when used in controlled clinical trials.

10.8 The issue is that ecstasy pills on the illicit drug market often contain more than just MDMA. The Committee heard that Australian ecstasy is dangerous because it often contains other substances such as methamphetamine and novel psychoactive substances. Australians are often unsure about the content and strength of their ecstasy, and contamination and adulteration can cause poisoning and overdose, sometimes fatally. Another concern is that people are increasingly consuming higher strength and purity ecstasy in crystal or capsule form, rather than pills.

10.9 The WA Police Force agree that Australian ecstasy is dangerous and unpredictable, and could even contain addictive drugs like fentanyl:

In both WA and other jurisdictions...the chemical analysis of a single tablet can contain a mix of drugs and other material within each individual pill in a single batch.

10.10 Emergency physician Dr Jessamine Soderstrom told the Committee that most people presenting to the emergency department of Royal Perth Hospital with ecstasy in their system had actually ingested a mixture of drugs, although she did not know whether this was intentional:

What we are finding is that people do not just have MDMA in their blood; they have MDMA, they have amphetamines, they have other things in their blood that is just not MDMA. The number of people who actually just have pure MDMA is relatively small.

10.11 WA has not lost any young people so far during the recent spate of deaths in 2018 and 2019, mostly likely due to a smaller population and electronic dance music scene than some of the eastern states. Notwithstanding this, the Committee acknowledged that young Western Australians have tragically lost their lives in the past. However, the Committee heard that recently, clusters of emergency department presentations at Royal Perth Hospital were relatively common during music festivals.

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536 Submission 74 from Students for Sensible Drug Policy, 30 January 2019, p 10.
537 Submission 57 from Palmerston Association, 9 January 2019, p 4.
541 ibid., p 8.
Results of the WA illicit substance evaluation (WISE) project reveal that between 2016 and 2018, 46 out of 347 presentations at Royal Perth emergency had detectable ecstasy in their blood samples. Common symptoms include agitation, psychosis, restlessness and seizures. Hyponatremia (low sodium in the blood) can result from the unusual side effect of water retention, which can result in brain swelling and seizures. The consequences of hyponatremia on the brain can be severe, including permanent disability, irreversible brain damage and death.

The Committee heard that information on ecstasy-related harms in WA was difficult to obtain. Research projects such as WISE at Royal Perth Hospital are useful in identifying new psychoactive substances. This data could be used to develop an early warning system to alert people who use ecstasy about new or dangerous contaminants.

FINDING 68

Australian illicit drug market ecstasy is often dangerous due to contamination and strength, which can result in harms including seizures, hyponatremia, poisoning and death.

The current approach to drug use at music festivals in WA – sniffer dogs

Trained drug detection dogs (sniffer dogs) are used to combat drug taking and selling at music festivals. This policing strategy emerged in New South Wales in the early 2000s and has since expanded across the country.

The WA Police Force use sniffer dogs in a range of settings, including crowded venues and events, for the purposes of prevention and gathering intelligence. The Assistant Commissioner for State Crime told the Committee that the most important role for sniffer dogs in this context was in identifying people who intend to deal drugs at the event.

In 2006, the New South Wales Ombudsman questioned the effectiveness of deploying sniffer dogs at music festivals:

Despite the best efforts of police officers, the use of drug detection dogs has proven to be an ineffective tool for detecting drug dealers.

Overwhelmingly, the use of drug detection dogs has led to public searches of individuals in which no drugs were found, or to the detection of (mostly young) adults in possession of very small amounts of cannabis for personal use.

Evidence suggests that sniffer dogs are unreliable in detecting drugs. For example, South Australia Police figures for 2016-17 showed that drugs were found on fewer than 15% of people searched after sniffer dogs or electronic tests indicated that they were carrying drugs. In most cases, the dogs detected people who did not have drugs on them, but admitted to having come into contact with drugs previously.

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545 Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Answer to question on notice 3 asked at hearing held 17 June 2019, dated 10 July 2019, p 5.
548 R Puddy, ‘Drugs found in fewer than 15 per cent of sniffer dog searches in South Australia’, *ABC News*, 5 July 2018.
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.\(^5\)

**FINDING 69**

Drug detection dogs are an unreliable means of detecting drugs at music festivals.

10.18 The Committee received evidence to suggest that sniffer dogs do little to deter people from taking drugs at music festivals. NDRI researchers surveyed Australian festival-goers online in 2018. The study found that of those who expected sniffer dogs to be present at their last festival, only four percent decided not to take drugs based on this threat. Others concealed their drugs to gain entry (48%), had someone else take their drugs in (15%), bought drugs inside the festival (11%) or took their drugs before entering (7%):

We also know that the most risky drug use purchases happen in festivals where people are rushed for time, they do not know the person that they are buying from, and so on. If people ditch their drugs or do not take drugs in and try to buy them at the festival, the evidence is that that is likely to be most harmful.\(^6\)

10.19 In conclusion, the study found that almost no respondents were deterred by the presence of sniffer dogs, but instead used a range of potentially dangerous strategies to avoid detection. As a result, NDRI submit that governments should urgently reconsider the use of drug detection dogs at Australian music festivals:

**Hon MICHAEL MISCHIN:** Is not the point of sniffer dogs not so much to effect an 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.\(^7\)

10.20 The Committee asked the WA Police Force about their use of sniffer dogs, which are deployed at events on a case-by-case basis:

Canine assets are primarily utilised to deter and detect drug dealers from selling illicit drugs in or in close proximity to these venues however the WA Police Force is cognisant that this may impact users as identified in the research conducted by the National Drug Research Institute (NDRI) at Curtin University, and published in the International Journal of Drug Policy.

This study from 2018 appears to be the first in Australia to investigate actual behavioural responses to the expected presence, and sighting, of drug detection dogs in the context of outdoor music festivals. It should be noted that although this research is informative there are a number of limitations as acknowledged by the authors.

Further research in this area is required to provide a clearer picture on whether there is validity in the suggestion that sniffer dogs creates an increased risk in encouraging people to take all their drugs at once.\(^8\)

10.21 The WA Police Force point out that limitations of the NDRI study include:\(^9\)

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\(^5\) Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Transcript of evidence, 17 June 2019, p 12.

\(^6\) Professor Simon Lenton, Director, National Drug Research Institute, Transcript of evidence, 10 June 2019, p 13.

\(^7\) Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Transcript of evidence, 17 June 2019, p 13.

\(^8\) Western Australia Police Force, Answer to question on notice A6 asked at hearing held 15 April 2019, dated 2 May 2019, p 3.

\(^9\) Ibid.
- Due to the sampling methodology, the results are not representative of the wider population of festival-goers.
- Some survey respondents may have been out of the detection range of the sniffer dogs.
- Respondents may have been drawing on different past experiences with this policing strategy, which may have impacted their deterrence.
- The deterrence question was only asked of respondents who were expecting sniffer dogs to be present at the last festival they attended.

### FINDING 70
Research suggests that sniffer dogs deter very few people from taking drugs at music festivals.

10.22 Sniffer dogs in WA cost $40 000 to train and maintain. It has been estimated that each sniffer dog deployed at a festival costs $2000 an hour. The Committee notes that such funding could be used in other ways in a festival setting, including increasing the number of paramedics and health professionals onsite.

### RECOMMENDATION 25
TheWestern Australian Government commission an independent evaluation into the efficacy and cost-effectiveness of using drug detection dogs at music festivals in Western Australia.

10.23 In addition to concerns about the strategy’s effectiveness, there are concerns that the presence of sniffer dogs increase risks to festival attendees by prompting them to ingest all their drugs at once. The NDRI study found that 10% of people consumed their drugs on the spot in response to seeing sniffer dogs.

10.24 In 2009, 17-year-old Gemma Thoms died at Perth’s Big Day Out festival after taking three ecstasy pills. She told police that she had taken all three pills at once at the festival entrance because she was scared of being caught by the sniffer dogs:

It’s an absolute tragedy. She could have dropped them on the ground and even if she had been caught, the most she could have expected was a juvenile caution.

10.25 The President of the WA Branch of Students for Sensible Drug Policy, Joe Panaia, told the Committee that people still react this way to sniffer dogs, although thankfully there has not been another fatal incident:

**The CHAIR:** Of course, it has been well reported that the concern with sniffer dogs is that what happens is that people panic and take all of their drugs at once. What would be your experience? What would be your advice as to how people respond to sniffer dogs?

**Mr PANAIA:** I have seen that type of behaviour before, waiting to get into a festival.

**The CHAIR:** You have seen it yourself?

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Mr PANAIA: Yes. People were panicking because the cops were starting to do their rounds of walking up and down the entry lines and that sort of thing. I do not really know what the best way to combat that would be, apart from having a reduced police presence at these types of events, as opposed to them going in to catch people with small amounts of drugs.

If the punters knew that the cops were there for their protection, as opposed to trying to catch them out, I think that would kind of reduce that type of behaviour a lot. 559

**FINDING 71**

The presence of sniffer dogs at music festivals may prompt patrons to engage in risky drug taking behaviour.

**The current approach to drug use at music festivals in WA – amnesty bins**

10.26 This incident led to the trialling of ‘amnesty bins’, which are typically deployed at events with a sniffer dog presence. Amnesty bins are secure bins placed outside a festival entrance. Festival-goers can dispose of their drugs outside a festival without fear of prosecution, which they may choose to do if they see sniffer dogs.

10.27 A UK study found that amnesty bins serve multiple purposes, including decreasing the amount of drugs entering the venue, advertising that drugs are not tolerated at the event and providing a secure place for police and event staff to store any drugs they find before they can be moved off site. 560 Amnesty bins were first trialled in WA at the Rock It festival in Perth in 2009, but were only used by a few people. 561

**WA Police Force outcomes from the 2018 Origin Fields festival**

10.28 Both sniffer dogs and amnesty bins were used at the two-day Origin Fields festival in Perth in December 2018. To mitigate risks at this particular festival, the WA Police Force engaged with the community and used social media to warn attendees about the availability of amnesty bins:

> Drug bins were placed prior to the entrance of the event supported by a Variable Message Board (VMB) electronic sign warning people to dispose of drugs in the drug disposal bins provided. General purpose police dogs and narcotic detection dogs were also used as a visual deterrent just prior to the venue entrance. 562

10.29 The WA Police Force reported recovering 12 capsules/pills during the course of the operation.

**Table 15. Substances recovered in amnesty bins at Origin Fields festival 2018**

<table>
<thead>
<tr>
<th>Date</th>
<th>Bin</th>
<th>Substances recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 December 2018</td>
<td>Bin one</td>
<td>Two capsules testing positive for MDMA.</td>
</tr>
</tbody>
</table>


562 Western Australia Police Force, Answer to question on notice A6 asked at hearing held 15 April 2019, dated 2 May 2019, p 3.
<table>
<thead>
<tr>
<th>Date</th>
<th>Bin</th>
<th>Substances recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 December 2018</td>
<td>Bin one</td>
<td>Six capsules in two separate clip seal bags, all tested positive for MDMA.</td>
</tr>
<tr>
<td></td>
<td>Bin two</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: WA Police Force

10.30 Separate to this, five young men aged between 17 and 25 were charged at Origin Fields with a range of drug-related offences. Three of these men were charged with intent to sell or supply and two were charged with simple possession.⁵⁶³

Conclusions

10.31 The WA Police Force intend to continue using sniffer dogs at music festivals, primarily as a mechanism for identifying potential drug dealers.⁵⁶⁴ Noting that, the WA Police Force does not have any specific protocols concerning the deployment of sniffer dogs at music festivals or other large public events to deal with the associated risks.

10.32 The Committee heard that the WA Police Force are primarily using sniffer dogs to detect potential dealers, and do not target individual users at these events.⁵⁶⁵ However, police charged two people with simple possession (paragraph 10.30). The Committee notes that the objectives of the strategy are not clearly defined, and potentially more could be done to communicate objectives to festival-goers, so that they do not put themselves at risk trying to evade detection by the police.

**RECOMMENDATION 26**

If the Western Australia Police Force continue to use drug detection dogs, that they develop policies and procedures around their use at festivals to reduce the risk to festival patrons.

**RECOMMENDATION 27**

The Western Australia Police Force develop, publish and communicate clearly defined objectives for the use of drug detection dogs at music festivals.

**Pilot of Drug Aware Medix Campaign**

10.33 The Committee is aware that between 2017 and 2019 the Mental Health Commission received funding to support a pilot of the Drug Aware ‘Medix’ campaign and associated research. The campaign sought to reduce drug-related harm by providing harm reduction information at festivals and events to people who were considering or chose to use drugs, or was with someone using illicit drugs.⁵⁶⁶

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⁵⁶³ Western Australia Police Force, Answer to question on notice A4 asked at hearing held 15 April 2019, dated 2 May 2019, p 2.


⁵⁶⁵ Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, *Transcript of evidence*, 17 June 2019, p 13.

What are drug checking services?

10.34 Drug checking is a public health measure that aims to reduce drug-related morbidity and mortality. People submit their drugs for forensic analysis and receive timely feedback on the content and likely effects of their substance. Drug checking aims to:

- Provide information to people who plan to use drugs, so that they may make a more informed choice about their substance and quantity.\(^{567}\)
- Use information from the testing to inform the public, paramedics and police officers of particularly dangerous drug samples detected. Results may be displayed on information billboards at the event, or posted on the event webpage.
- Provide education and counselling to a group of people who would otherwise be unlikely to discuss their drug use with medical professionals.

10.35 Although the origins of drug checking date back to the 1960s, contemporary drug checking services emerged in response to the European rave scene in the early 1990s. Today, drug checking is embedded in the national drug policy of the Netherlands. A ‘third wave’ of drug checking services has emerged in the past decade in response to drug-related deaths and overdoses in the United Kingdom, New Zealand and Australia.

10.36 Researchers from NDARC reviewed drug checking services operating across the world in 2017. The review covered 31 different checking services operating in 20 countries across Europe, the Americas and Australasia, some of which have been operating for 25 years. Most services operated on-site at events, others at fixed locations and three were postal services. Typically, only a scraping of the pill is required to identify the substance. Most services only take the required scraping and do not take possession of the whole drug, as legal and ethical issues can arise when handing the drug back, particularly if it is found to be dangerous. The median time users wait to receive their results ranges from 15 to 29 minutes.\(^{568}\)

10.37 All but one service delivers a brief one-on-one intervention between a volunteer/staff member and the user. Most provide harm reduction information and material, and nine provide safe disposal bins. Most services receive some form of government funding, although some reported receiving no funding at all.\(^{569}\)

The arguments for and against

10.38 In the wake of recent drug-related deaths, drug checking has received significant media attention across the country. The Committee heard significant support for drug checking in WA from a range of private citizens, advocacy and public health groups, academics and drug service providers.

PHAA [Public Health Association of Australia], in line with other key Australian health bodies including the Australian Medical Association and the Royal Australian and New Zealand College of Psychiatrists, publicly supports alternative approaches to harm reduction such as pill testing, and advocates for this approach to harm minimisation to be seriously considered as part of this review.\(^{570}\)

Harm reduction strategies, such as pill testing, are evidence-based and have been shown to avoid drug related fatalities and incidents. We encourage the Select


\(^{568}\) ibid., p 5.

\(^{569}\) ibid., p 7.

\(^{570}\) Submission 65 from Public Health Association of Australia, 18 January 2019, p 8.
Chapter 10 Alternative harm reduction initiatives

Committee to support opportunities for pill testing to be introduced at future large scale events, such as music festivals, in WA.\textsuperscript{571}

Based on the evidence, the case for a trial of drug checking in the Australian context has been strong.\textsuperscript{572}

Allow drug testing at festivals to save lives. There’s no need to be so draconian.\textsuperscript{573}

10.39 Students for Sensible Drug Policy told the Committee that introducing drug checking is their number one priority for drug policy reform.\textsuperscript{574}

10.40 Some drug checking services in Europe have been operating for more than 20 years, and the experiences of these services have been used to guide best practice.\textsuperscript{575}

10.41 However, the evidence base is still developing. Conducting controlled research in nightlife or festival settings is difficult, which has limited empirical studies.\textsuperscript{576} Most of the available evidence relates to attitudinal changes, legal issues and analysis techniques, and there is limited evidence about the effect of drug checking on drug taking behaviours and health outcomes. Noting these limitations, evidence from Europe suggests that drug checking services have not increased ecstasy use or uptake.\textsuperscript{577}

10.42 According to Professor Alison Ritter of NDARC, based on evidence from Europe there are six main reasons to trial drug checking in Australia:

- Strong public support for such measures, including among young people. Over two thirds of Australians aged 16-25 support the introduction of drug checking.\textsuperscript{578}
- The impact on the black market. Evidence from the Netherlands suggests that the safety of the illicit drug market can be improved in areas with drug checking services.\textsuperscript{579}
- Impact on consumption choices in a less harmful direction. Evidence on how drug checking influences behaviour is mixed, but studies from the United Kingdom and Austria suggest that most users who are told that their substance contained something dangerous or unexpected will choose to discard it.\textsuperscript{580}
- Potential use in early warning systems. Drug checking can identify particularly dangerous or new psychoactive substances, and this information can be used to alert the public.\textsuperscript{581}

\textsuperscript{571} Submission 47 from Australian Health Promotion Association, 3 December 2018, p 4.
\textsuperscript{572} Submission 41 from National Drug Research Institute, 30 November 2018, p 6.
\textsuperscript{573} Submission 72 from Killian Harty, 19 January 2019, p 1.
\textsuperscript{574} Joe Panaia, President, Students for Sensible Drug Policy, Transcript of evidence, 5 August 2019, p 2.
\textsuperscript{575} Public Health Ontario, Evidence brief: drug checking as a harm reduction intervention, Dr Pamela Leece, Ontario, 2017, p 1.
\textsuperscript{576} Nightlife Empowerment and Wellbeing Implementation Project, Drug checking service good practice standards, report prepared by M Ventura et al, p 3.
\textsuperscript{578} Australian Council on Drugs, Young people’s opinions on alcohol and other drugs issues, report prepared by K. Lancaster et al, Drug Policy Modelling Program, NDARC, Sydney, August 2013, p 66.
• Opportunity to provide education, information and support to people who may be at risk of harm. Drug checking in Zurich was found to reach a group of people who engage in poly-drug use relatively frequently.582

• Data opportunities for improved understanding of the drug market. Evidence from the Netherlands suggests that drug checking services helped to identify the rise in mephedrone583 in 2009.584

**FINDING 72**
Drug checking services have been operating in Europe for over 20 years, and evidence suggests that drug checking services do not increase ecstasy use or uptake.

10.43 The Committee also heard arguments against drug checking. While the WA Police Force unequivocally supports health professionals to provide advice to young people at music festivals, Police Commissioner Chris Dawson told the Committee that he did not support a trial of drug checking in WA:

> Whether you test a single tablet, you could not know with any certainty whether the other 10 tablets in a person’s possession would have the exact same chemical composition. You would have to test every single tablet to have any certainty as to the composition of each individual tablet.585

10.44 The WA Police Force do not think that drug checking can be safe, as results cannot be tailored to individual consumers:

> Surely, you cannot denote that it is a safe tablet to take, because who knows what undiagnosed medical condition a young person may have?

> Different aspects of the tablet taken by one person could have completely different outcomes for another person. So, it is a very dangerous aspect of pill testing that needs to be considered as well: what underlying health issues might a person have.586

10.45 The major arguments against drug checking are that it may legitimise drug use, send contradictory messages about safety and lull users into a false sense of security.587 This is a genuine concern, as testing for toxicological compounds cannot guarantee that a drug is safe.588 A further concern is that dealers may use the service as an opportunity to test their product before distributing it. Service providers therefore need to ensure that they are not complicit in drug dealing.589

10.46 While some argue that people should simply not take drugs at these events, Professor Simon Lenton thinks that this ignores the reality of the situation.

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583 Mephedrone is a synthetic stimulant drug of the amphetamine and cathinone classes, also known as bath salts.


585 Chris Dawson, Commissioner, Western Australia Police Force, Transcript of evidence, 15 April 2019, p 10.

586 ibid.


588 European Monitoring Centre for Drugs and Drug Addiction, Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges, report prepared by Dr Tibor Brunt, 2017, p 11.

60 to 65 percent of people who have attended a festival said that they used illicit substances at the last festival they attended. That is a reality that we need to engage with.

We might think that that is not a great thing, we might think we would rather people did not use substances, but even with illegality, sniffer dogs, all that stuff, we have 65 percent of people saying that they used an illicit drug at their last festival.590

**Trials in the Australian Capital Territory**

10.47 On 29 April 2018, the first Australian pilot of a drug checking service took place at Groovin the Moo music festival in Canberra. The Safety Testing Authority (STA-SAFE), a consortium of harm reduction advocates and non-government organisations led by Harm Reduction Australia, developed and delivered the service. The ACT Government did not provide funding for the pilot, but offered a ‘supportive policy environment’ and support from ACT Health and ACT Policing.591

10.48 The on-site service employed a harm minimisation approach. It sought to advise patrons about the contents of submitted substances, deliver harm minimisation information and provide data on the drugs in circulation to health and law enforcement agencies.592 Volunteer medical and harm reduction staff delivered the service.

10.49 In the first trial year, 125 festival attendees accessed the service. This was just less than one percent of festival attendees, which is similar to international take up rate. Out of the 85 samples submitted for testing, two substances responsible for overdose and serious injury were identified and health authorities were swiftly advised. Ninety three percent of patrons had used drugs before this occasion, and 30% indicated that they would stop or reduce their use after their engagement with the service.593 Two patrons were hospitalised for intoxication, but neither had undertaken pill testing.594

10.50 The pilot was approved to operate at the Groovin the Moo Canberra again in 2019. In its second year, 234 patrons used the service. Health and safety warnings were provided to all patrons accessing the service and 171 samples were tested. MDMA was the predominant substance identified and seven samples contained the dangerous substance n-ethylpentylone.595 All patrons whose drugs contained this substance chose to discard their drugs in the amnesty bin provided.596

10.51 The Australian National University (ANU) is currently evaluating the second year trial. As the first independent analysis of drug checking in Australia, the evaluation will contribute to the evidence base required to prove the feasibility of drug checking in Australia and its effectiveness for changing drug-taking behaviour.597 The ANU is currently collating follow-up data, and the report is due for release by the end of 2019.

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590 Professor Simon Lenton, Director, National Drug Research Institute, *Transcript of evidence*, 10 June 2019, p 13.
591 Submission 51 from ACT Health, 4 December 2018, p 2.
593 Submission 51 from ACT Health, 4 December 2018, p 3.
595 N-ethylpentylone is a substituted cathinone (bath salt), which can be very potent and has been associated with deaths.
10.52 In a submission to this inquiry, the ACT Minister for Health and Wellbeing, Meegan Fitzharris told the Committee that the trial shows that a service like this can be operated in Australia:

The pill testing pilot at the Canberra Groovin the Moo festival demonstrated that the service could be successfully conducted with the support of the venue owner, promoter, experts and volunteers conducting the service and government. 598

10.53 The ACT Government made it clear to the Committee that these measures are not intended to condone drug use. However, the ACT Government is firmly committed to harm reduction.

The ACT Government has not softened its approach to illicit drugs. It remains illegal to possess, manufacture and distribute illicit drugs.

The Government does not approve or condone illicit drug use. It is risky and dangerous to consume illicit drugs. The pill testing service provided this message to everyone who attended the service.

The ACT Government is committed to harm minimisation, in line with the National Drug Strategy 2017-2026. Harm reduction makes up one of the three pillars of the balanced harm minimisation approach outlined in the National Drug Strategy. Harm reduction includes measures aimed at reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community.

The Government considers that pill testing as a component of harm reduction measures is a sensible approach to limiting the dangers of illicit drug use at ACT music festivals. 599

FINDING 73
The Australian Capital Territory has trialled drug checking for two consecutive years and evaluation of the second year trial is pending.

FINDING 74
The drug checking trials in the Australian Capital Territory are intended to minimise harm and are not intended to condone drug use.

Western Australians currently look to the internet for their safety

10.54 About two thirds of young people who attend festivals, particularly electronic dance music festivals, do take drugs. 600 The Committee has heard that consumers of party drugs already try to access information that will help them to stay safe. Some rely on websites like Pill Reports, or word of mouth:

**The CHAIR:** Where do people get their information now?

**Ms HAZELL:** Usually word of mouth. There is a lot of stigma. Some people might go out of their way to research on the internet and things, but a lot of it…they might have a mate that goes, “You’re okay to take that” and they might actually take that as gospel.

**Miss BLACK:** Online, there is pill reporting as well. On there, that is where everyone is self-reporting, which can also be a danger at the same time because it

598 Submission 51 from ACT Health, 4 December 2018, p 3.
599 ibid., p 2.
600 Professor Simon Lenton, Director, National Drug Research Institute, Transcript of evidence, 10 June 2019, p 13.
is a highly subjective experience. It is not the safest way to provide the information, so we need to provide a safer way to do that.\textsuperscript{601} 

10.55 Some people use reagent pill testing kits that can be bought online. At-home pill testing kits contain reagent chemicals that react to certain chemicals by changing colour.\textsuperscript{602} A recent survey of Australians who use ecstasy found that one in four had used an at-home pill testing kit or sent a drug sample to an overseas laboratory for analysis.\textsuperscript{603}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|}
\hline
\textbf{FINDING 75} & \\
\hline
Many Western Australians who take ecstasy use online pill testing kits, word of mouth or online pill reports to learn about the safety of their drugs. & \\
\hline
\end{tabular}
\end{table}

10.56 The Committee heard about the risks and dangers associated with online pill testing kits. These include the dangers of handling caustic chemicals at home and the unreliability of these tests in picking up certain substances or novel substances:

- Reagent chemicals are caustic and should be handled with care. Further, some at-home pill testing kits are not well labelled. For 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[s] 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.\textsuperscript{604}

10.57 According to Professor Bright, the tests can pick up some potentially dangerous adulterants, including para-Methoxyamphetamine (PMA) and N-methoxybenzyl (NBOMes).\textsuperscript{605} However, the tests will not pick up a range of other potentially dangerous substances. This situation is complicated by the fact that hundreds of new psychoactive substances have been identified in the past few years.\textsuperscript{606} The risk is that people using these tests will assume that it identifies any dangerous substances, giving them a false sense of security.

10.58 Unlike onsite drug checking services, online pill testing kits miss a vital opportunity to engage with people and provide information and education:

- If you have people there, you would give them a range of health information. You might look at issues to do with some, with sexual risk taking, as well as the risks that might be associated with the drug use itself. It is an overarching health piece of advice rather than a piece of paper that says, "This is what's up."\textsuperscript{607}

\begin{table}[h]
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\textbf{601} & Natalia Hazell, Treasurer and Rebecca Black, Vice President, Students for Sensible Drug Policy, \textit{Transcript of evidence}, 5 August 2019, p 7. \\
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\textbf{602} & Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, \textit{Answer to question on notice 4 asked at hearing held 17 June 2019}, dated 10 July 2019, p 5. \\
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\textbf{604} & Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, \textit{Answer to question on notice 4 asked at hearing held 17 June 2019}, dated 10 July 2019, p 6. \\
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\textbf{605} & PMA is a stimulant with psychedelic effects similar to MDMA, but with more toxic effects. NBOMes refer to a series of new psychoactive substances with psychedelic effects. \\
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\textbf{607} & Professor Steve Allsop, private citizen, \textit{Transcript of evidence}, 13 May 2019, p 7. \\
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Online pill testing kits may be unreliable and dangerous, and miss a vital opportunity for people who intend to take drugs to engage with service and peer support workers.

**A drug checking service for WA**

10.59 The Committee inquired into what makes for an effective and safe drug checking service to consider what a trial in WA might look like. Students for Sensible Drug Policy told the Committee that people would not use such a service unless they felt safe from arrest. Police can establish small amnesty zones around the drug checking location and agree not to target people in that area, as occurs in the United Kingdom.\(^608\)

10.60 Dr Stephen Bright told the Committee that people tend to be suspicious of government-run drug checking services. Students for Sensible Drug Policy advised that such a service would be most likely to appeal if it were peer-led:

> People who have been in the party scene for \(X\) number of years, have come out the end of it and want to impart some things they have learnt back to the younger generation who are coming up. That would allow the younger generation to have a level of trust with the people providing that service as well.\(^609\)

10.61 Organisations such as DanceWize, a dance scene peer-based harm reduction group that is active in the eastern states, do not have a strong presence in WA. Dr Bright told the Committee that the first step should be for the WA Government to develop some sort of peer-based harm reduction service for festivals:

> 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.

> 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.\(^610\)

10.62 The Department of Health is responsible for medical harm reduction services such as NSPs and the Mental Health Commission is responsible for funding drug and alcohol services in WA. However, the Committee is of the view that with support, WA organisations such as Peer Based Harm Reduction could lead or partner in delivering harm reduction measures at festivals.

**RECOMMENDATION 28**

The Mental Health Commission fund a peer-based harm reduction organisation to deliver peer-based harm reduction services in music festival settings.

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\(^608\) Joe Panaia, President, Students for Sensible Drug Policy, *Transcript of evidence*, 5 August 2019, p 3.

\(^609\) ibid.

\(^610\) Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, *Transcript of evidence*, 17 June 2019, p 11.
The appropriate technology is also important. While some stationary drug checking laboratories use a range of advanced chemical analysis techniques, such state-of-the-art facilities are not mobile and take days to produce results.\footnote{European Monitoring Centre for Drugs and Drug Addiction, \textit{Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges}, report prepared by Dr Tibor Brunt, 2017, p 7.}

Evidence is building for a number of fast and mobile analysis techniques, such as infrared spectroscopy (FT-IR), which is currently being used in the United Kingdom, Amsterdam and the ACT.\footnote{ibid., p 15.} Many services use a combination of analysis techniques.

Although the technology is promising, the continually growing number of new psychoactive substances presents a challenge for drug checking. Up-to-date databases are required so that emerging substances can be tested for, which is why early warning systems are important. The Committee notes that the evidence around which drug checking analysis techniques are most appropriate requires further investigation.

### FINDING 77

A range of mobile drug checking analysis techniques are now available, but concerns remain about their ability to detect new psychoactive substances.

Evidence suggests that drug checking has significant potential to save lives by warning users of potentially dangerous drugs being circulated. For example, when a toxic substance was identified by the Drugs Information and Monitoring System, the Netherlands and Belgium immediately embarked on a media warning campaign and subsequently avoided any fatalities. In the United Kingdom, where no drug checking system was in place at the time, the same substance caused the death of four young people.\footnote{A Hill, ‘Fourth death linked to potentially fatal “Superman” ecstasy batch’, \textit{The Guardian}, 2 January 2015.}

### FINDING 78

Drug checking results can be used to monitor drug use trends and emerging substances of concern in real time.

The principles outlined by the International Harm Reduction Association principles include that ‘the defining features are the focus on prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs’.\footnote{Harm Reduction Australia. See: \url{https://www.harmreductionaustralia.org.au/what-is-harm-reduction/}. Viewed 18 July 2019.}

The Committee asked Peer Based Harm Reduction how a peer worker would respond if a dangerous substance were to be identified, but the patron indicated that they intend to take the drug anyway. Chief Executive Officer Angela Corry told the Committee that ‘harm reduction education always begins from the point that the best way to avoid drug related harm is not to use drugs’. Whether or not the drug identified is the substance that the patron expected, education can be offered appropriate to the general class of substances involved. This includes:\footnote{Angela Corry, Chief Executive Officer, Peer Based Harm Reduction, Letter, 5 November 2019, p 1-2.}

- general ‘safer use’ strategies, such as avoid mixing different drugs, use a small dose first and wait 90 to 120 minutes to test the effect before taking more
• specific strategies to reduce the adverse risk associated with particular classes of substances (for example, with MDMA, how to avoid dehydration and heat stroke while guarding against hyponatremia)
• education about potential adverse effects associated with the identified substance (for example, how to recognise symptoms of concern and the importance of seeking help in a timely manner).

10.69 Based on international evidence, the ACT trial and evidence presented to the Committee, the following elements of a drug checking service appear to be best practice:

• The initiative should initially be piloted.
• The drug checking facility should be co-located within the medical precinct at the festival, signalling that the festival is treating drug use as a health issue, and to ensure patrons can easily find medical assistance later should they require it. This also allows for the rapid exchange of information between the drug checking and medical services.616
• Patrons should sign a waiver acknowledging that they understand the service and acknowledge that taking illicit drugs is unsafe. The waiver should explain that the drug checking service cannot provide complete information about their drugs, to avoid giving patrons a false sense of security.617
• The service should use a combination of evidence-based analysis techniques that are equipped to test for multiple substances, purity and dosage.618
• A scraping sample of the substance is given to the onsite health professional, who runs it through the analysis tool (for example, infrared scanner).
• While the patron is waiting for their results (approximately 15 minutes), an AOD counsellor should talk to them, providing a brief education and harm reduction intervention. The counsellor might provide information about how much is too much, what to do if the person starts feeling bad, how much water to drink and why they might want to consider not using drugs.
• Staff should explain the results of the test to the patron.
• Information should be entered into an early warning system, and service operators should relay information about dangerous substances to the public and key stakeholders via an alert. Potential broadcasting methods include apps, websites or visible billboards within the festival.
• The service provider should maintain a database of analysis results.
• The service should be subject to ongoing monitoring and evaluation, and adapted in response to evaluation findings.619

10.70 This educative opportunity may help to address some of the misconceptions around ecstasy use. For example, the Department of Health told the Committee that:

There is a misconception in the general public that when one takes ecstasy it is important to drink lots of water to prevent dehydration. This can worsen the symptoms [low salt in the blood and water retention] and cause seizures.  

The Alcohol and Other Drug Consumer and Community Coalition advised the Committee not to focus too much on the testing element, which in reality is only one facet of a good drug checking service. Other elements could include chill out zones, safe spaces and roving counsellors who walk through crowds to make sure people are okay. Some of these measures already occur at particular WA festivals:  

Pill testing as a method of reducing harm from drug use is supported. An emphasis needs to be on creating safe spaces at festivals which allow people to either ‘chill out’, seek advice or get help without risk of police involvement.

Drug checking services need not be government operated or funded. Not-for-profit organisations deliver services in the United Kingdom, ACT, Canada and US. In New Zealand, community volunteer group KnowYourStuffNZ has partnered with the New Zealand Drug Foundation. Funding aside, the Committee heard that collaboration across all sectors is key, but particularly with police:  

Any approach that occurs has to occur with collaboration across the various sectors. It is law enforcement and health, but there are other people: people who organise the festivals, people involved in public transport. Obviously, you have to bring those sectors together.  

Law enforcement officers need to be onside and provide the regulation and mechanisms to ensure they are able to be onside within the law.

The Committee is aware that drug checking services have operated in Australia, for example in Victoria, without any form of government support or partnership:  

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.

Based on its investigations, the Committee considers the following elements to be essential for a feasible and effective drug checking trial in WA:

- peer-based non-government organisation leadership
- support from key government agencies, including the Mental Health Commission, WA Police Force and the Department of Health

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621 Submission 75 from Alcohol and Other Drug Consumer and Community Coalition, 28 February 2019, p 3.
622 Professor Steve Allsop, private citizen, Transcript of evidence, 13 May 2019, p 7.
623 Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Transcript of evidence, 17 June 2019, p 11.
• development in consultation with other key stakeholders, including the event promoter, venue and St John’s Ambulance
• use of adequate technology
• feeding information into a monitoring and early warning system.

**RECOMMENDATION 29**

The Western Australian Government establish a working group with representation from the Mental Health Commission, the Western Australia Police Force, the Department of Health, the alcohol and other drug services sector and the peer/consumer sector to consider strategies for optimising safety at music festivals.

**RECOMMENDATION 30**

The working group consider strategies for optimising safety at music festivals, including:
- trialling a drug checking service
- appropriate drug checking analysis methods
- establishing an early warning system to alert people who use ecstasy about new or dangerous substances.

**Drug Consumption Rooms**

10.75 Drug Consumption Rooms, also known as Medically Supervised Injection Centres (MSIC) are a harm minimisation measure that allow people to use drugs under the supervision of medical staff, with access to clean equipment and emergency care if required. The Australian National Drug Strategy 2017-2026 identifies Drug Consumption Rooms as a harm reduction strategy.

10.76 The first MSIC opened in Switzerland in the 1980s. Today, there are over 90 centres operating around the world, most of which are in Europe. A MSIC has been operating in Kings Cross, Sydney since 2001 and another is being trialled in Richmond, Melbourne.

10.77 This section will refer to both MSICs and Drug Consumption Rooms. The term ‘Drug Consumption Room’ is common in Europe because it includes non-injection facilities, such as smoke inhalation rooms.

**Arguments for and against**

10.78 The Committee received several submissions supporting MSICs as an important and effective harm minimisation measure.\(^{624}\) The WA Branch of the Australian Public Health Association submitted that they would support a MSIC trial in WA. MSICs aim to:
- provide a safer environment for drug use
- improve the health of drug users
- reduce public disorder.

10.79 While the use of illicit drugs can never be considered safe, MSICs provide an environment for people to inject or otherwise consume drugs using clean equipment and provide access to

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\(^{624}\) For example, Submission 65 from the Public Health Association of Australia, dated 18 January 2019, Submission 47 from the Australian Health Promotion Association, dated 3 December 2019 and Answers to Questions on Notice from Associate Professor Kate Seear, dated 9 July 2019.
emergency care if required. Evidence suggests that MSICs can deliver a number of benefits to individual users and wider communities, including:

- reduced fatal and non-fatal overdoses
- reduced attendances at emergency departments
- reduced transmission of HIV and hepatitis C
- encourage marginalised drug users to access psychological support, blood testing, health education and social and therapeutic services
- reduce drug use on the street or in the community
- reduce local criminal activity
- provide ‘real time’ drug market information.

10.80 The MSIC in Kings Cross, Sydney opened in 2001, and has since managed more than a million injections without a fatality. An evaluation of the MSIC concluded that the service reduced the impact of health related consequences of injecting drug use, including overdose-related events, and provided access to services for highly marginalised community members, without increasing crime rates or social disturbances:

We do not see any evidence of increased use or increased risky behaviour. I spent a week working on the floor there some years ago, and just saw these nurses responding to overdose after overdose. It definitely has an impact.

10.81 A second centre is currently being trialled in Richmond, Melbourne. The trial was initiated following 34 overdose deaths in the North Richmond area in 2017, and has courted controversy by allowing users to inject meth onsite.

10.82 While the primary objective of MSICs is to save lives by preventing overdose deaths, the Committee heard that an added benefit is facilitating contact with health and social services for a highly marginalised group of people:

**Dr ROBERTSON:** I think there are a couple of other things from it. If you look at the Kings Cross medical injecting room, the figures there were around 5900 overdoses were prevented, and 70 per cent had never accessed local health services prior to going there. Probably more than 12 000 referrals were made to external health and social welfare services.

**The CHAIR:** So it did actually serve as a first contact for many people.

**Dr ROBERTSON:** That is correct, yes.

**Drug Consumption Room in Lausanne, Switzerland**

10.83 In April 2019, the Committee visited the Accueil a Bas Seuil (ABS) Foundation’s Drug Consumption Room (Room) in Lausanne, Switzerland. Although Drug Consumption Rooms have existed in Switzerland for decades, this facility is new. The Room is located in a built up,
high-density residential area just outside the city centre in a hospital district, about one kilometre from the train station.

10.84 The Committee heard that political argument in Lausanne spanned 12 years before the Room became operational. People living in neighbouring areas were apprehensive when the Room opened, but today locals support the Room. The City of Lausanne provided three million Swiss Francs to fund the structure and an accompanying bus service for a three-year pilot.632

Figure 23. Staff of Accueil a Bas Seuil Foundation demonstrate processes to members of the Select Committee at the Drug Consumption Room in Lausanne
Source: Committee site visit, 26 April 2019.

10.85 The Room is open between 11am and 7pm every day. Nine people can use the service at a time, which typically takes about 45 minutes. People can stay as long as they wish in the adjoining space, which provides food, shelter and a place to interact with others. Approximately 120 people access the service each day, mostly to inject heroin, although around 30% of attendees use the inhalation room for crack cocaine.633

10.86 Specialist nurses dispense needles, ensure equipment is properly sterilised and provide advice as required. A medical room is available onsite for people who consult with a nurse about a medical issue. Staff also operate a needle exchange, dispense methadone and run a small jobs program for attendees to check neighbouring areas for discarded needles.

632 Jennifer Hasselgard-Rowe, Executive Coordinator, Groupement Romand d’Etudes des Addictions, Email, 31 October 2019.
633 ibid.
10.87 The main purpose of the Room is to prevent overdoses and the transmission of HIV and hepatitis C. However, it also increases social connections and interactions with support and services amongst a highly isolated, marginalised group.

10.88 The ABS Foundation recognise that abstinence is not achievable for all, and deliver services across the whole spectrum of addiction. The ABS has operated ‘The Terrace’, an alcohol consumption space, on the same site for 15 years. The Terrace is an ‘accessibility centre’ where alcohol consumption is tolerated. People addicted to alcohol can receive psycho-social support, engage with peers, access basic needs like showers and food, and receive counselling and assistance to liaise with services.

10.89 ABS Foundation staff told the Committee that while there is still drug use in Lausanne, since the facility opened there has been a decrease in other types of crime and public nuisance. Police cooperation is essential to ensure that people accessing the service are not arrested for drug possession.

**FINDING 79**

Despite the initial concerns of the local community, the drug consumption room in Lausanne has not led to increased crime.

10.90 The Committee also spoke to members of the Judiciary and Police Committee of the Grand Council of Geneva about the Genevan drug consumption room, which opened in 2002. Members told the Committee that infringements in the area decreased by 85% within two years of the facility opening. Robberies and crime decreased, because services were now constantly in contact with a group of people who had mostly been homeless.

**FINDING 80**

Apart from reducing overdoses and the transmission of blood-borne viruses, Drug Consumption Rooms provide a key point of interaction and referral for marginalised people who may not otherwise be accessing services.

### A Drug Consumption Room for WA

10.91 The Committee heard that a MSIC in WA is worthy of further investigation. As these facilities are expensive, a cost-benefit analysis would be required to establish need:

I guess in terms of cost effectiveness, if you have got a localised area with a high volume of injecting going on in the street, a medically supervised injection centre is probably going to be a very cost effective intervention. If you have a widely geographically dispersed population of people injecting drugs—maybe not so useful.

I would want to see someone do an analysis before I would say yes or no for Western Australia. We want these sorts of decisions to be driven by evidence, but I suspect that it might not be as good an intervention in Perth, just because of the huge suburban sprawl we have. If I am a heroin user in Butler, I am unlikely to drive to the CBD every day to inject under medical supervision.

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634 The Terrace is open between 11.45am and 7pm every day of the week.
636 Diego Esteban, Vice President, Judiciary Committee, Grand Council of Geneva, Email, 27 August 2019.
The average cost to the state per person of presenting to an emergency department in WA is $838. A concentration of high-risk injecting drug users in the part of town where a Drug Consumption Room is established may result in significant savings in ambulance and emergency department costs.

However, the Committee heard that Perth might not have the concentration of high-risk drug users to justify such a facility:

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.

This is due in part to the population size of WA:

**Ms RUNDLE:** I do not think that WA is in a position where we could have safe injecting rooms or those sorts of things.

**The CHAIR:** Why do you say that?

**Ms RUNDLE:** At the moment, simply because of the population size. There is no real location. If it is evidence-based, and if it fits with the context of Western Australia, then WANADA would definitely be supportive of it.

Potentially suitable areas are inner city suburbs that are easily accessible by train and close to services like homelessness shelters – for example, Northbridge and East Perth. The Committee heard that a location worth investigating would be near the McIver train station, where Peer Based Harm Reduction are located and successfully provide needle and syringe exchange services to over 18,000 people per year.

Another option that may be worth investigating is a mobile drug consumption unit. Some Canadian cities, such as Montreal, are deploying vans to deal with large numbers of opioid overdoses occurring outside of city centres.

**FINDING 81**

Drug Consumption Rooms may be cost-effective harm reduction strategies, but demand for such a facility in Perth has not yet been established.

**RECOMMENDATION 31**

The Department of Health and the Mental Health Commission consult with service providers and people who use drugs to ascertain the demand for a Drug Consumption Room in Perth.

**Other services for injecting drug users**

Peer Based Harm Reduction told the Committee that rather than establishing a MSIC in Perth, the WA Government might get a better return on its investment by increasing the availability of home and outreach needle and syringe exchange services and naloxone distribution:

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639 Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Answer to question on notice 10 asked at hearing held 17 June 2019, dated 10 July 2019, p 7.
642 J Miller, ‘How a mobile drug consumption unit could save lives far from Toronto’s downtown safe injection sites’, *The Star*, 16 August 2019.
If you look at the “Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025”, there is a breakdown in that plan of the number of hours invested in harm reduction and support services. In 2015, that was 5000 hours. The projected increase required to meet demand to 2025 was up to 285 000 hours’ increase.

When a review was conducted last year of how that plan is tracking, that increase in investment in harm reduction and support services had increased by two per cent, so we are a long way off the projected goal, so there needs to be a greater commitment to the important role that harm reduction approaches, strategies and initiatives play in addressing drug-related harm in the community.643

**RECOMMENDATION 32**

The Western Australian Government fund harm reduction activities in line with the demand forecasted in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.

**Heroin Assisted Treatment**

10.98 HAT is aimed at the small proportion of people addicted to heroin who do not respond to lower threshold opioid substitution, like methadone and buprenorphine.

10.99 The Committee heard that a small number of Australians would likely benefit from HAT:

   We have about 4000 people in Western Australia on alternative pharmacotherapy, so that is methadone or Suboxone. I would guesstimate that there would be around about 10 per cent of people who do dreadfully on methadone for a range of reasons... Four hundred—it is perhaps as many as that.644

10.100 According to the National Drug Strategy Household Survey, only 36% of Australians would support a HAT trial:645

   I do not think we are ready for it and I do not think we need it. I would be saying, “Can we please look at how we can get more people in WA and Australia involved in the provision of pharmacotherapy?” We struggle all the time to get practitioners involved in the provision of that treatment.646

10.101 The Committee heard that rather than proceeding with HAT, the Government should focus on eliminating the barriers to currently available opioid substitution therapy, as discussed at paragraph 5.48.

**FINDING 82**

The need for Heroin Assisted Treatment in Western Australia has not been established. Ensuring equitable access to opioid substitution therapy should be prioritised.

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646 Dr Richard O’Regan, Director, Clinical Services, Next Step, Mental Health Commission, *Transcript of evidence*, 17 June 2019, p 20.
Needle and syringe programs in prisons

10.102 As outlined in CHAPTER 5, NSPs are one of the key tenets of harm reduction in WA. NSPs are effective and cost-effective measures responsible for preventing the spread of thousands of blood-borne viruses.

10.103 The Committee is aware that despite the best efforts of the authorities, people use drugs in prisons. Six percent of Western Australian prisoners admit to injecting drugs while in prison.\(^{647}\) However, Western Australian prisons do not deliver NSPs.\(^{648}\) The Committee heard that clinicians, AOD service providers and academics would support the consideration of NSPs in WA prisons:\(^{649}\)

These programs should also be introduced in prisons so those people who are engaged in the justice system also have the opportunity to clean and safe injecting equipment.\(^{650}\)

10.104 The risk posed by blood-borne viruses transmitted in prisons affects the wider community:

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.\(^{651}\)

10.105 Associate Professor Kate Seear advised the Committee that a failure to deliver NSPs in prisons might violate human rights:

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 [by] numerous international human rights principles and instruments. For instance, Principle 9 of the United Nations Basic Principles for the Treatment of Prisoners states that:

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.\(^{652}\)

10.106 Prison-based NSPs are delivered in 13 countries worldwide, including Spain, Switzerland and Germany. Methods of delivery include vending machines, hand-to-hand distribution from prison health care staff, and programs using trained prison peer workers.\(^{653}\)

10.107 The ACT has attempted to implement prison-based NSPs twice, but stopped due to staff safety concerns.

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\(^{648}\) ibid., p 53.

\(^{649}\) For example, submission 27 from Western Australian Network of Alcohol and other Drug Agencies, dated 18 January 2019, evidence by the Department of Health dated 15 April 2019, evidence from Professor Steve Allsop dated 13 May 2019 and answers to questions on notice from Associate Professor Kate Seear, asked at hearing held 17 June 2019, dated 9 July 2019.

\(^{650}\) Submission 47 from Australian Health Promotion Association, 3 December 2018, p 2.

\(^{651}\) Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Answer to question on notice 14 asked at hearing held 17 June 2019, dated 10 July 2019, p 8.

\(^{652}\) Associate Professor Kate Seear, Associate Professor in Law, Monash University, Answer to question on notice 17 asked at hearing held 17 June 2019, dated 9 July 2019, p 14.

\(^{653}\) Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Answer to question on notice 12 asked at hearing held 17 June 2019, dated 10 July 2019, p 7.
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".

Given that 6% of WA prisoners admit to injecting drugs while in prison, there are already needle and syringes in WA prisons that could be used as weapons.654

10.108 In 2018, the Meth Taskforce recommended that the Department of Health and Justice introduce NSPs in WA prisons. The WA Government did not support this recommendation, but committed to progressing the expansion and continuation of existing programs.655

10.109 Professor Steve Allsop told the Committee that a measure like NSPs cannot be imposed on the justice system, and the prison system must have buy-in for such a program to work.656 This means acknowledging the concerns of staff and unions.

10.110 The Inspector of Custodial Services, Professor Neil Morgan, does not think WA is likely to get a prison-based NSP any time soon. Instead, he recommends that Justice ensure that prisoners can access needle-cleaning agents.657

10.111 The Committee has not inquired into this matter in any detail. Due to the potential of NSPs to reduce drug-related harm, the Committee is of the view that the WA Government should consider introducing NSPs in WA prisons. However, the Committee acknowledges that concerns for the safety of other prisoners and prison staff are realistic and must be taken into account.

**FINDING 83**

Needle and syringe programs can assist to reduce drug-related harms in prisons and are delivered in prisons in 13 countries.

**FINDING 84**

Other prisoners and prison staff may have realistic safety concerns about the introduction of needle and syringe programs in prisons.

**RECOMMENDATION 33**

The Western Australian Government investigate the viability of needle and syringe programs in prisons.

**Peer support**

10.112 In the context of drug use and drug problems, ‘peers’ refer to people who also have lived experience of drug use. Peer-based approaches are based on the notion that highly

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654 Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Answer to question on notice 13 asked at hearing held 17 June 2019, dated 10 July 2019, p 7.


marginalised people, such as problematic drug users, are more comfortable discussing their issues with peers rather than medical staff or authorities.658

10.113 Beyond calls for specific harm reduction measures, the Committee heard support for the involvement of peers in delivering AOD services, initiatives and education. In its consultation with members of its organisation, the Alcohol and Other Drug Consumers and Community Coalition found that:

Peer workers and peer led education are seen to be the most effective ways to engage those experiencing, or at risk of, harm from drug use however, they are undervalued as non-professionals and consequently underutilised.659

10.114 Peers play a key role in reducing stigma and helping people to navigate and engage with a service system that can seem overwhelming.

If you are wanting to build a rapport with someone, to safely engage them with any course of treatment, it is the peers that can make that contact, and normalise their process and what is happening for them.660

10.115 The Committee notes that the WA Mental Health, Alcohol and Other Services Plan 2015-2025 provides for expanding the capacity of the peer work sector. The Plan acknowledges that peer workers have an important role in driving person-centred approaches within services, and that research shows that individuals have improved recovery and recidivism where peer workers are involved.661

**FINDING 85**

Peer workers play an important role in delivering treatment and harm reduction initiatives.

10.116 The WA Mental Health, Alcohol and Other Services Plan 2015-2025 acknowledges that the peer workforce must be substantially increased and embedded in both clinical and community settings. However, the Committee heard that the current approach to training new peer workers is piecemeal. While some AOD service delivery organisations deliver internal training, there is no system-wide workforce development for the peer sector.662

10.117 The Mental Health Commission advised the Committee that a Workforce Strategic Framework is being developed, and will include provisions for the peer workforce.663

**RECOMMENDATION 34**

The Mental Health Commission finalise and implement the Workforce Strategic Framework for peer workers, in co-design with the alcohol and other drug sector.

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659 Submission 75 from Alcohol and Other Drug Consumer and Community Coalition, 28 February 2019, p 9.
661 Mental Health Commission, Western Australia Mental Health, Alcohol and Other Drugs Services Plan, Perth, 2015, p 156.
CHAPTER 11
Alternative ways of responding to meth in emergency departments

Meth in emergency departments

11.1 One of the many harms associated with meth is the chaos it causes in hospital emergency departments. The Department of Health told the Committee about the challenges facing emergency health care workers in WA because of meth. For these reasons, the Committee wished to consider alternative responses.

11.2 Meth-affected patients are often agitated and aggressive, and studies suggest that up to half of all violence against emergency health care workers is the result of substance use.664 Emergency physician, Dr Jessamine Soderstrom, told the Committee that meth is involved in 70% of illicit drug emergency presentations at Royal Perth Hospital. According to Dr Soderstrom, it is common for doctors and nurses to be ‘kicked and punched, spat on, and held in a headlock during a shift’:

Can I paint you a picture, please, of what it is like in our ED? We have 29 cubicles in our emergency department. Picture a corridor with about eight cubicles. In each one of these cubicles is a patient that is sedated, with a single nurse looking after them. This peaceful scene only belies the fact that during that 10-hour shift, eight patients have been brought in, one after the other, either by paramedics or by the police. There is a man who was convinced that his mind was being read by his credit card strips and he was found at a petrol station throwing his credit cards around; a few patients running in and out of traffic, usually naked. One was convinced that Godzilla was chasing him. There was a young man who had jumped off a balcony several stories high, convinced there was a crocodile chasing him. There is a young lady cowering in the back of a paddy wagon, terrified, convinced that she had been fishing dead bodies out of the Swan River.

This is eight patients with drug-induced psychosis who now occupy a third of the cubicles in our ED, for an average of 11 hours. Each of them has a single nurse solely devoted to their care for their safety and close observation for aggression and violence. As each of these patients arrive, agitated, aggressive and very distressed, two-thirds of them will actually need a drip put in and intravenous sedation, and a third of them would need security assistance to actually physically restrain so that we can chemically sedate them. So the impact on our ED is significant, because a third of our beds have now been taken up by these drug-affected patients for an average of 11 hours, which means they are not available for us to review other patients.665

11.3 Between July and December 2017, 3369 (1.3%) of all emergency department attendances across seven select WA hospitals were meth-related. A quarter of those (866) were at Royal Perth Hospital, where meth-related presentations account for 10% of all emergency admissions.666

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664 Submission 20 from Department of Health, 19 November 2018, p 1.
666 Department of Health, Meth-related emergency department attendances, report prepared by Emergency Department Data Collections, Perth, 10 September 2018, p 10.
11.4 In most cases, attending the emergency department does not lead a person to drug treatment. Patients often come in psychotic and physically injured. After chemical sedation and a long sleep, many simply wake up and leave.\(^\text{667}\)

### FINDING 86

Royal Perth Hospital deals with a disproportionately high amount of meth-related emergency presentations.

11.5 A recent survey found that almost 80% of WA hospital staff had experienced or witnessed a violent incident at work.\(^\text{668}\) The Minister for Health convened the Stop the Violence Summit in June 2019 in response.

11.6 Following the Summit, the WA Government has committed five million for short-term actions, including:\(^\text{669}\)

- increasing security staff and improving security training for staff
- developing a public awareness campaign that encourages patients and visitors to consider the impact of their actions on others
- employing additional specialist AOD staff at five metropolitan hospitals.

11.7 However, the Committee heard that the greatest need might be in regional hospitals:

**The CHAIR:** How does the situation compare with our regional hospitals as well?

**Dr SODERSTROM:** It is terrible. I work in Albany regional hospital and I work in a high-dependency unit there. I can only speak about Albany because that is where I work, but the situation is much worse. At Royal Perth, I am very privileged, because at any one time, if I have a patient who is aggressive, I have [four] burly security guards next to me, because I am going to be no good at holding anybody down. I have six burly security guards behind me who are well trained and able to protect me. We can physically restrain a patient, so we can chemically sedate them to keep them safe. At any one time, there are [four] helping us in the hospital. In Albany, there are two. When they are sedated, they get put in the high-dependency unit where there are two nurses. It is very unsafe. The security guards come from outside [the health system] and they are not allowed to touch patients.\(^\text{670}\)

11.8 The Committee visited Geraldton Regional Hospital to investigate how a regional hospital copes with this situation. Front line health care staff in Geraldton reported seeing four or five drug-related emergency department presentations per day. Most people come in under the influence of both meth and alcohol. Although staff have experienced injuries, they are more concerned about the safety of the young children and elderly people in neighbouring beds:

> It’s part of our job now – it’s not shocking anymore.\(^\text{671}\)

11.9 Because there is only one security guard servicing Geraldton Regional Hospital, staff are very dependent on police to assist with restraints and escorting patients in and out. Sometimes a single restraint requires up to four people – one per limb. Police also spend many valuable hours waiting with patients at emergency departments.

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\(^\text{671}\) Dr Derek Fraser, Geraldton Regional Hospital, *Email*, 25 October 2019.
Or if, as we have heard in the past, it is a small regional country hospital, where there are two nurses on at night, and if someone knocks on the door in an aggressive way, their response is to ring the police, because that is their only response. They have another group of patients that they have to safeguard.

But it is not a great response if you are the person knocking at the door or the family member of the person who needs help.672

11.10 Staff at Geraldton Regional Hospital told the Committee that they would like to see a team of security guards at the Hospital with the training and powers to restrain. Powers similar to those of transit guards might be sufficient and would likely reduce the reliance on police. A specialist alcohol and other drug nurse and a safe and secure place to monitor meth-affected patients were also identified as potential ways of dealing with the situation.

**RECOMMENDATION 35**

The Western Australian Government’s recently announced measures to combat drug-related violence in hospitals are extended to regional hospitals.

11.11 The Committee also heard that emergency rooms are the ‘very worst place to be for people experiencing psychosis’:

People are coming in, trauma, road injuries, someone is actively voice hearing, they may or may not be intoxicated, they need a quiet space to be to kind of get a little bit of space in that psychosis to just settle. They are unlikely to get that.673

11.12 Staff at Geraldton Regional Hospital said that although the emergency department is fine while the person is sedated, the environment is too noisy and chaotic when they are awake and waiting transfer.674

11.13 Advocacy group Mental Health Matters 2 contend that drug users also experience stigma in the emergency department:

**Hon AARON STONEHOUSE:** In your experience, is there a stigma perhaps attached to the use of these substances that is acting as a block to people seeking services?

**Ms CATTERALL:** Without a doubt. If you present to ED and somebody knows that you are under the influence of an illicit substance, particularly meth, for example, you will experience significant stigma.

**The CHAIR:** Are you then advising the committee that in your experience if someone is psychotic as a direct result of their drug taking, you believe that they receive a lesser treatment than if someone is presenting with psychosis that is deemed to be primarily due to mental health?

**Ms CATTERALL:** Yes, I absolutely believe that.675

11.14 Emergency departments save the lives of people who use drugs every day. Beyond that, it is unclear whether emergency department admissions lead people to choose to address their drug use. The Committee heard that although hospital staff will encourage patients to seek

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673 ibid., p 6.
674 Dr Derek Fraser, Geraldton Regional Hospital, Email, 25 October 2019.
treatment, most meth-affected patients are ‘quite happy continuing to use’. At least 20% will re-present to the emergency department for meth use later.

11.15 A trip to the emergency department is expensive. Forty percent arrive by ambulance and police transport a further 20% to hospital. The average cost per person of presenting to an emergency department in WA is $838.

11.16 In summary, the current situation in emergency departments is:
- dangerous to hospital staff
- distressing for meth-affected patients
- disruptive and potentially dangerous to other emergency department patients
- unlikely to lead to a drug treatment episode
- expensive and resource intensive.

**FINDING 87**
Methamphetamine-affected patients contribute to disruption and risk in WA hospital emergency rooms.

11.17 For these reasons, the Committee has considered a number of alternative approaches to dealing with meth-affected patients in emergency situations.

**Dedicated drug and alcohol emergency department – Stockholm**

11.18 The Stockholm Centre for Dependency Disorders (Centre) is Sweden’s largest clinic for treatment of substance use disorders. The Centre operates Beroendeakuten Stockholm (BAS), a dedicated emergency department for patients with substance use problems. BAS is located at St Gorans Hospital and is open 24 hours a day, 365 days a year.

11.19 Patients attend BAS:
- if they require emergency care for substance-related problems
- if they need to sober up
- to receive a detoxification program
- to be admitted to hospital.

11.20 After receiving emergency care, patients can go to the outpatient clinic that suits them best. Emergency care is usually voluntary, but is sometimes implemented in accordance with Sweden’s compulsory care for substance abuse disorder legislation.

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678 Stockholm Centre for Dependency Disorders, *We see the individual, not just the addiction*, Stockholm, p 9.
679 Stockholm Centre for Dependency Disorders, *We see the individual, not just the addiction*, Stockholm, p 9.
11.21 BAS covers the entire city of Stockholm. Patients arrive at BAS by ambulance, police escort or on their own accord. A patient care assistant meets patients on arrival and assists them to store their belongings in a locker. The average wait time is less than in a mainstream emergency department in Stockholm. Almost all staff are AOD specialists, including senior clinicians who are psychiatry specialists. 680

11.22 BAS report that most patients are affected by amphetamines and alcohol, similar to the situation in WA emergency departments. This means that patients are often highly agitated

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680 Notes from Committee site visit, 24 April 2019.
and experiencing psychosis. The minimum stay at BAS is 24 hours, and while there is no maximum length of stay, patients typically stay for only a few days to detox. 681

11.23 A major advantage is that the hospital is co-located with the Stockholm Centre for Dependency Disorders. Staff immediately refer some patients to the neighbouring outpatient clinic if they determine that the situation is not an emergency. Patients admitted to BAS will receive continuity of care through to outpatient treatment on discharge.

FINDING 88

The benefits of a dedicated alcohol and drug emergency ward include increased throughcare to outpatient treatment, staff with alcohol and other drug experience and specialty, and decreased stigma for patients.

Mental health co-response

11.24 The WA Police Force delivered the Mental Health Co-Response Commissioning Trial (Trial) in 2016. The Trial co-located mental health practitioners with police at the Police Operations Centre, the Perth Watch House and two mobile teams operating in the Perth metropolitan area. The WA Police Force instigated the trial in response to increasing demand on police to attend and manage incidents that involved mental health.

11.25 A 2018 evaluation of the Trial showed a range of benefits, including a 45% reduction in service consumers requiring Police transport to hospital, saving 1300 emergency department attendances during the trial period. 682 The Mental Health Commission notes the evaluation did not specifically account for incidences of meth psychosis, but it is anticipated that this will be reported on once the program is expanded to include AOD-related responses.

11.26 The Committee heard that by dealing with situations in the home, co-response teams might also be an effective and cost-effective way of diverting meth-affected people from emergency departments. 683

11.27 The Committee also heard from the Alcohol and Other Drug Consumer and Community Coalition that the Mental Health Co-Response Program is a good example of breaking down silos to integrate service delivery. 684

FINDING 89

The Western Australia Police Force Mental Health Co-Response program is an effective and cost-effective way of diverting people from emergency departments.

11.28 The evaluation also showed that the majority of mental health incidents that police are called to are not criminal incidents. People are regularly calling police for welfare checks, in the perceived absence of appropriate mental health services. Because police are not, and are not expected to be, mental health practitioners, the Trial demonstrated a clear need for mental health expertise in crisis response situations. 685

681 ibid.
684 Submission 75 from Alcohol and Other Drug Consumers and Community Coalition, 28 February 2019, p 6.
11.29 The Government has expanded the Police Mental Health Co-Response Program. The number of Mental Health Co-Response Mobile Teams\(^686\) has doubled to become a full metropolitan service. The Government has provided $200 000 in funding towards planning to expand the Program into regional areas and to include support for AOD issues.\(^687\)

### RECOMMENDATION 36

The Western Australia Police Force and Mental Health Commission proceed with plans to expand the Police Mental Health Co-Response Program to include support for drug issues.

### RECOMMENDATION 37

The Western Australia Police Force and Mental Health Commission proceed with plans to expand the Police Mental Health Co-Response program to regional areas.

**Urgent care clinic**

11.30 Royal Perth Hospital opened the state’s first Urgent Care Clinic (UCC) in 2018. The UCC is a six-bed unit within the emergency department, which provides specialised services delivered by specialist staff for people who are intoxicated or drug-affected and attempts to decongest the main emergency department.\(^688\)

> There are people going in and out and if you have ever been to the Royal Perth ED, it is quite small. There are people going in and out. There is a lot of activity. It is well recognised that if you are treating someone who is agitated, that is the worst environment you could be treating them in because they get stimulated, and if you are hearing things and seeing things and there are a lot of people traffic around in the ED, it is going to be distressing and very stimulating for them. We recognise that because they have taken up so much of our ED floor space and they are in there for 11 hours, on average.

> So what we have done, they built a special unit called the urgent care centre, which has six beds. That is a locked area whereby the acutely psychotic patients can be cohorted in that area. Rather than needing a one-to-one nurse, you have two nurses for a six-bed area. It is much quieter and it is separate from the main ED, where they can be cohorted.\(^689\)

11.31 The UCC is different to a Mental Health Observation Area (MHOA), which will also be established at Royal Perth Hospital. MHOAs are dedicated units located next to emergency departments for people with psychiatric illness. The Committee heard that dealing with drug-affected patients may not be the best use of a MHOA:

> For the acutely drug-affected patients, they may not be necessarily suitable because the majority of patients will recover after a sleep; only about two per cent of them need ongoing psychiatric care.\(^690\)

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\(^{686}\) Teams that travel within a district area, including at least one co-response police officer and at least one authorised mental health practitioner.


\(^{688}\) Hon Mark McGowan MLA, Premier, *Urgent Care Clinic opens at Royal Perth Hospital*, Media statement, Department of the Premier and Cabinet, Perth, 22 May 2018.


\(^{690}\) ibid., p 5.
11.32 An initial review of the UCC found that it had: 691

- decreased admission times
- decreased length of stay
- decreased reported violence
- decreased the use of restraints
- slightly increased time taken for a doctor to review
- increased the number of psychiatric admissions
- decreased the number of patients discharging against medical advice.

**FINDING 90**

The Urgent Care Clinic at Royal Perth Hospital is a promising alternative for dealing with drug-affected patients in emergency situations.

11.33 The Committee notes that the primary objectives of the UCC are to decrease violence and free up space in the main emergency department. 692 The Committee would also encourage the Government to focus on using the UCC as an opportunity to reduce the stigma experienced by patients and improve pathways to treatment.

11.34 The BAS model in Sweden, for example, provides direct pathways from emergency discharge to onsite outpatient treatment. A potential option for increasing access to immediate and direct treatment pathways may be to co-locate an AOD service onsite or near the UCC. Emergency physicians could refer patients to this service, so that on discharge they have the option of meeting with an AOD counsellor right away. This may avoid cases of people simply going home after being discharged from emergency, without having had any opportunity to address their drug use.

11.35 The fact that the UCC is specifically for patients with problematic drug use makes it an ideal context for reducing stigma. AOD specialists are generally trained in stigma and discrimination, so the UCC could provide a useful context for training other staff and passing on this knowledge.

11.36 The Committee recommends that the Department of Health seek to measure the levels of perceived discrimination and stigma in the UCC and compare the results to emergency departments in other hospitals to determine if the dedicated focus on drug issues is having this effect.

**RECOMMENDATION 38**

The Mental Health Commission and the Department of Health consider options for creating direct treatment pathways from the Urgent Care Clinic at Royal Perth Hospital, including co-locating or involving an alcohol and other drug service.

**RECOMMENDATION 39**

In future reviews of the Urgent Care Clinic, the Department of Health measure stigma experienced by patients and referrals to ongoing alcohol and drug treatment.

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691 East Metropolitan Health Service, Department of Health, Answer to question on notice A1 asked at hearing with the Mental Health Commission, held 17 June 2019, dated 24 July 2019, p 1.

692 Hon Mark McGowan MLA, Premier, Urgent Care Clinic opens at Royal Perth Hospital, Media statement, Department of the Premier and Cabinet, Perth, 22 May 2018.
CHAPTER 12
Alternative approaches to treatment

Introduction
12.1 Compulsory treatment and compulsory detox are not available in WA. This chapter considers:
   - compulsory treatment in other jurisdictions
   - the ability to hold patients experiencing meth-induced psychosis under the Mental Health Act 2014
   - compulsory detoxification as a potential means of reducing drug-related harms.

Compulsory treatment
12.2 Compulsory alcohol and drug treatment involves a legal order to detain a person for a specified period to provide treatment. Most compulsory treatment is delivered in a justice setting, through court-mandated treatment and drug court programs. This section is about compulsory treatment outside of the justice system, also known as ‘civil commitment’ in residential rehabilitation. Compulsory treatment is for situations where the person is a threat to themselves or others.

12.3 WA does not have compulsory treatment laws, but debate has ignited in recent years because of meth. As meth requires longer treatment periods and many meth dependent people do not think of themselves as needing treatment, families suggest that compulsory treatment may be necessary.

What the Committee heard
12.4 The Committee heard from the father of a meth addict. His son has cycled in and out of both prison and rehabilitation for the past few years. This father told the Committee that the only thing that could help his son at this point is enforced rehabilitation for up to 12 months.

12.5 The Committee is aware that many WA families are in similar situations. The choice between compulsory rehabilitation and prison sounds like a simple one. People are desperate to see their loved ones get the help they need, before their lives are ruined forever by a cycle of prison stays, criminal charges and drug relapses.

12.6 The Committee notes that both the health and justice systems have failed these families, and understands why compulsory treatment seems like the only solution. The Committee has the utmost sympathy for people facing this situation.

FINDING 91
Families of people with severe addiction may see compulsory treatment as the only way to help their loved ones.

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694 Private citizen, Transcript of evidence, 10 June 2019.
12.7 Although some people will use compulsory treatment as an opportunity to change their lives, the Committee heard that people cannot be forced into a lifestyle change.\textsuperscript{696} Several expert stakeholders told the Committee that compulsory drug treatment is problematic and does not work:

There is no evidence that it makes things better, and there is a potential for it to make things worse.\textsuperscript{697} Empirical evidence relating to the effectiveness of compulsory treatment models is inadequate and inconclusive. The evidence is even far more limited with regards to its specific impact on Aboriginal people and children and young people in our community.\textsuperscript{698} Compulsory treatment or the proposed “compulsory crisis intervention” should be a last resort and undertaken with caution. Freedom is a basic human right and any imposition on this is cause for alarm.\textsuperscript{699}

12.8 The Committee heard that the priority should be delivering sufficient services for people who want to access treatment:

WANADA received feedback from hundreds of consumers, service users, as well as the service sector, and the majority of people felt that it was an expensive option that was not cost-efficient at a time when we have inadequate voluntary services to meet demand. So, where is our priority here?

If we do not have enough voluntary services and you push for mandatory treatment, it is pushing money or expending money at the treatment end that does not necessarily meet community need.\textsuperscript{700}

12.9 The Aboriginal Health Council of WA drew the Committee’s attention to the potentially disproportionate impact that compulsory treatment laws can have on Aboriginal people. Given previous tragic events, such as the death of Ms Dhu in police custody in 2014, the temporary detention of Aboriginal people in regional and remote areas is of significant concern:

The Northern Territories Alcohol Mandatory Treatment Act 2013 has been widely criticised for its discriminatory effect on Aboriginal people whereby it is estimated that 98% of those subject to orders are Aboriginal people.

**Compulsory care in Sweden**

12.10 Since 1982, Sweden has provided for compulsory treatment for up to six months through the Care of Substance Abusers Act. An administrative court may place a person on an order if it is necessary to protect that person or others from harm.\textsuperscript{701} Approximately 1250 applications for compulsory care of substance abusers were submitted in 2013.

12.11 The Care of Substance Abusers Act provides the option for people on orders to receive some or all of their treatment in a community-based outpatient setting. People who breach their order while receiving community-based outpatient treatment must return to a residential

\textsuperscript{696} Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, Transcript of evidence, 17 June 2019, p 13.

\textsuperscript{697} Professor Steve Allsop, Transcript of evidence, 13 May 2019, p 12.

\textsuperscript{698} Submission 52 from Aboriginal Health Council of Western Australia, 4 December 2018, p 22.

\textsuperscript{699} Submission 75 from Alcohol and Other Drug Consumers and Community Coalition, 28 February 2019, p 6.

\textsuperscript{700} Jill Rundle, Chief Executive Officer, Western Australian Network of Alcohol and other Drug Agencies Transcript of evidence, 15 April 2019 p 9.

rehabilitation centre. The Committee heard that it is common for people to go between residential and community based compulsory treatment.\textsuperscript{702}

12.12 The primary purpose of compulsory care in Sweden is to motivate at-risk people to seek voluntary treatment. People are given the opportunity to transfer to voluntary treatment during their compulsory order period. According to the Swedish government, the vast majority of people choose to take this opportunity.\textsuperscript{703}

12.13 The Committee heard that compulsory care orders in Sweden are mainly used when a person’s life is in genuine danger.\textsuperscript{704} While it does save lives, the risk of relapse is high. Criticisms of the Swedish compulsory care model include that six months is too long, and the average number of days spent in compulsory treatment has increased in recent years.

\textbf{Australian developments}

12.14 New South Wales, Victoria, the Northern Territory and Tasmania have legislated for compulsory treatment outside the justice system. The legislation provides for maximum periods of detention from 14 days to 12 months, and a medical practitioner usually informs the decision to impose an order. In New South Wales and Victoria, compulsory treatment will only be authorised when a person does not have the capacity to make decisions about their substance use. In New South Wales, the person must first have refused treatment.\textsuperscript{705}

12.15 In a review of compulsory treatment programs, NDARC found that:\textsuperscript{706}

\begin{itemize}
\item There is limited research that directly tests the effectiveness of compulsory treatment in reducing AOD use or dependence in the long-term.
\item There are significant gaps in the research on the effectiveness of civil commitment programs.
\item Involuntary treatment programs are not cost-effective.
\end{itemize}

12.16 Conversely, coercive treatment, such as court-mandated treatment and drug court programs, can be effective and cost-effective.

12.17 In 2015, the National Ice Taskforce reported on the effectiveness of compulsory treatment. The Taskforce noted that calls for compulsory treatment generally came from families who have reached their capacity in supporting a loved one with drug addiction. However, most of the evidence the Taskforce received was critical of the effectiveness of compulsory treatment. The Taskforce did not make specific recommendations supporting or dismissing compulsory treatment.\textsuperscript{707}

12.18 In 2016, the Mental Health Commission released background and discussion papers relating to proposed compulsory treatment in WA, and subsequently released an exposure draft bill for public comment. Stakeholder feedback raised concerns about the lack of evidence of the effectiveness of compulsory treatment programs. The Government suggested it would...

\textsuperscript{702} Anna Rune, Committee Secretary, Swedish Riksdag, Email, 11 July 2019.


\textsuperscript{704} Anna Rune, Committee Secretary, Swedish Riksdag, Email, 11 July 2019.


\textsuperscript{706} National Drug and Alcohol Research Centre, Bulletin No. 27: Mandatory alcohol and drug treatment: what it is and does it work?, report prepared by T Vuong et al, Sydney, March 2019.

reconsider the possibility of compulsory treatment in WA following the release of an evaluation of the Involuntary Drug and Alcohol Treatment Program in New South Wales.\textsuperscript{708}

12.19 The Committee hoped to report on the outcomes of the Involuntary Drug and Alcohol Treatment Program, as the evaluation was due for release in November 2018. However, at the time of writing this report, the evaluation had not been published.

**FINDING 92**
There is insufficient evidence to support introducing compulsory drug treatment in Western Australia.

12.20 The Meth Taskforce advised the WA Government in 2018 that the state’s voluntary treatment needs should be met before considering compulsory residential rehabilitation treatment.\textsuperscript{709} The Committee agrees with the Meth Taskforce and stakeholders including WANADA and the Royal Australian and New Zealand College of Psychiatrists on this point.

Particularly in Western Australia where there are always limited resources in health and when ample people are voluntarily trying to seek access into care, we would be seen as negligent as psychiatrists if we were using treatment modalities that were not terribly evidence based.\textsuperscript{710}

**RECOMMENDATION 40**
The Western Australian Government meet voluntary treatment needs and demand before any consideration is given to compulsory treatment.

**Detention under the Mental Health Act**

12.21 Although WA does not have compulsory alcohol and drug treatment, it does provide for the involuntary treatment of mentally ill patients. The Mental Health Act 2014 (MHA) enables authorised staff to detain a person involuntarily for treatment, or examination in order to assess whether an involuntary treatment order (ITO) is appropriate. Relevant sections of the MHA are included at Appendix 5.

12.22 The MHA provides for detention for up to 72 hours, or 144 hours in regional areas, for the purposes of assessing whether a person is suitable for an ITO. A psychiatrist can make an ITO when specific criteria is met, including that:
\begin{itemize}
\item the person has a mental illness that requires treatment
\item there is significant risk to the person or another
\item the person is not well enough to make decisions about treatment
\item there is no less restrictive way of providing the person with treatment.
\end{itemize}


\textsuperscript{710} Associate Professor Mathew Coleman, WA Representative of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists, Transcript of evidence, 5 August 2019, p 4.

\textsuperscript{711} Mental Health Commission, Answer to question on notice 8 asked at hearing held 17 June 2019, dated 5 August 2019, p 11.
12.23 The MHA provides that a person does not have a mental illness simply because they use drugs, but has a mental illness if the person has a condition that:
\[712\]
- is characterised by a disturbance of thought, mood, volition, perception, orientation or memory
- significantly impairs (temporarily or permanently) the person’s judgement or behaviour.

12.24 The Committee heard from clinicians who agree that a person can be held under the MHA while they are experiencing psychotic symptoms, because they meet the criteria. Psychotic symptoms usually resolve within a day or so. People in this situation will often simply be held under hospital duty of care:

In that situation when someone is acutely intoxicated and having those symptoms and their judgement is impaired, they would more commonly be detained in hospital under the principle of duty of care to protect their safety until a period when they are no longer intoxicated and regain the capacity to make decisions about their welfare and discharge.\[713\]

12.25 Clinicians often find it difficult to ascertain the cause of psychosis when a person presents at hospital:

What actually happens is a person presents in crisis, generally to an emergency department, and if they have a psychosis, the clinicians are not going to know that this is a meth-induced psychosis.

Quite often you cannot determine that the substance use necessarily is the cause of the psychosis. So invariably a person will be admitted to hospital, potentially under the act, but it will be a number of days before it becomes clear whether that psychosis settles down with the absence of the drug or whether it persists.\[714\]

12.26 The Chief Psychiatrist told the Committee that it becomes more complicated when the initial psychosis arising from the intoxication subsides:

The question is: how many episodes of psychosis do you need before someone will say you need a longer-term focus on the Mental Health Act—is it two; is it three? That is where the debate is and I am not sure that legislation can actually flesh that out. I think that is a broader cultural discussion within the mental health sector.\[715\]

12.27 The Chief Psychiatrist told the Committee that there are various views amongst clinicians as to how they manage this group of people under the MHA:

There are some clinicians who will take a very strong view that because, for example, someone who might be using drugs intermittently and becoming intermittently psychotic, it is a chronic problem and they may make a submission to the Mental Health Tribunal for someone to be on a community treatment order long term. The tribunal then has to decide whether they will allow that person to be kept. It may get to a point where the person is well enough for the tribunal to take them off the order.

There are other clinicians who have a different view, who believe that they do not have the grounds to push those issues. It is often about clinician perception of

\[712\] Mental Health Act 2014 s 6.
\[713\] Dr Michael Verheggen, Member, WA Branch Committee, WA Faculty of Consultation – Liaison Psychiatry, Royal Australian and New Zealand College of Psychiatrists, Transcript of evidence, 5 August 2019, p 2.
\[714\] Dr Richard O’Regan, Director, Clinical Services, Next Step, Mental Health Commission, Transcript of evidence, 17 June 2019, p 3.
\[715\] Dr Nathan Gibson, Chief Psychiatrist of Western Australia, Transcript of evidence, 15 April 2019, p 8.
how far they can push the act [Act], and then it is about the Mental Health Tribunal, who decides whether someone stays under the act [Act] or not, making that decision.\footnote{ibid., p 7.}

12.28 The Committee notes that there is uncertainty about the power to detain drug-affected people under the MHA. The Mental Health Commission advised the Committee that this issue will be considered in the upcoming statutory review of the MHA.\footnote{David Axworthy, Assistant Commissioner, Mental Health Commission, Transcript of evidence, 17 June 2019, p 2.}

**FINDING 93**

Psychiatrists are interpreting the *Mental Health Act 2014* differently, and there is a lack of clarity around how these provisions should apply to people experiencing drug-induced psychosis.

**RECOMMENDATION 41**

The Mental Health Commission clarify through the statutory review of the *Mental Health Act 2014* how and when the Act can be used to detain people experiencing drug-induced psychosis who may not also be mentally ill.

**Compulsory detox**

12.29 Some psychiatrists accept that people experiencing drug-induced psychosis can be detained under the MHA while psychotic, which is typically no longer than a day. However, the Committee received evidence that the time required to detox from meth is between 10 and 14 days.\footnote{Methamphetamine Action Plan Taskforce, *Final Report of the Methamphetamine Action Plan Taskforce*, Department of the Premier and Cabinet, Perth, November 2018.}

Given the questions about detaining meth-affected people under the MHA, the Committee considered whether compulsory detox would be a suitable short-term option for people who pose a threat to themselves or others.

12.30 While the Committee found little evidence to support the effectiveness of compulsory treatment, it should be distinguished from compulsory detox.

12.31 Compulsory detox is a short-term form of involuntary treatment for people who pose a threat to themselves or others while under the influence of drugs. It involves the involuntary detention of a person to provide supervised, medically assisted withdrawal.\footnote{National Institute on Drug Abuse. See: https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/7-medical-detoxification, Viewed 25 October 2019.}

12.32 Compulsory detox can be an alternative form of crisis intervention to an emergency department, police lock-up or prison:

Families and users who are in crisis want an alternative to a police cell or hospital. This is often referred to as a ‘Halfway House’.\footnote{Tabled by Ron Alexander, Meth Action Plan Taskforce during hearing held 15 April 2019, p 3.}

12.33 The National Ice Taskforce concluded in 2015 that there may be a role for compulsory residential treatment in instances where a person is likely to harm themselves or others around them.

12.34 As with compulsory treatment, the Committee understands why the families of people who are dependent on meth would call for compulsory detox. When someone is suffering from meth-based psychosis and acting erratically and violently, a week or two in a compulsory detox facility may provide the opportunity for the user to make clearer decisions about
seeking treatment options, as well as providing a much needed reprieve for families and carers.

FINDING 94
Compulsory detox can be a crisis intervention for people dependent on methamphetamine, and an alternative to an emergency department, police lock-up or prison.

Victoria and New South Wales

12.35 The Victorian Severe Substance Dependence Treatment Act 2010 (SSDT Act) provides for the detention and treatment for up to 14 days of severely substance dependent people who are incapable of making decisions about their substance use, health, safety and welfare. During this time, the person will receive medically assisted withdrawal and potentially recover their capacity to make decisions about their wellbeing.

12.36 Any person over the age of 18 can apply to the Magistrates Court to have a person placed on a detention and treatment order, with the recommendation of a medical practitioner. The Magistrates Court will only order detention and treatment as a last resort, and detention must be the only way that treatment can be provided. Detention may occur at declared treatment centres, St Vincent’s Hospital in Melbourne or the co-located Depaul House.

12.37 A statutory review of the SSDT Act in 2015 reported that only 23 clients were detained and treated in the first four years of operation. Alcohol dependence led to the admission of 16 clients. The remaining seven clients reported poly-drug use, and all cases involved alcohol. The review found that the period of involuntary treatment improved the capacity of most clients to make decisions about whether they would continue with voluntary treatment. After six months, seven of the 23 clients (30%) had reduced their use or abstained. The evaluators note that this is an encouraging result in a group of very complex and ill clients:

While stakeholders recognised the infringement on human rights associated with involuntary detention and treatment and strongly supported the concept that detention and treatment should be a consideration of last resort, they also noted the infringement on safety and dignity experienced by members of the target client group as a result of their severe substance dependence.

The vast majority of stakeholders agreed that involuntary detention and treatment remains appropriate for a small group of people with highly complex health and wellbeing needs associated with severe substance dependence. The exception to this was some consumer representatives, who strongly objected to the concept of involuntary detention and treatment.

12.38 Dr Stephen Bright told the Committee that although the SSDT Act had been used infrequently, it provided a good opportunity for people to step back from their substance abuse and reassess:

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

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722 ibid., p 2.
perspective and make their own choice from there on in whether or not they do something about it.\textsuperscript{723}

12.39 The New South Wales \textit{Drug and Alcohol Treatment Act 2007} provides the legislative basis for the Involuntary Drug and Alcohol Treatment (IDAT) Program. IDAT provides for detention and treatment up to 28 days and includes a medically assisted detox component. One of the expected clinical outcomes of IDAT is safe completion of the withdrawal episode. A Court may extend an IDAT order by up to three months to deliver longer-term treatment.

12.40 The Committee heard that the eastern states experience is primarily about alcohol:

Talking to some of the clinicians in the eastern states who participate in compulsory treatment, they have anecdotes where people’s lives have literally been turned around.

Every single case that I have heard of has been a person who has been affected by alcohol. Nobody has spoken to me ever of a situation, and I do not know of any areas where methamphetamine-induced psychosis or methamphetamine problems have led to compulsory treatment.\textsuperscript{724}

\begin{center}
\textbf{FINDING 95}
\end{center}

Compulsory detoxification in Victoria has achieved some reduction in dependency in a small group of people with very complex needs, albeit predominantly alcohol dependent.

12.41 Compulsory detox may be better suited to alcohol than meth:

For methamphetamine, the main pattern of use for the majority of people is that they will use in periods, and they will often go through withdrawal themselves. They will use for a couple of weeks and then often have a week or two off—not everyone, but a good proportion of people are almost going through their own detox fairly regularly.\textsuperscript{725}

12.42 Compulsory detox from meth may put the person in a much better position to make decisions about engaging in treatment. However, the Committee heard Dr O’Regan of Next Step that it is yet to be properly tested:

But if the question is what do I think about compulsory meth detoxification, I have never seen it and I have never heard of it being applied anywhere, so anything I say would be really conjecture and speculation.\textsuperscript{726}

\begin{center}
\textbf{Developments in WA}
\end{center}

12.43 In 2018, the Meth Taskforce recommended a crisis-intervention response that would provide a short-term place for meth users when they are in crisis to keep them, their families and the community safe, especially in regional areas. The WA Government subsequently announced that it would trial compulsory detox treatment for meth addicts.\textsuperscript{727}

\textsuperscript{723} Dr Stephen Bright, Senior Lecturer, Edith Cowan University, Public Health Association of Australia, \textit{Transcript of evidence}, 17 June 2019, p 14.

\textsuperscript{724} Dr Richard O’Regan, Director, Clinical Services, Next Step, Mental Health Commission, \textit{Transcript of evidence}, 17 June 2019, p 3.

\textsuperscript{725} Associate Professor Mathew Coleman, WA Representative of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists, \textit{Transcript of evidence}, 5 August 2019, p 5.

\textsuperscript{726} Dr Richard O’Regan, Director, Clinical Services, Next Step, Mental Health Commission, \textit{Transcript of evidence}, 17 June 2019, p 3.

\textsuperscript{727} Staff writers, ‘Compulsory detox for meth addicts to be trialled in WA’, \textit{Perth Now}, 26 November 2018.
12.44 According to Government comments in the media, this is likely to involve a short-term crisis centre in a health-style facility offering stabilisation and withdrawal services.\(^7_2^8\) Planning is contingent on a positive evaluation of the NSW IDAT Program, which is yet to be released.\(^7_2^9\) Mental Health Matters 2 told the Committee that if WA pursues compulsory detox or treatment, it should be with a view to contribute to the evidence base, which is currently lacking.\(^7_3^0\)

12.45 The Committee also heard concerns that putting someone through detox then allowing him or her to leave may set them up for failure or even overdose, as their tolerance will have decreased.\(^7_3^1\) Just providing detox in and of itself is really insufficient; it is only a very small part.\(^7_3^2\)

12.46 Any regime that removes individual rights also requires significant safeguards, including a review process. The Committee notes that a compulsory detox regime would require a new administrative decision-making process, legislative provisions and potentially infrastructure.

**The need in WA**

12.47 Current evidence regarding the effectiveness of compulsory detox as a method of reducing substance abuse is limited. However, the Committee considers that the primary purpose of compulsory detox is not to resolve dependency, but to act as an appropriate form of crisis intervention. Given that approximately two-thirds of Perth police lock-up detainees are on meth, there is clearly a need for a safe, secure place for people to resolve symptoms of drug-induced psychosis.\(^7_3^3\)

12.48 If such an intervention could help people to make clear-headed, informed decisions about seeking further treatment, as well as protect the community from meth-related violence and disorder, the Committee is of the view that it is worth trialling.

**RECOMMENDATION 42**

The Western Australian Government proceed with plans to trial compulsory crisis detoxification for people addicted to methamphetamine or other drugs.

12.49 The Alcohol and Other Drug Consumer and Community Coalition told the Committee that rather than compel a small number of people to undergo detox, the Government should make detox more widely available.\(^7_3^4\)

12.50 The Committee heard that currently, people are waiting to access the state’s only medical detox facility, which is located in Perth, before they are able to enter residential rehabilitation.\(^7_3^5\)

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\(^7_2^8\) ibid.


\(^7_3^0\) Margaret Doherty, Convenor, Mental Health Matters 2, *Transcript of evidence*, 18 March 2019, p 13.

\(^7_3^1\) ibid.

\(^7_3^2\) Associate Professor Mathew Coleman, WA Representative of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists, *Transcript of evidence*, 5 August 2019, p 5.


\(^7_3^4\) Juanita Koeijers, Project Lead, Alcohol and Other Drug Consumers and Community Coalition, *Transcript of evidence*, 17 June 2019, p 11.

\(^7_3^5\) Shannon Dixon and Juanita Koeijers, Alcohol and Other Drug Consumers and Community Coalition, *Transcript of evidence*, 17 June 2019, pp 10-11.
RECOMMENDATION 43

The Mental Health Commission fund supervised detoxification programs in line with the demand forecast in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

The San Patrignano model of residential rehabilitation

12.51 Some of the challenges associated with severe meth dependency include there being no proven pharmacotherapy to treat it, and due to associated brain damage to users, the recovery time might be much longer than for other drugs:

For several years, the conversation around treatment time has been in question. The available evidence appears to support longer term engagements for people with high levels of dependency and chronic harm, with significant deteriorations in outcomes being experienced across most treatment populations post-exit.\textsuperscript{736}

12.52 The Committee heard support for the Italian San Patrignano model of community recovery as a way to respond to these challenges. San Patrignano is a therapeutic community located on a cooperative farm, running a three to four year residential rehabilitation program. Residents work, learn skills and receive drug treatment and healthcare. San Patrignano operates extensive social enterprises, producing cheese, wine and other quality goods that are sold in department stores:

The San Patrignano model in Rimini, Italy has shown that residential treatment programs delivered for greater than two years have significantly better outcomes than those offered for shorter periods of time.

This program reports 70% better treatment outcomes four years post exit, including maintaining employment and healthy relationships. In Australia there is a push to offer at least 12 months of residential support.\textsuperscript{737}

12.53 Four years of treatment is long and costly. However, Debra Zanella from Ruah Community Services pointed out that it is more cost-effective to properly address the issue the first time around than to have someone cycling in and out of services for five, ten or fifteen years.

Hope Springs Community Farm

12.54 In May 2019, the Committee visited Hope Springs Community Farm near Geraldton. Hope Springs Community Farm is a residential rehabilitation program operated by Hope Community Services. Hope Springs is based on the San Patrignano model, and residents live, learn skills and work on the farm while receiving treatment and counselling. Hope Springs operate some social enterprises, including baking bread.

12.55 Staff and residents at the Farm told the Committee that the most common drugs to which residents are addicted are meth and alcohol, followed by cannabis. People can stay in the program for as long as they feel they need to. Many initially only choose to stay for three to six months, but it is common for those people to come back very quickly. Re-entering the program after leaving involves going through detox again in Perth and orientation in Geraldton before returning to the farm.

12.56 The length of a standard AOD treatment program is about four months. Staff at Hope Springs told the Committee that the Government funds residents to stay for the standard

\textsuperscript{736} Submission 62 from Ruah Community Services, 17 January 2019, p 5.

\textsuperscript{737} ibid.
four months, after which time Hope Springs cover the cost through funding from their social enterprises.

12.57 The Committee heard that current procurement processes do not facilitate longer-term treatment options. Some service providers are able to obtain funding for 12 or 18-month programs, but this typically involves working around the existing funding mechanisms. If longer-term treatment options are to become a core part of how we deal with meth addiction, consideration should be given to procurement processes.

**RECOMMENDATION 44**
The Mental Health Commission review whether current procurement processes are appropriate for funding longer-term alcohol and other drug services.

**Regulation of service providers**

12.58 Government funded AOD services in WA are required to be certified under a recognised accreditation standard. This ensures that services meet community expectations around quality, accountability, and evidence-based practice.

12.59 AOD services that do not receive government funding (private providers) are not required to be certified. There is currently no legislative basis to ensure the quality of alcohol and other drug services that are not funded by government. WANADA advised the Committee that although most AOD providers are accredited, a number of non-accredited AOD services are operating in WA.

**FINDING 96**
Privately funded alcohol and other drug services in Western Australia are not required to be certified under a recognised accreditation standard.

12.60 The Committee heard that all rehabilitation service providers should be regulated to provide transparency around key performance indicators, costs, program philosophy and expected recovery rates. A major concern is providers offering services that have no foundation in evidence-based practice. This is particularly relevant for AOD services, as families may pay many thousands of dollars for a service with little evidence to support its efficacy, simply because they are desperate to see their loved ones receive some sort of help:

We have many private providers in the market that are charging large sums of money without any real published rates of success.

Why? Because families are unclear about the effectiveness of available programs and some assume that they will have greater success in aiding their loved one in a higher cost program.

12.61 The Commonwealth Ministerial Drug and Alcohol Forum is developing a National Quality Framework for AOD Services. A quality framework aims to ensure consistent and appropriate treatment in accordance with best practice, but does not necessarily mean that services are

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738 Debra Zanella, Chief Executive Officer, Ruah Community Services, Transcript of evidence, 8 April 2019, p 6.
739 Submission 70 from Western Australian Network of Alcohol and other Drug Agencies, 18 January 2019, p 21.
740 Submission 53 from Murray Kinnane, 6 December 2018, p 3.
741 Jill Rundle, Chief Executive Officer, Western Australian Network of Alcohol and other Drug Agencies, Transcript of evidence, 15 April 2019, p 8.
742 Submission 53 from Murray Kinnane, 6 December 2018, p 3.
accredited.\textsuperscript{743} Government funded service providers will be required to comply with the quality framework through contracting arrangements. Private providers will be required to meet the quality framework through regulatory or other processes as determined by individual jurisdictions.

12.62 The Ministerial Drug and Alcohol Forum confirmed that responsibility for the regulation of private providers is with the states and territories. However, the Mental Health Commission was not aware of any work to progress the regulation of private providers in WA.

\textbf{The CHAIR:} Are there any moves at this state level to address the concern of private providers who are not in receipt of government money who perhaps are potentially not meeting minimum standards?

\textbf{Mr Kirby:} Not that I am aware of.\textsuperscript{744}

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\textbf{RECOMMENDATION 45} \\
\textbf{The Western Australia Government consider introducing mechanisms to ensure the quality of private alcohol and other drug service providers.} \\
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\textsuperscript{743} Alcohol Tobacco and Other Drug Association ACT, ‘A national alcohol and other drug quality framework brief 1: for AOD peak bodies’ State, Territory and Australian health department contacts’, 27 March 2017.

\textsuperscript{744} Gary Kirby, Director, Prevention Services, Mental Health Commission, Transcript of evidence, 17 June 2019, p 12.
Chapter 13
A way forward

13.1 Throughout this inquiry, the Committee has investigated both discrete and overarching approaches to reducing the harms associated with illicit drug use. Drug addiction is a complex issue, and there is no single approach that can be expected to resolve it.

13.2 However, the Committee found that a number of approaches used within Australia and internationally have successfully reduced drug-related harms by shifting policy priorities from prohibition towards health, prevention and harm reduction.

13.3 The Committee is confident that WA can also reduce drug-related harms. The approaches proposed in this report require a refocussing away from a criminal justice approach and towards a health-based approach. In summary, the Committee recommends that:

- the protection of individuals and the community from drug-related harms remain a priority
- drug use is treated primarily as a health issue
- criminal penalties for the use and possession of drugs for personal use are replaced with administrative penalties
- current practices are reviewed and continually improved in line with contemporary evidence
- people who need help for drug-related issues, including those in regional and remote areas or in prison, are able to access that help
- there be measures in place to reduce harms for those who are unwilling or unable to stop using drugs.

13.4 This way forward will mean accepting some fundamental, but challenging, truths:

- Some people will always use drugs, regardless of the legal frameworks in place.
- Not everyone who uses drugs does so in a harmful way.
- For those people addicted to drugs, complete abstinence will not always be a realistic goal.
- Removing criminal penalties for drug use and possession for personal use is unlikely to significantly impact drug use, but it will decrease drug-related harm.

13.5 Operationalising the recommendations of this report will require:

- a coordinated approach across multiple agencies, including government, the AOD sector and in consultation with people with lived experience of drug dependency
- a long-term strategic view spanning more than a single term of government
- clear and measurable objectives from the outset
- regular evaluation and improvement.
RECOMMENDATION 46

The next iteration of the Western Australian Alcohol and Drug Interagency Strategy:
  • is a 10-year strategy
  • aims to reduce the harms associated with drug use to individuals and the community
  • addresses the priorities and recommendations put forward by this Committee
  • incorporates learnings from other Australian and international jurisdictions
  • is evaluated every two years.

Hon Alison Xamon MLC
Chair
### APPENDIX 1

**STAKEHOLDERS INVITED TO SUBMIT, SUBMISSIONS RECEIVED AND PUBLIC HEARINGS**

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<td>Hon Martin Aldridge MLC, Member for the Agricultural Region</td>
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<td>114</td>
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<td>Hon Alannah MacTiernan MLC, Member for the North Metropolitan Region</td>
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<td>Hon Martin Pritchard MLC, Member for the North Metropolitan Region</td>
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<td>Hon Matthew Swinbourn MLC, Member for the East Metropolitan Region</td>
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<td>Hon Dr Sally Talbourn MLC, Member for the South West Region</td>
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<td>Hon Dr Steven Thomas MLC, Member for the South West Region</td>
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<td>140</td>
<td>Hon Colin Tincknell MLC, Member for the South West Region</td>
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<td>141</td>
<td>Hon Darren West MLC, Member for the Agricultural Region</td>
</tr>
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<td>142</td>
<td>Hon Pierre Yang MLC, Member for the South Metropolitan Region</td>
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## SUBMISSIONS RECEIVED

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<td>Dr Charles Slack</td>
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<td>Dunstan Hartley (Family Council of Western Australia)</td>
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<td>24</td>
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<td>Legal Aid Western Australia</td>
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<td>National Drug Research Institute, Curtin University</td>
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<td>Dr George O’Neil, Fresh Start Recovery Program</td>
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<td>Alcohol and Drug Foundation (WA)</td>
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<tr>
<td>68</td>
<td>Craig Cumming, School of Population and Global Health (UWA)</td>
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<tr>
<td>69</td>
<td>Dr Erin Kelly, School of Population and Global Health (UWA)</td>
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<tr>
<td>70</td>
<td>Western Australian Network of Alcohol and other Drug Agencies</td>
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<td>71</td>
<td>Dr Martin Whitely, Curtin University</td>
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<td>72</td>
<td>Killian Harty</td>
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<td>Western Australia Police Force</td>
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<td>Alcohol and Other Drug Consumer and Community Coalition</td>
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<td>Reverend George Davies</td>
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## PUBLIC HEARINGS HELD

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<tr>
<th>Date</th>
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| 11 March 2019   | Office of the Inspector of Custodial Services  
Professor Neil Morgan, Inspector of Custodial Services  
Rowena Davis, Director Reviews  
Cyrenian House  
Carol Daws, Chief Executive Officer  
James Hunter, General Manager |
| 18 March 2019   | Mental Health Matters2  
Margaret Doherty, Convenor  
Caroline Waddington, Steering Group Committee Member  
Virginia Catterall, Independent Consumer Representative  
Department of Justice  
Tony Hassall, Commissioner of Corrective Services  
Michael Johnson, Acting Executive Director, Court and Tribunal Services |
| 8 April 2019    | Ruah Community Services  
Debra Zanella, Chief Executive Officer |
| 15 April 2019   | Western Australia Police Force  
Chris Dawson, Commissioner of Police  
Gary Budge, Assistant Commissioner, State Crime  
Chief Psychiatrist of Western Australia  
Dr Nathan Gibson, Chief Psychiatrist  
Department of Health  
Dr Andrew Robertson, Chief Health Officer, Assistant Director General, Public and Aboriginal Health  
Dr Hui-Min Jessamine Soderstrom, Emergency Consultant, Clinical Toxicologist, Royal Perth Hospital |
| 13 May 2019     | Professor Steve Allsop  
Peer Based Harm Reduction  
Angela Corry, Chief Executive Officer  
Paul Dessauer, Outreach Coordinator |
<table>
<thead>
<tr>
<th>Date</th>
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| 20 May 2019| Sycamore Tree Project / Doors Wide Open  
Dr Jane Anderson, Administrator and Facilitator, Sycamore Tree Project, and Chair, Doors Wide Open  
Ms Michellina Pugh, Operations Manager, Doors Wide Open |
| 10 June 2019| National Drug Research Institute, Curtin University  
Professor Simon Lenton, Director |
| 17 June 2019| Public Health Association of Australia  
Dr Stephen Bright, Senior Lecturer, Edith Cowan University |
|            | Mental Health Commission  
David Axworthy, Assistant Commissioner  
Sue Jones, Assistant Commissioner, Alcohol, Other Drugs and Prevention Services  
Gary Kirby, Director, Prevention Services  
Dr Richard O’Regan, Director Clinical Services, Next Step |
|            | Alcohol and Other Drug Consumer and Community Coalition  
Juanita Koeijers, Project Lead  
Shannon Dixon, Chair |
|            | Dr Kate Seear, Associate Professor in Law, Faculty of Law, Monash University |
|            | European Monitoring Centre for Drugs and Drug Addiction  
Brendan Hughes, Principal Scientist, Drug Legislation |
| 5 August 2019| Students for Sensible Drug Policy  
Joe Panaia, President  
Rebecca Black, Vice President  
Natalia Hazell, Treasurer |
|            | Royal Australian and New Zealand College of Psychiatrists  
Professor Megan Galbally, Chair, WA Branch Committee  
Associate Professor Matthew Coleman, WA Representative of Faculty of Addiction Psychiatry  
Dr Michael Verheggen, Member, WA Branch Committee  
Dr Brendan Jansen, Consultant Psychologist, WA Representative |
## EXTERNAL MEETINGS AND SITE VISITS

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<tr>
<th>Date</th>
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<tr>
<td>1 April 2019</td>
<td>Perth Drug Court Team</td>
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<tr>
<td>24 April 2019</td>
<td>Committee on Health and Welfare, Parliament of Sweden</td>
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<td>Stockholm Centre for Dependency Disorders</td>
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<td>25 April 2019</td>
<td>Stockholm Users Association</td>
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<td>Swedish Police Authority</td>
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<td>Centre for Social Research on Alcohol and Drugs, Stockholm University</td>
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<td>26 April 2019</td>
<td>Accueil a Bas Seuil Foundation, Lausanne Drug Consumption Room</td>
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<td>City of Lausanne Security, Health Observatory and Federal Office of Public Health</td>
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<td>Heroin Assisted Treatment Program, University Hospital Centre of the Canton of Vaud</td>
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<td>29 April 2019</td>
<td>Global Commission on Drug Policy</td>
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<td>Judicial Committee and Health Committee, Cantonal Parliament of Geneva</td>
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<td>30 April 2019</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<td></td>
<td>General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD)</td>
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<td>Mobile Low-Threshold Methadone Van</td>
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<td>2 May 2019</td>
<td>Addictive Behaviours and Dependencies Intervention Division – CRI Lisbon Oriental (DICAD)</td>
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<td>Drug Addiction Dissuasion Commission Lisbon (CDT)</td>
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<td>28 May 2019</td>
<td>Midwest Community Alcohol and Drug Services</td>
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<td>Geraldton Regional Hospital</td>
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<td>WA Police Force – Midwest-Gascoyne</td>
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<td>29 May 2019</td>
<td>Hope Community Services, Hope Springs Community Farm</td>
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<td></td>
<td>Aboriginal Legal Service of WA, Mid-West Office</td>
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<tr>
<td>24 June 2019</td>
<td>Wandoo Rehabilitation Prison for Women</td>
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## DEPARTMENT OF JUSTICE RESPONSE TO QUESTION ON NOTICE

### Drivers for increase in outstanding Individual Management Plans

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| Lack of opportunity for staff to complete assessments within the required timeframe | - The adaptive regime reduces access to prisoners for their assessments and sees prison officers redeployed to other roles, thus reducing their capacity to undertake IMPs and security classifications.  
- Population pressures has resulted in prisoners being moved within the 28 day timeframe requiring staff to travel to prison sites across the state to carry out assessments.  
- Staff in regional areas undertake multiple roles, which places competing demands on the assessment process.  
- The 28 day timeframe placed on the completion of the assessment process was arbitrarily chosen without being informed by baselines. |
| Resourcing | - Staff resources have reduced over the years despite an increase in the prisoner population.  
- The funding model for staff does not address all ancillary services, such as increases to staffing for treatment assessment.  
- The current staff qualification level places restrictions on finding suitable staff, and limits the pool of staff available to undertake assessments.  
- Access to suitable infrastructure to carry out assessments (i.e. suitable individual office space to interview prisoners). |
| Lack of integration of systems and processes | - There may be inconsistent processes and standards across Corrective Services that are implemented and monitored differently across business areas.  
- Operational policy is dated and requires updating as there have been changes to the assessment process.  
- Assessment tools, whilst validated and reliable, are implemented by various levels of qualified staff and with various levels of clinical guidance.  
- Lack of flow of information across assessments leads to a lack of connectivity between the community and prisons. |
| The process is too comprehensive in the initial stages and requires streamlining | - Security classification is included in the comprehensive assessment process. |

Source: Department of Justice answers to questions taken on notice
APPENDIX 3

1999 NATIONAL DRUG STRATEGY OF PORTUGAL - PRINCIPLES

The national drug strategy is based on eight structuring principles:

1. The principle of international cooperation – The principle of international cooperation, defined in the light of the global dimension of the drug problem, signifies the optimisation of Portugal’s intervention, on an international and European level, in the definition and execution of joint strategies and initiatives on the drug problem, as well as the coordination of national policies with international commitments. The principles of international cooperation, therefore, involve five concrete implications for the national drug strategy, which are the following:

   a) Optimisation of Portugal’s active participation in the evaluation and definition of the international community’s drugs strategy, and also in the development of international cooperation initiatives in this field, in compliance, in particular, with the principle of shared responsibility;

   b) Harmonisation of national policies with the international strategy adopted within the framework of the UN and with the international commitments to which the Portuguese State is voluntarily and legally bound;

   c) Optimisation of the active participation of Portugal in the evaluation and definition of the European Union’s strategy on the drug problem, as well as in the development of Community cooperation initiatives;

   d) Harmonisation of national policies with the political and legal instruments in effect in the legal framework of the European Union, as well as the commitments made under the Schengen Agreement;

   e) Optimisation and promotion of bilateral and multilateral cooperation initiatives involving the problem of drugs and drug addiction, especially with Spain and Portuguese-speaking countries and within the framework of Ibero-American cooperation.

2. The principle of prevention – The principle of prevention consists of the primacy of preventive interventions designed to combat drug demand, through appropriate educational and informative actions in the community or with certain target groups, the concrete implications of which are:

   a) The promotion of primary prevention initiatives, in and outside schools, especially in places and institutions frequented by adolescents and young adults, including workplaces and the Armed Forces;

   b) The use of the mass media to publicise information and to mobilise the community towards the drug problem, including raising awareness among media professionals;

   c) The selection of target-groups and the identification of their different characteristics, as well as their potential factors of risk or protection; d) Awareness and publicity of the dangers inherent to the use or abuse of different types of drugs and the different methodologies of their use;

3. The humanistic principle – the humanistic principle means recognition of the human dignity of the people involved in the drug phenomenon and consequently an understanding of the complexity and relevance of the individual, his/her family and background, as well as an awareness of drug addiction as an illness and the consequent assumption of responsibility by the State in upholding the drug

Viewed 12 March 2019.
addict’s constitutional right to health and the avoidance of social exclusion, without prejudice to his/her individual responsibility. Several concrete implications for the national drug strategy arise from this principle:

   a) A guarantee of the conditions needed for access to treatment for all drug addicts who seek treatment, through a national, public network of consultation centres and health care provision, as well as funding for treatment and social reintegration;
   b) A guarantee of minimum standards of quality at the institutions providing services in the field of treatment and social reintegration of drug addicts, through a demanding system of licensing and monitoring;
   c) The promotion of incentives for effective social and professional reintegration of drug addicts, with the adoption of exceptional measures of positive discrimination;
   d) The adoption of harm reduction policies to help preserve an awareness among drug addicts of their own dignity and constitute a means of access to treatment programmes or programmes minimising social exclusion;
   e) Scrupulous definition of the legal framework for the different behaviours related to the drug phenomenon, in compliance with the humanistic principles that shape our justice system as the system of a democratic state governed by the rule of law. These are, namely, the principles of subsidiarity, of the ultima ratio of criminal law and of proportionality, with their corollaries, which are the subprinciples of necessity, appropriateness and prohibition of excess;
   f) The guarantee of access to treatment for imprisoned drug addicts and the promotion of treatment measures as an alternative to prison terms.

4. The principle of pragmatism – The principle of pragmatism, as a principle that inspires the national drug strategy, complements the humanistic principle and determines an attitude of openness to innovation, through the consideration, without dogma or preconceptions, of the scientifically proven results of experiments made in diverse areas of the fight against drugs and drug addiction and the consequent adoption of solutions that are appropriate for the national situation and that can provide positive and practical results. This principle implies:

   a) The promotion of harm reduction policies which, whilst they minimise the effects of use among drug addicts and safeguard their socio-professional reintegration, can also protect society, by favouring a reduction in the risk of spreading infectious diseases and a reduction in the criminality associated with certain forms of drug addiction;
   b) Interested and critical accompaniment of the innovative experiments in course in other countries in the many different fields of the fight against drugs and drug addiction, namely harm reduction and the therapeutic administration of substances, as well as evaluation of their results;
   c) Adoption of solutions that prove to be appropriate for the national situation, having considered the nature of the problems facing Portuguese society, the resources available and the priorities arising from the national drug strategy, as well as the provisions of international conventions.

5. The principle of security – The principle of security involves guaranteeing protection of people and property, in the fields of public health and protection of minors, as well as the prevention and repression of crime, in order to maintain peace and public order. Some essential corollaries emerge from the principle of security:

   a) The fight against illicit trafficking, including the enforcement of appropriate penalties to traffickers and trafficker-users;
b) The legal recognition of mechanisms to permit, in all cases, the seizure of illicit drugs by police authorities and the carrying out of investigation activities necessary in the combat against trafficking;

c) Maintenance of the illegality of use and possession of drugs;

d) Provision for differentiated penalties for acts involving drugs that are more dangerous to health or whose purchase tends to be associated with behaviours injurious to the community’s essential legal assets;

e) The promotion, in the same line as the implications for the principle of pragmatism, of harm reduction policies. That may favour a reduction in the risk of propagation of infectious diseases, a reduction in the criminality associated with drug addiction, or the social and professional reintegration of drug addicts;

f) Promotion of special security measures in schools and other locations frequented by adolescents and young adults.

6. The principle of coordination and rationalisation of resources – The principle of coordination and rationalisation of resources is an organisational principle of the public authorities that involves mechanisms that ensure coordination or efficient articulation between different departments, services and organisations with responsibility in the field of drugs and drug addiction, as well as the optimisation of resources, and avoid overlap and waste. The consequences of this principle are the following:

a) The existence of a system of interdepartmental coordination on drugs and drug addiction;

b) The elimination of overlapping attributions and responsibilities existing among different State organisations;

c) The optimisation of management of existing human resources and materials, including the promotion of vocational training initiatives and evaluation in this field;

d) The coordination of the funding to be granted to projects and initiatives that are the responsibility of private entities and the evaluation of the respective results.

7. The principle of subsidiarity – The principle of subsidiarity implies the distribution of responsibilities and competencies enabling decisions and actions to be entrusted to the level of Administration that is closest to the population, except when the objectives in mind are better fulfilled at a higher level. This principle comprises three subprinciples:

a) The subprinciple of decentralisation, which requires the involvement of local authorities in the issue of drug addiction, especially in the area of primary prevention.

b) The subprinciple of deconcentration, which proposes a model for the structuring of central administration organisations in the field of drugs and drug addiction which is not limited to central services but also includes services closer to the population, on a local level, in particular;

c) The subprinciple of centralisation, which determines the attribution of responsibilities to central administration on issues of drugs and drug addiction when this permits more efficient execution of the objectives envisaged.

8. The principle of participation – The principle of participation consists of the intervention of the community in the definition of policies on drugs and drug addiction, as well as its mobilisation for different aspects of the fight against drugs. The following are specific implications of the principle of participation:
a) Optimisation of the National Council for Drug Addiction and other mechanisms of organic and procedural participation by citizens, by representative associations and by institutions interested in the definition of policies towards drugs and drug addiction;

b) Support for the initiatives of institutions representing civil society in the domains of primary, secondary and tertiary prevention;

c) Incentives for the operation of a network of private institutions providing services in the fields of treatment and social reintegration of drug addicts, through financial funding to be granted to families, above all to the most needy;

d) Increasing awareness and mobilisation among families, teachers, schools, institutions representing civil society, media professionals and, above all, young people themselves, in relation to the problem of drugs and drug addiction and to individual roles in relation to the drug issue.
APPENDIX 4

1999 NATIONAL DRUG STRATEGY OF PORTUGAL – GENERAL OBJECTIVES

There are six general objectives of the national drug strategy:

I. To contribute to an appropriate and efficient international and European strategy for the world drug problem, as regards demand and supply reduction and which includes the fight against illicit trafficking and money laundering.

II. To provide Portuguese society with better information about the phenomenon of drugs and drug addiction, as well as the dangers of particular drugs, from a preventive perspective.

III. To reduce the use of drugs, especially among younger members of the population.

IV. To guarantee the necessary resources for treatment and social reintegration of drug addicts.

V. To protect public health and the security of people and property.

VI. To repress illicit traffic of drugs and money laundering.
APPENDIX 5

IN VOLUNTARY TREATMENT UNDER THE MENTAL HEALTH ACT 2014

Mental Health Act 2014

24. Making involuntary treatment order

(1) Only a psychiatrist may make an involuntary treatment order.

(2) A psychiatrist cannot make an involuntary treatment order except in accordance with this Act.

(3) A psychiatrist cannot make an inpatient treatment order in respect of a person unless satisfied, having regard to the criteria specified in section 25(1), that the person is in need of an inpatient treatment order.

(4) Before deciding whether or not to make an inpatient treatment order in respect of a person, a psychiatrist must consider whether the objects of this Act would be better achieved by making a community treatment order in respect of the person.

(5) A psychiatrist cannot make a community treatment order in respect of a person unless satisfied, having regard to the criteria specified in section 25(2), that the person is in need of a community treatment order.

(6) An involuntary treatment order made in respect of a person must —
   (a) be in force for as brief a period as practicable; and
   (b) be reviewed regularly; and
   (c) be revoked as soon as practicable after the person no longer meets the criteria for the order.

25. Criteria for involuntary treatment order

(1) A person is in need of an inpatient treatment order only if all of these criteria are satisfied —
   (a) that the person has a mental illness for which the person is in need of treatment;
   (b) that, because of the mental illness, there is —
      (i) a significant risk to the health or safety of the person or to the safety of another person; or
      (ii) a significant risk of serious harm to the person or to another person;
   (c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;
   (d) that treatment in the community cannot reasonably be provided to the person;
   (e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on
the person’s freedom of choice and movement than making an inpatient treatment order.

(2) A person is in need of a community treatment order only if all of these criteria are satisfied —
   (a) that the person has a mental illness for which the person is in need of treatment;
   (b) that, because of the mental illness, there is —
       (i) a significant risk to the health or safety of the person or to the safety of another person; or
       (ii) a significant risk of serious harm to the person or to another person; or
       (iii) a significant risk of the person suffering serious physical or mental deterioration;
   (c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;
   (d) that treatment in the community can reasonably be provided to the person;
   (e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person’s freedom of choice and movement than making a community treatment order.

(3) A decision whether or not a person is in need of an inpatient treatment order or a community treatment order must be made having regard to the guidelines published under section 547(1)(a) for that purpose.

Note for Division 1:
Part 21 Division 3 confers jurisdiction on the Mental Health Tribunal to conduct reviews relating to involuntary patients.

Division 2 — Referrals for examination

Subdivision 1 — Person suspected of needing involuntary treatment order

26. Referral for examination at authorised hospital or other place

(1) A medical practitioner or authorised mental health practitioner may refer a person under subsection (2) or (3)(a) for an examination conducted by a psychiatrist if, having regard to the criteria specified in section 25, the practitioner reasonably suspects that —
   (a) the person is in need of an involuntary treatment order; or
   (b) if the person is under a community treatment order — the person is in need of an inpatient treatment order.
(2) The practitioner may refer the person for an examination to be conducted by a psychiatrist at an authorised hospital.

(3) The practitioner —
   (a) may refer the person for an examination to be conducted by a psychiatrist at a place that is not an authorised hospital if, in the practitioner’s opinion, it is an appropriate place to conduct the examination having regard to the guidelines published under section 547(1)(b) for that purpose; and
   (b) if the practitioner refers the person under paragraph (a) — must make any arrangements that are necessary to enable the examination to be conducted at that place.

(4) Subdivision 3 applies in relation to the referral of a person under subsection (2) or (3)(a).

(5) Sections 27 to 30 apply in relation to a person who is referred under subsection (2) or (3)(a).

Notes for section 26:
1. A person who is referred under section 26(2) or (3)(a) can be detained under an order made under section 28(1) or (2) to enable the person to be taken to the authorised hospital or other place and can be detained there under section 52(1)(b) or 58(1)(b) to enable the person to be examined.
2. Part 7 Division 4 applies in relation to the release of a person who is detained under section 28(1) or (2), 52(1)(b) or 58(1)(b).
3. Part 7 Division 5 applies if a person who is detained under section 28(1) or (2), 52(1)(b) or 58(1)(b) is absent without leave from the authorised hospital or other place where the person is be detained.

27. Person to be taken to authorised hospital or other place as soon as practicable

The person must be taken to the authorised hospital or other place as soon as practicable and, in any event, before the referral expires, whether or not a transport order is made under section 29(1) in respect of the person.

28. Detention to enable person to be taken to authorised hospital or other place

(1) A medical practitioner or authorised mental health practitioner may make an order authorising the person’s detention for up to 24 hours from the time when the order is made if satisfied that the person needs to be detained to enable the person to be taken to the authorised hospital or other place.

(2) A medical practitioner or authorised mental health practitioner may, immediately before the end of the period of detention authorised under subsection (1) or any further period of detention authorised under this subsection in respect of the person, make an
order authorising the continuation of the person’s detention for up
to 24 hours from the end of that period to enable the person to be
taken to the authorised hospital or other place.

(3) The person cannot be detained under orders made under this
section for a continuous period of more than —
(a) if the place where the referral is made is in a metropolitan
area — 72 hours; or
(b) if the place where the referral is made is outside a
metropolitan area — 144 hours.

(4) A practitioner cannot make an order under subsection (2) in
respect of the person unless —
(a) immediately before making the order, the practitioner
assesses the person; and
(b) as a consequence, the practitioner is satisfied that the
person still needs to be detained to enable the person to
be taken to the authorised hospital or other place.

(5) Subdivision 4 applies in relation to an assessment required by
subsection (4)(a).

(6) An order made under this section must be in the approved form
and must include the following —
(a) the date and time when it is made;
(b) the date and time when it expires;
(c) the reasons for making it;
(d) the name, qualifications and signature of the practitioner
making it.

(7) A practitioner who makes an order under this section in respect of
the person must, as soon as practicable, file it and give a copy to
the person.

(8) The making of an order under this section is an event to which
Part 9 applies and the practitioner who makes the order is the
person responsible under that Part for notification of that event.

(9) A practitioner who makes an order under this section in respect of
the person must ensure that the person has the opportunity and the
means to contact any carer, close family member or other personal
support person of the person, a health professional who is
currently providing the person with treatment and the Chief
Mental Health Advocate —
(a) as soon as practicable after the order is made; and
(b) at all reasonable times while the person is detained under
the order.
(10) The person cannot continue to be detained if, by the end of a period of detention authorised under this section in respect of the person —
   (a) the person has not been taken to the authorised hospital or other place; and
   (b) an order under subsection (2) authorising the continuation of the person’s detention from the end of the period has not been made or, because of subsection (3), cannot be made; and
   (c) the person has not been apprehended under a transport order made under section 29(1).

(11) The person cannot continue to be detained if the referral expires before the person is taken to the authorised hospital or other place.

(12) The release of a person because of subsection (10) or (11) is an event to which Part 9 applies and a medical practitioner or authorised mental health practitioner is the person responsible under that Part for notification of that event.

29. Making transport order

(1) A medical practitioner or authorised mental health practitioner may make a transport order in respect of the person.

(2) The practitioner cannot make the transport order unless satisfied that —
   (a) the person needs to be taken to the authorised hospital or other place; and
   (b) no other safe means of taking the person is reasonably available.

(3) Part 10 applies in relation to the transport order.

(4) The making of a transport order under subsection (1) is an event to which Part 9 applies and the practitioner who makes the order is the person responsible under that Part for notification of that event.
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ABS Foundation</td>
<td>Accueil a Bas Seuil Foundation</td>
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<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<td>Act</td>
<td><em>Misuse of Drugs Act 1981</em></td>
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<td>ANU</td>
<td>Australian National University</td>
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<tr>
<td>AOD</td>
<td>Alcohol and other drug</td>
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<td>BAS</td>
<td>Beroendeakuten Stockholm</td>
</tr>
<tr>
<td>Bupropion</td>
<td>Prescription drug used mainly to treat depression and cease smoking</td>
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<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
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<tr>
<td>CDT</td>
<td>Commission for the dissuasion of drug addiction (Portugal)</td>
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<tr>
<td>Centre</td>
<td>Stockholm Centre for Dependency Disorders</td>
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<tr>
<td>CIRS</td>
<td>Cannabis Intervention Requirement Scheme</td>
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<tr>
<td>CIS</td>
<td>Cannabis Intervention Session</td>
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<tr>
<td>CIN</td>
<td>Cannabis Infringement Notice</td>
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<tr>
<td>Committee</td>
<td>Select Committee into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community</td>
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<tr>
<td>DCR</td>
<td>Conditional Drug Court Regime</td>
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<tr>
<td>Demand reduction</td>
<td>Strategies aimed at reducing the desire for drugs</td>
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<td>Detox</td>
<td>Detoxification</td>
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<tr>
<td>Drug checking</td>
<td>A harm reduction service providing chemical analysis of an illegal drug, often accompanied by education, information and brief intervention. Also commonly known as pill testing</td>
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<tr>
<td>Drug use disorder</td>
<td>A medical condition in which the use of one or more substances leads to clinically significant impairment or distress. Also known as substance use disorder.</td>
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<tr>
<td>Drug-related offending</td>
<td>Other offending that relates to a person's drug use. This may include acquisitive property crime to feed drug addiction and violent crimes committed while under the influence of drugs.</td>
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<tr>
<td>Ecstasy</td>
<td>Street name for MDMA</td>
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<tr>
<td>EMCDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<tr>
<td>ESPAD</td>
<td>The European Schools Survey Project on Alcohol and Other Drugs</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Four pillars policy</td>
<td>National drug policy of Switzerland including law enforcement, treatment, prevention and harm minimisation</td>
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<tr>
<td>GHB</td>
<td>Gamma hydroxybutyrate</td>
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<tr>
<td>GREA</td>
<td>Groupement Romand d’Etudes des Addictions</td>
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<tr>
<td>Hallucinogens</td>
<td>A class of psychedelic drugs that change a person’s perception of reality, including LSD (D-lysergic acid diethylamide) and psilocybin mushrooms</td>
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<tr>
<td>Harm reduction</td>
<td>Public health policies and practices that aim to reduce the harms associated with drug use for those people who are unable or unwilling to stop</td>
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<tr>
<td>HAT</td>
<td>Heroin assisted treatment</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>Hyponatremia</td>
<td>Low sodium concentration in the blood, which may result in confusion, seizures, kidney failure or heart failure</td>
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<tr>
<td>Illicit drug offending</td>
<td>Use, possession, cultivation, manufacture and distribution under the Misuse of Drugs Act 1981</td>
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<tr>
<td>IDAT</td>
<td>The Involuntary Drug and Alcohol Treatment Program (NSW)</td>
</tr>
<tr>
<td>IMP</td>
<td>Individual Management Plan</td>
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<tr>
<td>INCB</td>
<td>International Narcotics Control Board</td>
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<tr>
<td>ITO</td>
<td>Involuntary Treatment Order under the Mental Health Act 2014</td>
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<tr>
<td>Justice</td>
<td>WA Department of Justice</td>
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<tr>
<td>Lifetime drug use</td>
<td>A measure capturing whether a person has ever used an illicit drug in their lifetime</td>
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<tr>
<td>Lisdexamfetamine</td>
<td>Prescription drug used to treat attention deficit hyperactivity disorder</td>
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<tr>
<td>LSD</td>
<td>D-lysergic acid diethylamide</td>
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<tr>
<td>MDMA</td>
<td>Methylenedioxymethamphetamine</td>
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<tr>
<td>Mephedrone</td>
<td>Mephedrone (4-methyl ephedrine) is a synthetic stimulant drug of the amphetamine and cathinone classes, also known as bath salts or meow meow.</td>
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<tr>
<td>Meth</td>
<td>Methamphetamine</td>
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<tr>
<td>Meth Taskforce</td>
<td>WA Government Methamphetamine Action Plan Taskforce</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act 2014</td>
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<tr>
<td>MHOA</td>
<td>Mental Health Observation Area</td>
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<td>Term</td>
<td>Definition</td>
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<tr>
<td>Modafinil</td>
<td>Prescription drug used to treat narcolepsy-related sleepiness</td>
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<tr>
<td>MSIC</td>
<td>Medically Supervised Injection Centre, also commonly known as a Drug Consumption Room</td>
</tr>
<tr>
<td>NAC</td>
<td>N-acetylcysteine</td>
</tr>
<tr>
<td>National Strategy</td>
<td>National Strategy for the Fight Against Drugs (Portugal)</td>
</tr>
<tr>
<td>NBOMES</td>
<td>N-methoxybenzyl - a series of new psychoactive substances with psychedelic effects</td>
</tr>
<tr>
<td>N-ethylpentylone</td>
<td>N-ethylpentylone is a substituted cathinone (bath salt), which can be very potent and has been associated with deaths.</td>
</tr>
<tr>
<td>N-ICE Trial</td>
<td>NDARC study on whether N-acetylcysteine can treat meth dependence</td>
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<tr>
<td>NDARC</td>
<td>National Drug and Alcohol Research Centre, University of New South Wales</td>
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<tr>
<td>NDRI</td>
<td>National Drug Research Institute, Curtin University</td>
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<tr>
<td>Non-problem drug use</td>
<td>Drug use that does not negatively affect a person’s life, including occasional or recreational use</td>
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<tr>
<td>NSEP</td>
<td>Needle and syringe exchange program, used interchangeably with NSP</td>
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<tr>
<td>NSP</td>
<td>Needle and syringe program, used interchangeably with NSEP</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>NZ Act</td>
<td><em>Misuse of Drugs Amendment Act 2019 (NZ)</em></td>
</tr>
<tr>
<td>ODIRS</td>
<td>Other Drug Intervention Requirement Scheme</td>
</tr>
<tr>
<td>ODIS</td>
<td>Other Drug Intervention Session</td>
</tr>
<tr>
<td>Past year drug use</td>
<td>A measure capturing whether a person has used an illicit drug in the past 12 months</td>
</tr>
<tr>
<td>PMA</td>
<td>Para-Methoxymphetamine - a stimulant with psychedelic effects similar to MDMA, but with more toxic effects.</td>
</tr>
<tr>
<td>Polydrug use</td>
<td>When a person uses two or more drugs, either at the same time or at different times or in combination</td>
</tr>
<tr>
<td>Problem drug use</td>
<td>Regular or long-term drug use, particularly that resulting in dependency</td>
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<tr>
<td>Room</td>
<td>Drug Consumption Room in Lausanne, Switzerland</td>
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<tr>
<td>UCC</td>
<td>Urgent Care Clinic at Royal Perth Hospital</td>
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<tr>
<td>US</td>
<td>United States of America</td>
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<tr>
<td>Reagent pill testing kits</td>
<td>Chemical test kits that react to a drug sample by changing colour</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>SICAD</td>
<td>General-Directorate for Intervention on Addictive Behaviours and Dependencies (Portugal)</td>
</tr>
<tr>
<td>SKL</td>
<td>Swedish Association of Local Authorities and Regions</td>
</tr>
<tr>
<td>Sniffer dogs</td>
<td>Drug detection dogs</td>
</tr>
<tr>
<td>STA-SAFE</td>
<td>The Safety Testing Advisory Service</td>
</tr>
<tr>
<td>Stigma</td>
<td>Associations of public disapproval that may result in discrimination</td>
</tr>
<tr>
<td>STIR</td>
<td>Supervised Treatment Intervention Regime</td>
</tr>
<tr>
<td>SSDT Act</td>
<td><em>Severe Substance Dependence Treatment Act 2010</em> (Vic)</td>
</tr>
<tr>
<td>Supply reduction</td>
<td>Strategies aimed at reducing the availability of drugs</td>
</tr>
<tr>
<td>THC</td>
<td>Tetrahydrocannabinol</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
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<tr>
<td>WANADA</td>
<td>WA Network of Alcohol and Other Drug Agencies</td>
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<tr>
<td>Wandoo</td>
<td>Wandoo Rehabilitation Prison for Women</td>
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<tr>
<td>WISE project</td>
<td>WA Illicit Substance Evaluation Project</td>
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Select Committee into alternate approaches to reducing illicit drug use and its effects on the community

Date first appointed:
17 October 2018

Terms of Reference:

(1) A Select Committee examining alternate approaches to reducing illicit drug use and its effects on the community is established.

(2) The Select Committee is to inquire into and report on —

   (a) other Australian state jurisdictions and international approaches (including Portugal) to reducing harm from illicit drug use, including the relative weighting given to enforcement, health and social interventions;

   (b) a comparison of effectiveness and cost to the community of drug related laws between Western Australia and other jurisdictions;

   (c) the applicability of alternate approaches to minimising harms from illicit drug use from other jurisdictions to the Western Australian context; and

   (d) consider any other relevant matter.

(3) The Select Committee is to report no later than twelve months after the motion is agreed to.

(4) The Select Committee shall consist of five members; Hon Alison Xamon (Chair); Hon Samantha Rowe (Deputy Chair); Hon Colin de Grussa; Hon Michael Mischin; and Hon Aaron Stonehouse.