Submission

on the

Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia

to the

Education and Health Standing Committee

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1. Introduction

On 14 May 2009 the Education and Health Standing Committee resolved to inquire into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia, with particular reference to:

(a) the evidence base, content, implementation and resourcing (including teacher training) for health education and other interventions on alcohol and illicit drugs for school-aged students;

(b) the evidence base, adequacy, accessibility and appropriateness of the broad range of services for treatment and support of people with alcohol and drug problems and their families, and the most appropriate ways to ensure integrated care; and

(c) the adequacy of the current education and training of medical and allied health professionals in the alcohol and drug field.

The Committee has called for public submissions to be lodged by 31 July 2009. The Committee will report to the House by 30 March 2010.

This submission addresses:

- Illicit drug policy: Harm minimisation or a drug free society?
- Cannabis laws
- Naltrexone

2. Harm minimisation or a drug free society?

Before analysing specific prevention and treatment services for illicit drug problems, consideration needs to be given to the fundamental policy approach to illicit drugs.

The current National Drug Strategy 2004-2009 explicitly endorses harm minimisation as "the primary principle underpinning the National Drug Strategy." It refers to "policies and programs aimed at reducing drug-related harm... Harm minimisation includes preventing anticipated harm and reducing actual harm." Harm reduction strategies are defined as "strategies that are designed to reduce the impacts of drug-related harm on individuals and communities. Governments do not condone illegal risk behaviours such as injecting drug use: they acknowledge that these behaviours occur and that they have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause."[1]

Two comprehensive reports by committees of the House of Representatives have called for the replacement of the harm minimisation policy.

2.1 Road to Recovery - 2003

In September 2003 after a three and a half year inquiry, the Standing Committee on Family and Community Affairs, issued on 8 September 2003, a very significant report on illicit substance use in Australian communities. The report, entitled Road to Recovery, had as its key recommendation (122) that "the Commonwealth, State and Territory governments replace the current focus of the National

Drug Strategy on harm minimisation with a new focus on harm prevention and treatment of substance dependent people."[2]

Harm minimisation has been one of the key principles of Australia's drug strategy since 1985. It has been used to justify a range of measures that tolerate the use of illicit drugs while attempting to minimise particular harms to drug users, such as overdosing, contracting infectious diseases and other adverse side effects. Many of the supporters of harm minimisation stress the impossibility of significantly reducing the level of illicit drug use and often tend to ascribe harm to the illicit nature of the drugs consumed rather than to the substances themselves. Harm minimisation measures implemented or proposed in Australia include needle and syringe exchanges, injecting rooms, heroin prescription, methadone substitution, liberal cannabis laws and testing kits for ecstasy.

The Committee's recommendation, if implemented, would re-focus our drug strategy towards preventing new users from taking up illicit drugs and providing effective treatments aimed at cessation of substance abuse for those who are chronic substance abusers.

In regard to treatment for heroin addicts, the Committee recommended that the ultimate objective of methadone maintenance must be to assist users to become abstinent from all opioids (52) and that priority be given to treatments, including naltrexone, that focus on abstinence at the ultimate outcome (54). The committee also recommended that, as a matter of urgency, the Commonwealth fund a trial of naltrexone implants, coupled with the support services required for efficacy, and that naltrexone be placed on the Pharmaceutical Benefit Scheme for the treatment of opioid dependence.

The Committee was impressed with the beneficial results from therapeutic communities, such as those run by Teen Challenge. It recommended funding to establish such communities throughout urban and rural areas in every State (56).

The Committee recommended that heroin prescription trials not proceed (57).

The myth, often propagated by advocates of liberal drug laws, that cannabis use is relatively harmless was seen as a major problem, and as one factor in the widespread use of cannabis, especially by young people. The Committee accepted the weight of evidence that there are serious dangers to physical and mental health associated with regular cannabis use and called for urgent development and dissemination of cannabis cessation strategies (61-63).

Labor MPs Graham Edwards, Julia Irwin and Harry Quick unfortunately dissented from the Committee's report on key recommendations, defending the longstanding focus on harm minimisation, supporting injecting rooms, prescription heroin trials and methadone maintenance without any abstinence goal, and opposing the Committee's support for naltrexone and therapeutic communities.

Significantly, and to her credit, Labor MP and former ACTU head, Jennie George not only refused to join her colleagues in their dissent but in her own additional remarks strongly endorsed the view that "prevention and treatment of substance abuse should be enhanced". She stressed "the urgent need for further research into the use of naltrexone given that many people are now 'parked' on methadone maintenance programs." She accurately described opioid dependency as a "chronic, relapsing disease" that cannot be wished away. Society has an "obligation to provide the necessary support for people seeking to break their dependency".

One disappointing aspect of the Report was its partial endorsement of needle and syringe distribution programs. At a cost of over $20 million to taxpayers nearly 32 million needles were distributed in the year 1999/2000. The Committee noted the claim in the "Evaluation of Council of Australian Government's initiatives on illicit drugs: final report" that needle distribution programs had resulted in the prevention of 25,000 cases of HIV and 21,000 cases of hepatitis C over the ten years from 1991. Nonetheless the Committee did recommend that the Australian National Audit Office undertake a

complete evaluation of needle and syringe programs assessing distribution, inadequate exchange, accountability and the impact on both HIV and hepatitis C (66).

The Committee expressed particular concern that the incidence of HIV and hepatitis C was escalating despite the quantity of syringes distributed. The Committee did not seem to be aware of the body of evidence which demonstrates that needle exchanges actually increase the rate of needle sharing and that hepatitis C is spread among users of needle exchanges even when they refrain from sharing needles but share drug ampoules, water, cotton swabs, and other paraphernalia.[3]

2.2 The winnable war on drugs - 2007

Four years later in September 2007 the Standing Committee on Family and Human Services reported on its inquiry into the impact of illicit drug use on families.[4]

The report was scathing about the detrimental impact of the harm minimisation strategy:

> *The destruction of an individual's humanity by the use of illicit drugs is unarguable.*
>
> *What is required is policy to prevent harm to individuals from illicit drugs, not policy to merely reduce or minimise it.*
>
> *Prevention necessitates self-control and self-esteem. Thus policies need to be based on higher principles and morality. Those who promote harm minimisation say it has a morally neutral stance, stating that drug use is neither good nor bad.*
>
> *It is the prevalence of this amoral stance that has allowed the plight of families, particularly vulnerable little children, to be hidden victims of illicit drug use. The aim for these people is not to prevent harm but merely to reduce or minimise it.*
>
> *One witness, Ryan Hidden, told the committee:*
>
> *"I survived harm minimisation, because it literally threatened to destroy my life and my family's life through the messages that it can implant into that structure and the way it threatened to tear us apart, literally. It was almost like that was its objective; it did not want me to escape my addiction, it wanted me to stay stuck there."*
>
> *Australia needs a prevention policy to protect her young and a rehabilitation policy to save those who slip.*[5]

The committee recommended that:

> *The Commonwealth Government develop and bring to the Council of Australian Governments a national illicit drug policy that:*
>
> - *replaces the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free; and*
> - *only provide funding to treatment and support organizations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants.*[6]

The committee also recommended that:

> *The Commonwealth Government:*
>
> - *amend the National Pharmacotherapy Policy for People Dependent on Opioids to specify that the primary objective of pharmacotherapy treatment is to end an individual's opioid use; and*
>
> - *renegotiate funding arrangements for methadone maintenance programs to require the states and territories to commit sufficient funding to provide comprehensive support services to meet the revised National Pharmacotherapy Policy for People Dependent on Opioids objective.*[7]

This recommendation is addressed to methadone maintenance programs that have no end goal of getting an individual free of opioid use.

The committee also called for the listing of naltrexone implants on the pharmaceutical benefits scheme[8] and for "a review of needle and syringe exchange programs to assess whether they are successful in directing drug users to appropriate treatment to enable them to be drug free individuals."[9]

On drug education, the committee called for the "reviewing and updating the National School Drug Education Strategy to reiterate a commitment to a zero tolerance approach to illicit drugs and reflect the desire of parents for their children not to use illicit drugs."[10]

2.3 The Swedish model

The table below compares Australia and Sweden for annual prevalence of use of various categories of illicit drug expressed as a percentage of the population aged 15-64. Prevalence in Australia ranges from 235.3% (for opiates) to 1400% (for ecstasy) of prevalence in Sweden for use of particular drugs.[11]

	Prevalence as % of population aged 15-64 who have used in the last twelve months		
DRUG USED	**Australia**	**Sweden**	**Australia/Sweden%**
Opiates	0.40	0.17	235.3%
Cocaine	1.9	0.6	316.7%
Cannabis	10.6	2.1	504.7%
Amphetamines	2.7	0.6	450%
Ecstasy	4.2	0.3	1400%

A recent review of Sweden's drug policy by the United Nations Office of Drugs and Crime concluded:

> "*Following a short period of liberalization in the second half of the 1960s, Sweden has pursued restrictive drug control strategies that address both drug supply and drug demand.*
>
> *"In parallel, Sweden has invested heavily in addressing the drug problem. Drug-related expenditures were equivalent to 0.5 per cent of GDP, the second highest proportion among all EU countries. This investment has paid off.*
>
> *"The number of drug users in Sweden today seems to be smaller than it was before the advent of a concerted drug policy, starting in 1969 when the Government introduced a ten point programme against drugs.*
>
> *"In 2006, 6 per cent of the students age 15-16 had used drugs, down from 15 per cent in 1971… While average levels of life-time prevalence of drug use among 15-16 years in Europe amounted to 22 per cent on average, the corresponding rate in Sweden was 8 per cent in 2003, before falling to 6 per cent in 2006…*
>
> *"The ambitious goal of the drug-free society has been questioned not only outside the country but in Sweden itself, as a number of research papers on the subject attest. Nevertheless, despite several reviews of expert commissions, the vision has not been found to be obsolete or misdirected. As shown in this report, the prevalence and incidence rates of drug abuse have fallen in Sweden while they have increased in most other European countries. It is perhaps that ambitious vision that has enabled Sweden to achieve this remarkable result."*[12]

The current Swedish National Action Plan on Drugs was unanimously endorsed by the Swedish Parliament in April 2006. Cross party support for this policy is a notable feature.

> *"All parties agreed that the overall goal of the Swedish drug policy remains to strive for a drug-free society… There is a wide consensus about the overall goal of the drug policy, namely the drug-free society and its objectives: to reduce the recruitment of young people to drug abuse; to enable drug abusers to stop their drug abuse, and to reduce the availability of illicit drugs… The goal is outlined as follows: The drug policy is based on the right to a life with dignity in a society that guards the needs of the individual to feel safe and secure. Narcotic drugs should never be allowed to threaten the health, the quality of life and the security of the individual nor the general welfare or the development of democracy. The goal is a society free of drugs."*[13]

2.4 Abandoning harm minimisation

This Committee should recommend that the current focus on harm minimisation be replaced with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free.

Specifically, the Committee should recommend to the government that it cease all financial support for harm minimisation programs including needle exchanges, cannabis infringement notice schemes, and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence).

The Committee should recommend that the government investigate the detailed operation of the successful Swedish drug policy and adopt it as a model for a new Western Australian Drug Strategy.

Recommendation 1:

The Committee should call on the government to replace the current focus on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free.

Recommendation 2:

The Committee should call on the government to cease immediately all financial support for harm minimisation programs including needle exchanges, cannabis infringement notice schemes, and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence).

Recommendation 3:

The Committee should call on the government to investigate the detailed operation of the successful Swedish drug policy and to adopt it as a model for a new Western Australian Drug Strategy.

3. Cannabis

3.1 Prevalence of cannabis use

The 2007 National Household Survey reported that 10.8% of Western Australians aged 14 or over had used cannabis in the past twelve months. This was second only to the Northern Territory (13.8%) and higher than the national average of 9.1%.[14]

Recent use by males aged 14-24 was 25% (national average 19%) and females aged 14-24 was 19.3% (national average 15%).[15]

3.2 Harms of cannabis use

Since the Cannabis Infringement Notice (CIN) scheme was introduced in March 2004 there has been further information on the harms due to cannabis use.

A New Zealand longitudinal study found that "the results of the present study add to a growing body of evidence suggesting that regular cannabis use may increase risks of psychosis. The present study suggests that: (a) the association between cannabis use and psychotic symptoms is unlikely to be due to confounding factors; and (b) the direction of causality is from cannabis use to psychotic symptoms."[16]

A meta-analysis published concluded that "The evidence is consistent with the view that cannabis increases risk of psychotic outcomes independently of confounding and transient intoxication effects, although evidence for affective outcomes is less strong. The uncertainty about whether cannabis causes psychosis is unlikely to be resolved by further longitudinal studies such as those reviewed here. However, we conclude that there is now sufficient evidence to warn young people that using cannabis could increase their risk of developing a psychotic illness later in life." The study reported "an increase in risk of psychosis of about 40% in participants who had ever used cannabis", and a clear dose-response effect with an increased risk of 50–200% in the most frequent users.[17]

On the basis of this review, and other recent studies, the editors of the Lancet renounced their 1995 position that "The smoking of cannabis, even long term, is not harmful to health."[18]

In January 2009 the UK government reclassified cannabis as a Class B drug reversing the 2004 decision to downgrade it to a Class C drug.[19]

This decision reflected the growing consensus about the adverse impacts on mental health from cannabis use.

3.3 Cannabis Infringement Notice Scheme

The previous government ordered a review of the Cannabis Infringement Notice Scheme which had come into effect under the Cannabis Control Act 2003. The report of the review was tabled on 29 November 2007.[20]

The review recommended the continuation of the Cannabis Infringement Notice scheme with some modifications.

- The CIN scheme should no longer apply to cultivation (two non-hydroponic plants per household are covered) or to amounts of cannabis greater than 15 g (the upper limit is 30 g).

- The scheme should be extended to juveniles but with expiation being by means only of an individualised intervention of at least one session.

The second proposal has some merit as there is evidence that many juveniles are simply being given unrecorded verbal warnings. However, the proposal could be supported only if after the intervention there was a period of drug testing to ensure change of behaviour.

The review acknowledged the problem of non-compliance (25% of those issued CINs neither attend a Cannabis Education Session nor pay the fine) but minimised this problem by comparing this to non-compliance for other fines. The only proposal was to include Work Development Orders as an outcome for non-payment. (These are used for non-payment of court costs.)

The low rate of electing attendance at a Cannabis Education session was identified as of some concern. However, the only recommendation adopted was to increase the fines to make the CES seem more attractive. It did not seem to occur to the review that this may merely increase the non-compliance rate.

The whole discussion is worth quoting:

> *"Whilst the review considered that mandatory education was feasible as the only option for complying with a CIN, it was decided that on balance there is not a strong case for making this change for adults.*
>
> *"The current arrangement already achieves a high rate of expiation (up to 75%) and limiting the options for expiation may reduce compliance rates. In addition, mandatory education already applies for offenders who receive CINs on more than two separate days in the past three years.*
>
> *"Accordingly, the review determined that it was appropriate to retain the ability to comply with the CIN either by attending an education session or by payment of a financial penalty. However, the review determined that the financial penalty should be increased to provide a greater incentive to attend a cannabis education session.*
>
> *"Importantly, the review considered that for adults, a valuable mechanism to support the downward trend in cannabis use would be to implement targeted public education campaigns… The review determined that any future evaluation of the CIN scheme should revisit the issue of*

mandatory education for adults and also assess the impact of the changes that are currently proposed."

The review does have an extensive discussion on the latest research on the harms of cannabis, especially the mental health issues. There is some attempt to minimise this but the important Swedish and New Zealand longitudinal studies are reported in detail.

The review recommended that:

> *(a) there should be an ongoing program of general community and targeted education campaigns that are able to contribute to changing behaviours related to cannabis use over time; and*
>
> *(b) the Drug and Alcohol Office review and enhance, where appropriate, training and resource materials for relevant health professionals on cannabis and related risks.*

The review failed to come to grips with the implications of the data showing that convictions for the relevant drug offences have barely declined (in some cases they have gone up) but the CIN scheme has increased the total number of "consequences". This effect, "net widening" is discussed in the report, but the obvious conclusion that the CIN scheme is not reducing the contact of minor drug users with the criminal justice system is not drawn.

In light of the failure of the CIN scheme to direct offenders to appropriate education and help, and to significantly reduce convictions for cannabis offences, as well as the new information confirming the harms of cannabis use, and the evidence from Sweden of the success of a model based on aiming for a drug free society, the Cannabis Infringement Scheme should be abandoned.

In its place the government should restore criminal penalties, including custodial sentences, but link these to the possibility of participation in effective education and rehabilitation programs, that include regular drug testing to ensure compliance. The Government should investigate the detailed operation of the successful Swedish model.

3.4 Government policy

One of the outstanding items from the "*Liberal plan for the first 100 days in office*" is to "repeal Labor's soft-on-cannabis laws and legislate tougher penalties for drug possession, cultivation, the sale of drugs to children, and the sale of drug paraphernalia."[21]

The committee should call on the government to implement this election commitment as a matter of priority.

In its election policy statement "*Tackling Illicit Drugs in our Community: Law Enforcement*" the Liberal Party stated:

> *The Liberal Party is realistic about the use of cannabis in Western Australia. We recognise that there should be some room to divert experimental cannabis users into education and treatment. But, the Liberal Party believes the on-going tolerance of cannabis provided under Labor's laws is unacceptable.*

The policy included commitments to:

- *Repeal Labor's soft-on-cannabis legislation (Cannabis Control Act 2003) and reinstate the one-time cautioning system for possession only;*

- *Introduce a new limit for possession of 10g of cannabis or less – down from 30g allowed under Labor;*

- *Require first time offenders, juvenile and adult, to attend a mandatory cannabis education programme;*

- *Prosecute as criminal offences all subsequent possession offences; and*

- *Prosecute as criminal all cultivation offences*

These commitments should be implemented as a matter of priority.

Any diversion of "*experimental cannabis users into education and treatment"* must include drug testing during and for a reasonable period after the conclusion of any education and treatment program to ensure the effectiveness of the program.

Recommendation 4:

The Committee should call on the government to implement as a matter of priority its election commitments to change the cannabis laws. Any support for diversionary programs must include adequate drug testing during and for a reasonable time after the program to ensure its effectiveness.

4. Naltrexone

The closure of Dr George O'Neil's Fresh Start Recovery Program, which had been providing naltrexone implants to drug addicts, is a human tragedy that could result in the unnecessary deaths of Western Australians and great heartache to families.

The Committee should seek evidence form Dr O'Neil as to what is needed to restore this vital treatment service and to establish it on a sound footing as a permanent component of illicit drug treatment services in Western Australia.

Recommendation 5:

The Committee should seek evidence from Dr O'Neil as to what is needed to restore this vital treatment service and to establish it on a sound footing as a permanent component of illicit drug treatment services in Western Australia and recommends that the necessary action be taken by the Western Australian and Commonwealth governments as required.

5. Endnotes

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2. http://www.aph.gov.au/house/committee/fca/subabuse/report.htm

3. Payne, Fred J., "An Evidence Based Review of Needle Exchange Programs", February 2005 at: http://www.childrensaidsfund.org/showarticle.asp?id=246

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5. *Ibid.*, p ix.

6. *Ibid.*, p xxiii (Recommendation 8).

7. *Ibid.*, p xxiii (Recommendation 10).

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