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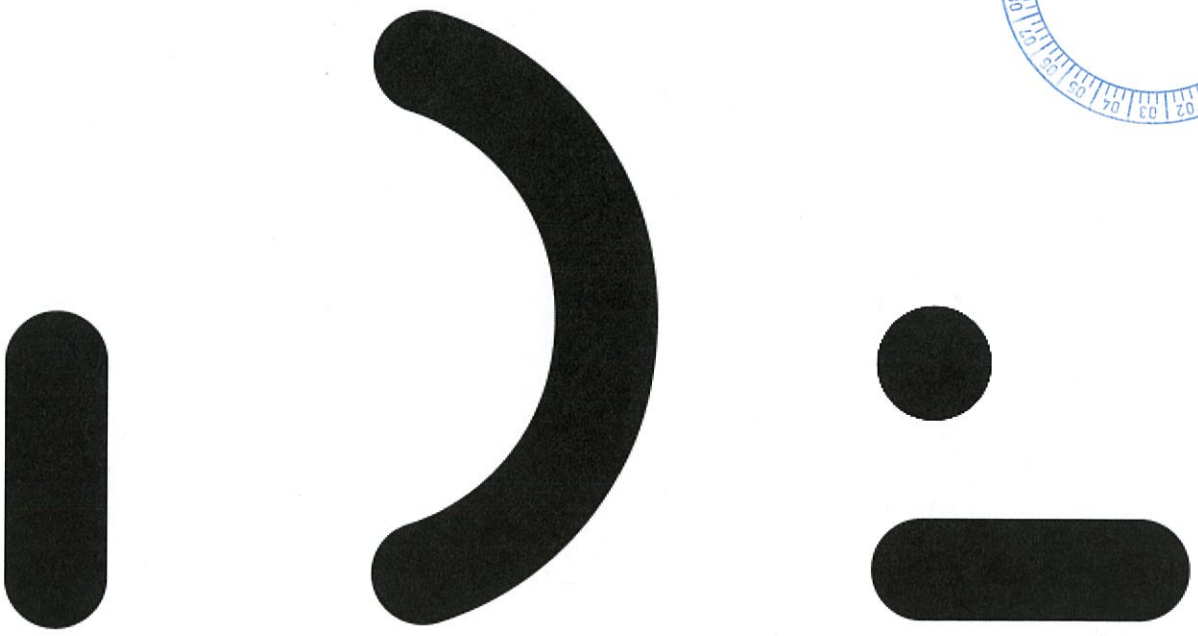
PREVENTING HARM IN AUSTRALIA



WA Select Committee to Examine Alternate Approaches to Reducing Illicit Drug Use

For Legislative Council of Western Australia

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Alcohol and Drug Foundation

Response to WA Select Committee to examine alternate approaches to reducing illicit drug use

1 The Alcohol and Drug Foundation

The Alcohol and Drug Foundation (ADF) welcomes the opportunity to contribute to this important inquiry. For almost 60 years, the ADF has been committed to preventing harm from alcohol and other drugs. We have always been an independent, evidence-based body that has encouraged Australians to avoid using illicit substances. Concurrently, we have supported the harm minimisation approach adopted by Australian federal and state governments since the 1980s which recognizes the reality of licit and illicit drug use.

The ADF works to prevent and minimise alcohol and other drug related harms through information, education, health promotion, evidence-based programs, policy development, advocacy, and research across the country.

We work with communities to create change and reach millions across Australia.

Our information services are accessible to all Australians through our website (www.adf.org.au), SMS and telephone. We conduct seminars and webinars for alcohol and other drug (AOD) and health professionals, researchers, academics, policy makers and the public.

Supported by the latest evidence, we advocate for change in policy and practice within government, business and society. We work to reduce misinformation and stigma about alcohol and other drugs.

The ADF would welcome an opportunity to meet the Committee and appear at inquiry hearings.

2 Summary of Recommendations

Recommendation 1: That the Select Committee recommends to the WA government that they invest in strengthening capacity of communities to undertake evidence based actions to prevent uptake and misuse including a pilot of the Planet Youth approach

Recommendation 2: That the Select Committee recommend that all WA schools adopt mandatory evidence-based alcohol and other drug education programs like the CLIMATE School program.

Recommendation 3: That the Select Committee recognise the link between social determinants of health and the prevalence of alcohol and other drug problems in Aboriginal and Torres Strait Islander communities and recommend actions to address alcohol and other drug problems and harms among Aboriginal and Torres Strait Islander people.

Recommendation 4: That the Select Committee recommend the WA Government conduct trials of front-of-house pill testing services at music and youth festivals.

Recommendation 5: That the Select Committee recommend that the WA Government commission an expert inquiry into the viability of decriminalisation of illicit drugs in Western Australia, with reference to overseas models including Portugal.

Recommendation 6: That the Select Committee recommend the WA Government adopt emerging and innovative models of naloxone distribution to ensure ready access to people at risk of opioid overdose.

Recommendation 7: That the Select Committee recommend that the RTPM program in WA be conducted with adequate investment, national compatibility and access to appropriate training and support for health professionals and consumers.

Recommendation 8: That the Select Committee recommend work to ensure that the WA drug information services is adequately meeting needs of Western Australians across the continuum of use (from early use, to misuse to dependency)

Recommendation 9: That the Select Committee recommends the WA Government take action to reduce stigmatisation of people who use illicit drugs, including by adopting the following recommendation from the 2018 WA Methamphetamine Action Plan Taskforce: That the Mental Health Commission develop guidelines for government agencies on the use of objective and nonjudgmental language regarding substance use

1.0 Drug use in Western Australia

In 2016, illicit drug use in WA was above the national average of 15.6% at 16.8% (1). Meth/amphetamine and ecstasy use were the highest in WA with meth/amphetamine use at 2.7% (higher than the national average of 1.4%) and ecstasy at 3.2% (higher than the national average of 2.2%). Ice use in WA decreased between 2013 to 2016 but remained the highest in the country (around 1.5%) (1). The daily tobacco smoking rate of around 12% remained consistent between 2013 to 2016 (1). Alcohol consumption in WA remained high, particularly amongst people in their 40's and Country WA had the highest proportion of lifetime risky drinkers at 29% and single occasion risky drinkers at 37% (1). 1 in 5 West Australians over 14 years of age were drinking at risk of lifetime harm and more than half of domestic assaults were alcohol related (2).

100% of WA participants in the Ecstasy and Related Drugs Reporting System Interviews reported polydrug use on the last occasion of psychostimulant use (3), with the most common drugs being ecstasy, alcohol, tobacco and cannabis. In 2017-18 WA Police reported 32,708 drug offences (Drug Dealing, Cultivate or Manufacturing Drugs, Drug Possession, Possession of Drug Paraphernalia and Other Drug Offences) (4).

It is important to note that nationally, those living remotely, the unemployed, people who identify as homosexual/bisexual and those living in low socioeconomic areas are more likely to use meth/amphetamines and other illicit drugs, smoke daily and consume risky levels of alcohol (1). Those who live in the high socio-economic areas use more cocaine and ecstasy than those in low socio-economic areas, highlighting that all levels of society are affected by AOD issues and that prevention strategies at community level are vital (1) (2)

Nationally, the community acknowledge the harms and deaths from alcohol but feel meth/amphetamine is the drug of most concern (1). There has been an increase in tolerance for medical cannabis use with more people supporting legalisation (87%) (1).

2.0 The National Drug Strategy

The National Drug Strategy 2017 build on the three pillars of harm minimisation and recognises that efforts to reducing illicit drug use must focus on reducing demand, reducing supply and reducing harm. This submission provides an overview of programs and policies that have proven either effective in reducing illicit drug use or subsequent harm or have sufficient evidence to warrant further investigation and research.

3.0 Reducing Demand

3.1 Community-led Primary Prevention

Prevention programs seek to delay or prevent uptake and are often focused on young people, as this is the most likely time people are initially exposed to drugs. They have proven effective across several age

groups and often work intergenerationally (for example, with parents and children). Prevention programs are often characterised by setting (school, sporting clubs, community, etc).

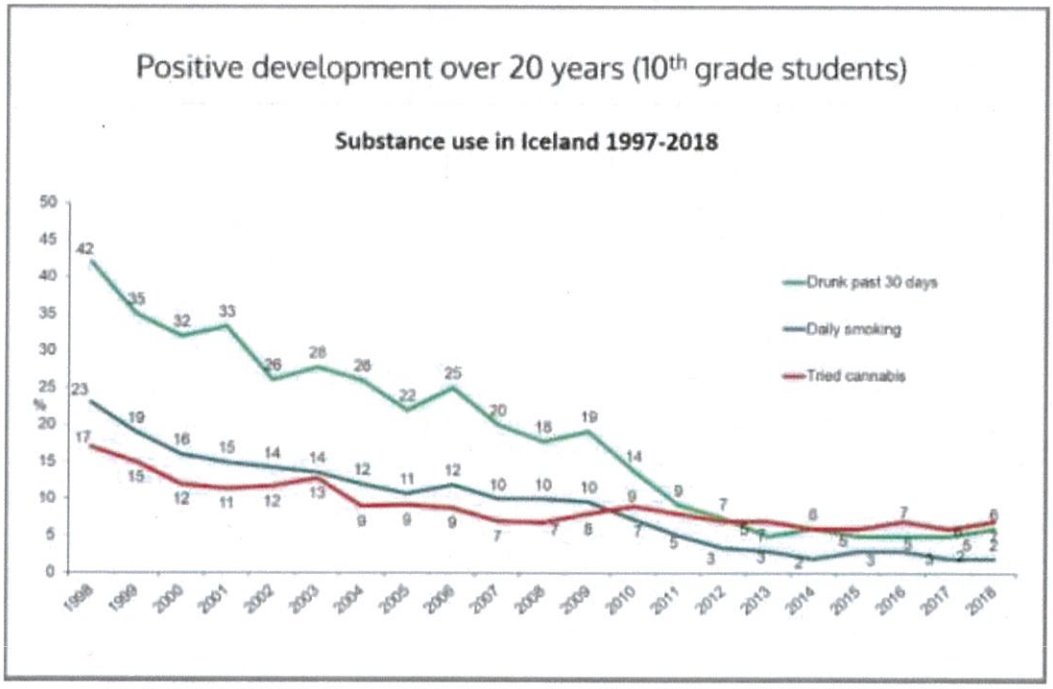
The WA strategies to reduce illicit drug use will be strengthened long-term by giving priority to community led preventive strategies. These seek to strengthen protective factors and reduce factors that increase risk of uptake and misuse of illicit drugs including isolation, poor relationships, conflict, early and excessive alcohol and other drug use, unemployment and mental illness. By strengthening and supporting personal and community protective factors the risk of harmful AOD use is lowered, thus improving their life chances (5). An "upstream" approach that helps prevent early alcohol and other drug use will reduce the need for more complex and costly interventions by the health system, drug treatment sector, emergency services, law enforcement and the justice system.

There are several successful programs internationally and within Australia that could inform efforts to strengthen this activity in WA.

3.1.1 Planet Youth (Iceland)

A concerted sustained implementation of interlocking, community-based health promotion programs over two decades in Iceland has contributed to an impressive reduction in adolescent use of tobacco, alcohol and cannabis while leading to improved relationships between parents and children and the development of social capital. (2) (6) Key components of the 'Icelandic model' are support for parents in building positive relations with children; adolescent participation in organised sport; and supervised work and recreational activities (including organised sport) with respected adult role models outside the home. The creation of social environments that are high in protective factors and low in risk factors reduce the likelihood of young people engaging in substance use and promote physical and mental health more generally. The ADF considers families, community sporting clubs and schools as vital for the prevention of alcohol and drug problems and wider health promotion activities.

The Iceland Model is now operating in 23 countries in Europe, South America and Africa, modified to meet local needs. Planet Youth is scheduled to visit Australia in June as part of a study tour with the Alcohol and Drug Foundation.



3.1.2 Community Drug Action Teams (CDATs)

In NSW, the Community Drug Action Team Program has been operating since 2000 and at June 2018, there were 72 CDATs across NSW. CDATs enable people to be involved in addressing AOD issues in their local communities through volunteering and community action. CDATs thereby build community strengths and capacity for community participation. The objectives for the CDAT program are —

- To build strong partnerships between community members, businesses, local service providers, and government and non-government organisations.
- To identify legal and illegal drug and alcohol related problems in the local community.
- To increase community knowledge and awareness of legal and illegal drug and alcohol harms and consequent social, health and well-being problems.
- To increase communities' capacity to prevent the uptake of illicit drug use and the misuse of legal drugs and alcohol, to reduce drug and alcohol related harms; and

The central coordination body (ADF) supports the CDATs through small grants and resources, enabling CDATs to deliver best practice prevention and early intervention activities to reduce alcohol and drug related harm at the local community level.

The range of strategies adopted by CDATs include AOD information sessions for groups including parents, students, young people; providing entertainment and recreation activities for youth; leadership camps; organising parent/child education on AOD; providing links to services; running local campaigns (such as Stop the Supply and Safe Partying) and participation in local liquor licensing issues.

3.1.3 Local Drug Action Team Program (LDAT)

The LDAT Program is partly modelled on the CDAT program and operates nationally. LDATs assist communities develop evidence-informed social change projects that prevent and reduce alcohol and other drug harms. LDATs are required to align their local community action plans to broader social and health plans of local, regional or state authorities and typically include combinations of non-government organisations, community groups, local government, police, sporting clubs and health services.

25 LDATs are established across WA with strong demand from other groups to join in the latest Round. Unfortunately, due to current resourcing only three will be accepted, presenting an opportunity for the WA Government to invest and extend the reach of the program.

3.1.3.1 Nannup LDAT

Nannup LDAT are strengthening family relationships and helping parents reduce AOD use and harm amongst young people. Activities include workshops focused on increasing awareness of alcohol and other drugs (AOD) issues in young people, the role parents play in role modelling, discussing AOD, setting boundaries and the importance of spending time and connecting with young people. They are also delivering eight activities/events which create an environment where parents can spend meaningful time with their children, including in the home. The messages promoted will be around the importance of spending time with your children and teenagers.

3.1.3.2 Bunbury LDAT

Bunbury host regular Friday night recreational activities as a part of LDAT program. Bunbury LDAT also aims to strengthen family relationships by encouraging, parents, caregivers and close relatives to attend the Friday night sessions also. Anecdotal evidence from the Community Bunbury Police suggests a reduced amount of curfew breaches over the weekend due to this program.

3.1.4 Addressing Illegal Drugs and Alcohol in Community Based Sports Clubs

Community based sporting clubs are an invaluable public health asset due to their reach and place in Australian culture. Regular participation in physical activity and sport promotes physical, social and mental health. Increased participation in community sport is also a key aspect of successful prevention programs,

strengthen protective factors against illicit drug use. Additionally, sports clubs provide non-playing members with regular social contact. Physical inactivity, overweight/obesity and excessive alcohol use are three of the five biggest risk factors for disease in Australia (7). It is critical that sporting clubs do not allow alcohol (or other drugs) to undermine the health promoting aspects of their activities.

However, ingrained cultures linked to risky alcohol consumption along with the prevalence of participants in high risk age groups mean that risky drinking behaviours and risk of poly drug use with illicit drugs can be more common in the sporting club setting. This can also impact on club culture, reducing active participation from community members.

The ADF's Good Sports program has demonstrated success in reducing excessive alcohol consumption and related harms in the community sports setting. It also works with community sporting clubs to tackle illicit drug use.

Good Sports assists community sporting clubs control the use of alcohol and promote community safety by implementing effective alcohol policies and practices. It is the first primary prevention alcohol program in community sport in the world to be proven successful.

A randomised control trial showed the Good Sports program reduces the likelihood of risky drinking by club members (down 37%) and risk of club members experiencing alcohol related harms (down 42%) (8) .

Good Sports has also been proven to increase participation in community sporting clubs (8). By changing their environment from a 'boozy culture' to a 'family friendly' environment sporting clubs attract more members. The community gains an amenity that promotes positive connection and models low risk alcohol consumption to adults and juniors. By developing strong community bonds, Good Sports promotes mental health and thereby a protective factor against excessive drinking and drug use.

A recent innovation has Good Sports helping sporting clubs reduce the risk of illicit drug use.

Communities often express concern about their inability to address the prevalence of illegal drugs. However, when sporting clubs adopt a policy that rejects illegal drug use (without stigmatising those who may consume them) it can return to the community a sense of purpose and control.

Good Sports is addressing illegal drugs via the Tackling Illegal Drugs (TID) program that supports community sporting clubs implement practices and policies to prevent and manage illegal drug-related issues. The key objectives of this are to:

- Build confidence of club leaders and members to prevent and manage illegal drug-related issues in a supportive, structured and consistent manner;
- Support community sports clubs to develop, implement and promote a tailored illegal drugs policy;
- Build local networks where ideas and experiences can be shared and ongoing support can be obtained;

Recommendation 1: That the Select Committee recommends to the WA government that they invest in strengthening capacity of communities to undertake evidence based actions to prevent uptake and misuse including a pilot of the Planet Youth approach

3.2 School based education

> "Extensive research has been conducted into the efficacy of drug education programs. The results are mixed. Some programs have made a discernible difference in reducing the incidence of risky use of alcohol, cigarettes, and cannabis, while others have been associated with an increased use of drugs or increased delinquency among the target participants. It is therefore important that, rather than relying entirely on intuitive approaches, the drug educator is informed by the evidence base about effective drug education." (9)

The above quotation emphasises the need for schools to act on the best available evidence when delivering drug education and their practice must be informed by the guidelines published by the Australian Government (10) and the latest research findings (11). The 12 principles enunciated in that document are as follows: (1) drug education practice must be based on evidence; (2) be informed by a whole school approach; (3) bear clear educational outcomes; (4) be delivered within a positive school climate; (5) sit within a safe and supportive environment; (6) be culturally appropriate and targeted (7) be

informed by relevant risk and protective factors (8) have consistency with policy and practice (9) delivered in a timely fashion(10) be delivered by classroom teachers (11) employ interactive strategies and skill development (12) and use credible and meaningful activities for learning (11). The *Principles* elaborates on each of these aspects in detail and a satisfactory school drug education program will accord with each of them (12).

The *Principles* is augmented by the review of alcohol education by the National Centre for Education and Training in Addictions (12), and the Positive Choices website at the National Alcohol and Drug Research Centre (NDARC), which includes internet access to various resources (13).

Schools promote protective factors and reduce risk factors for young people through their educational, health promotion and pastoral care programs. Effective drug education programs provide accurate information about drugs, have a focus on social norms, and take an interactive approach which assists students in the development of interpersonal skills. A Cochrane Review found the most effective programs teach social and coping skills to deal with drug taking issues and have substantial duration - between 10–20 sessions with follow up sessions (14). It is important that teachers are trained in health education because programs that simply provide information on drugs have no impact (14) and presentations to children by ex-drug users may even be counterproductive (15).

Australian programs such as School Drug Road Aware (SDERA), the School Health and Alcohol Harm Reduction Project (SHAHRP) and the CLIMATE program have reported reducing drug use and related harm. Students who participated in SHAHRP were 23 per cent less likely to experience alcohol-related harm (16). The Climate Schools program reduced student weekly drinking and cannabis use after 12 months (17) (12). All schools have access to on-line training and resources via the internet through the Positive Choices website directed by the National Drug and Alcohol Research Centre (NDARC). In addition, schools can download the CLIMATE drug education program on the Positive Choices website. SDERA's Changing Health Acting Together (CHAT) Program has helped schools develop and strengthen drug and road safety guidelines, develop curriculum plans focusing on resilience, drug and road safety education and parent engagement strategies.

School ethos is also an important protective factor. Schools actively involved in health promotion can diminish the effect of personal and social risk factors that encourage substance use, and at the same time, promote protective factors that lower the likelihood of drug use (18). Key protective factors include feeling connected to and enjoying school; having harmonious relationships with peers and teachers; and having multiple opportunities to contribute and participate in the school's activities (18).

Recommendation 2: That the Select Committee recommend that all WA schools adopt mandatory evidence-based alcohol and other drug education programs like the CLIMATE School program.

3.3 Adoption of culturally relevant health and education interventions

Specific and tailored interventions designed and implemented with the support and agency of Aboriginal and Torres Strait Islander peoples are required to prevent and reduce AOD problems and harms among Indigenous population.

Alcohol, tobacco and drug use is higher among Aboriginal and Torres Strait Islander peoples than the non-Indigenous population of Australia. Indigenous Australians are more likely to drink alcohol at risky levels for immediate and long term harm and are 1.8 times more likely to use any illicit drug, 1.9 times more likely to sue cannabis, 2.2 times more likely to meth/amphetamines, and 2.3 times more likely to misuse pharmaceuticals (19).

The impact of alcohol upon Aboriginal and Torres Strait Islander populations has been documented many times: excessive consumption of alcohol is directly and indirectly responsible for high rates of mortality and morbidity. It is implicated in a multitude of acute harms such as injury, motor vehicle accidents, and antisocial behaviours including assault, street violence, domestic violence, homicide and suicide and contributes to family breakdown (20). Alcohol is the fifth leading cause of disease among Aboriginal and Torres Strait Islander Australians and the burden of disease that is attributable to alcohol among Aboriginal and Torres Strait Islander people is twice the level of non-Aboriginal and Torres Strait Islander Australians (21)

At the same time action to reduce problematic use of legal and illicit substances is unlikely to succeed unless and until the lives of Aboriginal and Torres Strait Islander people are founded more securely. The

social and economic determinants of health, including access to employment, education and training, appropriate housing in safe communities be addressed simultaneously with action to reduce problematic drinking and other drug use (20). Notably, young Aboriginal and Torres Strait Islander people who remain in school use are less likely to smoke tobacco and drink alcohol an outcome that improves their health prospects and reduces risk of chronic disease (20). Policies, programs and measures to improve the health and wellbeing of Aboriginal and Torres Strait Islander people should rest as much responsibility as is possible in Aboriginal and Torres Strait Islander peoples and their appropriate organisations.

Recommendation 3: That the Select Committee recognise the link between social determinants of health and the prevalence of alcohol and other drug problems in Aboriginal and Torres Strait Islander communities and recommend actions to address alcohol and other drug problems and harms among Aboriginal and Torres Strait Islander people.

4.0 REDUCING HARM

4.1 Pill testing

Pill testing or 'drug checking' is a form of risk mitigation for people who consume illicit substances. Established in several European countries (25), it enables drug users to determine the nature and concentration of constituents of their pills/drugs at the critical moment. (26). Drug checking also enables drug users to access counselling in a non-judgmental setting and referral to treatment services (27) (28) (25) (29). Additional collateral benefits include law enforcement and emergency agencies gaining accurate knowledge of the substances that are being consumed (30) and understanding provision of demographic data and patterns of use in monitoring trends (26) (27).

Attendees at music festivals should always be advised to avoid using illicit substances. Law enforcement to reduce supply is also important. However, despite concerted efforts, as well as several deaths over the past two decades, illicit pill consumption continues. The risk of death is greater than ever. Recent innovations in illicit drug synthesis, in particular MDMA, have led to higher potency. Psychoactive substances (NPSs) are rapidly appearing and are often sold in forms far more potent than 'traditional' psychoactive substances.

In countries where pill testing exists, surveys show two thirds of people would not consume a drug if it was not as presented. Importantly, research has demonstrated that pill testing does not encourage take-up of drug use (31) (32) (33). Results from an evaluation of Zurich's drug checking service showed no increase in the frequency of consumption. (34) This accords with a study that found access to a drug checking service resulted in lower consumption among ecstasy users. (34)

At festivals where drug testing exists, deaths due to recreational pills have not been reported. In the UK, after the first drug checking trial in 2016, there was a 95% decrease in the number of drug related hospital admissions over 12 months. (35) although the link is unclear as there was no study that controlled other variables.

Australia's first drug checking trial took place at the Groovin' the Moo festival on 29 April 2018, on the grounds of the University of Canberra. The trial, run by STA SAFE consortium, offered a front of house testing facility where consumers could have their substances testing *in situ*. A 'front-of-house' drug testing facility allows for consumers, who are already in possession of a substance, to purposefully engage in a low threshold service. A front-of-house facility informs and educates consumers by testing drug samples in real time – allowing services to transmit safer-use messages over many topics, such as acute/short term hazards, long term hazards, legal risks and harm minimisation strategies (29). This service type differs from a 'back of house' facility that tests discarded, seized or found substances that does not allow direct contact with consumers (36).

The results from the trial were encouraging. One hundred and twenty-five people engaged directly with the service, 83 samples were tested, and the quality of psychoactive substances ranged from low to high, while some samples were non-psychoactive (36). Over half the clients (61%) said they were surprised by the result of the test of their substance. One sample contained N-ethylpentylone, a cathinone responsible

for high numbers of overdoses in New Zealand in 2018 and deaths in the US, while one other substance was given a 'red flag' status because its constituents were indeterminate (36).

The trial showed that a drug checking intervention is practicable, has the support of police and emergency health staff, and proved the festival audience is willing to use the service and accept the results of the tests.

Recommendation 4: That the Select Committee recommend the WA Government conduct trials of front-of-house pill testing services at music and youth festivals.

4.2 Decriminalisation or legalisation of illicit drugs

Decriminalisation of drugs is a policy option that is adopted to reduce some harms related to drug use under the policy of strict prohibition. Typically, when drugs are decriminalised the production, manufacture, distribution, sale and purchase of drug/s remain illegal; however, people who use or consume the drug/s are not charged or convicted of a criminal offence. Instead they face civil administrative penalties or sanctions. 'Decriminalisation' is distinct from 'legalisation'. When drugs are legalised no offences are attached to the production, distribution and consumption of drugs distributed by regulated channels. This is the case with alcohol in Australia, and cannabis in Colorado, USA.

Decriminalisation can be achieved by *defacto or de jure* means. Under *defacto decriminalisation* all drug related activities remain illegal according to the law, though cases involving defined small quantities are subject to civil rather than criminal sanctions. In some cases individuals may be diverted to treatment/education by the police or by Drug Courts. A weakness of this system is that police have discretion to decide whether to pursue or charge an offender and that can lead to discriminatory enforcement of the law. By contrast under de *jure decriminalization* possession of certain types of drug for personal use are permitted under the statutes as in Portugal (37). Supply and manufacture outside of the regulated market remain illegal.

The theoretical underpinning of much of our criminal law, including our drug law, is deterrence theory which asserts that "undesirable behaviour can be curtailed if punishment is sufficiently certain, swift, and severe" (38). Much early research showed that individuals' perceptions of the likelihood of punishment, rather than the severity of punishment, deterred further offending. Where likelihood of detection is low, or hard to estimate, factors other than the law are likely to be more important determinants of behaviour (39). In mostly private behaviours such as illegal drug use, the likelihood of detection is low. For cannabis, the likelihood of someone being apprehended for using the drug in any one year is between 1 and 3 % (40) (39) It is therefore unsurprising that research shows little relationship between rates of cannabis use and whether strict criminal penalties or civil penalties apply (39).

The argument for reform of Australian drug law and decriminalisation as a response is the apparent intractability of illicit drug use. Half a century of concerted action to prevent use of illicit substances has not succeeded in eliminating drug use and there is no prospect that it will; secondly most drug related arrests are related to the minor offences of personal possession and/or use more than 88% of the 154,650 drug arrests nationally in 2016-17 related to drug consumer offences and the number of arrests for illicit drugs has increased from 78.675 to 154, 650 over the last 10 years (41).

The major harm that decriminalisation prevents is the criminal convictions acquired by people who are found guilty of personal possession and use of drugs. Conviction can disrupt their life seriously, including closing off career, employment and travel options and causing problems with personal relationships (42) Collateral benefits available under decriminalisation include putting people who use drugs in touch with health and welfare services and lessening stigma on illicit drug use that can prevent people from seeking help (43). Another benefit is the reduction of pressure on the legal and judicial systems although that may be balanced by the needs of administering the system and a potential increased commitment to drug treatment and drug prevention.

The concern put forward by those who fear that decriminalisation represents a more liberal policy that will encourage drug use and worsen the drug problem appears to be unfounded. After assessing global drug policy regimes, the UK Home Office reported there was no obvious relationship between levels of drug use in a country and the strictness of its drug laws (37). Similarly, a review of the South Australian decriminalisation of cannabis possession reported that none of the studies 'found an increase in cannabis use in the South Australian community which is attributable to the introduction of the Cannabis Expiation Notice scheme' (44).

Decriminalisation has benefits in terms of societal costs. Overall benefits in Portugal include an 18% improvement in social costs over the first decade of reform due to reduced imposts on the health and legal systems, lost income and lost productivity for people incarcerated (45)

Costings by the Victoria Parliamentary Budget office for Fiona Patten's Reason Party in 2018 indicated that decriminalisation based on the Portuguese model would change the state's budgeted net position by $168m over the 2018-19 budget and forward estimates. This was a result of a decrease in operating expenditure due to a reduction in law enforcement alongside a decrease in revenue due to lower fines for drug related offences[1]. These costings did not include increased treatment costs although the argument is that the expenditure saved could be diverted to support any increase in treatment needs.

Legalisation of cannabis has happened in several US states, Canada and Uruguay and there is insufficient evidence at this stage to draw conclusions about the impact of this on usage rates and harms. Data from Colorado is mixed with some suggestion that it does increase the proportion of adults reporting cannabis use, with less clear data on changes in youth use, and data to question the negative impact of the legislation on road safety. Income from revenue in Colorado increased from $67.6 million in 2014 to $247.4 million in 2017 (46).

Economic estimates from Vic estimate that legalisation of cannabis would change the state's net budgeted position by $204.6 million over the 2018-19 budget and forward estimates[2].

Decriminalisation in Portugal

Drug use has been decriminalised in Portugal since 2001. That means the possession and use of illicit drugs is treated as an administrative matter while the production, manufacture and large scale distribution of illicit drugs has remained a criminal offence.

Individuals found in possession of a personal supply of an illicit drug or found to use a drug, are referred to a tribunal known as the Commission for the Dissuasion of Drug Addiction. The role of this body is to make assessments of the individual drug users who are referred to it for appraisal. The Commission can refer drug dependent people to treatment services, while those who are assessed as not drug dependent, or who are not impaired by drug use, are offered other options: these include having their proceedings suspended, being required to attend a police station, being referred for psychological or educational intervention, or paying a fine (47).

Essentially Portugal's system is the reverse of the Australian schemes of *cautioning or diversion* schemes which limit cautions and diversions to first, second or third offenders. In Portugal, entrenched drug offenders are referred for treatment and the less entrenched receive civil penalties. There are conflicting claims over the effect of Portugal's' system (48) but available data suggests decriminalisation has not led to a substantial increase in drug use or related harms (47). It has in fact, reduced the prevalence of blood borne diseases and eased pressure on criminal and justice systems with a drop in the number of HIV cases from 800 in 2003 to 100 in 2016 and only 24% of prisoners having drug related offences in 2013 compared to 44% in 1999 (49)

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[1] The Victorian Parliamentary Budget costings are available on request

[2] The Victorian Parliamentary Budget costings are available on request

Any consideration of the Portuguese model must recognize that decrimalisation was not the only factor. "Decriminalisation is not a silver bullet. If you decriminalize and do nothing else, things will get worse. The most important part was making treatment available to everybody who needed it for free. This was our first goal." - João Castel-Branco Goulão, Portugal's National Coordinator on Drugs, Drug Addiction and the Harmful Use of Alcohol General-Director of SICAD.

Recommendation 5: That the Select Committee recommend that the WA Government commission an expert inquiry into the viability of decriminalisation of illicit drugs in Western Australia, with reference to overseas models including Portugal.

4.3 Provision of Naloxone

The ADF believes that a wide distribution of naloxone within the community is important to reduce preventable disability and fatalities due to opioid overdose. Naloxone is an opioid antagonist that can reverse the effects of opioids and its application for a person who has overdosed will often resuscitate them quickly and prevent the risks of permanent disability and death. Naloxone is equally effective for overdose of prescribed pharmaceutical opioids as for illicit opioids sourced on the street; it does not have capacity for misuse and there are few serious side effects (50).

As many opioid overdoses are witnessed by another individual, the distribution of naloxone among people who inject drugs (PWID) and their peers (friends and family) has the potential to reduce much opioid related harm. Naloxone can be administered via injection with a prefilled syringe by a lay person and this mode of application has reversed tens of thousands of overdoses worldwide (51). However, it is preferable that recipients of naloxone receive some formal training in opioid overdose management and the use of naloxone (51). Take-home naloxone was pioneered in Australia by the ACT in 2011 (52) although awareness, availability and distribution varies among PWID and their peers (53).

Take home naloxone programs are yet to target regular and high risk consumers of pharmaceutical opioids (54) though national mortality trends indicate that is an urgent need as deaths due to pharmaceutical opioids outnumber deaths due to 'street' opioids (55). An investigation is required into how members of this cohort who may not identify with PWID can gain access to a supply of naloxone. This issue may become more pressing with the introduction of real time monitoring of prescription pharmaceuticals in 2019 as vulnerable people may lose access to 'legal opioids' and seek an illicit alternative substance.

The cost of naloxone is a problem for many PWID whose disposable income is low, due to their marginalised circumstances (50). Naloxone is prescribed at a cost of $6.00 for a person with a (low income) concession card, or for $38.80 as a subsidised medicine on the Pharmaceutical Benefits Scheme (PBS); it is also available over-the-counter for $73.52, a charge that can be problematic for people who inject drugs regularly (56).

The widest coverage of naloxone supply to the key stakeholders of PWID, peers and support groups will be achieved through multiple channels and health settings (50). Unless legislative changes are made to allow for its supply outside prescribers and pharmacists, which, for example, could allow needle and syringe services to provide naloxone direct to hard-to-reach PWID, partnerships could be formed between community pharmacies and organisations that are unable to authorise supply but have close links to PWID; another option is a Scottish model in which trained peer workers are granted an exemption to enable them to supply naloxone (54) (50).

Recommendation 6: That the Select Committee recommend the WA Government adopt emerging and innovative models of naloxone distribution to ensure ready access to people at risk of opioid overdose.

4.5 Real time prescription monitoring

The misuse of pharmaceutical drugs is a significant contributor to the illicit drug problem. Misuse is defined as non-medical use of pharmaceuticals, their use without a valid prescription, the prescription of excessive quantities or at excessive frequencies, or due to a drug dependence that has developed following medical treatment (52). According to the 2016 National Drug Strategy Household Survey, 4.8% of the population aged over 14 years (one million Australians), misused a pharmaceutical in the past year (19)

Prescription drugs are now responsible for more deaths in Australia than illicit drugs. In 2016, of the 1608 people who died from drug induced deaths, two thirds died from prescription pharmaceuticals (663 due to benzodiazepines and 550 due to prescription analgesic opioids, including oxycodone, morphine and codeine) (54)

Pharmaceutical dependency can increase reliance on illicit drugs. A study of heroin dependent people undergoing drug treatment found that 75% were introduced to heroin via the initial use of prescription opioids and that they eventually preferred heroin because it was less expensive and more accessible than prescription drug (55). Of this group, nearly 94% indicated they used heroin because prescription opioids were far more expensive and harder to obtain. (55). The Centre for Disease Control and Prevention (CDCP) advised that the best way to decrease heroin dependence was to decrease the misuse of pharmaceutical opioids (56)

Real time prescription monitoring (RTPM) has been recognised as part of the solution to the high levels of pharmaceutical misuse by COAG with most jurisdictions now either implementing or planning a RTPM. However, the nature of these models varies across jurisdictions and the level of investment and sophistication also varies. Any RTPM therefore needs to have visibility of use in other jurisdictions, be monitoring in real time, monitor all Schedule 8 drugs and codeine, all benzodiazepines, z-drugs and quetiapine and ensure training and support for medical practitioners and pharmacists alongside support for those who are at risk of, or dependent on pharmaceutical drugs. Broader community education about appropriate use of pharmaceutical drugs and alternative approaches to pain management is also required.

Recommendation 7: That the Select Committee recommend that the RTPM program in WA be conducted with adequate investment, national compatibility and access to appropriate training and support for health professionals and consumers.

5.0 ACCESSIBLE INFORMATION AND EDUCATION

The improving of public knowledge of alcohol and other drugs is a crucial feature of a drug strategy and action plan. To protect their health and wellbeing, people need accessible, accurate information about alcohol and drug issues, the effects of drugs, and how they can avoid drug problems and harms. Misinformation may increase health problems if people misunderstand the relative risk associated with specific drugs, especially the risk posed by licit substances. Despite the larger contribution of alcohol and pharmaceuticals to the burden of disease, illicit drug use is popularly regarded as the biggest drug problem and its impact on mortality is exaggerated (19). Such misunderstanding can also result in pressure for governments to direct resources away from major drug problems to lesser problems. A dedicated drug information service is required to provide accurate, up to date information on topics that are often misunderstood or misrepresented in other information sources, such as media reporting. A responsive information service requires an online service, an email service and a phone information service.

The ADF supports social marketing campaigns to improve public awareness of AOD related issues but is aware that while they can be useful in drawing public attention to an issue and can help to create a social climate that is conducive to policy change, in themselves they are unlikely to create substantial behaviour change. Therefore, it is important that social marketing campaigns are integrated with other initiatives designed to change behaviour. It is also important that any campaigns educating people about AOD and potential harms do not further stigmatise people who use drugs (see below)

Recommendation 8: That the Select Committee recommend work to ensure that the WA drug information services is adequately meeting needs of Western Australians across the continuum of use (from early use, to misuse to dependency)

6.0 STIGMA

Stigma associated with alcohol or drug use ultimately leads to adverse health outcomes; it is a "fundamental cause of health inequalities" (57) Stigma, or the judgement caused by the stigmatisation, has been shown to worsen stress, reinforce differences in socio-economic status, delay help seeking and

can lead to a drop out of treatment and support services. (58) Research and experience suggest that stigma is a social determinate of health.

The Australian Government's 2017-26 National Drug Strategy notes: "Approaches and policy responses aimed at reducing alcohol, tobacco and other drug harms in priority populations should be informed by evidence as it develops and should be reviewed regularly. It is also important that any responses do not inadvertently or unintentionally further marginalise or stigmatise people who are at higher risk of experiencing alcohol, tobacco and other drug related harm."

Campaigns to combat stigma associated with drugs and drug use are still developing. As a result, there is not yet a robust body of evidence about what works. From the few specific campaigns that have been undertaken internationally some of the key methods used include:

- Messages promoting drug use as a health issue
- Information challenging myths about drug use
- Consumer stories challenging stereotypes
- Use of news and social media channels
- Resources that local areas can use (59)

The ADF has identified the stigma surrounding drug use as a barrier to seeking help. Tragically, evidence shows it is often decades between the onset of addiction and the seeking of treatment. Medical professionals, media and decision makers have roles to play in changing public discourse so that drug use and dependency is viewed as a health issue, not a moral failure. The ADF commends the Western Australian Government's efforts to address stigma through its the Social Inclusion Action Research Group (SIARG), as well as recommendations in the Western Australian government's 2018 Methamphetamine Action Plan Taskforce Final Report.

There is increasing recognition both internationally and at a national level that legislative frameworks can play a role in contributing to AOD related stigma. The ADF supports further research and the investment in programs designed to address stigma and discrimination related to AOD use.

Recommendation 9: That the Select Committee recommends the WA Government take action to reduce stigmatisation of people who use illicit drugs, including by adopting the following recommendation from the 2018 WA Methamphetamine Action Plan Taskforce: That the Mental Health Commission develop guidelines for government agencies on the use of objective and nonjudgmental language regarding substance use