Chapter 4

Demand and harm reduction under the National Drug Strategy

Introduction

4.1 As outlined in the previous chapter, the Commonwealth government's illicit drug policy is directed to three goals: supply reduction, demand reduction and harm reduction. Because the terms of reference of this inquiry focus on the responses of law enforcement agencies (LEAs), and particularly the Australian Crime Commission (ACC), to AOSD, the Committee's examinations could have been, strictly speaking, justifiably limited to the traditional area of concern for LEAs—that is, supply reduction.

4.2 However, the three goals that comprise the NDS prescribe what is essentially a holistic approach to the AOSD problem, and in practical terms LEAs operate in a broad policy environment that affects the nature and quality of the law enforcement effort. The Committee therefore considers it relevant to examine and report on demand and harm reduction as the critical context for any consideration or assessment of the adequacy of the law enforcement response to the AOSD problem.

Demand reduction

4.3 Under the National Drug Strategy (NDS), demand reduction is one of the policy goals to address the use of both licit and illicit drugs in the community. Principally, demand reduction uses education and public community awareness campaigns to achieved desired outcomes. Regulation of demand can occur through:

- preventive education targeting potential new market entrants;
- education of consumers on the risks of consumption and prolonged market participation;
- research into the impact of street-level or retail-level policing on consumer behaviour and perceptions of risk associated with involvement in various drug markets;
- diversion of consumers to mandatory counselling and education; and
- multifaceted strategies to reduce overall levels of intoxication in the community, especially among young adult males.[1]

1 Queensland Alcohol and Drug Research and Education Centre, *Submission 12*, p. 5.

4.4 The importance of education to reduce demand for AOSD was highlighted by Detective Chief Superintendent Denis Edmonds, of the South Australian Police, who told the Committee:

> What I do perceive is that there is a lack of knowledge across the community about drugs, their short- and long-term effects and the legal status of some of them. It really does come down to education. Effective education will impact on demand. As I said at the outset, we are talking about a commodity that is out there because there is a demand for it within the community. If we reduce the demand, we reduce the problems.[2]

Education and public awareness

4.5 At the Commonwealth level, the Department of Health and Ageing is responsible for a number of strategies aimed at demand reduction. The National Drugs Campaign (NDC) is a two-phase campaign targeted to parents of children aged eight to 17 years. The first phase of the campaign provided information, strategies and support to parents to assist them in their role of preventing drug use by their children and teenagers. The second phase of the campaign, conducted in 2005, consisted of:

- print, television and cinema advertisements targeting young people and their parents; and
- youth marketing activities to promote alternatives to drug use and encourage positive lifestyles.[3]

4.6 The campaign also produced a range of resource materials, including information for parents, service providers and stakeholders, and activities to address the specific needs of Indigenous Australians and people from non-English speaking backgrounds.[4]

4.7 The effectiveness of drug education programs is dependent on how information is presented. The Department of Health and Ageing, in a supplementary submission, argued that its national drug prevention campaigns and messages to young people are based upon a thorough, evidence-based social marketing approach, which includes extensive research conducted with young people themselves.[5]

4.8 To date, the evaluation survey of the NDC has found that these campaigns have been successful in raising awareness of AOSD. Based on a nationally representative sample of 1,490 young people aged 13 to 20 years, the survey found that, of those interviewed as part of the evaluation, 84 per cent recognised

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2 *Committee Hansard*, 3 May 2006, p. 21.

3 Department of Health and Ageing website, http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/media-campaign, viewed 8 February 2007.

4 Department of Health and Ageing, *Submission 16*, p. 3.

5 *Submission 16A*, p. 20.

advertisements pertaining to amphetamines and 81 per cent recognised advertisements about MDMA. Of the interviewees that recognised the advertisements for MDMA and amphetamines, 97 per cent stated that the advertisements were believable.[6]

4.9 However, the Committee notes that some of the evidence given to this inquiry questions the effectiveness of some campaigns to modify the behaviour of current drug users.

4.10 The current NDC aims to highlight the negative and terrifying effects of AOSD use, and it is reported that the Commonwealth government intends to use a scare campaign in future advertising on AOSD use. As part of the second phase of the NDC, this campaign is likely to be based upon the AIDS Grim Reaper advertisements of the mid-1980s.[7] Examples of current posters may be found at appendix 6.

4.11 The Committee received some useful evidence on this issue via contributions to a discussion about AOSD on the Triple J radio program *The Hack*. A number of comments suggested that the use of graphic scare campaigns was effective and that more was needed to illuminate the 'seedy' and uncontrolled industry that produces AOSD:

> I do fear what my friends and I will be like in our old age due to the delayed effects—we all dread to think (so we don't)! Education re: the negative effects, the dodgy ingredients, the seedy very unglamorous underworld that goes along with it and more graphic campaigns are needed.[8]

4.12 One submitter to *The Hack*, Clara, felt that people who have not been exposed to AOSD use are more likely to be influenced by campaigns which seek to shock—that is, scare campaigns:

> In reference to the TV ads about pills etc. I saw them and as a former pill user I didn't find them effective and agreed with the caller who said she saw them as unrealistic scare tactics. However, my younger brother who hasn't been involved in the 'party' scene told me that they really did deter him from ever trying a pill.[9]

4.13 Another submitter felt that if a user has a negative or adverse experience as a result of AOSD use then they are more likely to find scare campaigns more credible, because the message accords with their own experience:

> I felt that many of the callers perspectives that were voiced on Hack were really once (sic) sided, endorsing recreational drugs. Personally, I have a really negative experience with recreational drugs…From a personal experience I have been hospitalised from taking ecstasy and speed…After

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6 *Submission 16A*, p. 3.

7 Matt Price, 'Ice ads will rely on scare tactics', *Weekend Australian*, 28 October 2006, p. 3.

8 Corrinne, ABC Triple J, *The Hack*, *Submission 28*, p. 46.

9 Clara, ABC Triple J, *The Hack*, *Submission 28*, p. 59.

> this frightening experience with recreational drugs I have decided to not participate in taking party drugs ever again.[10]

4.14 In contrast to the evidence supporting the effectiveness of scare campaigns, particularly in raising awareness of a specific issue, the Committee heard evidence suggesting that such campaigns did little to curb or reduce demand.[11] Mr Michael Lodge, from the New South Wales Users and AIDS Association, told the Committee:

> Most people in health do not see that the Grim Reaper campaign was particularly successful, except that it raised the profile of HIV-AIDS within the Australian community. There were negatives—for example, it raised anxiety amongst groups of people who were never at risk. The AIDS information line had 80-year-old grandmothers, who had not been sexually active in a long time, ringing up worried that they might have contracted AIDS. So we raised the anxiety and we demonised sex in some ways but we did not give people appropriate ways to reduce their anxiety or necessarily change their behaviour.[12]

4.15 Similarly, the Family and Friends for Drug Law Reform told the Committee that the effectiveness of education programs that use scare tactics to prevent or stop drug use is limited, because they lack credibility with young people.[13] Lack of credibility meant that the balance of any drug education program was likely to be often discounted or ignored. One submitter to *The Hack*, Jonathon, said:

> I believe that the media through which synthetic drug education must be one credible to a young audience (sic). Government funded leaflets are treated with cynicism by youth, the credibility of message communicated via JJJ or community radio is more believable to youth. Independent media communication messages backed up by experiences of people who have already been through the rave scene achieves more than a Drug Aware sign in school, uni and club toilets.[14]

4.16 The need for truthful and realistic information was highlighted in the majority of comments provided by submitters to *The Hack*. A typical comment was:

> Education should be more realistic. The ads on television are bullshit. I've been to lots of raves and never seen anything like what happens on these educational ads.[15]

4.17 Another contributor to the program wrote:

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10 Alison, ABC Triple J, *The Hack*, *Submission 28*, p. 37.

11 Department of Health and Ageing, *Submission 16A*, p. 20.

12 Mr Michael Lodge, New South Wales Users and AIDS Association Inc., *Committee Hansard*, 13 October 2006, p. 71.

13 Family and Friends for Drug Law Reform, *Submission* 19A, p. 2.

14 Jonathon, ABC Triple J, *The Hack*, *Submission 28*, p. 20.

15 Name not supplied, ABC Triple J, *The Hack*, *Submission 28*, p. 36.

> I think truthful and realistic education is the only way to make a positive difference. All we hear is 'drugs are bad' not why or how or even that the exact same drug can be taken by 2 people and both can have completely different reactions! We need to target high schools and give kids the REAL information.[16]

4.18 A number of participants in *The Hack* program argued that the sensationalism of education campaigns was redundant because the facts about AOSD use were frightening enough:

> Use education rather than scare tactics (the facts are often scary enough!), lay out the facts![17]

4.19 Dr Susan Carruthers, a Research Fellow from the National Drug Research Institute, observed that education campaigns based on blanket assertions that 'all drug taking activities will have a negative impact' are often ineffective because their message does not accord with the experiences of AOSD users:

> The majority of the problems are caused by a minority of people who end up in trouble with it. I think that we have to be realistic when we are talking about campaigns on television which are supposed to educate young people about the use of drugs and how dangerous they can be. Yes, they can be very dangerous, but the reality is that most of the people who use these drugs do not experience any of these negative effects in terms of health. Therefore, a lot of these advertising campaigns become non-believable because people think, 'I know lots of people who use them and they don't end up in that situation.' It is a matter of being realistic.[18]

4.20 The Alcohol and other Drugs Council of Australia (ADCA), the peak national non-government organisation representing the interests of the Australian alcohol and other drugs sector, argued that there is a need for targeted and credible information:

> As AOSD are often used in social settings by young people, there is a need for the targeted dissemination of culturally appropriate and credible information on the different types of AOSD and the range of harms associated with their use, particularly the considerable risks associated with frequent use and use by injection.[19]

4.21 The Committee acknowledges that education campaigns designed to scare and shock can be effective in getting community attention and elevating awareness of certain issues. However, the evidence gathered by the inquiry, particularly from AOSD users, indicates that drug education programs must also consider the use of factual and realistic information. The use of public awareness scare campaigns should

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16 Carly, ABC Triple J, *The Hack*, *Submission 28*, p. 24.

17 Lauren, ABC Triple J, *The Hack*, *Submission 28*, p. 9.

18 Dr Susan Carruthers, National Drug Research Institute, Curtin University, *Committee Hansard*, 4 May, p. 23.

19 Alcohol and other Drugs Council of Australia, *Submission 7*, p. 1.

be resisted, or at the very least pursued with caution, as this approach can potentially reduce the credibility of education and harm-reduction campaigns more generally.

Recommendation 5

4.22 The Committee recommends that public education and demand-reduction campaigns for illicit drugs be factual, informative and appropriately targeted. The Committee also recommends that such campaigns seek input from young people, and take account of user experiences of amphetamines and other synthetic drugs (AOSD).

4.23 The Family and Friends for Drug Law Reform informed the Committee that any expectation that a particular type of drug education campaign will be effective is problematic. Their submission highlighted a 1998 study that undertook an analysis of drug education programs and evaluated their effectiveness. The study found that the effect of drug education programs was very small and that they were less effective with the passage of time. Notable findings in the study were:

- that the combined effect size of studies with follow-up to one year was small, at 0.037;
- that that figure suggests that drugs education has such a trivial impact on behaviour that in its present form it is of no practical relevance; and
- that another way of expressing the meaning of this effect size is that 3.7 per cent of young people who would use drugs, which is fewer than four in 100, delay their onset of use or are persuaded to never use.[20]

4.24 The effectiveness of drug education programs can be enhanced if these programs are targeted and based upon scientific data. Dr Carruthers told the Committee that there needs to be a sound research base that informs demand-reduction campaigns. Having produced this data, it would then be possible to design programs which are more credible:

> That is one of our major aims and that is why we do research to inform the type of prevention that we promote. We do not actually design the preventions. We provide the evidence base for other organisations whose responsibility it is to design the resources, the curriculums and the prevention. We do need to be realistic. If we keep saying to people, 'All drug use is really bad and will cause you major harm,' then we lose a lot of our audience because they know—or they think they know—differently.[21]

4.25 The need for education campaigns to be delivered by an appropriate person or in an appropriate forum was also raised with the Committee. The Committee heard that many AOSD users in the 18 to 30 age range were resistant to information that came from what they perceived to be distant official sources:

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20 Family and Friends for Drug Law Reform, *Submission* 19A, p. 3.

21 *Committee Hansard*, 4 May, p. 24.

> Young people who use illicit drugs recreationally tend to be highly sceptical of information they perceive as coming from "official sources" and are much more likely to act upon information that is accessed through a credible source and that is framed within a context of relevance to the young people.[22]

4.26 On this point, a submitter to *The Hack* from Melbourne argued:

> I believe such scenarios in anti-drug advertisements should be aired but in a creative manner to attract attention of the 15 – 30yr olds eg. animated cartoons which relate to today's youth and doesn't [sic] seem like something dreamt up by a 50yo, soon to be retiring politician! It is important for users to be informed of the negative affects [sic] by past users or other peers.[23]

4.27 The Committee heard that a common response to the use of AOSD is peer education. Peer education involves the use of peers to support and educate users to reduce the potential harms of AOSD use. The approach builds upon capacity within the target population to inform, disseminate and give credibility to health-promoting messages and strategies.[24] In their submission, the Alcohol and other Drugs Council of Australia noted that, although the evidence on the effectiveness of peer education is variable, it has been found that well-designed and sufficiently well-supported peer education initiatives can be effective in reducing drug use and harm.[25]

The role of the media

4.28 The media's reporting on AOSD use and its social and individual impacts focuses predominantly on the sensational and the controversial. Media headlines such as 'Ice party drug creates a new wave of addition';[26] 'The drug that's transforming normal people into monsters',[27] 'Ice scourge causes havoc'[28] and 'Party drug disguise for danger and death',[29] have fuelled community anxiety about the use of AOSD.

4.29 Some submitters were critical of the role the media played, accusing the media of scaremongering and thereby undermining the goal of responsible and effective drug education.[30] A number of submitters argued that inaccurate and sensationalised reporting of AOSD issues were driven by the media industry's preoccupation with enhancing newspaper and advertising sales:

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22 VIVAIDS, *Submission 32*, p. 3.

23 Name supplied, ABC Triple J, *The Hack*, *Submission 28*, p. 21.

24 VIVAIDS, *Submission 32*, p. 3.

25 Alcohol and other Drugs Council of Australia, *Submission 7*, p. 5.

26 Paola Totaro, *Sydney Morning Herald*, 1 December 2005, p. 8.

27 Catherine Munro, *Sun Herald*, 5 March 2006, p. 4.

28 Xavier La Canna, *Canberra Times*, 8 April 2006, p. 18.

29 Angela Kamper, *Daily Telegraph*, 16 May 2006, p. 4.

30 Bluelight, *Submission 29*, p. 12.

> Falsehoods about drug deaths are propagated in the media in order to sell papers or attract audiences. The media has a vested financial interest in presenting material in a sensational and alarming manner to ensure that the reader will buy their paper, or watch their broadcast. Truth and accuracy run a poor second to sales and ratings.[31]

4.30 Concerns were also raised over the media's use of the term 'party drug' and the name 'ecstasy' for MDMA.[32] The use of such terms reinforces particular positive social expectations or impressions and thereby undermines, to a degree, the efforts of health, education and law enforcement sectors. Detective Superintendent David Laidlaw, from the NSW Police, told the Committee that the media's continued use of terms other than MDMA was a concern because it tended to sensationalise or soften ideas about drug use:

> They [the media] are calling them recreational drugs. When we talk to our media, we refer to it as MDMA. You will see sometimes that, in some of the captions in newspapers that we have, they will call it MDMA and put in brackets 'ecstasy'. We are trying to work towards that. I suppose the media are there to sensationalise; they are there to sell papers, to be quite honest.

4.31 Sensationalist and inaccurate reporting of AOSD use in the media has the effect of stigmatising drug users. The Committee heard that stereotypes of drug users were often used in media stories and government advertising campaigns, producing a 'them and us' mentality. The marginalising of drug users consequently makes it less likely for AOSD users to seek assistance. One submitter argued:

> While these drugs have a huge stigma amongst mainstream society, for the vast majority of environments that stimulants are used there is no stigma at all. What has been created for both sides is an 'us and them' dynamic, whereby mainstream society perceives drug users as the degenerates in the government ad campaigns, and the users themselves scoff at these portrayals as the misperceptions of the establishment.[33]

4.32 In an attempt to address the issue of the stigmatisation of people with drug or alcohol problems, the Australian National Council on Drugs is looking to develop a set of media guidelines on the most appropriate way for the media to produce and report stories dealing with drug and alcohol issues.[34]

4.33 Mr John Ryan, the Chief Executive Officer of Anex, told the Committee that the media has a positive and valuable role to play in providing factual information to the community about these complex issues:

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31 Mr Andrew Swindells, *Submission 30*, p. 17.

32 Angela Kamper, *Daily Telegraph*, 16 May 2006, p. 4.

33 Name withheld, *Submission 25*, p. 1.

34 Ms Karen Price, Department of Health and Ageing, *Committee Hansard*, 5 June 2006, p. 57.

> We know from concentrating on needle and syringe programs and injecting drug use that there are literally thousands of people in Australia injecting drugs who are not aware of the risks that they are taking, the potentially fatal consequences or, just as importantly, the morbidity consequences of their behaviour. We cannot expect the Telegraph or the Age to provide that sort of information. What we do need to provide to parts of the community is absolutely full, frank and fearless information and advice, because people are operating with minimal or mythical understanding of the issues and the risks that they are taking. I think as a community we have an obligation to face up to that.[35]

4.34 As outlined in this chapter, education, public awareness campaigns and responsible media reporting on the detrimental health and social effects of AOSD use are able to play a significant role in reducing AOSD use in society. However, the fact that AOSD use in Australia continues to rise suggests that this approach has limited success. Under the NDS, harm reduction is the ultimate strategic policy approach to dealing with AOSD. Harm reduction is essential in dealing with the potentially devastating impact of AOSD use on individuals, families and the wider community, and on law enforcement, health and emergency services personnel.

Harm reduction

Health and social effects of AOSD

4.35 The damage inflicted by regular and frequent AOSD use is of concern from both a health and an economic perspective. A number of submitters made observations about the health effects of AOSD.[36] A report by the National Drug and Alcohol Research Council found the following:

- poor mental health among methamphetamine users; two-thirds experienced some degree of mental health disability and one in five suffered severe disability in their mental functioning;
- common problems included increased aggression, agitation, depression and symptoms of psychosis.[37]

4.36 The submission from the National Drug Research Institute observed:

> Accidental deaths in which AOSD were reported…numbered 50 with state differences. The rate per million did not change between 2002 and 2003 (4.4 and 4.9 per million respectively).

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35 *Committee Hansard*, 13 October 2006, p. 49.

36 For example: Queensland Alcohol and Drug Research and Education Centre, *Submission 12*; Family and Friends for Drug Law Reform, *Submissions 19 and 19A*; National Centre for Education and Training on Addiction, *Submission 22*; *The Hack*, *Submission 28*.

37 Australian Bureau of Criminal Intelligence, *Australian Illicit Drug Report 1999-2000*, Canberra, March 2001, p. 55.

> States where AOSD consumption is high also report higher number of hospital admissions attributed to AOSD. For example, in WA which has one of the highest rates of AOSD use the number of admission was 550 per million (aged 15 to 54 years) in 2001-02 and 448 per million (aged 15 to 54 years) in 2002-03.[38]

4.37 The rise in methamphetamine use—particularly regular use of its purer forms, base and ice—has been linked with an increase in mental illness in users. Common problems include increased aggression, agitation, depression and symptoms of psychosis.[39]

4.38 The FFDLR submission quoted work by McKetin et al.[40] that estimates 'the prevalence of psychosis among regular methamphetamine users was 11 times higher than that seen in the general population'.[41] The submission also notes that:

> …the onset of these severe behavioural and other problems is much quicker with the potent forms of methamphetamine than with forms that had long been available. Although the half-life of amphetamines is substantially longer than cocaine, use of it and its methamphetamine analogue are associated with bingeing and disinhibition. [C]rystal meth is described as acutely 'moreish' by many users, leading to episodes of bingeing that may last several days where little or no sleep or food is had.[42]

4.39 The Committee notes that, in a recent paper on methamphetamines, the Australian National Council on Drugs (ANCD) describes methamphetamine psychosis as 'perhaps the most concerning aspect of the current methamphetamine situation'.[43]

4.40 The ANCD paper sets out the particular relationship between methamphetamine use and psychosis:

> Methamphetamine use can induce a brief toxic psychosis characterised by persecutory delusions and hallucinations. Other manifestations of psychosis can include stereotyped repetitive behaviour…disorganised speech and illogical tangential thoughts.
>
> Symptoms typically last hours to days, and subside without intervention after blood levels of methamphetamine subside. In some instances, symptoms can run a more chronic course, lasting up to several months, and recur in the absence of drug intoxication. In these cases, it could be argued that methamphetamine has triggered a brief psychotic episode, and that the

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38 National Drug and Health Research Institute, *Submission 10*, pp 4-5.

39 Department of Health and Ageing, *Submission 16*, p. 1.

40 Rebecca McKetin, Jennifer McLaren and Erin Kelly, 'The Sydney methamphetamine market: patterns of supply, use, personal harms and social consequences', *NDLERF Monograph Series no. 13*.

41 Family and Friends for Drug Law Reform, *Submission 19*, p. 46.

42 *Submission 19*, p. 46 (footnotes omitted).

43 Australian National Council on Drugs, *Methamphetamine*, p. 4.

> person may have a lasting vulnerability to re-experience psychotic symptoms.[44]

4.41 At the Anex Australasian Amphetamines Conference, held from 28 to 29 September 2006, Associate Professor Janie Sheridan, from the University of Auckland, argued that research in the US and New Zealand has shown that the detrimental effects of amphetamine use extend well beyond injury caused to users. Families, support personnel, bystanders and, indeed, any person with whom an affected user comes into contact, can suffer the consequences of a violent episode or attack induced by AOSD use.[45]

4.42 Family and Friends for Drug Law Reform (FFDLR) similarly identified the effects of methamphetamine use on the mental health of users, its the flow-on effects to friends, family and service providers, as the most noticeable consequences of methamphetamine use. In relation to the difficulties families experience when a member becomes addicted to methamphetamine, the submission observes that in Queensland:

> …a number of workers in the health sectors "expressed concern over the incidence of unreported intrafamilial violence related to methamphetamine use, often within a relationship context but also directed at parents by teenage children". There is a dearth of support for families because use of the potent stimulants seems to have stretched the country's drug treatment and mental health services beyond their capacity. In short, the shift from heroin to stimulants among injecting drug users "has grave consequences".[46]

4.43 The Committee notes that, although the deterioration of family relationships is common when a member becomes dependent on drugs, the level of violence arising from crystal methamphetamine or ice use is a new phenomenon, at least in terms of scale. Further, the FFDLR noted:

> People using large amounts of methamphetamine-type stimulants are typically difficult to engage in treatment and demanding once engaged. There is "a great deal less evidence relating to the effectiveness and cost-effectiveness of treatments for stimulant dependence" than for heroin…Many who are "regular users experience methamphetamine-related financial, relationship and occupational problems".[47]

4.44 Along with the direct effects of methamphetamine use on users and their families and friends, the Committee identifies health and law enforcement authorities as being at the frontline of dealing with the problematic behaviour arising from

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44 *Methamphetamine*, p. 5.

45 'Methamphetamines and Injury', address to the Australasian Amphetamines Conference, 29 September 2006.

46 Family and Friends for Drug Law Reform *Submission 19*, p. 46 (footnotes omitted).

47 *Submission 19*, p. 47 (footnotes omitted).

methamphetamine use. The ANCD paper estimates that hospital presentations for methamphetamine psychosis have risen by almost a third in the last five years.[48] This often involves people experiencing 'severe agitation', who require chemical and physical restraint. In many cases, police intervention is necessary.[49]

4.45 The ANCD paper observes:

> Aggressive behaviour is one of the most challenging aspects of the frontline management of methamphetamine psychosis. Violence is related to persecutory ideation, and often occurs because the patient interprets their environment in a threatening way. For this reason, physical restraint and law enforcement intervention, although sometimes necessary, can exacerbate hostility and the risk of violent behaviour.[50]

4.46 The Committee notes that some much-needed steps are being taken in Australia towards assisting health and law enforcement authorities to deal with the AOSD-related increase of violence and mental health issues. The ANCD paper notes:

> Guidelines on the emergency management of methamphetamine psychosis have been developed specifically for police, ambulance workers and emergency departments. These guidelines include draft protocols which need to be actively disseminated, evaluated and refined where necessary.[51]

4.47 The Committee endorses the ANCD's recommendation that:

> Existing guidelines on management of methamphetamine toxicity for police, ambulance workers and emergency departments need to be actively disseminated. Adequate resources need to be made available to frontline emergency services to ensure that they can safely manage methamphetamine psychosis presentations.[52]

4.48 The Committee considers that, although the long-term health and social effects of the use of AOSD, particularly MDMA and methamphetamine, are not yet certain, there is sufficient evidence to be sure that their impact is often severe and devastating for users, their families and friends, and for the health and law enforcement authorities that are dealing with the significant behavioural problems that are emerging.

4.49 The Committee believes it is critical that adequate funds be made available to research the long-term effects of these drugs and to provide adequate treatment and assistance for the mental and physical health problems that arise from AOSD use. The

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48 Australian National Council on Drugs, *Methamphetamines*, p. 4.

49 *Methamphetamines*, p. 4.

50 *Methamphetamines*, p. 5.(footnotes omitted)

51 *Methamphetamines*, p. 5 (footnotes omitted).

52 *Methamphetamines*, p. 5.

Committee also considers that such funding should also be available for support for the families of users.

Recommendation 6

4.50 The Committee recommends that, in the execution of the National Drug Strategy, harm-reduction strategies and programs receive more attention and resources.

Harm-reduction programs

4.51 While no-one who appeared before the Committee was opposed to harm reduction per se, there were a variety of views on what the proper emphasis should be between it and other NDS strategies, and the kind of tactics that should be employed in seeking harm-reduction outcomes.

4.52 In their submission, the Alcohol and other Drugs Council of Australia (ADCA) argued that, because users come from all parts of society, various AOSD harm-prevention and harm-reduction initiatives are needed. The submission observed that there is a need for strategies:

> …that target both the traditional injecting drug use networks as well as other users who take pills at parties and who don't necessarily see themselves as 'drug users'. There is growing recognition that governments and the alcohol and other drugs sector need to maintain credibility with AOSD users through the provision of accurate, culturally appropriate and credible information.[53]

4.53 The effectiveness of current harm-reduction strategies was endorsed by Dr David Caldicott, who is the Convenor for OzTox, a harm-reduction coalition that attends rave parties to test pills that are to be used by the participants. Dr Caldicott told the Committee that, '[o]verall, harm minimisation has been shown to prevent more deaths and injuries than any other policy.'[54]

4.54 Harm reduction embraces those measures that have the effect of reducing the damage done by drugs to those who use them. One of the earliest examples was the introduction of needle and syringe exchange programs. The ADCA submission said:

> Tertiary prevention initiatives such as needle and syringe programs have made a significant contribution to preventing the spread of infections and have been directly responsible for the reduction in needle sharing amongst Australian injecting drug users. It is therefore essential that needle and syringe programs continue to be supported and adequately resourced to help maintain the health of injecting drug users and meet the likely rising demand for needles and syringes.[55]

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53 Alcohol and other Drugs Council of Australia, *Submission 7*, p. 4.

54 *Committee Hansard*, 3 May 2006, p. 26.

55 Alcohol and other Drugs Council of Australia, *Submission 7*, p. 5 (footnotes omitted).

4.55 The needle and syringe exchange programs are considered to have had a positive effect on the potential damage of contracting HIV-AIDS and hepatitis C.

4.56 In addition, there have been community initiatives that provide educational and first-aid support to users. An example is Ravesafe, which the Committee heard has been operating for over 11 years in Victoria. Funded by the Victorian Department of Human Services, Ravesafe is a peer-based education and support program that attends parties and events of more than 500 people. Ms Purple Hazelwood, a coordinator of Ravesafe, told the Committee:

> We have 12 key peer educators or volunteers who go out to parties and hand out information on harm reduction strategies and ways to reduce risk while at parties and taking drugs. At these events, we have a place where people can sit down, chill out and relax and talk to us. We give them a space to relax and get away from the noise, the music and all of that. While they are sitting there relaxing they can talk to our peers about anything that they want to talk about—and that ranges greatly. All of the peer educators are trained in first aid. So if something is going wrong or if someone is highly drug affected and needs further medical assistance, we can pass that on to first aid or the ambulance service that is usually at the parties that we attend. We are currently funded to do 15 events a year and we maintain 12 volunteers.[56]

4.57 Ravesafe works with the dance party community and has produced, in conjunction with the Victorian Department of Human Services, a code of practice for safer dance parties. Ravesafe also provides training for staff of other community organisations, including Turning Point and Enlighten Harm Reduction.

4.58 The Committee considers that there is much to commend in the peer support programs provided by community groups, including the emergency medical assistance they are able to render. The Committee has commented elsewhere in the report on the value of credible educational programs.

Pill testing

4.59 The Committee acknowledges that tension exists around the harm-reduction and demand-reduction potential of pill testing programs. There are concerns that such schemes equate to condoning drug taking, could expose pill-testing authorities or practitioners to civil or criminal liability, and could endanger users of such services.

4.60 Ms Catherine Quinn, Manager of the Drug and Alcohol Branch of the Victoria Police Forensic Services Centre, informed the Committee that pill testing is now largely based on commercial colour-test kits:

> You take a scraping from the tablet, drop a couple of drops of liquid onto it and you will get a colour from that. The colour is indicative of a class of drugs or a particular reaction but not a specific drug. For amphetamine type

56 *Committee Hansard*, 13 October 2006, p. 50.

> stimulants—the methamphets and amphets—you will get an orange colour; for ecstasy you will get black.[57]

4.61 Ms Quinn went on to raise some concerns over the sophistication and accuracy of colour-test kits:

> There is no component splitting in there, so you have no sense of what is in the tablet other than that the darkest reaction will be the predominant one. You have no way of assessing the quantity of material in there. It does not give you a purity test. There will be a lot of people saying, 'Oh, yes, it is a faint test, so you've got a lower level,' or 'It is a strong test, so you've got a higher level.' That really does not mean anything. The test responds to a certain quantity and it really depends how much you have in that sample, not how much is in that tablet. Because the tablets are not necessarily made to a pharmaceutical grade they are not necessarily homogeneous, so the little scrape may have been from the low side of the tablet et cetera, which is why when we analyse everything is ground and you have these scientific practices.[58]

4.62 The Committee received a considerable amount of evidence from law enforcement agencies, which all argued their opposition to pill testing. Deputy Commissioner Simon Overland, from the Victoria police, told the Committee:

> We do not support pill testing. I guess we understand the arguments for it…Our view is that, unless you do this stuff pretty carefully and you fully understand what is in a pill, you run all sorts of risks in doing it in a half-baked way, if I can put it that way. I think the science is such that you really need to do it pretty rigorously in a controlled way to be very clear about what is in there.[59]

4.63 Some witnesses, however, disagreed with the criticisms outlined above. Mr John Davidson, a spokesperson for Enlighten Harm Reduction, explained that colour-based testing of pills in clubs or at raves was an outdated model, and that, as such, criticisms based on this model were misleading. The Committee heard that more sophisticated laboratory-based testing of pills, conducted by medical professionals at dedicated locations, was now available.[60]

4.64 A number of witnesses supported the efficacy of pill testing as a harm-reduction strategy. Dr Caldicott felt that pill testing was effective in reducing harm, and that more sophisticated models, such as some being trialled in Europe, could enhance their effectiveness:

> …we can not only show that pill testing can reduce harm; we can also improve on the models that currently exist. We already have. The Swiss, for

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57 *Committee Hansard*, 13 October 2006, p. 16.

58 *Committee Hansard*, 13 October 2006, p. 16.

59 *Committee Hansard*, 13 October 2006, p. 13.

60 *Committee Hansard*, 13 October 2006, p. 32.

> example, are trying to introduce a pill testing program where doctors and nurses are involved, rather than other workers, because it is known that people will pay attention to them.[61]

4.65 Mr Davidson explained that pill testing is not merely a harm-reduction exercise carried out at rave parties, but has other, more significant, functions:

> The first is a monitoring service, to have an idea of what is out there in the market. As we have seen, we do not know, to a large degree. It seems as though these problems sneak up on the government out of nowhere and suddenly we have an ice epidemic or whatever. The second part is the information service that goes hand in hand with it.[62]

4.66 While the Committee acknowledges that pill-testing proponents are well-intentioned, a majority of the Committee considers that such programs have yet to overcome a number of legitimate and serious concerns:

- the perception that official conduct and sanction of such programs are akin to condoning drug-taking behaviour;
- that such programs could expose conducting authorities, bodies or individuals to liability for harm arising to users of pill-testing services; and
- that there are questions over the accuracy of the testing procedures employed.

4.67 The Committee was also concerned that, despite pill-testing proponents pursuing a neutral, information-based approach,[63] users of such services will tend to use the information provided to decide whether or not to ingest a particular MDMA pill. Given the critical and unpredictable role that individual physiology plays in cases of adverse or even fatal reactions to MDMA pills, the Committee was concerned about the extent to which MDMA users might seek to use the information provided by pill testers as the basis of, or to confirm, a decision to ingest a particular MDMA pill.

4.68 In responding to the Committee's concerns that pill testing sends the wrong message and appears to give official endorsement to the taking of illicit drugs, Dr Caldicott disputed that pill testing sends the wrong message to the community and to would-be users:

> That makes the assumption that people who are not using drugs understand what message it actually does send. In fact, as my colleague from the police mentioned, this is a commodity. Particularly the pill form of an illicit substance is a commodity and, if we wanted to destroy a legitimate commodity, one of the best ways we might go about doing that is by questioning the manufacturing technique, the purity and the intention of the supply of the substances. So, while there is an assumption that the wrong

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61 *Committee Hansard*, 3 May 2006, p. 27.

62 *Committee Hansard*, 13 October 2006, p. 34.

63 *Committee Hansard*, 3 May 2006.

> message is being sent, we believe that the message being received by young people who are faced with the results of pill testing is that it shakes their faith in what is often regarded within the community as a fairly pure product. If you go back to the history of ecstasy, it was marketed, along with health food supplements, as a pure product.[64]

4.69 The Committee notes the tension between, on the one hand, law enforcement agencies' concerns about the complexities and uncertainties surrounding pill testing and, on the other, pill-testing proponents' belief that it is an important and effective harm-reduction tool.

4.70 Mr Davidson told the Committee of the current 'preparation of a feasibility study for the development and implementation of an illicit tablet information and monitoring service'.[65] The Committee considers that such studies could contribute to debate on the issues outlined above. Without endorsing or otherwise approving pill testing, the Committee considers that the Victorian study should be monitored for information that could contribute to future considerations of the issues surrounding pill testing.

Recommendation 7

4.71 The Committee recommends that the Victorian feasibility study for an illicit tablet monitoring and information service be monitored and, as appropriate, the outcomes independently evaluated by the appropriate Commonwealth government agency.

Diversionary programs

4.72 Some states have established diversionary programs, which are designed to keep drug offenders out of the gaol system and to provide rehabilitation and support to overcome their addiction.

Illicit Drug Diversion Initiative

4.73 In their submission, the Department of Health and Ageing (DoHA) observed that $340 million has been allocated to the Illicit Drug Diversion Initiative (IDDI) for the period 1999-2000 to 2007-08.[66] The initiative has the following objectives:

- to increase incentives for drug users to identify and treat their illicit drug use early;
- to decrease the social impact of illicit drug use within the community; and
- to prevent a new generation of drug users and drug-related crime from emerging in Australia.[67]

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64 *Committee Hansard*, 3 May 2006, pp 24-25.

65 *Committee Hansard*, 13 October 2006, p. 23.

66 Department of Health and Ageing, *Submission 16*, p. 4.

4.74 The funding for IDDI is provided by the Commonwealth. The programs are managed by the states and territories and run by preferred providers, which deliver services 'such as assessment and treatment to ensure that those diverted have the fullest opportunity to address their drug use and expiate their diversion.'[68]

4.75 The table below is based on information provided by the department and summarises the IDDI funding allocation by state for the 2005-06 financial year.

State/ Territory	Number of programs	Amount ($)
New South Wales	9	16,982,144
Victoria	8	12,307,766
Queensland	2	2,700,000
Western Australia	7	4,853,447
South Australia	3	3,500,000
Tasmania	3	927,168
Northern Territory	3	1,200,000
Australian Capital Territory	4	1,041,513

4.76 Additional information supplied by the department explained that the programs fall into two major groups: one administered by the police and the other by the courts. Within these groups, programs are further categorised as being for adults, youth, the Indigenous population and those in rural and remote areas.[69]

Police programs

4.77 Some of the police diversion programs are aimed at one specific drug (several states have a cannabis cautioning program, for example). In Victoria, the police have a drug diversion program that allows an apprehended person to be cautioned rather than charged, if they will accept a clinical assessment and a period of treatment, which must be completed within 28 days.[70]

4.78 In Western Australia, the All Drug Diversion program aims to divert people without prior convictions for drug offences or crimes of violence within the previous

67 *Submission 16A*, p. 33.

68 *Submission 16A*, p. 33.

69 *Submission 16A*, p. 33.

70 Victoria Police website, http://www.police.vic.gov.au/content.asp?Document_ID=5059, viewed 23 November 2006.

three years. The South Australian Police conduct a drug diversion scheme aimed at juveniles aged 10 to 17 years.[71]

4.79 The ACT, Northern Territory and Tasmanian police also have similar schemes aimed at keeping users of small amounts of illicit drugs out of the gaol system and channelling them into treatment as early as possible.

Court diversion

4.80 In the last twenty years, the courts have played an increasing role in providing opportunities for drug offenders to rehabilitate themselves and thereby avoid custodial sentences. Known generally as 'drug courts', they are specialist courts that deal with drug dependent offenders. Drug courts were instituted because of 'growing disenchantment with the ability of traditional criminal justice approaches to provide long-term solutions to the cycle of drug use and crime.'[72]

4.81 The United States established the first drug court in 1989, a model later followed by Canada, the United Kingdom and several Australian jurisdictions. Commencing operation in 1999, the Drug Court of New South Wales was the first in Australia. It has been the subject of an evaluation by the Bureau of Crime Statistics and Research.[73] Drug courts have been established in Queensland, Victoria, South Australia and Western Australia.

4.82 In some states, drug court programs devolve into further specialisation; there are courts for young offenders, rural offenders and Indigenous offenders, all of which have support from counsellors and the police.

4.83 Generally, the minimum eligibility criteria for a person to be diverted to a drug court program are:

- sufficient admissible evidence of the offence of possession or use of a drug;
- the person must admit to the offence;
- the person should have no history of violence; and
- the person must give their informed consent to undertake a diversion.

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71 Divert website, South Australian Police Drug Diversion Initiative, http://www.divert.sa.edu.au/, viewed 23 November, 2006.

72 Lawlink New South Wales website, http://www.lawlink.nsw.gov.au/drugcrt/drugcrt.nsf/pages/drugcrt2, viewed 15 November 2006.

73 Lawlink New South Wales website, http://www.lawlink.nsw.gov.au/drugcrt/drugcrt.nsf/pages/drugcrt2, viewed 15 November 2006. The Bureau of Crime Statistics and Research evaluation can be found at www.lawlink.nsw.gov.au/bocsar.

4.84 Some courts are able to provide options for rehabilitation before a plea is entered. The person must show some potential for successful treatment but is not required to plead guilty to the offence.

4.85 The DoHA advised the Committee that 'diversion for amphetamines and other synthetic drugs is included as part of the states and territories diversion programs.'[74] The department observed that the states and territory governments have the flexibility to allocate the use of funding as they see fit.[75]

4.86 The Committee notes that diversion programs depend on the participation of the health and law enforcement sectors in working to integrate the two facets of the program to give offenders the opportunity to be rehabilitated in terms of both their criminal behaviour and health.

4.87 Drug diversion programs are being evaluated to 'inform the future of the program.'[76] The Committee notes that there are tailored diversion programs, with some focused on people as young as 10 years and some directed towards other discrete sectors of the community. The Committee considers that any program able to minimise the incarceration of non-recidivist and non-violent offenders should be provided with a level of funding to ensure its success. Such programs must be able to engage the services of sufficient numbers of fully professional staff to meet the need for support and to provide the greatest opportunity for success.

Conclusion

4.88 The Committee has come to the view that, in dealing with the escalating problems surrounding the use of AOSD and their effects, particularly on young people, harm reduction must receive more support in the execution of the NDS. It is an unpalatable fact that AOSD are being used increasingly in our society. Prohibition, while theoretically a logical and properly-intentioned strategy, is not effective, as it has the effect of driving AOSD use underground. Consequently, drug-induced illness is frequently going untreated because people who use illicit substances are reluctant to seek medical help for fear of the possible consequences of criminal conviction.

4.89 The Committee does not consider that the efforts of law enforcement agencies to reduce supply of AOSD should be diminished in any way. However, the evidence to the inquiry suggests there is a need to place greater emphasis on, and resources in, the area of harm reduction. The current national approach to illicit drugs—supply reduction, demand reduction and harm reduction—will achieve greater outcomes if a better balance between these approaches can be reached. As one submitter argued:

> The problem with current drug strategies is not that they include law enforcement; it is that law enforcement is the nucleus around which all

74 Department of Health and Ageing, *Submission 16*, p. 33.

75 *Submission 16A*, p. 34.

76 *Submission 16A*, p. 34.

> other programs must work. Most people agree that harm minimisation should be the objective of drug strategies. If this is the case, resources should be directed to those areas that offer the greatest returns. This means putting treatment and prevention at the centre of drug strategies, and letting law enforcement fit around the priorities set by these programs.[77]

4.90 The problems caused by AOSD are multifaceted, and supply reduction is one aspect of their solution. In its submission, Anex argued that the best approach to formulating policy in the area of AOSD:

> …involves a balance between the interconnected aspects of supply reduction, demand reduction and harm reduction. The complexity of illicit drug use and the associated harms requires a multi-faceted approach to the development and implementation of strategies including supply reduction strategies. Demand and harm reduction strategies are important components of any comprehensive approach to illicit drug use, including the use of amphetamines.[78]

4.91 Similarly, the Hon. Dr John Herron, Chairman of the Australian National Council on Drugs (ANCD), at the recent launch of the ANCD's position paper on methamphetamines, argued:

> I would also like to stress that to address methamphetamines and indeed all drug use requires a balanced, pragmatic and partnership approach, and that if there is one way we could make an immediate impact it would be to recognise that treatment is the great investment. As I said at the start, no-one sets out to become addicted to drugs and to hurt those around them, and treatment provides a real pathway out of this mire.[79]

77 The Australia Institute, *Submission 24*, p. 13.

78 Anex, *Submission 31*, p. 3.

79 The Hon. Dr John Herron, speech to National Press Club, 31 January 2007, p. 9.