HealthCare Consumers

SUBMISSION

Select Committee on the Drugs of Dependence (Personal Use) Amendment Bill 2021:

Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021

May 2021

Health Care Consumers' Association
100 Maitland Street, HACKETT ACT 2602 Phone:02 6230 7800
ABN: 59 698 548 902 Email: adminofficer@hcca.org.au
hcca.org.au | HCCA.ACT | @HealthCanberra

Background

The **Health Care Consumers' Association (HCCA)** is a health promotion agency and the peak consumer advocacy organisation in the Canberra region. HCCA provides a voice for consumers on local health issues and provides opportunities for health care consumers to participate in all levels of health service planning, policy development and decision making.

HCCA involves consumers through:

- consumer representation and consumer and community consultations;
- training in health rights and navigating the health system;
- community forums and information sessions about health services; and
- research into consumer experience of human services.

We shared the terms of reference and the summary of the legislative changes with members of our Health Care Policy Consumer Reference Group. We have drawn on this input in preparing our response.

Please do not hesitate to contact us if you wish to discuss our submission further.

Contact
Darlene Cox
Executive Director
darlenecox@hcca.org.au

Anna Tito
Policy Officer
annatito@hcca.org.au

1. Executive Summary

The *Drugs of Dependence (Personal Use) Amendment Bill 2021* (The Bill) is a taking a much-needed step in the right direction towards harm minimisation and improving community outcomes in the ACT. The evidence shows that countries that decriminalised minor drug offences saw significant financial savings, less incarceration, significant public health benefits, and no significant increase in drug use. However, the Bill doesn't address all the complexities of alcohol, tobacco and other drug (AOD) policy in the ACT. This submission highlights a number of these community concerns, including the need for:

- Drug policy to take a health and human rights perspective, with a harm minimisation focus. We want to particularly highlight the need for addiction to be treated as a health issue.
- Increased investment in AOD treatment and harm reduction services, like residential rehabilitation, day services, residential withdrawal, counselling and education programs.
- Considering investment in alcohol and tobacco harm reduction programs, as alcohol and tobacco still represent the greatest negative health impact from AOD substances in Australia.
- Coordinated work with the local AOD sector to provide targeted programs to higher use groups e.g. people experiencing homelessness, Indigenous Canberrans and those living with other forms of social disadvantage.
- A comprehensive evaluation of the issues around the supply of illicit substances, with the intention of identifying mechanisms to reduce harm. This may include exploring aspects such as contamination, cost and quality and the flow on effects for people using illicit substances and their interactions with the criminal elements of society.
- Ensuring a proper evidence basis for our drug driving legislation. Currently there is inconsistency between the research and the current legislation, particularly in the case of cannabis, but also with other substances which are on the list for decriminalisation.

It is clear from our consultation that the Government needs to work closely with AOD services, consumer, family and community groups to ensure that they invest in a comprehensive harm minimisation approach to alcohol, tobacco and other drugs. This approach needs to go beyond the decriminalisation for personal use highlighted in the Bill and tackle the larger issues for AOD users in the ACT for example, access to AOD treatment services, to ensure that we have the best possible outcomes for the whole of the ACT community.

2. General comments

The evidence shows that countries that decriminalised minor drug offences saw significant financial savings, less incarceration, significant public health benefits, and no significant increase in drug use[1]. This is in line with the research conducted in Australia comparing the social harms and drug use rates in places where civil rather than criminal penalties for minor cannabis offences are applied[2,3]. The Bill is a taking a much needed step in the right direction towards harm minimisation and improving community outcomes in the ACT. However, it doesn't address all the complexities of AOD policy in the ACT, nor has it been accompanied by appropriate announcements of an increased investment in other harm minimisation strategies.

The challenge of minimising harms from alcohol, tobacco and other drug use is best viewed from a health and human rights perspective. The right to health and access to health care is set out in the *Universal Declaration of Human Rights*, *Article 25.1*[4] , the *International Covenant on Economic, Social and Cultural Rights*, *Article 12*[5] and the *United Nations Declaration on the Rights of Indigenous Peoples*, *Article 24*[6]. In the explanatory comments the UN Committee on Economic, Social and Cultural Rights clarifies the idea of the "right to health" stating:

> *"the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."*[7]

The World Health Organisation (WHO) in its constitution has a similar understanding of the "right to health defining heath as:

> *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."*[8]

In treating health care as a right, we acknowledge that to deny this care for people with an addiction is a breach of their rights. This means that it is critical that funding for treatment and harm reduction services, like residential rehabilitation, day services, residential withdrawal, counselling and education programs be high enough to meet the demand for these services. Many specialist AOD services in the ACT are chronically underfunded and subsequently have long waiting periods for people seeking access to their services. Ensuring that these services are funded appropriately will help make sure that people seeking treatment for AOD issues are able to access the health care they need.

The Bill is only part of the picture. There are several other issues that impact the Bill's ability to really support harm minimisation. These include:

- The difficulties in accessing drug/addiction support in the ACT.
- The supply aspect of drug use, particularly the difficulty in accessing a quality supply.
- The possible legal issues for people who may get caught between conflicting federal and ACT provisions on drug possession.
- Challenges around the length of time drugs are detectable in the blood stream beyond their impact on capability, resulting in issues around drug driving convictions.
- A lack of a clear evidence base for personal use amounts allowed in the Bill.
- Recognising that those who suffer social disadvantage are more likely to be affected by drug addiction.

This list highlights that the Bill, if it passes, will present a number of opportunities and challenges for implementation. It is vital the ACT Government work closely with local AOD specialist services, organisations that work with at-risk groups and the wider community to ensure that we can achieve the greatest possible harm reduction around AOD for the Canberran community.

This submission touches on many of the inquiry's terms of reference (ToR). It is divided into two main parts: Section 2 highlights the high-level issues raised by consumers; and Section 3 highlights specific issues that were of key concern to consumers and have particular importance to the implementation of the Bill when looking at it from a harm minimisation approach.

3. Consumer Highlighted Issues

People with a drug addiction primarily have a health issue. The research shows that taking a health focused and harm minimisation approach to drug policy is key to improving the individual and societal outcomes. Decriminalisation of minor drug offences and investment in appropriate health and social services has shown to have a dramatic impact on reducing incarceration rates and financial costs to the community, as well as providing significant health benefits[9]. On top of this the decriminalisation of minor drug offences also has a larger flow on effect, with people who receive notices rather than criminal charges having substantially less negative employment, relationship and accommodation consequences, as well as less continued problems with the law[10]. However, the funding allocation in Australia is not in line with these evidence-based strategies for harm minimisation. In 2009/10 it was estimated that the vast majority of Australian Governments' drug related expenditure went into law enforcement at 66%, compared to 2% on harm reduction, 9% on prevention and 21% on treatment[11]. In a 2006 report it was estimated that about 22% of government expenditure on preventing and responding to drug abuse went to the health sector while 77% went to the criminal justice sector[12]. In the ACT, AOD harm minimisation and treatment programs currently do not have the capacity to meet demand. With the decriminalisation of minor drug offences, it is likely that more people will seek to use treatment and harm minimisation services. It is, therefore,

important that the funding adequately reflect the demand for these services in the ACT.

In addition to the inadequacy of funding for services for people seeking to manage addictions, and the long waiting times for assistance for counselling etc, people often fall into the criminal justice system through other related consequences e.g. theft to purchase the drugs or driving with drugs in their blood stream, even if their driving ability is not affected. In addition, since the Australian Federal Police administer the laws in the ACT as well as Commonwealth laws, and there will be a likely inconsistency between Federal and Territory law in relation to these amendments, people may be exposed to risk of Federal prosecution, even if the ACT law has changed. The risk in the ACT of the ACT law being overturned is even greater because of our status as a Territory.

Related to the public discourse about drug use, we have not yet been able to overcome problematic behaviours relating to alcohol and cigarette smoking and other forms of addiction, such as gambling. As part of the health approach to recreational drug use, we need to develop better messaging and interventions in these areas. Young people are often particularly unaware of the considerable physical and mental health risks associated with high levels of substance use, particularly of those substances they have been told are harmless (like cannabis) or other legal substances, like alcohol. The peer pressure and other social behaviours surrounding the culture of drug use can also compound the negative impact of addictive behaviours.

Where these behaviours adversely affect someone's engagement with work, education or relationships, the social impacts of the supply and use issues are compounded. The public conversation about drug use is often seen as two ends of a spectrum: either permission or prohibition. To truly implement a health approach, we need a much more nuanced public dialogue that examines evidence from other countries that are further along in moving from a criminal justice to a health focus.

In discussing the Bill and inquiry with our members they highlighted a wide range of challenges and issues that need to be taken into consideration, and these are outlined below.

Policy Issues

- AOD use disproportionately affects people who are socially disadvantaged and are likely to have interactions with other government services, e.g. child protection, which may exacerbate problem drug behaviours[13].
- It was unclear from the Bill as to the evidence basis for the quantities of drugs allowed. It is important that the Government work with consumers and AOD

services to ensure that the amounts listed are in line with actual personal use amounts.
- The ACT needs to look at addiction programs that support a clean supply so that the focus is drawn to recovery.
- The importance of developing a local and culturally appropriate clinical and residential rehabilitation services for Indigenous Canberrans, consumers highlighted the possibility of expanding the services available through the Ngunnawal Bush Healing Farm to include this role. The Bush Healing Farm recovery model uses culturally appropriate knowledge as well as clinical knowledge to address the damaging effects of cultural disconnection on the wellbeing of many Aboriginal young people.

Funding

- Current funding levels for harm minimisation and treatment programs are inadequate.
- Funding for mental health services needs to take into consideration the large overlap between people who use AOD and people who have complex and/or serious mental health conditions. There needs to be better programs and more funding available to support women with children in withdrawal and treatment services. It is particularly important that women seeking treatment do not risk losing their children to the child protection system because they are seeking treatment[14].

Services

- The ACT needs to continue work on the Supervised Injecting Drug Facility, that was to be collocated with a Needle and Syringe Program along with appropriate counselling and support.
- The ACT should continue to offer pill testing at various music events for young people, again with appropriate support from trained counsellors and/or via a peer education model.
- Both pill testing and needle/syringe programs are opportunities for education and improving health literacy.

Legislation and drug offences

- The legal grey area between ACT legislation and federal provisions or federal over-riding ACT legislative changes may have a negative impact on consumers, particularly those who are following the ACT law. The question was raised that if the Australian Federal Police were required to follow federal rather than ACT laws around drug possession, then it is not clear as to what would happen to consumers.
- Small drug offence notices could be used as education and health literacy opportunities as well as a chance to connect people with support and treatment services.
- The cost of small drug offence notice fines needs to be set in consultation with AOD services and consumers to adequately reflect the most affected user groups. Illicit and problem drug use tends to disproportionately affect those

who suffer other forms of disadvantage. In these sections of the community $100 is often an incredibly difficult amount to come by, this may result in unpaid finds and unnecessary interactions with the criminal justice system.

3. Additional Related Matters

3.1 Tobacco and Alcohol

Alcohol and Tobacco still represent the greatest negative health impact from AOD substances in Australia. In 2015 Tobacco use was the highest contributing risk factor to the burden of disease and injury in Australia at 9.3%, Alcohol use also ranked highly at 4.5%[15]. In contrast illicit drug use only made up 2.7%[16]. While the ACT has reduced the percentage of people who smoke daily from 18.4% in 2001 to 8.2% in 2019[17] there is still more to be done. These numbers highlight that AOD harm minimisation strategy needs to include a strong focus on alcohol and tobacco use and abuse.

As mentioned above, any strategy looking at AOD use reduction needs to take into consideration that groups experiencing other forms of disadvantage are much more likely to smoke[18] and drink. A 1995-96 study in Melbourne found that 77% of people who were experiencing homelessness were smokers 74% were drinkers, this increased to 93% and 87% for those who were living on the streets[19]. The study also showed that rates of injecting drug use, cannabis use, and risky sexual behaviour was also much higher in those people who were experiencing homelessness and living on the streets. The ACT Government needs to draw on successful harm reduction programs from other jurisdictions, like the e-cigarettes program trialled in the UK[20] or the programs evaluated in Sydney[21], and the experiences of its own AOD services to develop appropriate harm minimisation programs for these high-risk groups.

Young men are also a key demographic to target when looking at AOD harm minimisation. Men suffer almost three times the disease burden from alcohol use disorders than women. For men ages 15-24yrs it makes up the highest non-fatal disease burden at 11.1% and the second most for men aged 25-44yrs at 9.6%[22]. There is also a high prevalence of alcohol and other substance use involvement in other criminal offences. Across these age groups[23]

3.2 Supply

While it is good to see that the legislation begins the journey away from criminal justice solutions to essentially a harm minimisation/health-based approach, simply allowing people to carry currently illicit drugs for personal use does not address some of the most concerning issues that relate to harm minimisation. Two of these relate to supply concerns:

- While people will be able to carry small amounts of these drugs for personal use, the quality of these drugs (which are still supplied in an illegal market) can be a great risk to health, for example, through the inclusion of inappropriate substances at some point in the illegal supply chain. In North America and Europe heroin sold on the streets has been found to contain

anything from anthrax, fentanyl, and benzodiazepines though to less harmful additives such as caffeine and sugar[24]. Similar contamination problems appear to be a growing issue in Australia, with the highly potent synthetic opioid fentanyl being found as a contaminant in cocaine and methamphetamines[25]. If Governments are really concerned about harm minimisation to users, there must be provision of a safe supply and scrutiny of use patterns, for example through prescription or other regulated mechanisms. Already with cannabis, there are examples of people with heavy usage having their lives considerably disrupted. This is compounded by inadequate availability of addiction related health services once someone (often belatedly) recognises that their use patterns are having a negative influence on their lives. In countries like Switzerland and Germany they have used medically administered heroin for opioid dependence, known as heroin-assisted therapy or HAT[26]. This approach has allowed the local health authorities to control the dosage and purity of the prescribed drug reducing the risks around contamination and allowing them to assist in supporting people towards recovery.

- Given that supply of all illicit drugs and their commercial sale will remain illegal under the Bill, people seeking to acquire such drugs must interact with criminals and must spend considerable time and money acquiring these substances. These interactions can lead, often inadvertently or through contamination, to their use of other drugs which may be more addictive. If they have problematic usage, this can take a lot of their time and their capacity to lead a normal life is further inhibited.

3.3 Drug Driving

Drug driving offences were also raised as a concern. The challenge for consumers is that for several of the substances allowed in the Bill, the active chemicals are detectable in the body far longer than they affect a person's capacity to drive. This is particularly the case for drugs like Cannabis. Unlike alcohol there is no clear relationship between the blood THC levels and impairment, as such it is difficult to determine when THC induced driving impairment subsides[27]. Studies have shown that it takes 5-7hrs post inhalation of cannabis to regain safe driving capacity. Blood and Oral (saliva) tests, however, can detect THC in a person's system well beyond this time limit. For example, blood tests typically can detect substance use that occurred within 2-12 hours and saliva tests can be used to detect substance use 24-48 hours after last use[28]. Drink and drug driving laws in the ACT state:

> *"under section 20 of the Road Transport (Alcohol and Drugs) Act 1977 it is an offence for a person to drive a motor vehicle on a public street or in a public place if the person has a prescribed drug present in the person's blood or oral*

fluid. A 'prescribed drug' means the active ingredient in cannabis (delta-9-tetrahydrocannabinol), methamphetamine or MDMA (ecstasy)."[29]

This means that even when a person is safe to drive based on the research e.g. 24hrs after smoking cannabis, they can still be convicted for drug driving. This inconsistency between people's lived experience, the research and the legislation make it difficult for people to make safe assessments about their capacity to drive. It is important that we examine this issue and ensure that the ACT legislation on drug driving is in line with the evidence.

4. Concluding remarks

As was highlighted in this submission the Bill is an important step in a harm minimisation approach to AOD, however there is also a lot more work to be done. HCCA wants to highlight the important place for consumers and their families in this work and the need for the Inquiry to listen to the lived experiences of people who use illicit substances in the ACT. It is also important to really understand the experiences of consumers and their families when looking at problem AOD use to look at what the barriers to accessing care may be and what we as a community can do to help reduce the harm that AOD use, and misuse, can cause.

[1] Csete, Joanne, Adeeba Kamarulzaman, Michel Kazatchkine, Frederick Altice, Marek Balicki, Julia Buxton, Javier Cepeda et al. (2016). "Public health and international drug policy." *The Lancet.* 387(10026). 1427-1480.
[2] Maurice Rickard (2001) *Reforming the Old and Refining the New: A Critical Overview of Australian Approaches to Cannabis*, Social Policy Group, Parliamentary Research Paper 6 2001-2002. https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp0102/02RP06
[3] Lenton, Simon, Rachel Humeniuk, Penny Heale, and Paul Christie. (2000). "Infringement versus conviction: The social impact of a minor cannabis offence in South Australia and Western Australia." *Drug and Alcohol Review* 19(3), 257-264.
[4] United Nations. (1948). *Universal Declaration of Human Rights.* https://www.un.org/en/about-us/universal-declaration-of-human-rights
[5] United Nations. (1966). *International Covenant on Economic, Social and Cultural Rights*. *https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx*
[6] United Nations. (2007). *Declaration on the Rights of Indigenous Peoples*. https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html
[7] United Nations Economic and Social Council. (2000). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. https://www.refworld.org/pdfid/4538838d0.pdf
[8] World Health Organisation. (2006). *Constitution of the World Health Organization*. https://www.who.int/governance/eb/who_constitution_en.pdf
[9] See note 1.
[10] See note 3.
[11] Ritter, Alison, Ross McLeod, and Marian Shanahan. (2013). *Government drug policy expenditure in Australia-2009/10*. Sydney: National Drug and Alcohol Research Centre.
[12] McDonald, David. (2006). *Australian Capital Territory Government Expenditure on Preventing and Responding to Drug Abuse, 2004-05*. Consultant in Social Research & Evaluation for the Alcohol and Other Drug Policy Unit, ACT Health, Canberra
[13] Tito Wheatland, Fiona (2018). *Bright Ideas from people, places and research: Canberra on the journey to become a Restorative City Evidence Paper*. ACT Law Reform Advisory Council. https://www.canberrarestorativecommunity.space/blog/2020/3/22/bright-ideas-from-people-places-and-research-canberra-on-the-journey-to-become-a-restorative-city
[14] See note 1.
[15] Australian Institute of Health and Welfare. (2019). *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015*. Canberra: AIHW. https://www.aihw.gov.au/reports/burden-of-disease/burden-disease-study-illness-death-2015/summary
[16] See note 15.
[17] Australian Institute of Health and Welfare, Tobacco and Smoking in Australia, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/data-by-region/tobacco, Accessed 3/5/2021
[18] Greenhalgh, E. M., Hanley-Jones, S. , Jenkins, S. & Scollo, M. (2020). 9.6 Smoking, ill-health, financial stress and smoking-related poverty among highly disadvantaged groups. In Greenhalgh, EM, Scollo, MM and Winstanley, MH [editors]. *Tobacco in Australia: Facts and issues*. Melbourne: Cancer Council Victoria . Available from: http://www.tobaccoinaustralia.org.au/chapter-9-disadvantage/9-6-smoking-ill-health-financial-stress-and-smokin
[19] Kermode, Michelle, Nick Crofts, Peter Miller, Bryan Speed, and Jonathan Streeton. (1998)."Health indicators and risks among people experiencing homelessness in Melbourne, 1995–1996." *Australian and New Zealand journal of public health* 22(4). 464-470.

[20] Dawkins, Lynne, Linda Bauld, Allison Ford, Deborah Robson, Peter Hajek, Steve Parrott, Catherine Best et al. (2020). “A cluster feasibility trial to explore the uptake and use of e-cigarettes versus usual care offered to smokers attending homeless centres in Great Britain.” *PloS One.* 15(10).
[21] Power, Joseph, Claire Mallat, Billie Bonevski, and Olav Nielssen. (2015). "An audit of assessment and outcome of intervention at a quit smoking clinic in a homeless hostel." *Australasian Psychiatry* 23(5): 528-530.
[22] See note 15.
[23] Payne J. Gaffney A. (2012) How much crime is drug or alcohol related? Self-reported attributions of police detainees. *Trends and issues in crime and criminal justice* no 439. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/tandi/tandi439 . See also Doherty L & Sullivan T 2020 *Drug use monitoring in Australia: drug use anong police detainees 2019.* Statistical Report no. 30. Canberra : Australian Institute of Criminology. https://www.aic.gov.au/publications/sr/sr30
[24] See note 1.
[25] Voce A & Sllivan T. (March 2020). Is there fentanyl contamination in the Australian illicit drug market?. *Statistical Bulletin 21*. Australian Institute of Criminology https://www.aic.gov.au/publications/sb/sb21
[26] See note 1.
[27] McCartney, Danielle, Thomas R. Arkell, Christopher Irwin, and Iain S. McGregor. (2021)."Determining the magnitude and duration of acute Δ9-tetrahydrocannabinol (Δ9-THC)-induced driving and cognitive impairment: A systematic and meta-analytic review." *Neuroscience & Biobehavioral Reviews*.
[28] Hadland, Scott E., and Sharon Levy. (2016). "Objective testing: urine and other drug tests." *Child and Adolescent Psychiatric Clinics* 25(3), 549-565.
[29] Justice and Community Safety Directorate, ACT Government, *Drink and drug driving laws for the ACT.* https://www.justice.act.gov.au/drink-and-drug-driving-laws-act, Accessed 3/5/2021