LRRCSC - INQUIRY INTO DRUG LAW REFORM
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VICTORIAN multicultural commission
strengthening our community

VICTORIAN MULTICULTURAL COMMISSION

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

SUBMISSION TO THE INQUIRY INTO DRUG LAW REFORM

1. INTRODUCTION

1.1. The Victorian Multicultural Commission (VMC) is the voice of Victoria's culturally and linguistically diverse communities and is the main link between them and the government. The VMC provides independent advice, informed by regular community consultations and Regional Advisory Councils (RAC), to the Victorian Government in accordance with its statutory role under the *Multicultural Victoria Act 2011*.

1.2. The VMC welcomes the opportunity to make a submission to the Law Reform, Road and Community Safety Committee Inquiry into Drug Law Reform on behalf of Victoria's multicultural communities. This submission is structured around themes of public health approaches, settlement effects, access to treatment and support services, and gaps in research and evidence that more broadly inform approaches to drug law reform relating to the particular circumstances and needs of people from multicultural backgrounds.

1.3. In this submission the VMC advocates for the specific needs of the multicultural community in regards to illicit drug use. We have found that there is more evidence of illicit and synthetic drug use in multicultural communities than for the misuse of prescription medication. We also highlight the need for further research and the building of an evidence base that relates to multicultural communities. This will better inform the development of relevant policy and its effective implementation to ensure equitable outcomes for Victoria's multicultural community.

1.4. The submission addresses the laws, procedures and regulations that criminalise drug use with a view to decriminalising those aspects that would benefit from public health approaches. This includes advocating for harm minimisation strategies, and treatment programs that are targeted and culturally responsive.

2. CONTEXT

2.1. Migrant populations include some of Victoria's most vulnerable cohorts, particularly asylum seekers and refugees. These communities need specific supports that a public health approach to drug law reform can bring rather than punitive measures that can further exacerbate harm. Victorian health services need to build effective cultural responses to the needs of this multicultural and increasingly young population.[1]

2.2. In 2015-2016 Australia issued 17,555 Refugee and Humanitarian Assistance Visas and 1,552 Temporary Protection and Safe Haven Enterprise visas, granting entry to a total of 19,107

[1] Posselt, Galletly, de Crespigny, & Proctor, 2013.

people.[2] Many of these individuals were fleeing war, organised violence and civil unrest. International students are another potentially vulnerable cohort.

2.3. As at 30 June 2016 there were 401,423 international students in Australia, with over a third of students emanating from China (22.7%) or India (13.4%). In 2015-2016 young people aged between 12-24 years accounted for more than a quarter (27%) of Humanitarian entrants, and almost one fifth (18%) of all migrant groups.[3]

2.4. Poor mental health, emanating from pre-settlement experiences, is a pertinent issue and potential trigger in refugee communities for substance abuse. For example, recent research highlights the significant behavioural changes and psychosomatic symptoms in children who have experienced sustained periods of war and conflict. Studies into the mental health of Syrian refugee children have shown staggering levels of trauma and distress.[4] In the worst cases these children are turning to substance abuse, self-harm or even attempting suicide.[5]

2.5. Practitioners working in the refugee and alcohol and drug sectors have reported a relatively high prevalence of mental illness, including post-traumatic stress disorder (PTSD) symptoms, anxiety and depression and comorbid substance misuse.[6] Anecdotally the VMC has been informed by refugee health services that assess drug use in new arrivals, that often drug use (licit and illicit) emanates as a coping strategy for PTSD, and that this needs to be addressed early in settlement.

2.6. Understanding the risk factors in relation to the stressors associated with adjusting to a new country can assist in informing targeted public health approaches for particular community cohorts. The study of the settlement of young people of refugee backgrounds in Melbourne found that 'risk-taking' behaviours including substance use increased in years two and three of settlement in Australia, especially among youth.[7]

2.7. Research suggests there is a gap between early intervention and crisis youth services and a gap between mainstream and specialist services, including a lack of funding for longer term interventions.[8] Thus the Victorian health system needs to be resourced to be culturally responsive to tackle the problem early in the settlement process.

3. THE EVIDENCE BASE – MULTICULTURAL COMMUNITIES

3.1. Evidence relating to the prevalence of drug use among people from CALD backgrounds in Australia is both limited and conflicting.[9] Multicultural communities are often under-represented in drug trends monitoring studies including the National Drug Strategy Household Survey.[10] One drawback relates to the self-completion drop-and-collect questionnaire which is available only in

[2] Australian Government Department of Immigration and Border Protection (DIBP), *2015-2016 at a glance*. Retrieved 7 March 2017: http://www.border.gov.au/about/reports-publications/research-statistics/statistics/year-at-a-glance/2015-16

[3] Australian Government Department of Social Services, Settlement Reporting Facility (SRF). Sourced 7 March 2017: https://www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy/settlement-services/settlement-reporting-facility

[4] McDonald, Buswell, Khush, & Brophy, 2017.

[5] Ibid

[6] Kennedy & Goren, 2007.

[7] Gifford, Correa-Velez, & Sampson, 2009.

[8] Foundation House and the Centre for Multicultural Youth, 2013.

[9] Donato-Hunt, Munot, & Copeland, 2012.

[10] The National Drug Strategy Household Surveys provide cross-sectional data on alcohol, tobacco and other drug use in Australia. The survey is part of the *National Drug Strategy* 2016-2025, which aims to improve the health, social and economic outcomes for the Australian Society.

English.[11] At the same time smaller studies have reported drug use to be more common among people from multicultural backgrounds than the general population.[12]

3.2. It is well established that drug and alcohol problems are commonly experienced by individuals with mental health problems.[13] This comorbidity of conditions has been identified in refugee adults and children who have witnessed or experienced torture, suicide attempts, murders, the deaths of loved ones, sexual abuse, and starvation.[14]

3.3. There is little robust data on drug and alcohol use among Australia's multicultural communities. One study that has quantitatively measured alcohol and illicit drug use among representative samples from multicultural communities relates to a survey conducted in 2004–2005 to investigate the risk of drug-related harm among Chinese, Vietnamese, Italian, Pasifika, Arabic-speaking and Spanish-speaking communities in Sydney.[15] The results of the aforementioned survey demonstrate the need for tailored programs that can meet the needs and contexts of particular communities.[16]

3.4. There is also a significant need for statistical evidence and further research focusing on multicultural communities specifically, to tease out the pathways into and out of drug use for these cohorts. This view is supported by the priorities of the National Drug Strategy 2016-2025.

4. THE VMC'S INTEREST IN THE ISSUE

4.1. The VMC is concerned with the health and wellbeing of multicultural communities, especially newcomers. New migrants face a myriad of challenges, and ongoing social and economic disadvantage has been noted to enhance the vulnerability of migrant communities to illicit drug use.[17] The pre-migration experiences of humanitarian entrants for example, pose significant psychological distress and post-migration stressors.

4.2. Difficulties with resettlement and the loss of social and cultural support add significantly to PTSD symptoms. Once settled, other factors can add to ongoing stress causing susceptibility to the harmful use of alcohol, tobacco and other drugs. These factors include family stressors, unemployment, language barriers and a lack of understanding of the services available, which are known to exacerbate mental health outcomes.[18]

4.3. Further, social categories such as class, gender and race can influence access to resources, vulnerability to marginalisation, and cultural roles and expectations, which in turn can affect health outcomes, drug use and drug outcomes.[19]

4.4. A major concern for multicultural communities is stigma, which is a barrier to open community dialogue about substance use (particularly across generations) and to the uptake of health services. The experience of stigma can have wide ranging impacts on a person's health and general quality of life, including their ability to participate socially and economically to society

[11] Above n 9
[12] Ibid
[13] Posselt, Galletly, de Crespigny, & Proctor, 2013.
[14] Ibid
[15] Above n 9
[16] Ibid
[17] Horyniak, Higgs, Degenhardt, Cogger, Power , & Dietze, 2012.
[18] Porter & Haslam, 2001.
[19] Spooner & Hetherington, 2004.

and affect willingness to access treatment and other support services.[20] The National Drug Strategy supports this view by identifying the need to develop a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards drug dependence.

4.5. A public health approach involves the scaling up of health services for people who use drugs, which demonstrates to society the value of responding with support rather than punishment to people who commit minor drug infractions.[21] Creating an environment that encourages help seeking, rather than discriminating against drug users through legal sanctions, supports the achievement of optimum health and wellbeing and active participation in community life.

5. TERM OF REFERENCE 1

> The effectiveness of laws, procedures and regulations relating to illicit and synthetic drugs and the misuse of prescription medication in minimising drug-related health, social and economic harm.

5.1. The VMC whilst not in a position to comment on the effectiveness of laws, procedures and regulations relating to illicit and synthetic drugs, would like to bring to the attention of the Inquiry the experiences of multicultural communities in relation to illicit drug use which requires a public health approach to minimising drug-related health, social and economic harm.

5.2. While whole of population strategies can be effective at reducing total harm and social impact, there are community sub-sets, including multicultural communities that would benefit from more tailored approaches.[22] While people in the general population experience challenges in accessing treatment, this is only exacerbated for people from multicultural communities.[23]

5.3. This has been specifically highlighted to the VMC in its recent RAC meetings, where members have spoken about barriers to accessing appropriate supports and treatment in relation to illicit drug use. Such as, fear of ostracisation by families or wider community in seeking support and treatment, and general lack of awareness of available treatment models.

5.4. Despite high rates of psychopathology for example, many refugees experience significant difficulties accessing mental health services.[24] RAC members at Dandenong and Bendigo report that refugees who experience prolonged periods in detention can arrive in the community with undiagnosed mental health conditions.

5.5. In addition, substance misuse can hinder the ability of refugee youth for example, to re-engage with family, community and educational and occupational pathways. Young people and their families often attempt to deal with it on their own, not seeking support or treatment.[25]

5.6. The way services are funded can add to the difficulties. For example, mental health and alcohol and other drug (AOD) services are generally separately funded and organised, with few specialist services focusing on the care and treatment of people affected by both disorders.[26] As a result individuals with comorbidity often fall through the gaps between relevant services. This may be

[20] Social Inclusion Action Research Group, 2013.
[21] Csete, et al., 2016.
[22] The National Drug Strategy also identifies Aboriginal and Torres Strait Islander people and older people.
[23] Posselt, Galletly, de Crespigny, & Proctor, 2013.
[24] Ibid
[25] Reid, Crofts, & Beyer, 2001.
[26] Above n 23

heightened for multicultural communities, particularly those from non-English speaking backgrounds, due to the lack of understanding and awareness of the seriousness of drug issues, as well as how to recognise signs and symptoms.

5.7. The VMC welcomes the National Drug Strategy that promotes a cooperative environment between the law enforcement and health sectors, and a commitment to harm minimisation approaches that facilitate referral pathways to alcohol and drug treatment.[27] It provides a national framework and guidance for action by Commonwealth, state and territory governments in partnership with service providers, local government authorities and the community. The strategy notes that priority populations and drug types change over time.[28]

VMC RECOMMENDATIONS - THE EFFECTIVENESS OF LAWS, PROCEDURES AND REGULATIONS

Recommendation 1

Specific to Terms of Reference 1, the VMC recommends that the Inquiry considers:

i. Increasing measures to ensure the capacity of health and social services to address drug-related harms or problematic drug use as needed and improve targeting to multicultural communities;

ii. creating a public awareness and education campaign similar to public health campaign for tobacco; but also targeted at those multicultural communities that are particularly vulnerable and have low levels of awareness and understanding; and

iii. resourcing a central body like Quit Victoria to extend its remit to include other drugs such as cannabis.[29]

The VMC also supports the following:

i. A public health approach to drug use, and having primary prevention and harm reduction measures as a central pillar of health systems and drug policy;

ii. the commissioning of research to build the evidence base in relation to:

   a. illicit drug use prevalence among multicultural populations;

   b. the comorbidity of mental health and substance misuse in young people from migrant and refugee populations within the first 5 years of settlement; and

   c. suitable treatment and support service alternatives for migrants from non-English speaking backgrounds employing co-design principles.

[27] National Drug Strategy 2016-2025, 2015.
[28] Ibid
[29] Quit Victoria engages with multicultural communities and provides translated resources. http://www.quit.org.au/multicultural

6. TERM OF REFERENCE 2

> The practice of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law.

The practice of other Australian states and territories

6.1. The VMC supports the New South Wales (NSW) approach to best practice in reducing harm associated with alcohol and other drugs specific to culturally and linguistically diverse communities. The Drug and Alcohol Multicultural Education Centre (DAMEC) is premised upon a client-centred approach that recognises the significance of culture, community and migration. This is done by:

- Promoting service access strategies such as familiarising newly arrived cohorts with health services. For example, storyboards are an effective tool and useful for explaining alcohol and other drug matters in culturally appropriate ways;
- Prioritising client needs and emphasis on genuine choice through access to trained interpreters as a means to not only earn trust, but to effectively explain what intake and assessment processes involve, particularly to alleviate confidentiality issues.[30]

Other approaches to drug law reform

6.2. The VMC advocates investigating further the effectiveness of public health approaches consistent with the growing evidence from Australian and overseas jurisdictions and authorities.

6.3. For example, the Johns Hopkins–*Lancet* Commission on Drug Policy and Health (UK) has sought to examine the emerging scientific evidence on public health issues arising from drug-control policy in order to inform and encourage a central focus on public health evidence and outcomes in drug-policy debates.[31] The 'war on drugs' and zero-tolerance policies that grew out of the prohibitionist consensus are now being challenged on multiple fronts, including their health, human rights, and development impact.[32]

6.4. The 2013 National Drug Strategy Household Survey, found that Australians support a range of non-criminal actions, those which equate with the decriminalisation of use and possession of illicit drugs.[33]

6.5. A key feature of decriminalisation relates to drug use not carrying a criminal record, at least in the first instance, as is currently the case in Victoria. The greatest distinction for decriminalisation is whether it is *de jure* or *de facto*. Currently Victoria practices *de facto* reform of criminal penalties, controlled by 'eligibility requirements',[34] which occurs through:

- non-enforcement of the law, via police discretion or prosecutorial guidelines, and
- referral of offenders to education and or treatment instead of court for a first offence.

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[30] See 'Working with Diversity in Alcohol and other Drug Settings', http://www.nada.org.au/media/59706/nada_working_with_diversity_sept14.pdf.

[31] Csete, et al., 2016.

[32] Ibid

[33] Cited in, Hughes, et al., 2016.

[34] To be eligible people often have to admit to the offence, not have been detected by police more than once or twice, and carry only a particular quantity of drug. Anyone who does not meet the strict requirements is processed through the usual court mechanism (Hughes, et al., 2016).

6.6. The VMC considers *de jure*[35] decriminalisation an alternative option, especially for multicultural communities because there are fewer eligibility restrictions which maximise program access and equity, and for greater resources to be invested in public health through primary prevention initiatives working together with decriminalisation to reduce drug dependency.

6.7. Decriminalisation of drug use is considered a core element in any public health strategy.[36] Victoria has taken this step in relation to the medicinal use of marijuana under the *Access to Medicinal Cannabis Act 2016.* Portugal decriminalised the use and possession of all illicit drugs in 2001 by eliminating criminal penalties for low-level possession and consumption of all illicit drugs. It reclassified these activities as administrative violations and at the same time, expanded investment in drug treatment, harm reduction and social reintegration.[37]

VMC RECOMMENDATIONS - THE PRACTICE OF OTHER AUSTRALIAN AND OVERSEAS JURISDICTIONS

Recommendation 2

The VMC recommends that the Inquiry:

i. *adopt a client-centred approach to minimise harm associated to alcohol and other drugs within culturally and linguistically diverse communities in Victoria, similar to the NSW DAMEC approach;*

ii. *further investigate de jure decriminalisation for cannabis and all illicit drugs, including modification that removes criminal sanctions for non-compliance;*

iii. *expands the use of diversion from the criminal justice system to appropriate treatment and education programs; and*

iv. *ensures that all drug policies are duly monitored and assessed as to their impact on multicultural community subsets, such as youth, women, and people living in poverty.*

[35] *De jure* decriminalisation occurs through a) removing criminal penalties, b) replacing criminal penalties with civil penalties (such as a fine), and c) replacing criminal penalties with administrative penalties. Above n 33.

[36] Global Commission on Drug Policy, 2016.

[37] Hughes, et al., 2016.

Bibliography

Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., et al. (2016). Public health and international drug policy. *The Lancet*, Vol.387, No.10026, pp.1427-1480.

Donato-Hunt, C., Munot, S., & Copeland, J. (November, 2012). Alcohol, tobacco and illicit drug use among six culturally diverse communities in Sydney. *Drug and Alcohol Review*, 31, pp.881-889.

Foundation House and the Centre for Multicultural Youth. (2013). *Responding to challenges of misuse of alcohol and other drugs by young people of refugee backgrounds. Reflections from two projects.* Retrieved March 10, 2017, from Mental Healthin Multicultural Australia: http://www.mhima.org.au/pdfs/responding%20to%20challenges%20of%20misuse%20of%20AOD%20young%20refugee.pdf

Gifford, S., Correa-Velez, I., & Sampson, R. (2009). *Good starts for recently arrived youth with refugee backgrounds. Promoting wellbeing in the first three years of settlment in Melbourne, Australia.* Melbourne: La Trobe Research Centre.

Global Commission on Drug Policy. (2016). *Advancing Drug policy Reform: A New Approach to Decriminalization.* Retrieved March 9, 2017, from GCDP: http://www.globalcommissionondrugs.org/reports/advancing-drug-policy-reform/

Horyniak, D., Higgs, P., Degenhardt, L., Cogger, S., Power , R., & Dietze, P. (2012). Injecting drug use and related health behaviours in a small case series of East African migrants in Melbourne. *Australian and New Zealand Journal of Public Health*, Vol.36, No.6, pp.586-587.

Hughes, C., & Wodak, A. (2012, July 6). *What can Australia learn from different approaches to drugs in Europe including especially Portugal, Switzerland, the Netherlands and Sweden?* Retrieved March 16, 2017, from Australia21 Shaping the Future: http://australia21.org.au/wp-content/uploads/2013/11/ASIllicitDrugsBP2.pdf

Kennedy, N., & Goren, N. (2007). Culturally and Linguistically Diverse Communities and Drug Prevention. *Prevention Research Quarterly*, No1; pp.1-12.

McDonald, A., Buswell, M., Khush, S., & Brophy, M. (2017, March). *Invisible Wounds. The impact of six years of war on the mental health of Syria's children.* Retrieved March 7, 2017, from Save the Children: https://i.stci.uk/sites/default/files/Invisible%20Wounds%20March%202017.pdf

National Drug Strategy 2016-2025. (2015, October). Retrieved March 6, 2017, from Australian Government National Drug Strategy: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/draftnds

Porter, M., & Haslam, N. (2001). Refugees and internally displaced persons: a meta-analysis. Predisplacement andpostdisplacement factors associated with mental health of. *Journal of the American Medical Association*, 294(5), pp.602-612.

Posselt, M., Galletly, C., de Crespigny, C., & Proctor, N. (2013). Mental health and drug and alcohol comorbidity in young people of refugee background: a review of the literature. *Mental Health and Substance Use*, pp.1-12.

Reid, G., Crofts, N., & Beyer, L. (2001). Drug Treatment Services for Ethnic Communities in Victoria, Australia: An Examination of Cultural and Institutional Barriers. *Ethnicity and Health*, 6(1), pp.13-26.

Social Inclusion Action Research Group. (2013, June). *Reducing Stigma nd Discrimination Relating to Alcohol and other Drugs in Western Australia, Position Paper.* Retrieved from Government of Western Australia Drug and Alcohol Office: www.dao.health. wa.gov.au

Spooner, C., & Hetherington, K. (2004). *Social Determinants of Drug Use.* Retrieved March 6, 2017, from National Drug and Alcohol Research Centre, University of New South Wales: https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf