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Alcohol and Drug Foundation

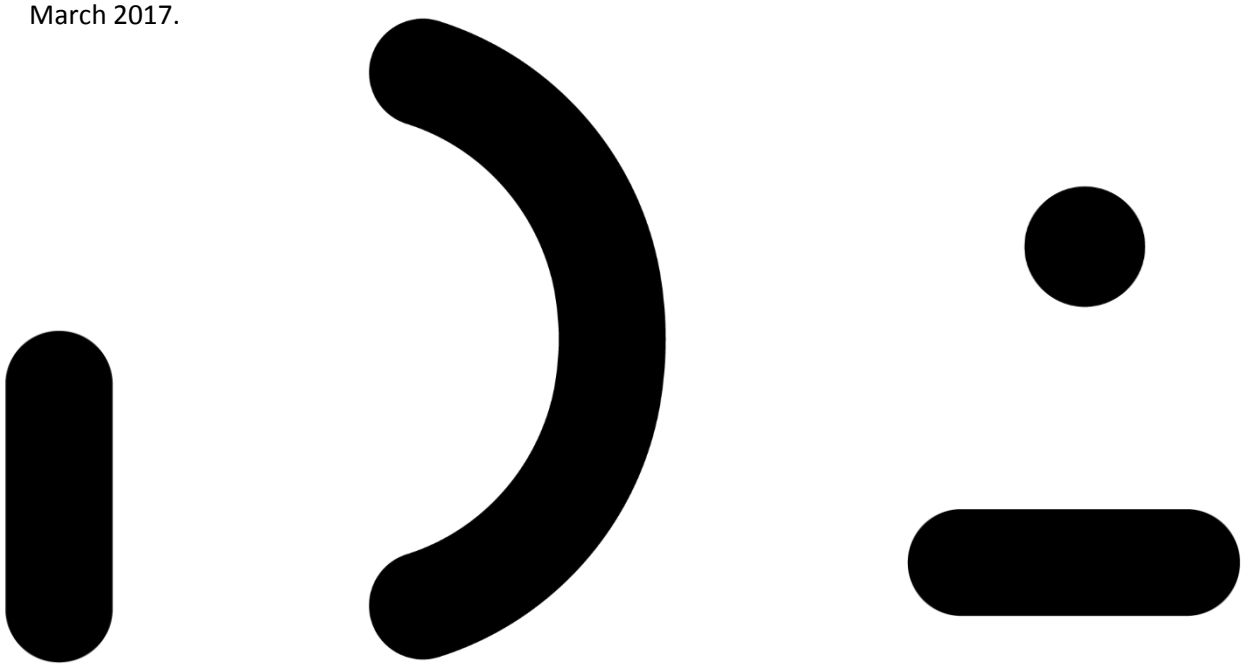
PREVENTING HARM IN AUSTRALIA

Inquiry into Drug Law Reform by the Parliament of Victoria's Law Reform Road and Community Safety Committee.

Submission by Alcohol and Drug Foundation

Mr John Rogerson CEO

March 2017.



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THE ALCOHOL AND DRUG FOUNDATION

Founded in Melbourne in 1959, the Alcohol and Drug Foundation (ADF) has nearly 60 years of continuous service to the community. The ADF is one of Australia's leading bodies working to prevent alcohol and other drug problems in local communities around the nation. It is one of the few national, primary prevention-focused organisations in the alcohol and drug field.

Our focus is on primary prevention and early intervention, to that end we employ community action, health promotion, education, information, policy, advocacy and research. Our vision is an Australia that is composed of 'Healthy People, Strong Communities'.

The ADF is shaping culture change through the provision of high-quality alcohol and drug information and education services, community capacity building programs and advocacy. We influence millions of Australians through our reach into the home, workplace, grassroots community space and professional sporting clubs. Our footprint extends across metropolitan, regional, rural and remote Australia across every State and Territory.

The ADF is the pre-eminent national source of accurate, up-to-date, high quality information regarding alcohol and other drugs, accessible free of charge for all community members. Our telephone, fax, email and web drug information services receive over a million contacts each year. The ADF also conducts seminars and webinars which attract professionals working in the AOD field, researchers, academics and policy makers, and members of the general public, as well as other information and education events.

We have developed alcohol harm reduction programs for workplaces (Good Hosts, ADF Inform, Workplace Consultancy Services) that have been implemented in over 40 Australian workplaces, including the Australian Defence Force, Comcare, RioTinto, St George Bank, NRMA, local government, and the tertiary education sector.

We are active in community and professional sport. Our *Good Sports* program has transformed the drinking culture of thousands of community sport clubs, assisting them to be healthier, safer and family-friendly places. We have partnered with the National Rugby League to introduce a whole-of-organisation, whole-of code approach to alcohol management and are working to increase our partnerships with other professional sport governing bodies and elite clubs.

We are committed to social inclusion and closing the gap in health and life expectancy between Indigenous and non-Indigenous Australians through partnerships and collaborations with Indigenous communities across the country. We have implemented *Good Sports* in remote towns in Central Australia and we are now working with the Northern Territory government to extend the program to the Tiwi Islands.

While the ADF addresses all types of drug related harm, our main focus is on alcohol because its contribution to personal and social harms and overall cost to the Australian community outweighs that of other drugs. Alcohol is second only to tobacco as a preventable cause of drug-related harm in Australia.

TERMS OF REFERENCE OF THE INQUIRY INTO DRUG LAW REFORM

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; and

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

THE ADF SUBMISSION

The ADF is pleased to respond to the invitation from the Parliament of Victoria's Law Reform Road and Community Safety Committee to provide a submission to the Inquiry into Drug Law Reform. The terms of reference are broad, addressing every psychoactive substance other than alcohol and tobacco. The ADF has chosen to concentrate on issues it considers of the utmost importance at present, these are:

- The overriding need for a visionary primary prevention strategy to lead Victoria's drug strategy
- The over use and overdose of pharmaceuticals such as opioids and benzodiazepines
- The continuing epidemic of fatal heroin overdoses which warrants a trial of a supervised injection facility
- The use of illicit drugs at music festivals and similar events which warrants a trial of pill testing or 'drug checking'
- Controls on the pharmaceutical forms of cannabis for medical purposes
- The provision of specialised Drug Courts to offer drug offenders a positive alternative to incarceration

EXECUTIVE SUMMARY

The submission of the Alcohol and Drug Foundation is based on the following precepts:

Use of psychoactive substances carries a unique risk as every action or behavior undertaken in a state of intoxication becomes more hazardous due to the impaired perception, judgement and motor skills generated.

Use of illicit psychoactive drugs and pharmaceutical drugs poses a severe threat to the health and wellbeing of Victorians and are responsible for a host of preventable physical and mental health illnesses and conditions.

An effective response to Victoria's drugs problem should give priority to supporting primary prevention programs that increase protective factors in our communities and reduce the appeal and perceived need for psychoactive drug use.

Understanding the social determinants of drug use suggests drug prevention strengthens individuals' resilience, fostering healthy connections between people, and building strong communities which offer support to troubled people.

By strengthening our communities, we reduce the prevalence of personal and social problems, including those related to drug use and mental ill-health, and the various costs associated with them.

A number of immediate opportunities exist for the government to reduce harm from the use of pharmaceutical drugs and illicit drugs. These opportunities relate to preventing the over use of pharmaceuticals; action to prevent fatal drug overdoses related to the use of heroin and to the use of amphetamine-like substances, the provision of Drug Courts, and controls on cannabis that is prescribed and consumed for medical purposes.

RECOMMENDATIONS

Recommendation 1: That the Committee recognise the contribution of primary prevention programs in reducing the drivers of problematic use of psychoactive drugs

Recommendation 2: That the Committee support the development of programs and resources that encourage and empower parents to have a positive influence in developing their children's resilience and decision making skills.

Recommendation 3: That the Committee support the development of programs and resources for school communities to support children identified as at-risk with the aim of encouraging students to complete school and retain retention pathways to further education or employment.

Recommendation 4: That the Committee recognise the value of providing all school students with pastoral care services and programs such as school nurses, school focused youth services, primary welfare officers and student welfare coordinators.

Recommendation 5: That the Committee acknowledge the need for councils to develop attractive recreational and entertainment opportunities for young people who do not have access to such activities due to lack of finance, training or opportunity.

Recommendation 6: That the Committee recognise the role Good Sports plays in educating members of community sporting clubs about the risk of illicit drugs, and how clubs can prevent their use, and respond effectively to potential signs of illicit drug use.

Recommendation 7: That the Committee encourage medical professionals and pharmacists to offer non-pharmacological treatments for ailments including stress, anxiety and chronic pain as an alternative to long term use of pharmaceutical drugs.

Recommendation 8: That the Committee recommend that Victoria should advocate for and assist the urgent development of a new national strategy for the reduction of harm related to Pharmaceutical Drugs

Recommendation 9: That the Committee recommend Schedule 4 Drugs be included in the real time monitoring scheme that is being implemented in Victoria.

Recommendation 10: That the Committee offer support for the continuance of the ADF's public information campaign on pharmaceutical misuse.

Recommendation 11: That the Committee recommend the commission of a rigorous evaluation of a trial of pill testing or 'drug checking' to ascertain its effectiveness in reducing drug overdoses and fatalities at music festivals and similar events.

Recommendation 12: That the Committee conclude there is an urgent need for a rigorous evaluation of a trial of a medically supervised injecting centre in Yarra to ascertain its effectiveness in reducing drug overdose fatalities.

Recommendation 13: That the Committee recommend continuing government support for research and clinical trials into the therapeutic use of cannabinoids to ascertain the conditions in which they are beneficial and the circumstances in which their use is indicated.

Recommendation 14: That the Committee recommends the government act to ensure that the public understands the distinction between medical/ therapeutic use of cannabinoids and the non-medical or 'recreational' use of cannabis.

Recommendation 15: That the Committee find that additional resources deserve to be committed to the Drug Court program for the collection of appropriate data that would allow a robust evaluation of the program.

SECTION 1: DRUG USE

Psychoactive drugs have been used throughout much of human history. Every known human society has used one or more psychoactive substances for medical, spiritual or hedonistic purposes. Psychoactive substances that have a medical purpose or application have often been used for pleasure or relaxation. In contemporary consumer societies many people also perceive psychoactive drugs, whether licit or illicit, as 'ordinary commodities' fit for regular or at least occasional use.

Goldstein and Kalant suggest that as psychoactive drugs can produce harm even when prescribed by medical professionals, it follows that government has a duty to protect citizens from the hazards of drug use as they may not have the necessary technical expertise to judge drug risks themselves (Goldstein A. Kalant., 1993).

Some argue that governments should not deny adults access to psychoactive drugs on the grounds of risk because other behaviours that involve risk of harm are permitted, such as horse riding, mountain climbing, scuba diving (Husak., 2002). However, there is a uniqueness to psychoactive drug use risk. The risk posed to individuals (and others) by the use of psychoactive substances is qualitatively different due to the effect of

intoxication. An additional level of risk is borne by an individual who is under the influence of a psychoactive substance because every action undertaken is more hazardous, with the subject liable to impaired perception, judgement and motor skills that can result in injury. So horse riding, mountain climbing and scuba diving risk is amplified and accentuated when the awareness and skill of the rider, climber or diver is impaired due to psychoactive substance intoxication.

The lawful availability of alcohol and tobacco does not necessarily justify adding new substances to the legal register: alcohol and tobacco were integrated into western culture before science was sufficiently advanced to discern their toxic effects. Governments around the world are now making strenuous efforts post haste to lower and even to eliminate the use of tobacco, and public health authorities are also trying to limit the excessive use of alcohol and pharmaceutical drugs.

While there is pressure in some quarters for a liberalisation of laws governing drug use, governments have a responsibility to act with caution, because easier access to psychoactive drugs may lead to greater use and consequently greater harms. Aggregate harm related to drug use is at least partly a function of the number of people who use the substance: for example, around 10-15% of users of any drug will become dependent on it (Hall, 2015). Thus the number of people who use a drug has a big impact on the consequential harm: for example, if 100,000 people use a drug, 10,000 individuals are likely to become dependent whereas if 1,000,000 use that drug, 100,000 are likely to be dependent. Enormous consequences follow not only for individuals but for society that has to respond with health, welfare and other services. Drug policy researchers also caution that it is difficult to predict the outcomes of drug liberalisation (Caulkins, Kilmer, & Kleiman, 2016) (Caulkins J, 2011) (A., 2014) and that even if outcomes are disturbing changes to drug laws may not be readily reversible, which can lead to new entrenched undesirable social norms (Caulkins J. & Lee, 2012).

One option for policymakers to consider is the depenalisation of illegal drug offences, (though often it is confused with decriminalisation (Weatherburn D. , 2014)) as practiced by Portugal and other states. Depenalisation would end the incarceration of people for drug offences and require their referral to drug treatment services or education services for further assistance. This option would require a large expansion of drug treatment and education services although the cost would likely be defrayed by cost savings in the judicial and custodial systems.

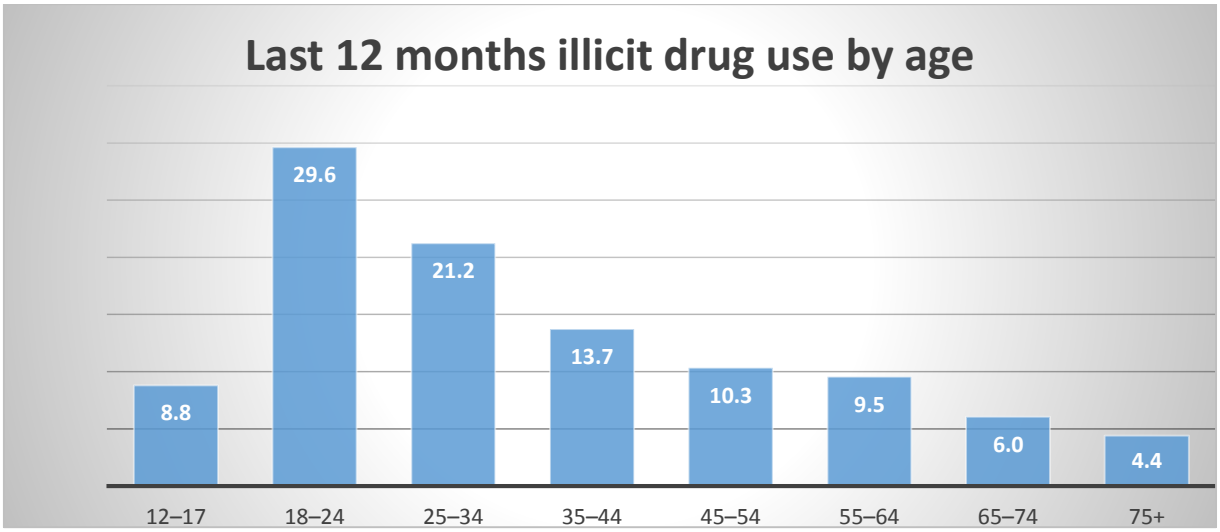
Nevertheless, the ADF believes that opportunities exist for immediate changes to Victoria's drug related laws and regulations to reduce the burden of the most harmful effects of drug use. These opportunities are elaborated upon in our submission and relate to: prevention of over use of pharmaceuticals, a supervised injection facility to prevent heroin related fatal overdoses, a trial of pill testing or 'drug checking', pharmaceutical forms of cannabis for medical purposes, and the provision of specialised Drug Courts to offer drug offenders a positive alternative to incarceration. Each of these options is supported by a body of evidence that suggests each would materially reduce the burden of illness and disease related to drug use.

An effective response to Victoria's drugs problem should give priority to supporting primary prevention programs that work to increase protective factors in our communities and reduce the appeal and perceived need for drug use. A second priority is for government to ensure that Victorians have fair and equitable access to drug treatment and counselling services rather than focusing on punitive penalties for drug use. Governments should support harm reduction services for those who are drug dependent, or who use illicit drug regularly, by supporting needle and syringe programs, medically supervised injecting rooms, justice diversion programs in drug courts and by 'drug checking'.

The ADF supports the national drug strategy emphasis on reducing drug supply, reducing drug demand through prevention and treatment, and reducing harm when drug use occurs.

OVERALL ILLICIT DRUG USE IN VICTORIA

According to the National Drug Strategy Household Survey, a reduction of illicit drug use by around 8% has occurred since 1998. However, in the past three years use of illicit drugs has remained relatively stable, despite a relatively small increase in the number of people who use crystal methamphetamine. The graph below highlights a recurring theme that illicit drug use peaks among young adults aged 18-30 years, and in from the mid-30s illicit drug use declines. (Australian Institute of Health and Welfare, 2014)



SECTION 2: DRUG PREVENTION

PREVENTING HARM

Australian national, state and local governments have the capacity and the responsibility to legislate to protect citizens from taking action or participating in behaviour that places themselves and others at risk of preventable harm, particularly when the risk of harm is high or when the individual may not fully understand the risk entailed. While governments cannot prevent citizens from harming themselves or others in all circumstances, as life inherently involves various types of risk, the mitigation of preventable harm should be a top priority.

Governments have a responsibility to facilitate and promote 'positive freedom' by assisting citizens to utilise their abilities, develop skills, achieve their potential and succeed in society. By providing education, for example, governments hope to enable individuals to take advantage of their innate abilities (Bessant, Watts, Dalton, & Smyth, 2006) and assist individuals to understand the choices before them, apply knowledge, and exercise true moral autonomy and hazard avoidance. It is also important however to avoid preventable harm by regulating the external conditions under which hazardous behaviour takes place including restricting the availability and use of psychoactive drugs that can disrupt, ruin or prematurely end people's lives. Further caution in allowing access to psychoactive substances is necessary because of their capacity to produce a dependence syndrome, or addiction – a state in which the consumer subjectively

loses control over use of the substance (Babor, 2010b), rendering the drug-dependent person unable to manage the most basic aspects of their life. Between 10% and 15% of people who commence using a psychoactive substance will become dependent upon it – and those who initiate drug use during adolescence face a greater risk of dependency (Hall, 2015). When governments act to reduce the incidence of drug use and dependency, they are acting to increase positive freedom.

SOCIAL DETERMINANTS OF HEALTH

Any person who uses a drug may suffer harm or come to rely on the drug; however, people at most risk of problematic alcohol and other drug use (AOD) are those who experience a severe difficulty or trauma in their life (personal, social, economic, etc.). This often includes mental illness, poverty, unemployment, isolation, dispossession and stigmatisation (Alexander, 2008). Often people in these conditions use a drug to try to cope with, avoid or mask a problem. Many people become vulnerable through no fault of their own – their disadvantage can come from environmental or biological factors over which they have little control. These can include (but are not limited to):

- People who are emotionally distressed, disengaged and disconnected from society through issues such as lack of employment or mental health problems
- Young people who are disengaged from the school system – children with learning difficulties, or from families that do not function well
- Young people without role models who might otherwise be guided towards more constructive life choices
- People who grow up with or live with drug use within their family or peer settings.

Many people who use illicit drugs heavily will consume the substance that is most readily available or is the easiest to obtain. Whilst it may be tempting to focus on dealing with the individual drug which is the major public focus at any single time (‘the drug du jour”), in doing so we weaken the opportunity to respond systematically to drug problems by addressing and removing the common sources of problematic drug use.

Understanding the social determinants of drug use suggests primary prevention for illicit drugs strengthens individuals’ resilience, fostering healthy connections between people, and building strong communities which offer support to troubled people. By strengthening our communities, we reduce the prevalence of personal and social problems, including those related to drug use and mental ill-health, and the various costs associated with them.

THE PUBLIC HEALTH FRAMEWORK

The public health framework divides interventions into three categories – primary, secondary and tertiary prevention (Russell L. R., 2008). Primary prevention focuses on preventing a disease or other adverse event from developing. Secondary prevention attempts to prevent relapse or the complications of a disease among those who are already affected. Tertiary prevention focuses on preventing the disability that can be associated with disease complications (Russell L. R., 2008).

PRIMARY PREVENTION

The goal of primary prevention is to protect people from developing an AOD-related problem or experiencing an accident or injury (Russell L. R., 2008). Examples of primary prevention include:

- informing and educating people about the effects and the harms associated with the use of AOD,
- making laws and regulations that govern sales of alcohol and tobacco,
- creating strongly bonded communities that promote connections between people
- providing positive role modelling of AOD use,
- promoting personal resilience, helping people to control and reduce stress, and
- developing safe environments that reduce the risk of AOD use.

SECONDARY PREVENTION

Secondary prevention is directed towards people who have a higher or specific risk of suffering an AOD problem. It responds to signals of a possible or emerging problem in order to prevent its development. Examples include

- helping tobacco smokers to cease smoking;
- providing education programs for drink drivers;
- offering counselling for people who use AOD at risky levels; and
- providing clean needles for people who inject drugs.

TERTIARY PREVENTION

The goal of tertiary prevention is to help people with an existing disease, disability or medical condition to overcome it, or to improve their quality of life. This includes

- AOD detoxification and withdrawal;
- cognitive-behavioural therapy;
- pharmacotherapy (substitute medication);
- twelve-step and other self-help programs;
- residential rehabilitation; and
- therapeutic communities.

BENEFITS OF PRIMARY PREVENTION

The primary prevention approach has been successful in improving public health with tobacco smoking, childhood immunisation, and reductions in the prevalence of HIV/AIDS, road trauma and heart disease (Russell, Rubin, & Leeder, 2008). Yet funding for primary prevention suffers in comparison with funding for secondary and tertiary drug treatment which addresses the needs of people experiencing current problems. While secondary and tertiary services assist people to recover from current drug problems, they do not reduce the future prevalence of problems in the population as they do not address the factors that produce drug problems in the first place (Holder, 1998). Instead, the 'rule of rescue' results in a priority of saving individual 'current lives' over interventions that do not have an immediate life-or-death impact but which may save future lives by improving the social conditions for the whole population (Musgrove, 1999). While we support harm reduction strategies such as needle and syringe exchange programs and drug treatment, we recognise that Victoria needs a systematic, integrated, coordinated long term approach to the prevention of drug problems that is informed by the best available evidence and professional judgment.

The ADF advocates for the use of preventive strategies to shift the focus "upstream" – preventing people from commencing (or delaying) drug use rather than waiting for their drug use to become a problem that requires reactive "downstream" emergency assistance. An upstream approach means taking action to prevent people from getting into trouble with drugs, thus reducing the need for (subsequent) interventions by justice officers, emergency workers and the treatment sector. By strengthening and supporting protective factors (Hawkins, Catalano, & Miller, 1992) the likelihood that young people will engage in AOD use can be reduced, improving their life chances. These factors include young people forming positive relations with parents and other family members; enjoying school and completing school or leaving to take

up employment pathways; having firm attachment to adult role models outside the home such as teachers, sporting coaches and/or youth leaders; developing future-oriented recreational pursuits and living in communities with lower levels of drug use. Thus there are key settings where upstream (primary) prevention is most relevant.

Recommendation 1: That the Committee recognise the contribution of primary prevention programs in reducing the sources of problematic use of psychoactive drugs.

Parents and families

Parents are an important influence on the AOD use of their children. Parents' influence comes via role modelling of good behaviour, general discipline, good parent-child relationships based on communication, and parental involvement in their children's lives (Hawkins, Catalano, & Miller, 1992). For parents who experience difficulties, special parenting programs can help them improve their skills. One example of a successful program is the Triple P Positive Parenting Program which has five levels of intervention to accommodate the various needs of families whose function is disrupted, or whose children have behavioural problems, at different levels of severity (Ralph & Sanders, 2004). Another is the Resilient Families program, which combined school and family interventions in Melbourne schools and which led to reductions in adolescent drinking in the experimental schools compared to adolescents in the control schools (Toumbourou, Gregg, Shortt, Hutchinson, & Slaviero, 2013).

Recommendation 2: That the Committee support the development of programs and resources that encourage and empower parents to have a positive influence in developing their children's resilience and decision making skills.

Schools

In 2013, one in twelve families with young children (8 per cent) showed signs of unhealthy family functioning (Victorian Department of Education and Training, 2015). Children in this situation are significantly more likely to have behavioural difficulties such as inappropriate conduct, hyperactivity, problems with peers or emotional symptoms. These children face a subsequent vulnerability to drug use and drug problems as well as a range of other mental health problems, including developmental delays and restricted educational engagement and achievement. Schools provide a setting and a framework for

interventions with those children that can improve the children's social and educational prospects including reducing the likelihood of alcohol and other drug involvement.

Recommendation 3: Support the development of programs and resources for school communities to support children identified as at-risk with the aim of encouraging students to complete school and retain retention pathways to further education or employment.

Recommendation 4: Provide all school students with pastoral care services and programs such as school nurses, school focused youth services, primary welfare officers and student welfare coordinators.

Local Government

Social connectivity is a protective factor against risk behaviours such as AOD use (Hawkins, Catalano, & Miller, 1992). Many youth related recreational activities and entertainment can be prohibitively expensive for disadvantaged young people, which prevents them from participating in pro-social activities in which they mix with a diverse range of peers, and/or responsible and caring adults.

Recommendation 5: **That the Committee acknowledge the need for councils to develop attractive recreational and entertainment opportunities for young people who do not have access to such activities due to lack of finance, training or opportunity.**

Sporting clubs

Sporting clubs provide a focus for community involvement and connectedness. Voluntary sporting clubs operate in most towns and suburbs across the state and bring together a diverse range of people with a common activity or interest. Health promotion programs in these clubs offer a mechanism to reach individuals in the community and effect change (Kingsland, et al., 2013). The ADF's Good Sports program helps 2500 community sporting clubs in Victoria to develop policy and practices to control the use of alcohol, and more broadly, to promote community health and safety.

Good Sports is a proven success because a randomised controlled trial showed that its alcohol management program reduced by 37% the likelihood that members of Good Sports clubs would engage in risky drinking (Kingsland M. W., 2015). While Good Sports has led sporting clubs to control the use of alcohol and reduce their risk of experiencing alcohol related problems, clubs are increasingly seeking

assistance in being better informed about illicit drugs, including amphetamine-type stimulants such as crystal methamphetamine.

In response Good Sports has developed 'Tackling Illicit Drugs' which aims to increase the capacity of sports clubs to address illicit drug-related problems, such as crystal methamphetamine (ice) at a local level. This innovation utilises the ADF's network of Good Sports clubs, partner organisations, face-to-face presentations and online resources. This program was successfully piloted in Victoria in 2014-2015 as part of the state's Ice Action Plan, with 1,500 club leaders and concerned citizens attending 19 community forums. Good Sports is now rolling out 'Tackling Illicit Drugs' across the country with funding from the federal Department of Health and Sport.

The key objectives of Tackling Illicit Drugs' are to (i) Support community sports clubs to develop and implement illegal drugs policies; (ii) Build the confidence of club leaders and members to prevent and manage illegal drug-related issues in a supportive, structured and consistent manner; (iii) Build networks where ideas and experiences can be shared, and ongoing support can be obtained; and (iv) Promote ongoing opportunities to build healthier club environments through participation in all aspects of the Good Sports program.

Recommendation 6: That the committee recognise the role Good Sports plays in educating members of community sporting clubs about the risk of illicit drugs, and how clubs can prevent their use, and respond effectively to potential signs of illicit drug use.

SECTION 3: PRESCRIPTION DRUGS

Whilst the successful introduction of prevention programs and harm reduction has somewhat mitigated the rise in Victorian's use of illegal drugs more generally (Australian Institute of Health and Welfare, 2014) there remains increasing concerns over particular licit and illicit drugs. One such problem is an increase in the misuse and overuse of pharmaceutical opioids and benzodiazepines.

The misuse of pharmaceutical drugs by Victorians produces severe harms that include the worsening of symptoms for the conditions for which they are prescribed, drug dependency, and overdoses, some of which are fatal. Various data sources including the Pharmaceutical Benefits Scheme (PBS), ambulance attendances, hospitalisations, coronial records and self-report surveys suggests pharmaceutical drug misuse is widespread and growing:

- According to the National Drug Strategy Household Survey, pharmaceutical drug use rose significantly in 2013 (Australian Institute of Health and Welfare, 2014).
- In 2013, the number of Australians who misused pharmaceuticals increased to 11.4 per cent from 7.4 per cent in 2010 (Australian Institute of Health and Welfare, 2014).
- Between 2010 and 2013, the greatest increases occurred among males in their 30s and females in their 40s (Australian Institute of Health and Welfare, 2014). The increase was larger for males than females across all pharmaceutical drug types (Australian Institute of Health and Welfare, 2014)
- More Australians are dying from a pharmaceutical overdose than all illicit drugs combined (Unit, 2016).
- The number of people dying after using the most common form of opioid painkiller – codeine – has doubled in the past decade (Roxburgh A. H., 2015).
- Most overdoses are accidental – often the result of mixing alcohol with medications and/or taking multiple medications together (Pilgrim J. L., 2015).

Of particular concern are opioids and benzodiazepines. Opioids are prescription and over-the-counter painkillers that often contain codeine, and benzodiazepines are minor tranquillisers used to treat stress, anxiety and insomnia. Both drugs are now overused (Monheit, 2010) and over prescribed (Macintyre, Opioids, ventilation and acute pain management, 2011). Consequently, Australians faces increasing rates of drug dependency (Degenhardt L. B., 2015), severe injury (McAvoy, 2011) and death (Pilgrim J. L., 2014).

The Therapeutic Goods Administration (TGA) has recommended that all over the-counter medicines containing codeine be rescheduled to prescription-only medicines due to increasing levels of codeine dependence (Department of Health, 2015). The merits of this approach are under debate; however, prescription of these and other opioids for chronic pain is increasing and evidence is growing of the adverse effects of their long-term use (Chou, 2015) (Australian Commission on Safety and Quality in Health Care, Australian Atlas of Healthcare Variation: Chapter 5 Opioid medicines, 2015).

Victorians need a better understanding of the risks of pharmaceutical drug use, as mortality from pharmaceutical drugs now outranks the road toll that Victoria has successfully lowered: 358 Victorians died from pharmaceutical drugs overdoses in 2015, while 257 died from road traffic injury. To add further context, 227 Victorians died from illegal drug overdoses. (Coroners Court of Victoria, 2016), with an estimated 70% of those deaths by accidental overdose.

3.1 Benzodiazepines

Benzodiazepines contributed to over half of all pharmaceutical drug overdose deaths In Victoria in 2015 (Coroner's Prevention Unit, 2016) and were the pharmaceutical drug associated with the highest rates of ambulance attendances in Melbourne between 2000 and 2009 (Lloyd & McElwee, 2011). Despite being commonly prescribed for stress, anxiety and insomnia, it is doubtful that benzodiazepines are the best treatment for those conditions, especially when the problem is an ongoing condition. The risk of developing dependence on a benzodiazepine rises as the period of use is extended and benzodiazepines generally should not be used for longer than a period of two weeks (NPS Medicinewise, Benzodiazepine dependence: reduce the risk, 2015). Between 1992 and 2011, the number of prescriptions for benzodiazepines dispensed through the PBS/RPBS across Australia fell – however, the amount of the drug prescribed per script increased (Islam, Conigrave, Day, Nguyen, & Haber, 2014). Evidence also suggests that benzodiazepines are used by people over long periods which suggests misuse (NPS Medicinewise, Benzodiazepine dependence: reduce the risk, 2015).

3.2 Opioid analgesics

There is growing evidence of harm associated with opioid based analgesics in Australia as deaths related to codeine (Roxburgh A. H., 2015), oxycodone (Pilgrim J. L., 2015) and fentanyl (Roxburgh A. B., 2013) have increased. Public alcohol and drug clinics reported a 4-fold increase in the number of treatments where codeine was a drug of concern, from 683 in 2003-04 to 2693 in 2013-14 (Australian Institute of Health and Welfare (AIHW), 2015). In 2013, 4.7% of Australians aged 14 or older reported “misusing” a pharmaceutical drug in the previous 12 months, which was a rise from 4.2% in 2010 (Australian Institute of Health and Welfare, 2014). Many of the deaths associated with opioid painkiller overdoses are accidental (Roxburgh A. H., 2015) (Pilgrim J. L., 2015).

3.3 Non-pharmacological solutions

People with chronic pain, stress, anxiety and insomnia can be referred to remedies that avoid the negative side effects associated with pharmaceutical drugs. In many cases, non-pharmacological treatments will have satisfactory results and lessen the risk of adverse outcomes of drug treatment. These treatments include cognitive behavioural therapy (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012), relaxation and mindfulness techniques, as well as changes of diet (Better Health Channel, Managing and treating anxiety,

2016) (Sarris J. , et al., 2015) and exercise (Beyond Blue, Staying well: a guide to recovering from anxiety and depression). These treatments may not be suitable for people in all circumstances, but while they are known to be effective, their uptake is low, and they often not considered by medical professionals.

A particular priority is providing these options for people in rural and remote areas where prescription rates and experience of opioid (Nielsen S. R., 2015) and benzodiazepine related harms is highest. Non-pharmacological solutions for chronic pain, stress, anxiety and insomnia deserve to be included in health benefit schemes and be subject to regulation based on the best evidence.

Recommendation 7: That the Committee encourage medical professionals and pharmacists to offer non-pharmacological treatments for ailments including stress, anxiety and chronic pain as an alternative to long term analgesic use

3.4 National Action

In 2010 the Ministerial Council of Drugs through the Inter-Governmental Committee on Drugs agreed to develop a national strategic response to address pharmaceutical drug misuse. This comprehensive work outlined the problem, its perspective in the broader policy context, and the potential responses Governments could adopt (Nichols, 2011). Nine priority areas were identified for action and included in the National Pharmaceutical Drug Misuse Framework for Action (2012–2015) (Commonwealth of Australia, 2013), driven by a focus on 'quality use of prescription and non-prescription opioids and benzodiazepines'. These are:

1. a coordinated medication management system;
2. supporting prescribers;
3. supporting pharmacists and other health professionals;
4. regulation and monitoring;
5. structural factors;
6. health information and other consumer responses;
7. treatment and harm reduction;
8. technological responses; and
9. data, research and evaluation (Australia C. o., 2011).

Since the adoption of this framework several initiatives and programs have been implemented or planned and these are listed below. However, this plan should be reviewed by Victorian Health Department.

3.4.1 National Pharmaceutical Strategy

An integrated national and state based response to the problem of misuse of opioid analgesics and benzodiazepines is required. A new national pharmaceutical strategy is needed to guide comprehensive, planned action on pharmaceutical drugs as the current National Pharmaceutical Drug Misuse Framework 2012-15 has run its course.

Recommendation 8: That the Committee recommend that Victoria should advocate for and assist the development of a new national strategy for the reduction of harm related to Pharmaceutical Drugs.

3.4.1.1 Regulation and monitoring

a. Re-scheduling

The rescheduling of benzodiazepine alprazolam (brand names include Xanax and Kalma) to schedule 8 was achieved in 2014.

b. Real time monitoring of prescriptions

The Electronic Recording and Reporting of Controlled Drugs (ERRCD) system will be developed with the Australian Digital Health Agency. Currently Tasmania and Victoria have implemented the program. ERRCD enables real time recording of prescription of Schedule 8 medications to the patient along with information about the patient's history of drug dependence or drug seeking behaviour and their past or current treatment for opioid dependence.

Tasmania implemented the DAPIS Online Remote Access (DORA) system in 2011. DORA is a decision support tool for prescribers that provides secure, real-time access to objective information about:

- supplies of Schedule 8 medications by Tasmanian pharmacies for a particular patient;
- authorities issued to the GP to prescribe Schedule 8 medications (including the indication);
- the patient's history of drug dependence or drug seeking;
- the patient's past or current treatment for opioid dependence.

In 2016 the Victorian government announced that real time monitoring would be implemented. The system will monitor all Schedule 7, 8 medicines, such as oxycodone (brand names include OxyContin® and Endone®), morphine (brand names include Kapanol®), alprazolam (brand names include Xanax® and Kalma®), methylphenidate (brand names include Ritalin®) and dexamphetamine, because of their high risk

of misuse. Further consultation with professional medical and pharmacy groups will determine how best to bring into the system other high risk medicines, such as diazepam (brand names include Valium®). (Victorian Department of Health and Human Services, 2016). However real time monitoring should also include schedule 4 drugs that contain codeine and Cannabidiol.

Recommendation 9: That the Committee recommend Schedule 4 Drugs be included in the real time monitoring scheme that is being implemented in Victoria.

3.4.2 Awareness raising

NPS/MedicineWise was funded to develop a suite of products to raise awareness of the issues surrounding pharmaceutical misuse, as well as providing practical advice to pharmacists and other health professionals on how to identify and address drug misuse and abuse. To support this matter, NPS/MedicineWise has launched a new online learning course, *'Drug misuse: implications for pharmacists'* and has developed a large range of factsheets.

3.4.3 National Opioid Substitution Treatment (OST) project

The OST project has developed a paper that analyses and discusses the current listing, fee and remuneration arrangements of the delivery of the OST pharmacotherapies program. It consolidates issues and recommendations raised in previous reviews and work undertaken over recent years, in order to determine what changes, if any, will make the OST pharmacotherapy program more accessible, equitable, affordable, and effective. National opioid substitution treatment project has been completed in Tasmania and is a cross government shared funding model project.

3.4.4 Social marketing for public education

Public education is required to alert the people of Victoria to the nature of the problem and its associated harms. Social marketing campaigns, similar to the effective and successful road safety campaigns, can help to ensure the issue of safe pharmaceutical use is understood as priority health matter by the public.

3.4.4.1 The Alcohol and Drug Foundation campaign

The Alcohol and Drug Foundation (ADF) has launched a major public awareness campaign 'Are You Taking a Risk?' to inform Victorians about the risks of misusing addictive medications and provide them with the tools to prevent harm. The campaign which is funded by the Department of Health and Human Services, is in its first phase and aims to (i) Increase public awareness and understanding of pharmaceutical use,

particularly amongst men in their 30s and women in their 40s (high risk cohorts); (ii) Highlight that anybody can find themselves dependent on addictive pharmaceuticals and (iii) Encourage people to question their own pharmaceutical use. The campaign draws on medical expertise and people with experience of pharmaceutical dependency and will use a combination of print media, digital media, social media and billboards.

Recommendation 10: That the Committee offer support for the continuance of the ADF's public information campaign on pharmaceutical misuse.

3.5 Control of marketing

Pharmaceutical companies have an obligation to market their products in a responsible way, without promising or offering exaggerated benefits to health professionals or consumers. Advertising prescription-only and certain pharmacist-only medicines to the general public is prohibited. In the ADF's view this should continue as the public does not have the expertise to determine the suitability of such substances for themselves (Therapeutic Goods Administration: Advertising therapeutic goods., 2016). Pharmaceutical companies self-regulate their marketing to health professionals though self-regulation has failed to prevent serious breaches of the code. While this issue is not within the Victorian Government's remit, it is in a position to advocate for tighter regulation of advertising by pharmaceutical companies.

3.6 Research

All research and results of clinical trials of pharmaceutical drugs, whether positive or negative, should be made available for public viewing. While this issue is not within the Victorian Government's remit, it is in a position to advocate for the public release of all clinical trials of pharmaceutical drugs.

SECTION 4: ILLICIT DRUGS

Although alcohol, tobacco and pharmaceuticals are the drugs responsible for the greatest aggregate harm to Victorians, use of illicit drugs continues to harm many, especially young adults. The ADF believes there are several illicit drug related issues that require urgent attention of the state government: they are the prevention of fatal drug overdoses among two identifiable groups of people: those who consume amphetamine type stimulants at music festivals and similar events, and people who consume heroin; the provision of Drug Courts to offer drug offenders a positive alternative to incarceration; and the continuance of ccontrol over the provision of pharmaceutical forms of cannabis for medical purposes.

4.1 PILL TESTING OR 'DRUG CHECKING'

Despite the best efforts of law enforcement officials, consumption of illicit substances in tablets, pills and powders is now common among a substantial minority of young adults. Nearly one in ten 20-29 year olds have taken Ecstasy (MDMA) over the last 12 months (AIHW, 2014) and about 70% of all Ecstasy consumed is taken at clubs, festivals and dance parties (Ritter, 2014). Several young people died and dozens were hospitalised over the 2015-16 summer holiday period after taking Ecstasy or other substances at Australian festivals (Butterfield RJ, 2016). These pills and substances can be highly potent, or contain substances such as ketamine, meth/amphetamine, MDA, MDEA and PMA which pose a high risk of fatal overdose due to toxic concentrations of the constituents (Camilleri & Caldicott, 2004) (Johnston, 2005). As conventional methods of harm reduction are not working, the ADF believes it is time for a new approach.

'Drug checking' is a form of risk mitigation for people who consume illicit substances. Established in several European countries (Ritter, 2014), it enables drug users to determine the nature and concentration of constituents of their pills/drugs at the critical moment. (Ventura, et al., n.d). Drug checking also enables drug users to access counselling in a non-judgmental setting and referral to treatment services (Camilleri & Caldicott, 2004) (Johnston, 2005) (Ritter, 2014) (Kriener, et al., 2001). Additional collateral benefits include law enforcement and emergency agencies gaining accurate knowledge of the substances that are being consumed (Tregonning, 2016) and understanding provision of demographic data and patterns of use in monitoring trends (Ventura, et al., n.d) (Camilleri & Caldicott, 2004).

Testing in Europe has not increased drug use and may have reduced levels of use (Trans European Drugs Information Workgroup, 2011). It has also resulted in hazardous drugs disappearing from the market in the Netherlands (Kriener, et al., 2001) (Butterfield RJ, 2016). The most accurate drug checking methods employed in Europe are Gas Chromatography-Mass Spectrometry (GC-MS) or liquid chromatography (HPLC). These technologies can identify multiple substances in a pill sample and determine the potency of each (Winstock, Wolff, & Ramsey, 2001). GC-MS and HPLC testing does not guarantee the consumer can assume the drug is safe, as an individual can have an adverse response to a substance on a particular occasion.

'Drug checking' by scientifically naïve people is hazardous as the "do-it-yourself" reagent testing kits that are purchased from retail shops and the internet do not provide reliable results. Reagent testing is based on the judging the change of colour in the substance following a chemical reaction between the substance and the reagent (Camilleri & Caldicott, 2004). It is an inferior process as it cannot identify the concentration or potency of the constituent substances; it can fail to identify substances in the pill other than the most prominent; it cannot differentiate between Ecstasy-like substances; it can produce false positive colour reactions and interpretation of the colour test is subjective (Camilleri & Caldicott, 2004) (Johnston, 2005) (Kriener, et al., 2001) (Winstock, Wolff, & Ramsey, 2001). In an experiment in South Australia, the reagent test correctly identified multiple substances in pills in only 11% of cases (Camilleri & Caldicott, 2004). (Caulkins J. & Lee, 2012)

The ADF believes there is a strong case for a rigorously evaluated trial of drug checking with the use of sophisticated instruments carried out by trained staff. The research should be performed over a limited period by trained analysts using sophisticated technology to ensure comprehensive and accurate analysis and supported by health workers to provide counselling and additional information to potential users of drugs in those settings.

Recommendation 11: That the Committee recommend the commission of a rigorous evaluation of a trial of pill testing or 'drug checking' to ascertain its effectiveness in reducing drug overdoses and overdose fatalities at music festivals and similar events.

4.2 INJECTING DRUG USE

Heroin use remains a major drug problem in Victoria as 172 people died of heroin related overdose deaths in 2016. Despite the best efforts of current services people are dying unnecessarily. A medically supervised injecting centre (MSIC) is required urgently and especially in the city of Yarra, the epicentre of illicit drug injection in Melbourne and Victoria. Yarra Council has voted in favour of a supervised facility and it has the support of several locally based health services and the Salvation Army.

Under the supervision of trained health care workers, nurses and social workers, MSICs bring risky injecting practices into a structured clinical environment that is integrated with other health and welfare services (Wright & Tompkins, 2004). By 2009 more than 90 official MISCs operated in Europe, Canada and Australia (Fitzgerald, 2013). MISC staff follow strict guidelines: they do not help users to inject but provide advice

clean injecting equipment, a structured environment (Rhodes T. H., 2010) and draw on resuscitation equipment when needed (Wright & Tompkins, 2004). Not only do they prevent fatal overdoses they reduce the risk of blood borne infections, including HIV, Hepatitis B and Hepatitis C, and injuries and diseases such as abscess, thrombosis and endocarditis that are associated with unhygienic drug use (The Salvation Army, 2016). Since establishment in XXX the Sydney MSIC has supervised more than 965,000 injections with 5925 overdoses but without any fatalities (Uniting, 2016).

In the City of Yarra, North Richmond and Abbotsford are sites of extensive drug dealing and drug use, particularly of heroin. This trade has continued for over a decade, despite intensive policing that included Operation Bia and Operation SCADO (Dwyer, Power, & Dietze, 2013). A recent report by the Burnet Institute identified public injecting to be widespread across particularly at retail and public transport access points in North Richmond and Abbotsford (Dwyer, Power, & Dietze, 2013). Public injecting of drugs was found to have a significant effect on the local community, specifically traders and residents as injecting paraphernalia was evident in street gutters, residential driveways and footpaths (Dwyer, Power, & Dietze, 2013). A public drug market and public drug use has increased demands on health, law enforcement and welfare agencies and served to reduce the public's perception of safety and wellbeing. Provision of a supervised centre will improve local amenity, relocating the street drug market out of the public arena and into the supervised a space in which drug users make contact with health services.

Support for an MISC does not condone, encourage or support drug use. It acknowledges the existence of a public health crisis and is proven to minimise risks to both the individual PWID and the wider community. The ADF understands public concern about the establishment of a supervised injecting centre: some people worry that it would condone drug use, attract more drug users to the area, create a hazardous environment and increase the rates of drug use. These concerns are seemingly unfounded. Evidence from 90 established centres around the world, including Sydney, demonstrates the 'honey pot' theory is not borne out in practice (Donnelly & Snowball, 2006). SFIs are likely to benefit police resources, as they can spend less time charging users and focus on targeting drug dealers (Rhodes T. H., 2010).

The factors that lead people to inject in public places are diverse and complex: they include limited access to safe and secure accommodation; an urgent need to cope with symptoms of drug withdrawal; fear of apprehension by police; a sense of their own 'community' and comradeship among other street based peers. Nevertheless, injecting drug use in open streets presents major risks for people who use drugs,

including risk of overdose, unhygienic practices, increased risk of transmission of blood-borne viruses, soft tissue injury due to poor injection practice, and risk of arrest.

In 2016 the Victorian Coroner recommended the establishment of a pilot supervised injecting centre as a life-saving initiative (Bucci & Preiss, 2017). Victoria already provides people who inject drugs (PWID) with needles and syringes in order to prevent the unnecessary transmission of disease and to maintain the health of PWIDs, on the basis that most surviving PWID eventually stabilise their lives and cease to inject drugs. Providing a space where they can inject in hygienic conditions under supervision of medically trained staff is the appropriate accompaniment to the needle and syringe service. It seems perverse that Victoria denies PWID a safe space to inject, on the grounds it might be seen to condone drug use, when for thirty years Victoria has ensured PWID have access to a supply of clean needles and syringes.

Recommendation 12: That the Committee conclude there is an urgent need for a rigorous evaluation of a trial of a medically supervised injecting centre in Yarra as a matter of urgency to ascertain its effectiveness in reducing drug overdoses and overdose fatalities.

4.3 MEDICINAL USE OF CANNABIS

Despite the availability of cannabis for medical or therapeutic purposes in many countries, there is not a consensus on the efficacy of 'medicinal cannabis' (Kilmer B., 2013). This is due partly to the lack of scientific knowledge of the full effects of cannabis, the lack of agreement among medical authorities on the appropriate use of cannabis products and derivatives, and partly due to political cultures and political considerations.

Most of the adverse consequences of cannabis are experienced by regular or daily users (Imtiaz S, 2015) Adverse acute effects include anxiety, panic, loss of attention and reduced motor coordination skills while negative health effects include risk of cannabis dependence syndrome and long term heavy smokers risk chronic bronchitis, respiratory cancers and cardiovascular disease (Room R, 2008). People who begin cannabis use in adolescence face higher risks of psychosocial effects including cannabis dependence, impaired educational attainment and an increased risk of mental health problems (Hall W, 2009) (van Ours, 2009). Around 9% of people who ever use cannabis become dependent upon it (Hall, 2015)

Early use of cannabis increases the risk of adverse effects. People who use cannabis during their teenage years face greater risks of adverse effects possibly due to important developmental changes that take place in the brain during adolescence and early adulthood (Ammerman S, 2015). Initiation of cannabis use before 17 years appears to increase risk of adverse outcomes, including dependence and mental illnesses, although a pre-existing psychiatric condition or predisposition toward schizophrenia may be an important additional risk factor. Much of this evidence comes from studies of young adults who initiated daily cannabis use in adolescence and continued to use regularly throughout young adulthood, the period with the highest risk of developing psychotic disorders (Degenhardt L. C., 2010). As the advent of 'medical cannabis' in Australia may lead some people to believe that cannabis is not potentially harmful the public deserves to be informed of the potential risks of use of cannabis, especially by young people.

4.1 AUSTRALIAN NARCOTIC DRUGS ACT 1967

In 2016 the Australian government amended the *Narcotic Drugs Act 1967* in order to permit individual states and territories to authorise the cultivation and manufacture of cannabis products for medicinal purposes. The Act defined medicinal cannabis as referring to "either the smoking or eating of raw herbal cannabis for the notional relief of symptoms or the use of pharmaceutical products derived from the active

compounds of cannabis" (Australia P. O., 2016). The federal Health Department noted that pharmaceutical products are preferable due to their being tested for quality, safety and efficacy prior to use (Australia P. O., 2016).

The Explanatory Memorandum to the *Narcotic Drugs Amendment Bill* suggested cannabis products might be useful in reducing symptoms of several medical conditions and illnesses: childhood epilepsy, terminal illness pain, chronic pain, nausea induced by chemotherapy and symptoms of multiple sclerosis. However the memorandum also noted that more research into the use of cannabinoids is warranted (Australia P. O., 2016).

4.2 VICTORIAN ACCESS TO MEDICINAL CANNABIS ACT 2016

The ADF supports the Victorian Parliament's passing of the *Access to Medicinal Cannabis Act 2016* that offers medical cannabis for defined groups of patients, the first of which are children diagnosed with intractable epilepsy. (Act, 2016). The ADF believes appropriate patients must have access to the most effective therapeutic means for managing illness and disease and that the prescription of cannabinoids is ultimately a matter for the medical profession which has the knowledge, expertise and experience required to make the appropriate therapeutic decisions.

4.3 CRITERIA FOR APPLICATION OF MEDICINAL CANNABIS

In the ADF's view the following conditions should inform the prescription of pharmaceutical forms of cannabinoids:

a. the patient is certified by a medical specialist, or a physician with specific training in the use of cannabinoids for medical purposes, as suffering from an ailment that is recognised as likely to be ameliorated by the consumption of pharmaceutical cannabinoids;
b. the patient's condition has proved resistant to current therapies and interventions;
c. the patient remains under the supervision of a medical specialist or physician so that their physical and mental health is monitored so that appropriate action can be taken if the use of pharmaceutical cannabinoids appears to have an unduly detrimental effect on the individual's quality of life.
d. the patient agrees to use the pharmaceutical cannabinoids for their own benefit only and not to transfer it to any other person for any purpose.

e. the patient is informed and is cognisant of the potential hazards inherent in ingesting cannabis products.

Recommendation 13: That the Committee recommend continuing government support for research and clinical trials into the therapeutic use of cannabinoids to ascertain the conditions in which they are beneficial and the circumstances in which their use is indicated.

Recommendation 14: That the Committee recommends the government act to ensure that the public understands the distinction between medical/ therapeutic use of cannabinoids and the non-medical or 'recreational' use of cannabis.

4.4 DRUG COURTS

The Drug Court of Victoria is a specialist division of the Magistrates' Court that is designed to divert offenders who have been charged with an Alcohol and Other Drug (AOD) related offence away from the prison system and into a system of therapeutic rehabilitation. During the voluntary program, which serves as an alternative to incarceration, offenders must undergo drug treatment, and are provided with services such as social support and counselling, and are subject to drug testing. Drug Courts aim to tackle the underlying causes of the offending in order to assist the offender in reducing AOD use, reintegrate them back into the community, and prevent recidivism. To be eligible for the program, offenders must reside within the catchment area, must plead guilty, must not be subject to a Parole Order or similar, and must not have committed an offence which is sexual or has resulted in actual bodily harm. The Court must also be satisfied that the offender has an AOD dependency and that the dependency contributed to the offence. Non-compliance can result in sanctions such as imprisonment or removal from the program.

Effectiveness

Evaluations of current Drug courts in Victoria and New South Wales have provided evidence to suggest that the Drug Court system is an effective alternative to traditional sanctions, such as imprisonment (Taplin, 2002), (Lind, et al., 2002), (VAADA, 2013).These evaluations show that the Drug Courts are meeting their aims, including reducing recidivism, reducing AOD use, increasing full-time employment, and reducing unemployment among participants. KPMG (Evaluation of the Drug Court of Victoria, FINAL REPORT, 2014) reported a 31% lower rate of reoffending in the first 12 months, and 34% lower rate of reoffending within 24 months for offenders who had undertaken the Drug Court Program, while Weatherburn found that

participants were significantly less likely to commit any further offence (Weatherburn D. J., 2008). Participants in the program reported that it was helpful in stopping or reducing AOD use (Taplin, 2002), and Freeman confirmed that drug use by participants reduced significantly, despite access to illicit substances remaining unchanged (Freeman, 2002). Furthermore, a 2006 review found that full-time employment among participants doubled upon the completion of the program, while there was a 32% reduction in unemployment (VAADA, 2013, p. 2)The structure of the program means that as the offenders are not separated from society, the period of readjustment upon completion is far less than with imprisonment (Freeman, 2002).

Two evaluations of Drug Courts have recommended that the system be extended with the addition of more specialised courts for suitable drug offenders (Weatherburn D. J., 2008) (VAADA, 2013). A further need is to extend the Drug Court program to rural areas, and this will require the addition of appropriate support services. Data collection has been also raised as an issue deserving improvement, with particular concern related to the number of referrals received to drug Courts compared to the number of participants accepted in order to gauge demand. Other data that should be recorded includes individual-level cost reports, trends in non-compliance, and data pertaining to the health, well-being and reoffending of former participants (Lind B. e., 2002) (KPMG, 2014).

Recommendation 14: That the Committee recommends the provision of Drug Courts in Victoria be extended to rural areas of need.

Recommendation 15: That the Committee find that additional resources deserve to be committed to the Drug Court program for the collection of appropriate data to enable a robust evaluation of the program.

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