

# Drug Use and Harm Reduction



Edited by Justin Healey

**ISSUES**  
**IN SOCIETY**

# Drug Use and Harm Reduction

Volume | 453

**ISSUES**  
**IN SOCIETY**

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 **THE SPINNEY PRESS**

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First published by



PO Box 438 Thirroul NSW 2515 Australia  
www.spinneypress.com.au

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Title: Drug Use and Harm Reduction / edited by Justin Healey.

Series: Issues in Society, Volume 453.

ISBN 978-1-922274-06-9 (paperback)

ISBN 978-1-922274-07-6 (PDF)



A catalogue record for this book is available from the National Library of Australia

Cover images courtesy of iStock.

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# INTRODUCTION

**Drug Use and Harm Reduction** is Volume 453 in the 'Issues in Society' series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

## KEY ISSUES IN THIS TOPIC

Harm reduction entails policies, programs and practices aimed at reducing the harms associated with the use of psychoactive drugs in people who are unwilling or unable to stop. The focus is on the prevention of harm, rather than on the prevention of drug use itself.

Harm reduction has been a principle of Australia's approach to drug use for several decades. However, recent overdose deaths and hospitalisations at music festivals highlight the clear risks of illicit drug use, prompting a debate over the introduction of pill testing, with political leaders being reluctant to implement the measure.

This book explores the ethical, legal and medical pros and cons in the drugs policy debate, featuring the topical issue of pill testing. Does testing give young people a false sense of security and promote risky drug use, when there is actually no safe level at which these substances can be taken? Or are harm reduction approaches such as pill testing and needle and syringe programs simply about saving lives and giving drug users a safety net?

## SOURCES OF INFORMATION

Titles in the 'Issues in Society' series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the 'Issues in Society' series lies in its diversity of content and perspectives.

**The content comes from a wide variety of sources and includes:**

- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

## CRITICAL EVALUATION

As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

## EXPLORING ISSUES

The 'Exploring issues' section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

## FURTHER RESEARCH

This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The 'Web links' section at the back of this book contains a list of useful websites which you can access for more reading on the topic.

## TYPES OF DRUGS

Drugs can be grouped together in different ways – by the way they affect the body or by how or where they are used. The [Department of Health](#) explains what drugs are harmfully consumed in Australia.

### DRUG CATEGORIES

**D**rugs can be categorised by the way in which they affect our bodies:

- **Depressants** – slow down the function of the central nervous system
- **Hallucinogens** – affect your senses and change the way you see, hear, taste, smell or feel things
- **Stimulants** – speed up the function of the central nervous system.

Some drugs affect the body in many ways and can fall into more than one category. For example, cannabis appears in all 3 categories.

#### DEPRESSANTS

Depressants slow down the messages between the brain and the body – they don't necessarily make you feel depressed. The slower messages affect:

- Your concentration and coordination
- Your ability to respond to what's happening around you.

Small doses of depressants can make you feel relaxed, calm and less inhibited. Larger doses can cause sleepiness, vomiting and nausea, unconsciousness and even death. Examples include:

- Alcohol
- Benzodiazepines (minor tranquillisers such as Valium)
- Cannabis
- GHB (gamma-hydroxybutyrate)
- Ketamine
- Opioids (heroin, morphine, codeine).

#### HALLUCINOGENS

Hallucinogens change your sense of reality – you can have hallucinations. Your senses are distorted and the way you see, hear, taste, smell or feel things is different. For example, you may see or hear things that are not really there, or you may have unusual thoughts or feelings.

Small doses can cause a feeling of floating, numbness, confusion, disorientation, or dizziness.

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Larger doses may cause hallucinations, memory loss, distress, anxiety, increased heart rate, paranoia, panic and aggression. Examples include:

- Cannabis
- Ketamine
- LSD (lysergic acid diethylamide)
- Psilocybin (magic mushrooms)
- PCP (phencyclidine).

#### STIMULANTS

Stimulants speed up the messages between the brain and the body. This can cause:

- Your heart to beat faster
- Your blood pressure to go up
- Your body temperature to go up – leading to heat exhaustion or even heat stroke
- Reduced appetite
- Agitation
- Sleeplessness.

You can feel more awake, alert, confident or energetic. Larger doses can cause anxiety, panic, seizures, stomach cramps and paranoia. Examples include:

- Amphetamines (speed and ice)
- Caffeine
- Cocaine
- Ecstasy (MDMA – methylenedioxyamphetamine)
- Nicotine (tobacco).

### COMMON GROUPS OF DRUGS

Drugs can also be grouped by how or where they are commonly used.

#### *Analgesics*

Analgesics – or painkillers – relieve the symptoms of pain. Some people take more than the recommended dose to get high, or to self-harm. They can also be overused by people who have chronic pain.

Some are available over the counter, such as:

- Aspirin

- Paracetamol
- Ibuprofen

Others require a prescription from a doctor, such as:

- Codeine and paracetamol combination products
- Fentanyl
- Morphine
- Oxycodone
- Pethidine.

### **Inhalants**

Inhalants are substances that you breathe in through the nose (sniffing) or mouth. They are absorbed into the bloodstream very quickly, giving the user an immediate high. There are 4 main types of inhalants:

- **Volatile solvents** – liquids that turn into a gas at room temperatures – for example, paint thinners and removers, glues, petrol and correction fluid (liquid paper)
- **Aerosol sprays** – for example, spray paints, deodorants and hairsprays, fly sprays and vegetable oil sprays
- **Gases** – for example, nitrous oxide (laughing gas), propane, butane (cigarette lighters), helium
- **Nitrites** – for example, room deodorisers and leather cleaners.

Most of these are depressants, except for nitrites.

### **Opioids**

Opioids are a type of painkiller that can be made from poppy plants (heroin) or produced synthetically (fentanyl). Also called opiates or narcotics, they are addictive as they can give you a feeling of wellbeing or euphoria. Examples include:

- Codeine
- Heroin
- Methadone
- Oxycodone.

### **Party drugs**

Party drugs are a group of stimulants and hallucinogens. They are often used by young people in an attempt to enhance a party, festival or concert experience. However, dozens of Australians become seriously ill or die after using party drugs each year.

The most common party drug is ecstasy (MDMA), but the pills/tablets/capsules are of variable purity or don't actually contain any MDMA and may contain a wide range of other substances. You cannot be sure what you're taking and the risks to your health are high.

### **Performance and image enhancing drugs**

Performance and image enhancing drugs are substances used by people to change their physical appearance or boost their sporting ability, for example, weightlifters and athletes. There are 3 main types of performance and image enhancing drugs:

- **Anabolic steroids** – synthetic hormones that help grow and repair muscles
- **Peptides** – stimulate the release of human growth hormone, which is involved in muscle and bone growth

- **Hormones** – both natural and artificial – for example, growth hormones, selective androgen receptor modules, insulin-like growth factors, mechano growth factor.

### **Prescription drugs**

Medicines prescribed by a doctor – also known as pharmaceuticals – that are not being used appropriately can cause harm, both short and long-term. People assume that all prescribed medicines are safe, but not following instructions or combining them with other medicines, drugs and/or alcohol can be dangerous.

### **Did you know?**

Drug-related deaths from prescribed drugs are more common than those for illegal drugs. Examples include:

- **Painkillers** – codeine, oxycodone
- **Sedatives and sleeping pills** – benzodiazepines.

### **Psychoactive drugs**

Psychoactive drugs affect the way you think, feel and behave. They act mainly on the central nervous system, changing brain functions and temporarily changing your consciousness. Examples include:

- Caffeine
- Cannabis
- Psilocybin (magic mushrooms)
- LSD.

### **Synthetic drugs**

Synthetic drugs are a range of drugs that have been developed to create similar effects to banned drugs. These new psychoactive substances are being developed quickly, trying to stay ahead of the law. They are also called 'legal highs', although in most cases they are not legal.

Because they are not regulated or tested and change constantly there is not a lot of information about their effects and side-effects. You cannot be sure what you are taking or how it will affect you. Examples include:

- Synthetic cannabis
- NBOMe (N-methoxybenzyl) – similar effects to LSD.

## **OUR PRIORITIES**

Our National Drug Strategy identifies a number of drug types that cause the most harm in Australia. These include:

- Alcohol
- Tobacco
- Cannabis
- Methamphetamines (e.g. MDMA) and other stimulants such as cocaine
- New psychoactive substances – synthetic drugs
- Opioids, including heroin
- The non-medical use of prescription drugs.

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Department of Health (Last updated 16 July 2019). *Types of drugs*. Retrieved from [www.health.gov.au](http://www.health.gov.au) on 8 August 2019.

# CURRENT USE AND TRENDS IN ILLICIT DRUGS

## OVERVIEW FROM THE AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE

According to the National Drug Strategy Household Survey 2016, 8.5 million (or 43%) people aged 14 and over in Australia had illicitly used a drug at some point in their lifetime (Figure 4.7.2).

This includes cannabis, ecstasy, meth/amphetamine, cocaine, hallucinogens, inhalants, heroin, ketamine, gammahydroxybutyrate (commonly known as GHB), synthetic cannabinoids, new and emerging psychoactive substances, and the misuse of pharmaceuticals (namely, painkillers/analgesics and opioids, tranquillisers/sleeping pills, steroids and methadone or buprenorphine).

Around 3.1 million (or 16%) people had illicitly used a drug in the last 12 months. This includes the non-medical use of pharmaceuticals. While the proportion of Australians using illicit drugs is higher than in 2007, there has been no clear trend since 2001. The number of people illicitly using drugs increased from about 2.6 million in 2001 to 3.1 million in 2016.

Among the 16% of people aged 14 and over in Australia who used illicit drugs recently in 2016, 4 in 5 reported using illegal drugs such as cannabis and cocaine, or other substances such as inhalants. The remaining 1 in 5 reported misuse of a pharmaceutical drug (without use of any illicit drug).

Overall, an estimated 1 million people (or 4.8%) aged 14 and over had used a pharmaceutical drug for non-medical purposes in the past 12 months. The pharmaceuticals most commonly used in Australia for non-medical purposes were painkillers/opioids (3.6%) and tranquillisers/sleeping pills (1.6%). The majority of people who used a painkiller/opioid for non-medical purposes reported misusing an over-the-counter codeine product (75%), followed by prescription codeine products (40%) (AIHW 2017).

Over one-quarter (28%) of people who misuse pharmaceuticals did so daily or weekly, making pharmaceutical misuse one of the most commonly used drugs; it was second only to cannabis (36% of users did so daily or weekly), and use was more frequent than for meth/amphetamines (20%). The 4 most commonly used illegal drugs in the previous 12 months among people aged 14 and over were cannabis (10%), cocaine (2.5%), ecstasy (2.2%) and meth/amphetamine (1.4%).

### CANNABIS

Cannabis is the most commonly used illicit drug in Australia – 35% of people have used it in their lifetime and 1 in 10 (10%) reported using it in the last 12 months. Lifetime and



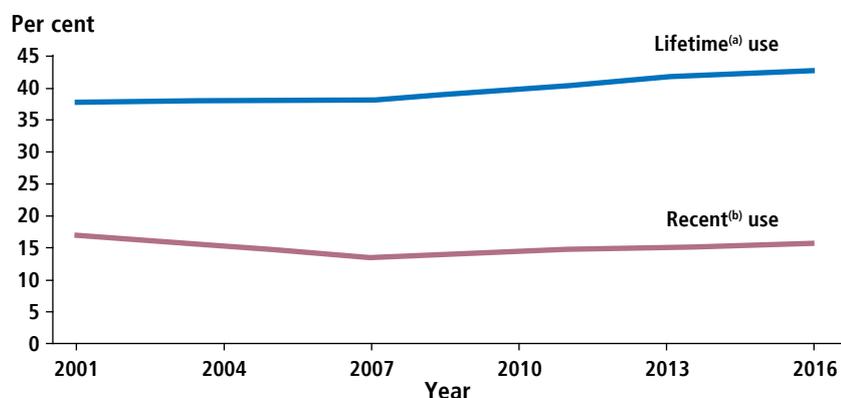
recent use of cannabis have remained relatively unchanged since 2004. Cannabis is used frequently among recent users, with more than 1 in 3 (36%) using it as often as daily or weekly (Table 4.7.1). Cannabis users were older in 2016 – both the age of first use and the average age of recent users have increased since 2013.

### COCAINE

In 2016, cocaine was the second most commonly used illicit drug in the previous 12 months, with 2.5% of the population aged 14 and over reporting its use. The proportion of people using cocaine rose from 1.0% in 2004, and cocaine use in Australia is currently at the highest levels seen since 2001. The proportion of people using cocaine in their lifetime has also increased, from 8.1% in 2013 to 9.0% in 2016, and has doubled since 2001 (from 4.4%).

Most people who use cocaine do so relatively infrequently, with about 2 in 3 (64%) using it only once or twice a year. Among people aged 14-29 in 2016, the average age of first use was 21; this has been consistent over the last decade. This is older than the average age of first use for other illicit drugs, such as cannabis (17) and ecstasy (19). Across all age groups, the average age of recent users increased by about 2 years between 2004 and 2016 (from age 29 to 31).

**Figure 4.7.2: Recent and lifetime use of any illicit drug, people aged 14 and over, 2001 to 2016**



(a) Used at least 1 of 16 illicit drugs in 2016 in their lifetime – the number and type of drug used varied between 2001 and 2016.

(b) Used at least 1 of 16 illicit drugs in 2016 in the previous 12 months – the number and type of drug used varied between 2001 and 2016.

Source: National Drug Strategy Household Survey; Table S4.7.3.

### Box 4.7.2: Medicinal cannabis in Australia

In 2016, the Federal Parliament of Australia passed the *Narcotic Drugs Amendment Act 2016* to allow the controlled cultivation of cannabis in Australia for medicinal and related scientific purposes, via a national licensing scheme (Hughes 2016). Both Australian and state and territory governments have implemented legislative and policy change to allow the cultivation, manufacture, prescribing and dispensing of medicinal cannabis products for patients in Australia (Department of Health Therapeutic Goods Administration 2017).

At the time of collecting the 2016 NDSHS data, however, no state or territory had legalised cannabis for medicinal use. Recreational use of cannabis remains illegal across all federal, state and territory laws in Australia.

**Table 4.7.1: Snapshot of drug use for the top 4 most commonly used illegal drugs, 2016**

	Cannabis	Cocaine	Ecstasy	Meth/amphetamines
<b>Among people aged 14 and over:</b>				
Lifetime use	34.8% (6.9 million)	9.0% (1.8 million)	11.2% (2.2 million)	6.3% (1.3 million)
Recent use (last 12 months)	10.4% (2.4 million)	2.5% (500,000)	2.2% (400,000)	1.4% (280,000)
Change in recent use since 2013	Stable (10.2%)	Stable (2.1%)	Stable (2.5%)	↓ 2.1%
Long-term trend in recent use since 2001	↓ (12.9% in 2001)	↑ (1.3% in 2001)	↓ (2.9% in 2001)	↓ (3.4% in 2001)
Average age of first use (14 years and over)	19	24	22	22
Average age of first use (14-29 years)	17	21	19	19
<b>Among recent users:</b>				
Age group most likely to use	20-29 (22.1%)	20-29 (6.9%)	20-29 (7.0%)	20-29 (2.8%)
Used weekly or more often	36.4%	3.2%	1.9%	20.4%
Main form used	Flowers/head (68.2%)	Powder (97.8%)	Pills (51.2%)	Crystal/ice (57.3%)
Average age of user	34	31	28	34
Diagnosed or treated for a mental illness	28.2%	24.6%	26.5%	42.3%
High or very high psychological distress levels	23.8%	21.9%	26.6%	37.2%

↑ Statistically significant increase.  
↓ Statistically significant decrease.

### ECSTASY

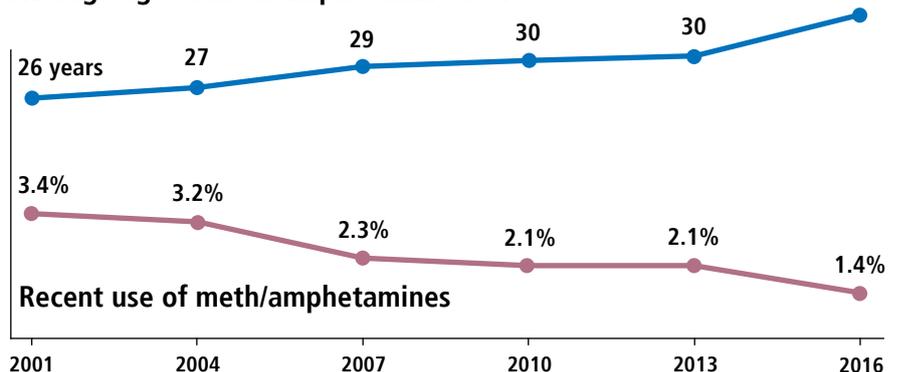
The recent use of ecstasy among people aged 14 and over peaked in 2007, at 3.5%, and has since declined – to 2.2% in 2016. The average age of first use for people aged 14-29 has remained stable, at about age 19 since 2007 (though slightly older in 2001 and 2004). The average age of recent ecstasy users was 28, which is younger than users of cannabis, cocaine and meth/amphetamines (Table 4.7.1). The majority of recent ecstasy users used it once or twice a year (51%).

Source: National Drug Strategy Household Survey.

### METH/AMPHETAMINES

Meth/amphetamine use has been de-

#### Average age of meth/amphetamine users



clining since 2001, when 3.4% of people aged 14 and over had used it recently. Recent use declined significantly between 2013 and 2016 (from 2.1% to 1.4%). This decline was mainly driven by a substantial decrease among people in their 20s; among whom recent use of meth/amphetamines halved between 2013 and 2016 (from 5.7% to 2.8%) and has declined by 75% since 2001 (from 11% to 2.8%). The average age of recent users rose between 2013 and 2016 from 30 to 34.

In 2013, the main form of meth/amphetamines used changed: ice replaced powder as the preferred form. This trend continued in 2016, with 57% of meth/amphetamine users reporting that crystal/ice was the main form of meth/amphetamines used in the previous 12 months (a significant increase from 22% in 2010).

Over the same period, the use of powder decreased, from 51% in 2010 to 20% in 2016. While overall recent meth/amphetamine use declined between 2013 and 2016, the proportion using crystal/ice remained relatively stable between 2013 and 2016 (1.0% and 0.8%, respectively) and has increased since 2010 (0.4%). Use of forms other than crystal/ice has fallen since 2007 and significantly declined between 2013 and 2016 (from 1.0% to 0.6%) (AIHW 2017).

### FREQUENCY OF DRUG USE

Some drugs are used much more often than others. Very few cocaine and ecstasy users used the drug as often as weekly (only about 2-3%) but 1 in 5 meth/amphetamine users used the drug weekly or more often (AIHW 2017).

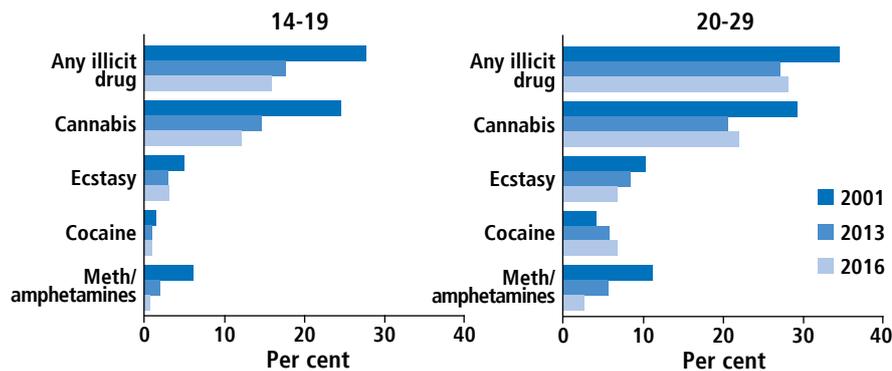
**Box 4.7.3: National Wastewater Drug Monitoring Program**

The NWDMP analyses wastewater samples from 54 treatment plants across Australia (excluding the Northern Territory and Tasmania). The third report in the series was based on data from sewage analysis of 14.2 million people, or 61% of the population.

The wastewater was tested for 13 illicit and licit (legal) substances, including cocaine, ecstasy (3, 4-methylenedioxymethamphetamine, abbreviated to MDMA), alcohol, tobacco and several prescription medications. Estimates are produced on the amount of each drug consumed by the community over a specified period (ACIC 2017).



**Figure 4.7.3: Proportion of people aged 14-29 who used illicit drugs in the previous 12 months, by age group, 2001, 2013 to 2016**



Source: National Drug Strategy Household Survey; Table S4.7.7.

Therefore, when examining the share of people in Australia using an illegal drug weekly or more often in 2016, meth/amphetamines was the second most commonly used illegal drug after cannabis. This is clear when comparing survey data with data from the Australian Criminal Intelligence Commission’s National Wastewater Drug Monitoring Program (Box 4.7.3). The NWDMP found that meth/amphetamine was the most highly consumed illicit drug tested across all regions of Australia (ACIC 2017), noting that the program does not test for cannabis or heroin.

**AGE AND SEX COMPARISONS FOR THE TOP 4 MOST COMMONLY USED ILLEGAL DRUGS People aged 14-29**

Young people aged 14-19 were far less likely to use illicit drugs in 2016 than in 2001. Use of cannabis halved over this period while use of ecstasy and cocaine declined by one-third, and use of meth/amphetamines dropped considerably, from 6.2% to 0.8% (Figure 4.7.3).

The Australian Secondary Students’ Alcohol and Drug Survey identified similar trends. Among secondary students aged 12-17, the use of an illicit drug declined from

20% in 2005 to 15% in 2014 (White & Williams 2016).

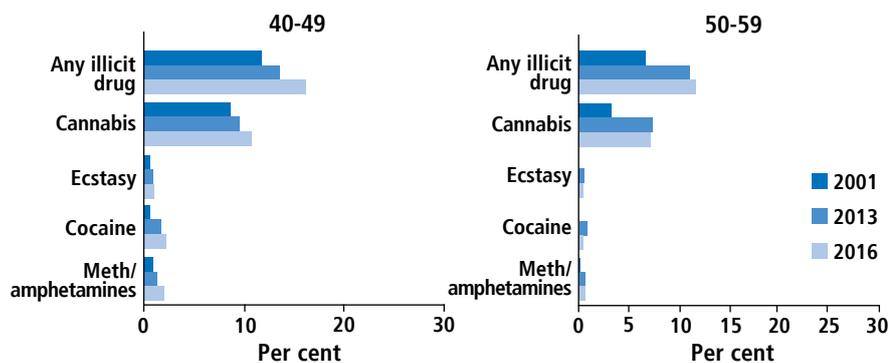
A smaller proportion of people in their 20s were using illicit drugs in 2016 than in 2001. Recent use of cannabis, meth/amphetamines and ecstasy were lower in 2016 than in 2001. However, people in their 20s continue to be more likely to use cannabis, ecstasy or cocaine in the previous 12 months than any other age group (Figure 4.7.3).

**PEOPLE AGED 40 AND OVER**

In 2001, about 12% of people in their 40s had used an illicit drug in the previous 12 months. This had increased to 14% by 2013, and to 16% in 2016. People in their 40s were the only age group to show a significant increase in use between 2013 and 2016. People in their 50s generally have some of the lowest rates of illicit drug use, but have also shown increases in recent use since 2001, from 6.7% to 12% in 2016. The rise in the use of any illicit drug was largely driven by an increase in both the recent use of cannabis and the non-medical use of pharmaceuticals (for both age groups) (Figure 4.7.4).

People who were using illicit drugs in their late 20s in 2001 would be in their early 40s in 2016. In 2001, people in their 20s had a high prevalence of illicit drug use compared with people in their 20s in 2016. The increase in illicit drug use seen among people in their 40s may be due to their continued use of illicit drugs as they age.

**Figure 4.7.4: Proportion of people aged 40-59 who used illicit drugs in the previous 12 months, by age group, 2001, 2013 to 2016**



Note: The 2001 ecstasy and cocaine estimates for people aged 50-59 are less than 0.1 and have a very high relative standard error.

Source: National Drug Strategy Household Survey; Table S4.7.7.

Australian Institute of Health and Welfare (20 June 2018). *Australia’s Health 2018*, Chapter 4: Determinants of health, 4.7 Illicit drug use, pp. 211-217. Retrieved from [www.aihw.gov.au](http://www.aihw.gov.au) on 26 November 2019.

# HARMS OF ILLICIT DRUG USE

## IMPACT OF ILLICIT DRUG USE

- According to the AIHW report *Impact of alcohol and illicit drug use on the burden of disease and injury in Australia* (AIHW 2018b), illicit drug use contributed to 2.3% of the total burden of disease and injury in 2011. This included the impact of opioids, amphetamines, cannabis, cocaine and other illicit drugs, as well as injecting drug use.
- One-third (33%) of the burden was from accidental poisoning. A further 31% was from drug dependence.
- Drug use disorders accounted for a large proportion of burden for ages 25-44: for men, it was the eighth leading cause of burden, contributing to 3.2% of burden in this age group (AIHW 2018b). Around 89% of the burden due to drug use disorders was non-fatal and a higher amount of burden was experienced by men (72%) than women (28%).
- Mental and substance use disorders (bipolar affective disorder, anxiety, substance use, behavioural and developmental disorders, schizophrenia and intellectual disability) includes disorders associated with alcohol and other drug use, as well as mental health issues that occur independently of substance use. In Australia in 2011, mental and substance use disorders:
  - Were responsible for an estimated 12% of the total disease burden, making it the third most burdensome group of diseases – together with musculoskeletal conditions (also 12%) – behind cancer (19%), and cardiovascular disease (15%)
  - Were the leading cause of non-fatal burden, accounting for almost one-quarter (24%) of all years spent living with disease
  - Were the main causes of burden for late childhood, adolescence and adulthood to age 44
  - Account for more years of life lost due to disability than any other disorders (AIHW 2016).

## DRUG-INDUCED DEATHS

- Drug-induced deaths are defined as those that can be directly attributable to drug use from toxicology and pathology reports. This includes overdoses (accident or suicide) or where drugs were found to be a direct contributor to the death, such as where a person was involved in a traffic accident and under the influence of drugs at the time of death (ABS 2017).
- In 2016, there were 1,808 drug-induced deaths, equating to 1.1% of all deaths (ABS 2017) – the highest number of drug-induced deaths recorded over the past 20 years.
- It is similar to the peak in 1999 of 1,740 deaths, which, at that time, was largely due to an increase in heroin-related deaths. However, the death rate per capita of 7.5 per 100,000 population in 2016 is lower than it was in 1999, when it was 9.2 deaths per 100,000.
- The most common drug class identified in data for drug-induced deaths over the past decade was opioids (this drug class includes the illegal use of heroin and licit and illicit use of opiate-based analgesics – such as codeine, oxycodone and morphine – and synthetic opioid prescriptions – such as tramadol, fentanyl and methadone).
- Between 1999 and 2016, there was a 4-fold increase in the number and rate of meth/amphetamine deaths, from 0.4 to 1.6 deaths per 100,000 population (ABS 2017).

Australian Institute of Health and Welfare (20 June 2018). *Australia's Health 2018*, Chapter 4: Determinants of health, 4.7 Illicit drug use, pp. 209-210. Retrieved from [www.aihw.gov.au](http://www.aihw.gov.au) on 26 November 2019.



# HOW DRUGS AFFECT YOUR BODY

## A FACT SHEET FROM BETTER HEALTH CHANNEL

### SUMMARY

- Different types of drugs affect your body in different ways.
- They can have short-term and long-term effects, which can be both physical and psychological.
- You might think drugs won't become a problem because you are only a casual user.
- Drug use can quickly start to affect your health and other aspects of your life.

**D**ifferent types of drugs affect your body in different ways, and the effects associated with drugs can vary from person to person. How a drug affects an individual is dependent on a variety of factors including body size, general health, the amount and strength of the drug, and whether any other drugs are in the system at the same time. It is important to remember that illegal drugs are not controlled substances, and therefore the quality and strength may differ from one batch to another.

Drugs can have short-term and long-term effects. These effects can be physical and psychological, and can include dependency.

You may act differently, feel differently and think differently if you have taken drugs. And you may struggle to control your actions and thoughts.

You might begin to use drugs without thinking about any harm to your body. You might think drugs won't become a problem because you are only a casual user. The more you take a drug, the more likely you are to build up a tolerance to its effects. This can lead to the need to take larger doses to obtain the effects of the drug. For this reason, evidence suggests that after prolonged use, many drugs can cause dependence. Drug dependence can quickly begin to affect your psychological and physical health, and can also affect your work and social life.

It is important to remember that there is no safe level of drug use. Be careful when taking any kind of drug.

### DIFFERENT DRUGS, DIFFERENT EFFECTS

Drugs affect your body's central nervous system. They affect how you think, feel and behave. The three main types are depressants, hallucinogens and stimulants:

- **Depressants** slow or 'depress' the function of the central nervous system. They slow the messages going to and from your brain. In small quantities depressants can cause a person to feel relaxed and less inhibited. In large amounts they may cause vomiting, unconsciousness and death. Depressants affect your concentration and coordination, and slow your ability to respond to situations. It is important to not operate heavy machinery while taking depressants. Alcohol, cannabis, GHB, opiates (heroin, morphine, codeine) and benzodiazepines (minor tranquillisers) are examples of depressants.
- **Hallucinogens** distort your sense of reality. You

may see or hear things that are not really there, or see things in a distorted way. Other effects can include emotional and psychological euphoria, jaw clenching, panic, paranoia, gastric upset and nausea. Ketamine, LSD, PCP, 'magic mushrooms' and cannabis are examples of hallucinogens.

- **Stimulants** speed or 'stimulate' the central nervous system. They speed up messaging to and from the brain, making you feel more alert and confident. This can cause increased heart rate, blood pressure and body temperature, reduced appetite, agitation and sleeplessness. In large amounts stimulants may cause anxiety, panic, seizures, stomach cramps and paranoia. Caffeine, nicotine, amphetamines (speed and ice), cocaine and ecstasy (MDMA) are examples of stimulants.

### RISK FACTORS FOR DRUG-RELATED HARM

The effects of a drug, and how long they last, depend on a number of factors:

- The type and strength of drugs that you use
- How the drug was made – substances manufactured in home labs may contain bacteria, dangerous chemicals and other unsafe substances, and have an unknown strength. Even one dose may cause an overdose that leads to brain damage or death
- Your physical characteristics (including height, weight, age, body fat and metabolism)
- The dose that you take
- How often and for how long you have been using drugs
- How you ingest the drug (by inhalation, by injection or orally). Compared with swallowing a drug, inhalation and injection are more likely to lead to overdose and dependence. If you are injecting drugs, sharing injecting equipment will increase your risk of contracting serious diseases such as hepatitis and HIV. It will also increase your risk of serious infection
- Your mental health, mood and environment (that is, whether you are in a secure, happy place or an unsafe place) can affect the experience you have when taking drugs. If you have a mental health condition, drugs may exacerbate or complicate the symptoms of that condition
- Whether you mix drugs, including alcohol. In particular, alcohol use may lead to high risk behaviour (such as drink driving) which can result in the serious injury or death of yourself or others.

### PHYSICAL HARMS FROM DRUG USE

Drug use can affect short- and long-term health outcomes. Some of these health outcomes can be serious, and possibly irreversible. Drug use can lead to risky or out of character behaviour.

When affected by drugs:

- You are more likely to have an accident (at home, in a car, or wherever you are)
- You may be vulnerable to sexual assault or you may engage in unprotected sex. Either of these could lead to pregnancy and sexually transmitted infection
- You could commit a sexual assault or other violent act
- You may find it hard to sleep, think, reason, remember and solve problems.

Drug use can also result in long-term health outcomes that include:

- Harm to organs and systems in your body, such as your throat, stomach, lungs, liver, pancreas, heart, brain, nervous system
- Cancer (such as lung cancer from inhaling drugs)
- Infectious disease, from shared injecting equipment and increased incidence of risk-taking behaviours
- Harm to your baby, if you are pregnant
- Acne, or skin lesions if the drug you are taking causes you to pick or scratch at your skin
- Needle marks and collapsed veins, if you inject regularly
- Baldness
- Male pattern hair growth in women, such as facial hair
- Jaw and teeth issues due to clenching and grinding your teeth; or bad breath, teeth cavities and gum disease
- Mood swings and erratic behavior
- Addiction
- Psychosis (losing touch with reality)
- Accidental overdose
- Higher risk of mental illness, depression, suicide and death.



## EFFECTS OF COMMON DRUGS

### ***Cannabis (hash, pot, dope, weed, grass, skunk, marijuana):***

- May cause relaxation and altered perception
- Can lead to increased heart rate and low blood pressure
- Can make you feel relaxed and happy, but can also cause lethargy, anxiety, paranoia, and psychosis in extreme cases. A history or family history of mental illness may increase the possibility of more extreme psychotic reactions
- Is linked to mental health problems such as schizophrenia and, when smoked, to lung diseases such as asthma, chronic bronchitis and lung, throat, mouth and tongue cancer
- Affects how your brain works. Regular use can make it hard for you to concentrate, learn and retain information
- Reduces your fertility
- When mixed with tobacco, is likely to increase the risk of heart disease and lung cancer.

### ***Cocaine (powder cocaine, coke, blow, Charlie, crack):***

- Gives you increased energy
- Makes you feel happy, awake, confident and less inhibited, but has a nasty 'comedown' that makes you feel depressed and unwell. (Using depressant drugs to help with the severity of comedowns can increase the chances of the development of negative cycles of dependence)
- Can overstimulate the heart and nervous system and lead to a seizure, brain haemorrhage, stroke or heart attack (people have died from cocaine-induced heart failure)
- Reduces your pain perception and may result in injury
- Carries greater risk if mixed with alcohol or other stimulants, especially if you have high blood pressure or if you have an existing heart condition
- Can harm your baby during pregnancy, and may cause miscarriage
- Can increase the risk of mental health issues such as anxiety, paranoia and psychosis
- If snorted, can cause damage to the lining of the nasal passage and nose
- If injected, can cause vein collapse and increased risk of HIV and hepatitis infection.

### ***Mephedrone (meow meow, m-cat, plant food, bubble, meph):***

- Can induce feelings of happiness, euphoria and confidence, but can also cause anxiety and paranoia
- Causes vomiting, sweating and headaches in some users
- Can overstimulate your heart and nervous system
- Can cause periods of insomnia
- Can lead to fits and agitated and hallucinatory states
- If used in large amounts, can cause tingling of the hands and feet, seizure and respiratory failure
- Has been linked to a number of deaths
- If injected, can cause vein collapse and increases the risk of HIV and hepatitis infection.

### **Ecstasy (MDMA, pills, E, eckies):**

- Can make you feel alert, warm and chatty
- Can make sounds and colours seem more intense
- May cause anxiety, confusion, paranoia and even psychosis
- Is linked (in cases of long-term use) to memory loss, depression and anxiety
- Can lead to overheating and dehydration
- Tends to stop your body producing enough urine, so your body retains fluid.

### **Speed (amphetamine, billy, whizz):**

- Can make you feel alert, confident and energetic
- Can reduce appetite
- May make you agitated and aggressive
- May cause confusion, paranoia and even psychosis
- Can make you very depressed and lethargic for hours or days, when used a lot
- Can cause high blood pressure and heart attacks
- Is more risky if mixed with alcohol, or if you have blood pressure or heart problems
- Puts you at risk of overdose, vein and tissue damage, and infectious disease (such as hepatitis C and HIV), if you inject speed.

### **Ice (crystal meth, shabu, crystal, glass, shard, P):**

- May create feelings of pleasure and confidence
- Can make you feel alert and energetic
- Can cause you to repeat simple things like itching and scratching
- Can cause enlarged or dilated pupils and a dry mouth
- May make you grind your teeth
- Can cause excessive sweat
- Can increase your heart rate and breathing
- May reduce your appetite
- May increase your sex drive
- Puts you at risk of infectious diseases (such as hepatitis B, hepatitis C and HIV) if you inject it
- Can damage your nasal passages and cause nose bleeds if you snort it.

The Alcohol and Drug Foundation has a list of drugs and their effects at: <https://adf.org.au/drug-facts/>

## **EFFECTS OF A 'COMEDOWN'**

A 'comedown' is your body's reaction to the substances that you have taken, after the initial reaction. In other words, it is the after effect.

How long it lasts, and how bad it is, depends on the type of drug (stimulant or depressant) and your age, sex and tolerance.

Common after effects are flatness, depression and exhaustion. Or you may feel:

- Shaky, dizzy, sweaty
- Headache
- Nauseous
- Fatigued
- Not hungry
- Sleepy or unable to sleep.

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ReachOut provides information on how to manage the effects of a comedown: <https://au.reachout.com/articles/how-to-manage-a-comedown>

## **WHERE TO GET HELP**

- Alcohol and Drug Foundation  
Tel. 1300 85 85 84
- DirectLine  
Tel. 1800 888 236 – to speak to a confidential telephone counsellor about any drug issue
- DrugInfo  
Tel. 1300 85 85 84, Email [druginfo@adf.org.au](mailto:druginfo@adf.org.au)  
– for information about drugs and drug prevention
- ReachOut NextStep  
– an anonymous online tool that recommends relevant support options based on the help that you want.

This page has been produced in consultation with, and approved by, the Alcohol and Drug Foundation (ADF).  
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State of Victoria. *How drugs affect your body*  
(Last updated December 2017). Retrieved from  
[www.betterhealth.vic.gov.au](http://www.betterhealth.vic.gov.au) on 8 August 2019.

# HELPING SOMEONE WHO HAS TAKEN AN ILLEGAL DRUG



A guide from [Positive Choices](#), an online portal to help school communities access accurate, up-to-date drug education resources and prevention programs.

The majority of people never use drugs, but it is important for people to know how to assist someone if a drug-related emergency happens. Drugs are unpredictable; they can affect people in different ways. As there is no quality control for illegal drugs there is no way of knowing their content or strength.

Call 000 for an ambulance immediately if there is even the slightest risk that someone is having an unusual reaction to a drug.

A parent or guardian will only be notified if the person is under the age of 18 and taken to hospital. Police will only be notified if there is a risk to their own personal safety or if someone dies.

Below is a guide to assisting a person in the following situations:

## PANIC ATTACKS

These can happen due to the increased feelings of paranoia, anxiety, and hallucinations that illegal drugs can bring on. These can be very frightening at the time, but it is important to know that these usually pass with time.

### *What are some of the signs?*

- Sweating and shaking;
- Chest pains and difficulty breathing;
- Increased heart rate;
- Sense of impending death;
- Dizziness, headaches, and lightheadedness;
- 'Spaced-out' and non-responsiveness.

### *What to do if someone has a panic attack?*

- Calm them down and reassure them that the

- feeling will pass;
- Take them somewhere cool and quiet away from crowds and bright lights;
- Encourage them to relax and take long, slow, deep breaths;
- If they pass out due to over-breathing, follow the DRS-ABCD life support chart (see below).

## OVERHEATING AND DEHYDRATION

There is a serious risk of overheating and dehydration when people do not maintain their fluids when taking drugs. Stimulants such as MDMA/ecstasy and methamphetamine will increase the body temperature. This can be made worse if taken while drinking alcohol which further dehydrates the body. Those who take stimulants should try to drink half a litre of water every hour, but make sure not to drink too much too quickly.

### *What are some of the signs?*

- Feeling hot, unwell, lethargic, faint, or dizzy;
- Inability to talk properly;
- Headache;
- Vomiting;
- Inability to urinate or urine becoming thick and dark;
- Not sweating even when dancing;
- Fainting, collapsing, or convulsing.

### *What to do if someone becomes overheated and dehydrated?*

- Take them somewhere cool and quiet such as the first aid area or 'chill-out' room;
- Get the person some cold water and get them to sip it slowly;
- Make sure someone stays with them;
- Give them salted foods like crisps or peanuts to



## DOCTOR'S DRS-ABCD: BASIC LIFE SUPPORT FLOW CHART

### **D – check for DANGER**

- First ensure that your safety is not at risk.
- If your safety is assured and the person is in danger move them out of the dangerous situation.

### **R – check for RESPONSE**

- Ask them their name or to open their eyes.
- If they respond, help to make them comfortable and continue to monitor their response.
- If you don't get a response, or they stop responding, send for help.

### **S – SEND for help**

- If you receive no response, call for an ambulance on '000'.
- If you are on your own with the person, first place them in the recovery position and then call '000'.
- If you know what drugs the person has taken tell the operator and ambulance officers.
- Ask them their name or to open their eyes.

### **A – open the AIRWAYS**

- If the airway is not clear, place them in the recovery position and open and clear the airway.
- If the airway is clear, leave on back, then tilt the head backwards and lift the chin.

### **B – check for BREATHING**

- Look and feel for chest movements. Listen for breathing from airways.
- If they are breathing, place them in the recovery position and monitor until ambulance arrives.
- If the person is not breathing, place the person on their back, pinch their nose closed, seal your lips over their mouth and give two initial breaths, ensuring that the chest rises with each breath.

### **C – CPR**

- If they are still not breathing, commence CPR until the ambulance services arrive.
- Place one hand on top of the other, palms facing down, over the centre of the chest.
- Compress the chest one third of the depth, 30 times, at a rate of two per second.
- Give 2 breaths for every 30 chest compressions (mouth-to-mouth can be considered unnecessary).
- Continue CPR until signs of life return, qualified help arrives, or it is impossible to continue (e.g. exhaustion).

### **D – Attach an automated external DEFIBRILLATOR if available and follow the prompts.**

This is correct on 19th September 2019.

Australian and New Zealand Committee on Resuscitation. Australian and New Zealand Committee on Resuscitation guidelines. Melbourne: ANZCOR, 2016. Available at <https://resus.org.au/guidelines/flowcharts-3/> [Accessed 19 September 2019].

replace salts lost through sweating;

- Fan them to cool them down;
- If symptoms persist or get worse seek first aid immediately, call 000, or take them to the nearest emergency department.

### FEELING VERY DROWSY

If someone becomes very drowsy from using drugs they could fall asleep and lose consciousness. It is important to keep them awake while waiting for the ambulance.

#### **What to do if someone becomes very drowsy?**

- Call an ambulance, but make sure they are not left on their own;
- Keep them awake; make them walk around or make them talk to you;
- Don't give them coffee or try to shock them;
- If they aren't responsive or lose consciousness put them in the recovery position.

### FITS OR SEIZURES (CONVULSIONS)

Large amounts of alcohol and some drugs can cause convulsions, otherwise known as a fit or seizure.

#### **What to do if someone starts convulsing?**

- Call an ambulance;

- Clear the area of any nearby harmful objects;
- Loosen any tight clothing;
- Cushion their head;
- It is important not to put anything in their mouth or to try and restrict their movement;
- Once the fit has finished, check their breathing and put them in the recovery position.

### A PERSON COLLAPSES

If a person collapses it may be necessary to perform cardiopulmonary resuscitation (CPR). CPR can temporarily maintain circulation to the brain to keep it functioning. An easy way to remember the steps involved in this process is to learn the acronym DRS-ABCD (*see above*).

#### **EVIDENCE BASE**

This factsheet was developed following expert review by researchers at the Matilda Centre for Research in Mental Health and Substance Use, the National Drug & Alcohol Research Centre, UNSW and the National Drug Research Institute, Curtin University. See Teacher Booklet, Parent Booklet or Student Booklet for more information.

The University of Sydney, The Matilda Centre for Research in Mental Health and Substance Use. *Helping someone who has taken an illegal drug* (Last reviewed 7 November 2019). Retrieved from <http://positivechoices.org.au> on 8 November 2019.

# CHAPTER 2

## Illicit drugs policy and reducing harm

### NATIONAL DRUG STRATEGY AT A GLANCE

A BRIEF OVERVIEW OF AUSTRALIA'S NATIONAL DRUG STRATEGY, REPRODUCED COURTESY OF THE **DEPARTMENT OF HEALTH**

#### PURPOSE

To provide a national framework which identifies national priorities relating to alcohol, tobacco and other drugs, guides action by governments in partnership with service providers and the community, and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply and harm reduction strategies.

#### AIM

To build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities.

#### UNDERPINNING STRATEGIC PRINCIPLES

- Partnerships
- Coordination and collaboration
- National direction, jurisdictional implementation
- Evidence-informed responses.

#### MEASURING SUCCESS

Assess progress by reviewing and reporting against the following headline indicators, using existing published and well-established data sources:

- Average age of uptake of drugs, by drug type;
- Recent use of any drug (people living in households);
- Arrestees' illicit drug use in the month before committing an offence;

#### A BALANCED APPROACH ACROSS THE THREE PILLARS OF HARM MINIMISATION



- Victims of drug-related incidents; and
- Drug-related burden of disease (including mortality).

Reporting will also consider new and emerging data sources, research and evaluation findings both nationally and internationally to ensure progress is monitored according to best available evidence.

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Department of Health. *National Drug Strategy 2017-2026*, The National Drug Strategy 2017-2026 at a glance, pp. 1-2. Retrieved from [www.health.gov.au](http://www.health.gov.au) on 8 August 2019.



# HARM REDUCTION

Australia's **Department of Health** explains how harm reduction strategies work in relation to legal and illicit drug use

**H**arm reduction strategies identify specific risks that arise from drug use. These are risks that can affect the individual who is using drugs, but also others such as family members, friends and the broader community. Harm reduction strategies encourage safer behaviours, reduce preventable risk factors and can contribute to a reduction in health and social inequalities among specific population groups.

The cost to Australian society of alcohol and other drug use in 2004-05 was estimated at \$55.2 billion, including costs to the health and hospitals system, lost workplace productivity, road accidents and crime. Of this, tobacco accounted for \$31.5 billion (56.2%), alcohol accounted for \$15.3 billion (27.3%) and illegal drugs accounted for \$8.2 billion (14.6%).<sup>1</sup>

## Reduce risk behaviours

Harms from alcohol, tobacco and other drugs can arise from risky behaviours associated with drug use in addition to directly from use. These behaviours can be positively influenced through public policy and



programs. Strategies that encourage safer behaviours reduce harm to individuals, families and communities.

Effective public policy has included drink driving laws that have reduced the incidence of driving while intoxicated, smoke-free area laws that have reduced

# HARM MINIMISATION

According to this information from the **Department of Health**, Australia's longstanding commitment to harm minimisation considers the health, social and economic consequences of drug use on individuals, families and communities as a whole and is based on the following considerations:

- Drug use occurs across a continuum, from occasional use to dependent use;
- A range of harms are associated with different types and patterns of drug use; and
- The response to these harms requires a multi-faceted response.

**A** harm minimisation policy approach clearly recognises that drug use carries substantial risks, and that drug users require a range of supports to progressively reduce drug-related harm to themselves and the general community, including families. This policy approach does not condone drug use.

Implementation of the approach presented in this strategy, including funding, legislation and programs, is the responsibility of relevant agencies in Commonwealth, state and territory jurisdictions. The mix of actions adopted in individual jurisdictions and the details of their implementation may vary to reflect local and/or national circumstances and priorities.

This approach reduces the harms of use through coordinated, multi-agency responses that address the three pillars of harm minimisation. These pillars are demand reduction, supply reduction and harm reduction. Strategies to prevent and minimise alcohol, tobacco and other drug problems should be balanced across the three pillars.

Harm minimisation includes a range of approaches to help prevent and reduce drug-related problems, and help people experiencing problems (including dependence) address these problems, including a focus on abstinence-oriented strategies.

The relative impact of strategies implemented under demand reduction, supply reduction and harm reduction varies for alcohol, tobacco and other drugs, due to differences in legality and regulation, prevalence of demand and usage behaviours.

Strategies are also more effective in combination than separately, and should be tailored to meet the varied needs of individuals, families, communities, and specific population groups.

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Department of Health. *National Drug Strategy 2017-2026*, Policy context, p.6. Retrieved from [www.health.gov.au](http://www.health.gov.au) on 8 August 2019.

# HARM REDUCTION APPROACHES

APPROACH	STRATEGIES
<b>TOBACCO</b>	
Safer settings	➤ Smoke-free areas
Smoking cessation aids	➤ Nicotine Replacement Therapy
<b>ALCOHOL</b>	
Safe transport and sobering up services	<ul style="list-style-type: none"> <li>➤ Sobering up facilities</li> <li>➤ Mobile assistance patrols</li> <li>➤ Access to public transport</li> </ul>
Safer settings	<ul style="list-style-type: none"> <li>➤ Promotion of responsible venue operations</li> <li>➤ Dry areas</li> <li>➤ Mandatory plastic glassware in high-risk venues</li> <li>➤ Availability of free water at licensed venues</li> <li>➤ Lock out times</li> <li>➤ Emergency services responses to critical incidents</li> <li>➤ Maintenance of public safety</li> </ul>
<b>ILLCIT AND ILLICITLY USED</b>	
Safer settings	<ul style="list-style-type: none"> <li>➤ Chill out spaces</li> <li>➤ Availability of free water at licensed venues</li> <li>➤ Information and peer education</li> <li>➤ Emergency services responses to critical incidents</li> <li>➤ Maintenance of public safety</li> </ul>
Diversion	➤ Diversion from the criminal justice system to treatment services
Blood-borne virus prevention	<ul style="list-style-type: none"> <li>➤ Hepatitis B vaccination</li> <li>➤ BBV and STI testing, prevention, counselling and treatment</li> <li>➤ Peer education</li> </ul>
Safer injecting practices	<ul style="list-style-type: none"> <li>➤ Diversity and accessibility of needle and syringe programs</li> <li>➤ Medically supervised injection centres and drug consumption rooms</li> <li>➤ Peer education</li> <li>➤ Prevent and respond to overdoses including increased access to naloxone</li> <li>➤ Police policy to exercise discretion when attending drug overdoses</li> <li>➤ Non-injecting routes of administration</li> </ul>
Replacement therapies	➤ Pharmacotherapy for opioid maintenance and other drug use
<b>ALL DRUGS</b>	
Periods of increased risk	<ul style="list-style-type: none"> <li>➤ Programs to reduce alcohol, tobacco and other drug use during pregnancy</li> <li>➤ Peer education and support</li> </ul>
Reduce driving under the influence of alcohol or other drugs	<ul style="list-style-type: none"> <li>➤ Random drink and drug driver testing</li> <li>➤ Zero blood alcohol concentration requirements on novice drivers</li> <li>➤ Penalties and intervention programs for recidivist drink or drug drivers</li> </ul>
Workforce	➤ Building the capacity of the workforce to deliver services and respond to emerging issues

Department of Health. *National Drug Strategy 2017-2026*, Appendix, pp. 50-51. Retrieved from [www.health.gov.au](http://www.health.gov.au) on 8 August 2019.

exposure to second hand smoke and needle and syringe programs that have reduced the incidence of people sharing injecting equipment.

## Safer settings

Environmental changes can reduce the impacts of alcohol, tobacco and other drug use. Examples include smoke-free areas, chill out spaces, providing food and

free water at licensed venues and the opportunity for the safe disposal of needles and syringes. Strategies that create safer settings reduce harm.

## Evidence of good practice

Harm reduction requires commitment from government and non-government programs, industry regulation and standards, and targeted communication strategies.

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Drug Use and Harm Reduction

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Strategies that affect harm reduction include:

- Reducing risks associated with particular context, including creating safer settings;
- Safe transport and sobering up services;
- Protecting children from another's drug use;
- Protecting the community from infectious disease including blood-borne virus prevention;
- Reducing driving under the influence of alcohol or other drugs; and
- Availability of opioid treatment programs.

Although Australia has achieved significant reductions in drink driving since the 1980s, it continues to be one of the main causes of road accidents, responsible for 28% of the burden due to road traffic injuries in Australia<sup>2</sup>.

Research shows between 20-30% of drink drivers re-offend and contribute disproportionately to road trauma<sup>3</sup>. Alcohol-attributable road accidents in Australia cost an estimated \$3.1 billion in 2004-05<sup>4</sup>.

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Department of Health. *National Drug Strategy 2017-2026*, Harm reduction, pp. 13-14. Retrieved from [www.health.gov.au](http://www.health.gov.au) on 8 August 2019.

# WHAT IS HARM REDUCTION?

A guide from [Harm Reduction Australia](#), a national organisation for individuals committed to reducing the health, social and economic harms potentially associated with drug use.

**T**he International Harm Reduction Association (IHRA) defines harm reduction as the 'policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.'

Harm reduction has been a principle of Australian governments' approach to drug use for several decades, beginning in the 1980s when the first needle syringe program was first introduced.

## FREQUENTLY ASKED QUESTIONS

### **Does harm reduction encourage drug use?**

**T**he evidence is quite clear that harm reduction programs, such as needle and syringe programs or heroin prescription programs, do not lead to an increase in drug use. There is research that shows such programs can actually lead to a decrease in drug use.

### **Does harm reduction save money?**

Some economists argue that harm reduction programs, such as needle and syringe programs, have seen the most cost-effective use of government money in Australia's history. \$27 is returned for each \$1 spent. The money we spend on policing and prisons for drug users is certainly much less cost-effective.

### **How many people are still alive because of harm reduction programs?**

Some studies have determined that thousands of Australian lives have been saved and many more improved because of harm reduction programs. Globally, the number is difficult to quantify but it is reasonable to assume that probably millions of lives have been saved.

Harm reduction has been a principle of Australian governments' approach to drug use for several decades, beginning in the 1980s when the first needle syringe program was first introduced.

### **How have needle and syringe programs reduced HIV?**

One of the most efficient transmission means of HIV and other blood-borne viruses is via used needles and syringes. Needle and syringe programs allow people who inject drugs the opportunity to protect their own health by getting access to sterile injecting equipment. The programs also bring many people who inject drugs into contact with health professionals for the first time in many years. Today, Australia has one of the world's lowest rates of HIV among people who inject drugs and the evidence is clear that this success is a result of the early introduction of needle and syringe programs, as well as peer-based organisation involvement.

### **Does HRA advocate legalising illicit drugs?**

HRA believes that criminalising people because they use drugs is actually more harmful and counterproductive. This is because it prevents users from accessing health and support services in a timely manner, jeopardises the wellbeing of users as well as their



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## FORMS OF HARM REDUCTION

### Harm reduction interventions include:

- Needle and syringe programs
- Medically supervised injecting facilities
- Opioid pharmacotherapy treatment
- Outreach services
- HIV education/information, testing and counselling
- Brief interventions (aimed at harm reduction)
- Overdose prevention interventions
- Legal and regulatory frameworks
- Peer education programs (e.g. DanceWise, save-a-mate)
- Diversion programs and caution schemes
- Chill out and sanctuary spaces at festivals.

Compiled by The Spinney Press

communities, and necessitates extremely high expenditures on policing and correctional services. In contrast, decriminalising use allows governments to redirect funds towards prevention, support and treatment, resulting in improved social and economic outcomes for individuals, communities and societies.

### ***Does HRA advocate decriminalising use of all drugs, even those with serious consequences like ice?***

HRA advocates for the decriminalisation of all drugs for personal use. Drug use, if it becomes problematic, should be treated as a health problem, not a legal problem. Treatment of drug use as a legal problem typically results in a number of other harms, such as a criminal record that limits employment, travel and other opportunities for a lifetime. Despite the claims often made to the contrary, there is advice, assistance and treatment available for people using ice or any other drug. Again, the evidence is quite clear that the best investment a country can make in reducing drug use and its associated harms is via education and treatment, not law enforcement.

### ***Does HRA condone drug use?***

HRA neither condemns nor condones drug use. People throughout history have used psychoactive substances and will continue to do so. Rather than cast judgment on people who use drugs, HRA believes that we should reduce the harms associated with drug use and provide opportunities for people to stop using drugs if they choose to do so.

### ***Won't decriminalisation lead to higher levels of drug use?***

The research is quite clear that drug use has not increased in countries and jurisdictions where drug use has been decriminalised. What does increase is the number of people seeking assistance and treatment.

### ***How do you distinguish between drug use and abuse?***

We don't. Drugs are used with minimal or no problems by the vast majority of people. Think of how many people consume alcohol without incident. Some people

do develop problematic use of drugs at times and they need to be the focus of our health-based efforts.

### ***Won't decriminalising drugs increase crime rates?***

Some studies have shown that crime is reduced by the introduction of harm reduction policies and decriminalisation of drug use.

### ***What will be the impacts of harm reduction policies on policing and road safety?***

Harm reduction policies do not encourage or condone unsafe driving practices. Just as people are able to consume alcohol but must not drive whilst impaired, similar rules would apply to all drugs that impair one's ability to drive.

### ***What will be the impacts of harm reduction policies on our health care system?***

There are likely to be more people willing to seek help and treatment but the costs of this increase would be offset by both reduced expenditure within the criminal justice system and longer-term health savings from earlier treatment. For instance, increasing access to pharmacotherapy programs, assisting peer-based user organisations and establishing needle and syringe programs all contributed to our low infection rates that have saved millions of dollars.

### ***What harm reduction programs does Australia have in place now?***

Currently we have in place a network of community- and pharmacy-based needle and syringe programs, as well as methadone and buprenorphine programs for people using opioids. There is also a single supervised injecting facility in Sydney. There are numerous treatment programs for people using methamphetamine, including innovative clinics that provide controlled management of problematic use. Importantly, we also have a number of national peer-based organisations that provide a vital communication link for drug users.

### ***What harm reduction programs should Australia introduce?***

Some of the key evidence-based programs that need to be introduced include heroin prescription programs, decriminalisation of personal use of drugs and prison-based needle and syringe programs.

### ***Isn't harm reduction against our international treaties?***

The drug law reforms introduced in many countries in the past few years show that harm reduction policies are not inconsistent with the international treaties. These treaties were primarily established to reduce the trafficking of drugs and not to punish individuals using drugs. The treaties are also largely out of date and have become an obstacle to effective global drug reform efforts.

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Harm Reduction Australia. *What is Harm Reduction?* Retrieved from [www.harmreductionaustralia.org.au](http://www.harmreductionaustralia.org.au) on 8 August 2019.

# History, not harm, dictates why some drugs are legal and others aren't

When considering harm to the user and to wider society, alcohol is much more of a problem than MDMA, according to [Nicole Lee](#) and [Jarryd Bartle](#)

Drug-related offences take up a lot of the resources within Australia's criminal justice system. In 2016-17 law enforcement made 113,533 illicit drug seizures and 154,650 drug-related arrests.

Harm reduction advocates are calling for the legalisation of some drugs, and the removal of criminal penalties on others. And there's public support for both. But how did some drugs become illegal in the first place? And what drives our current drug laws?

## LEGAL STATUS ISN'T BASED ON RISK OR HARM

Most people assume drugs are illegal because they are dangerous. But the reasons aren't related to their relative risk or harm.

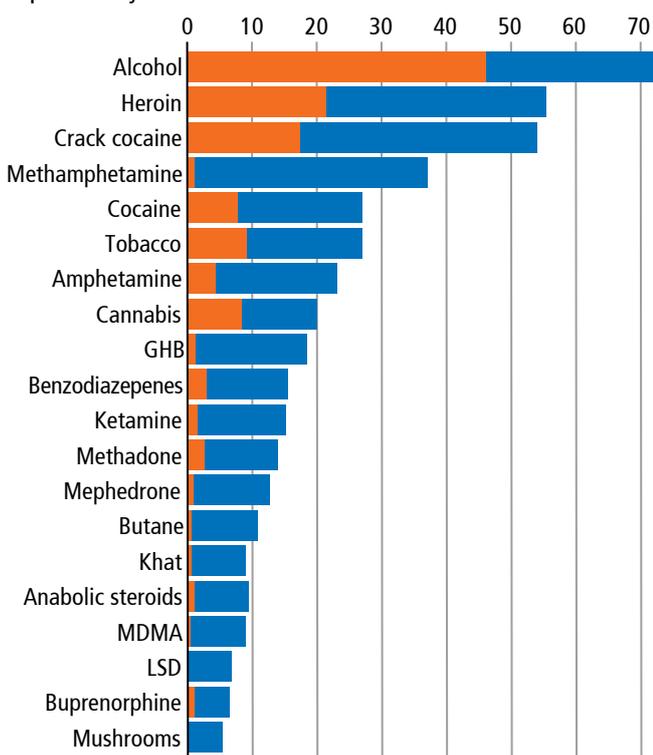
In a 2010 study, experts ranked 20 legal and illegal drugs on 16 measures of harm to the user and to wider society. This includes health damage, economic costs, and crime. Overall, alcohol was the most harmful drug. MDMA (ecstasy), LSD and mushrooms were among the least harmful.

At various times around the world, coffee has been illegal and cocaine has been widely available.

Many drugs that currently carry criminal penalties began life as useful medicinal therapies, such as opiates, cocaine, MDMA, and amphetamines. They

## OVERALL HARM OF SELECTED DRUGS

Drugs ordered by their overall harm scores (max score of 100), separated by [harm to users](#) and [harm to others](#).



Source: Drugs harms in the UK by David Nutt et al. The Lancet.

were often available over the counter at pharmacies or through licensed sellers.

## HISTORY OF DRUG LAWS IN AUSTRALIA

Australia, like the rest of the world, has had a patchy approach to criminalising substances, driven mostly by a desire to maintain international relations – particularly with the United States – rather than by concern for the public's health or welfare.

Before federation in 1901, very few laws regulated the use of drugs in Australia. The first Australian drug laws in the early 20th century imposed restrictions on opium, primarily as a means to discourage the entry of Chinese people to Australia.

*The National Drug Strategy came into effect in 1985, expanding from strict prohibition to explicitly include harm reduction, in addition to demand reduction (prevention and treatment) and supply reduction (customs and policing). In theory, that is. A recent study found just 2% of drug funding goes to harm reduction, while 66% goes to law enforcement.*

The temperance movement, mostly known today for the prohibition of alcohol in the 19th and early 20th centuries, played a key role in shaping global drug policy. Influenced by temperance activists, US President Theodore Roosevelt convened an international opium conference in 1909, which eventually resulted in the *International Opium Convention*.

Australia signed up in 1913, and by 1925 the convention had expanded to include the prohibition of opium, morphine, heroin, cocaine, and cannabis.

These drugs were prohibited in Australia well before their use became widespread or problematic. It wasn't until the 1960s that recreational drug use became a social concern. That's when cannabis, heroin, and new psychedelic substances such as LSD became more commonly used for pleasure or in pursuit of spiritual enlightenment.

In 1961, the *Single Convention on Narcotic Drugs* updated all existing international conventions and moved toward a strictly prohibitionist approach to recreational drug use (except alcohol and tobacco).

One of the key contributing factors of drug consumption in Australia was the Vietnam War, during which soldiers provided viable markets for heroin, cannabis, and other illicit drugs.

By 1970 all Australian states had enacted laws that made drug supply a separate offence to drug use or

possession, rather than merely a regulatory offence for misusing a medicine.

Drug use and related harms increased exponentially in Australia by the mid-1980s. The emergence of HIV/AIDS, as well as a dramatic increase in heroin-related deaths, led to calls for a more comprehensive approach to illicit drugs.

At that time, Australia led the world in a new way of thinking about drug policy. The National Drug Strategy came into effect in 1985, expanding from strict prohibition to explicitly include harm reduction, in addition to demand reduction (prevention and treatment) and supply reduction (customs and policing).

In theory, that is. A recent study found just 2% of drug funding goes to harm reduction, while 66% goes to law enforcement.

Cannabis possession and use is currently illegal in Australia. But starting around 30 years ago, several states and territories (South Australia, ACT and Northern Territory) removed the criminal penalties for personal use of cannabis. That means it's illegal, but not a criminal offence.

In all other jurisdictions charges of possession can be subject to "diversion" by police or court, allowing offenders to avoid a criminal penalty.

### HOW ARE DRUGS CURRENTLY CLASSIFIED AS ILLEGAL?

To be criminalised, a drug needs to be specifically scheduled under the relevant Poison Standards as well as having separate criminal drug legislation. Until recently, drugs needed to be specifically listed to be considered illegal, meaning legislation was constantly playing catch-up as new drugs were developed to circumvent the laws. Nearly 700 new psychoactive substances have been identified globally in the past decade. These synthetic drugs are designed to mimic the effects of common illicit drugs such as cannabis or cocaine.

Most Australian states and territories now ban the possession or sale any substance that has a "psychoactive effect" other than alcohol, tobacco and food. However, evidence from the United Kingdom indicates such broad bans are unlikely to be effective.

Selective bans have resulted in some drugs that are relatively safe in their pure form becoming much more dangerous. Bans on MDMA, for example, have led to the manufacture of illegal preparations with unknown potency and ingredients.

Cannabis criminalisation has encouraged the production of more potent cannabis and, more recently, synthetic cannabinoids.

The effect has also been implicated in the rise of fentanyl use in the United States as authorities crack down on heroin and pharmaceutical opioids.

### WHY REGULATE ILLICIT DRUGS?

The focus on reducing drug use doesn't translate to reducing harms. In fact, harms continue to increase despite a decrease in alcohol and other drug use in Australia.

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There is no evidence a prohibitionist approach to drug law has reduced the supply of illicit drugs. Instead, it has increased organised crime and acted as a barrier for people seeking help.

*Whether you morally agree with drug use or not, the current drug laws are neither reducing harm nor stopping use. It's time for a different approach.*

Given the failures of prohibition, jurisdictions around the world are starting to look at the issue differently. Several have brought cannabis under regulatory control, much like alcohol and tobacco, and others have removed criminal penalties associated with other drug use.

Most of the arguments to maintain current prohibitionist drug laws continue the moral objection to drug use that began in Australia with our early race-driven opium laws.

Since the beginning of recorded history, people have been taking mind-altering substances. Around 43% of Australians have tried an illicit drug at least once in their lifetime.

Whether you morally agree with drug use or not, the current drug laws are neither reducing harm nor stopping use. It's time for a different approach.

#### DISCLOSURE STATEMENT

Nicole Lee works as a paid consultant in the alcohol and other drug sector. She has previously been awarded grants by state and federal governments, NHMRC and other public funding bodies for alcohol and other drug research. Jarryd Bartle works as a paid consultant in the alcohol and drug sector. He was also a candidate for Fiona Patten's Reason Party in the 2018 Victorian election.

Nicole Lee is Professor at the National Drug Research Institute, Curtin University. Jarryd Bartle is Sessional Lecturer in Criminal Law, RMIT University.

## THE CONVERSATION

Lee, N, and Bartle, J (31 January 2019). *History, not harm, dictates why some drugs are legal and others aren't*. Retrieved from <http://theconversation.com> on 8 August 2019.

# How can making drugs easier to access save lives? 10 FAQs about drug law reform

Answers to frequently asked questions by [Dr Alex Wodak](#), published by Australia21



Police, prison officers and politicians are standing side by side with drug users to call for law reform. They say the current practice of jailing people for personal use and possession instead of focusing on their health and safety leads to unacceptable outcomes: lives lost and lives ruined. But it's hard to get your head around the idea that making drugs more easily available could actually reduce the risks.

So here are answers to frequently asked questions from Australia21 Director Dr Alex Wodak, former Director of the Alcohol and Drug Service, St Vincent's Hospital Sydney (1982-2012) and current President of the Australian Drug Law Reform Foundation.

## 1. Why does Australia need to change its drug policy?

Australia's approach to illicit drugs is seriously broken. It cannot be fixed by some minor tweaking. For over half a century our governments have relied heavily on law enforcement to curb the drug trade. But in that time the illicit drug trade in Australia has just kept getting bigger and bigger and more and more dangerous. We now have many more different types of drugs and more dangerous drugs than we ever had. During the last half-century we have had increasing drug-related deaths, disease, crime, corruption and violence.

Senior police now warn that Australia cannot arrest and imprison its way out of our serious drug problems. 'Tough on drugs' turned out to be an expensive way

of making a bad problem into a much worse problem. For example, cracking down on botanical cannabis gave us synthetic cannabis which is much more risky. In the US, trying to stop the use of powder cocaine led to crack. The more we push down on the drug trade, the worse it gets.

## 2. Isn't liberalising our drug laws just going to mean skyrocketing drug use?

Despite what many people think intuitively, the evidence from numerous studies is that drug laws have minimal or no effect on levels of illicit drug use. Punitive laws do not reduce drug use and liberal approaches do not increase drug use. But even if liberalising our drug laws did slightly increase illicit drug use, this might still be worth accepting if at the same time there was a huge decrease in some of the collateral damage from our drug laws. We should primarily focus on the harm that drugs do rather than just concentrate on reducing or eliminating their use.

## 3. How is handing out cocaine, heroin and ice to addicts going to work?

Australia should not – and never will – allow 1kg blocks of 100% pure cocaine, heroin or ice to be sold at a supermarket checkout. The public would never accept that, nor should they ever accept this extremist laissez-faire approach. The opposite extreme is prohibiting all use of illicit drugs and, by default, ensuring criminals run the black market (with zero government control).

What we need to do is find the ‘Goldilocks’ spot right in the middle: drugs that are attractive and available enough to satisfy demand while being tolerable to the public allowing politics to still work.

Australia had regulated and taxed edible opium until 1906. In the USA, Coca Cola contained cocaine until 1903. So we need to carefully select which drugs will be sold and have them available in small quantities and at low concentration. Most people who use drugs use small quantities infrequently and get into little or no trouble.

Drug treatment could look after people with the heaviest drug habits who are at highest risk and who probably also do the bulk of the recruiting.

When we start trying to regulate drugs, we shouldn’t start at the most difficult end but at the least difficult end with drugs like cannabis or MDMA (‘ecstasy’). Eight states in the USA have approved taxing and regulating cannabis and a number of countries are committed to going down this road soon (including Canada in 2018). Regulated cannabis packets could be required to have health warnings, help-seeking information and consumer product information. Proof of age at purchase could be a requirement (like alcohol) and thereby reduce sales to underage people. Revenue could be used in part to help fund drug treatment.

#### **4. Surely it’s just a matter of educating people about how dangerous these illegal drugs really are?**

At best, drug education has only a brief and modest benefit. But sometimes drug education has actually increased drug use. Drug education is not the panacea that many people believe. We should of course provide drug education provided that it’s realistic, aims to reduce harm rather than just eliminate use, and involves young people in its design and implementation.

#### **5. Why not get serious about zero tolerance of drugs and have a proper crackdown?**

The illicit drug trade is too big and too profitable for law enforcement to have any lasting impact. Even worse, the more law enforcement pressure applied to the illicit drug trade, the more profitable that trade becomes. Increased profits probably increase the recruitment of more would-be sellers.

In the USA, President Nixon declared a war on drugs in 1971 and America has since spent trillions of dollars on this war and thrown millions of its citizens in jail. But drug use and drug harm has continued at very high levels. The UN estimated that the global drug trade had an annual turnover of \$US320 billion in 2003. That was equivalent at that time to more than half Australia’s economy.

Then Prime Minister Tony Abbott said in 2014 that “the war on drugs is not a war that Australia could win and it is a war that Australia could lose”.

The Global Commission on Drug Policy, representing about 40 former presidents and prime ministers, argues that global drug prohibition has failed and more effective approaches are needed based on

evidence, while also respecting human rights. The criminal justice system should of course be involved when people who have used drugs harm others.

#### **6. Don’t we already have enough problems with Big Alcohol and Big Tobacco and now you want to create Big Cannabis?**

Alcohol and tobacco certainly cause many times more harm to the community than all the illegal drugs put together. The alcohol beverage industry is very effective at blocking reforms that might help the community but reduce the income of the drinks industry.

The tobacco industry used to be just as powerful as the alcohol industry but in recent decades has slowly been forced to accept some major reforms that have hugely benefitted the community. The fall in smoking levels in the community was only possible because cigarettes were legal and therefore could be strictly regulated.

Some painful lessons have been learnt from the mistakes made with policy on legal drugs. All advertising should be banned and any marketing and promotion strictly controlled. Somehow, donations to political parties have to be prevented. The question is not whether cannabis is harmless or very toxic but whether the harms of cannabis are more likely to be reduced if the drug is regulated by the government or by criminals, corrupt police or outlaw motorcycle gangs.

#### **7. Are any other countries changing their approach to illicit drugs?**

The international drug control system has been slowly unraveling for some time. About forty countries have





decriminalised in part or in full the use and possession of personal quantities of drugs.

Portugal decriminalised the use and possession of quantities of drugs consistent with personal consumption in 2001. Benefits were huge and negatives minimal. New Zealand began regulating certain new psychoactive substances in 2013. In 2012, majorities in Colorado and Washington states in the USA voted to tax and regulate cannabis and this policy was implemented in both states in 2014.

In Australia, the decriminalisation of drugs at a state level is far more extensive than many realise.

### **8. Surely Australia has to follow the international drug treaties that we have signed?**

Like other countries, Australia is faced with the dilemma of faithfully complying with international treaties or acting sensibly in the national interest. If Australia does this, we will not be the first country to breach the treaties. Bolivia was allowed to leave one of the drug treaties in 2011 and then return in 2013 minus a paragraph that was deeply resented in that country.

### **9. Should Australia decriminalise drugs?**

Australia already has (to some extent) decriminalised the use and possession of quantities of drugs consistent with personal consumption. But we should go much further.

Decriminalisation still leaves drugs to the unregulated black market which is responsible for much of the harm currently attributed to drugs.

So, for example, heroin prescribed by doctors used under medical supervision has many benefits and few adverse effects. Conversely, street heroin distributed by criminals is often very damaging to people who use the drug, their family and their community.

So what we need to do is try to regulate as much of the drug market as we can while recognising that we will never be able to regulate all of it. We already regulate some parts of the drug market such as the methadone/buprenorphine treatment system, needle and syringe programs and Sydney's drug consumption room. Major expansion and improvement of the drug treatment system is critical to the success of drug law reform.

### **10. What are the first steps needed in drug law reform?**

The threshold step for drug law reform is redefining drugs as primarily a health and social issue. This means that a major investment is required in health and social interventions if we are to reduce deaths, disease, crime, corruption and violence.

People with drug problems need help, not punishment. They also need help to reintegrate back into the community. Some will need education and training with the aim of getting a job. Many will need drug treatment. Marginalised and homeless people using drugs may need a drug consumption room where they can start a process of engagement that leads to drug treatment and healthcare. Young people attending music dance events should be able to have their pills tested.

Law enforcement should keep its budget but be offered the opportunity to invest in areas where the public gets a much better return on the investment. Australia has to stop seeing this issue through the lens of law enforcement.

For decades Australia has been debating its drug policy. There is now growing recognition that our current approach has been a dismal failure. An increasing number of Australians now look for vision and leadership on this issue from our politicians. We know that change is more likely and more sustainable if there is support across political parties. Standing still is no longer an option.

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Wodak, A and Australia21. *How can making drugs easier to access save lives? 10 FAQs about drug law reform.* Retrieved from <http://australia21.org.au> on 8 August 2019.

# Legal highs: arguments for and against legalising cannabis in Australia

MANY OF THE HARMS ASSOCIATED WITH CANNABIS USE ARE TO DO WITH ITS ILLEGALITY, OBSERVE **NICOLE LEE** AND **JARRYD BARTLE**

**G**reens leader Richard Di Natale wants Australia to legalise cannabis for personal use, regulated by a federal agency. This proposal is for legalisation of recreational use for relaxation and pleasure, not to treat a medical condition (which is already legal in Australia for some conditions).

According to the proposal, the government agency would licence, monitor and regulate production and sale, and regularly review the regulations. The agency would be the sole wholesaler, buying from producers and selling to retailers it licences.

The proposed policy includes some safeguards that reflect lessons we've learned from alcohol and tobacco. These include a ban on advertising, age restrictions, requiring plain packaging, and strict licensing controls. Under the proposal, tax revenues would be used to improve funding to the prevention and treatment sector, which is underfunded compared to law enforcement.

## CANNABIS LEGISLATION AROUND THE WORLD

In Australia, cannabis possession and use is currently illegal. But in several states and territories (South Australia, ACT and Northern Territory) a small amount

for personal use is decriminalised. That means it's illegal, but not a criminal offence. In all others it's subject to discretionary or mandatory diversion usually by police (referred to as "depenalisation").

Several jurisdictions around the world have now legalised cannabis, including Uruguay, Catalonia and nine states in the United States. Canada is well underway to legalising cannabis, with legislation expected some time this year, and the New Zealand prime minister has flagged a referendum on the issue.

In a recent opinion poll, around 30% of Australians thought cannabis should be legal. Teenagers 14-17 years old were least likely to support legalisation (21% of that age group) and 18-24 year olds were most likely to support it (36% of that age group).

The research to date suggests there is no significant increase (or decrease) in use or other outcomes where cannabis legalisation has occurred. It's possible the harm may shift, for example from legal harms to other types of harms. We don't have data to support or dispel that possibility.



In the latest National Drug Strategy Household Survey, around a quarter of respondents supported cannabis legalisation and around 15% approved of regular use by adults for non-medical purposes.

## WHAT ARE THE CONCERNS ABOUT LEGALISATION?

Opponents of legalisation are concerned it will increase use, increase crime, increase risk of car accidents, and reduce public health – including mental health. Many are concerned cannabis is a “gateway” drug.

The “gateway drug” hypothesis was discounted decades ago. Although cannabis usually comes before other illegal drug use, the majority of people who use cannabis do not go on to use other drugs. In addition, alcohol and tobacco usually precede cannabis use, which if the theory were correct would make those drugs the “gateway”.

There is also no evidence legalisation increases use. But, studies have shown a number of health risks, including:

- Around 10% of adults and one in six teens who use regularly will become dependent
- Regular cannabis use doubles the risk of psychotic symptoms and schizophrenia
- Teen cannabis use is associated with poorer school outcomes but causation has not been established
- Driving under the influence of cannabis doubles the risk of a car crash
- Smoking while pregnant affects a baby’s birth weight.

## WHAT ARE THE ARGUMENTS FOR LEGALISATION?

### **Reducing harms**

Australia’s official drug strategy is based on a platform of harm minimisation, including supply reduction, demand reduction (prevention and treatment) and harm reduction. Arguably, policies should therefore have a net reduction in harm.

But some of the major harms from using illicit drugs are precisely because they are illegal. A significant harm is having a criminal record for possessing drugs that are for personal use. This can negatively impact a person’s future, including careers and travel. Decriminalisation of cannabis would also reduce these harms without requiring full legalisation.

### **Reducing crime and social costs**

A large proportion of the work of the justice system (police, courts and prisons) is spent on drug-related offences. Yet, as Mick Palmer, former AFP Commissioner, notes “drug law enforcement has had little impact on the Australian drug market”.

Decriminalisation may reduce the burden on the justice system, but probably not as much as full legalisation because police and court resources would still be used for cautioning, issuing fines, or diversion to education or treatment. Decriminalisation and legalisation both potentially reduce the involvement

of the justice system and also of the black market’s growing and selling of cannabis.

### **Raising tax revenue**

Economic analysis of the impact of cannabis legalisation calculates the net social benefit of legalisation at A\$727.5 million per year. This is significantly higher than the status quo at around A\$295 million (for example from fines generating revenue, as well as perceived benefits of criminalisation deterring use). The Parliamentary Budget Office estimates tax revenue from cannabis legalisation at around A\$259 million.

### **Civil liberties**

Many see cannabis prohibition as an infringement on civil rights, citing the limited harms associated with cannabis use. This includes the relatively low rate of dependence and very low likelihood of overdosing on cannabis, as well as the low risk of harms to people using or others.

Many activities that are legal are potentially harmful: driving a car, drinking alcohol, bungee jumping. Rather than making them illegal, there are guidelines, laws and education to make them safer that creates a balance between civil liberties and safety.

## WHAT HAS HAPPENED IN PLACES WHERE CANNABIS IS LEGAL?

Legalisation of cannabis is relatively recent in most jurisdictions so the long-term benefits or problems of legalisation are not yet known.

But one study found little effect of legalisation on drug use or other outcomes, providing support for neither opponents nor advocates of legalisation. Other studies have shown no increase in use, even among teens.

The research to date suggests there is no significant increase (or decrease) in use or other outcomes where cannabis legalisation has occurred. It’s possible the harm may shift, for example from legal harms to other types of harms. We don’t have data to support or dispel that possibility.

### **DISCLOSURE STATEMENT**

Nicole Lee works as a paid consultant in the public, private and not for profit alcohol and other drug sector and to commonwealth and state governments. She has previously been awarded grants by the state and federal government, NHMRC and other public funding bodies for alcohol and other drug research. Jarryd Bartle works as a policy advisor for The Eros Association, the industry association for adult goods and services which has a commercial interest in the legalisation of recreational cannabis.

Nicole Lee is Professor at the National Drug Research Institute, Curtin University.

Jarryd Bartle is Sessional Lecturer in Criminal Law, RMIT University.

## THE CONVERSATION

Lee, N, and Bartle, J (17 April 2018). *Legal highs: arguments for and against legalising cannabis in Australia*. Retrieved from <http://theconversation.com> on 8 August 2019.

# Drug laws on possession: several countries are revisiting them with these options

What can countries do if they don't want to arrest or convict people because they use drugs? [Alex Stevens](#) and [Caitlin Hughes](#) explore the legal options

**M**any countries are changing the way they approach people who use drugs. The Irish government has just announced possible alternatives to criminalisation for possession of some drugs. Other countries, including Norway and Malaysia, are weighing options. But what can countries do if they don't want to arrest or convict people because they use drugs?

To inform the Irish government's decision, we carried out a detailed review of approaches in various countries. These countries were Australia, the Czech Republic, Denmark, Germany, Jamaica, the Netherlands, Portugal, the UK and the US.

We found three main approaches: depenalisation, diversion and decriminalisation. (We did not review models of legally regulating the production and sale of drugs. Decriminalisation is not the same as legalisation.)

*Depenalisation* is where the crime remains in law, but the police stop imposing penalties for some people. For example, police in England and Wales can issue written warnings to people found to be in possession of small amounts of cannabis for the first time, instead of arresting them.

*Diversion* is when people found to be in possession of drugs are sent to education sessions, treatment or social services, instead of being charged and prosecuted. These schemes have been adopted in Australian states, such as New South Wales, and in some parts of England and the US. Some schemes, including one in Queensland, are written into law. Others, like County Durham's Checkpoint scheme and the LEAD programme in Seattle, are based only on changes in police practice.

*Decriminalisation* involves legal changes so that it is no longer a criminal offence to possess a small quantity of drugs for personal use. But there are three approaches to this model.

Since the 1970s, many US states have replaced criminal sanctions and prison sentences with civil sanctions, such as fines for the possession of less than an ounce of cannabis. Similar schemes operate in the Czech Republic, Jamaica and some Australian states, such as South Australia.

Other countries and states, such as Germany and Vermont have decriminalisation with no sanction at all. Still others, like Portugal, have favoured decriminalisation with diversion to targeted health and social responses.

In 2001, Portugal decriminalised the possession of small amounts of all kinds of drugs, combined with the possibility to impose civil sanctions (such as fines or suspension of driving licences) and diverting people into treatment, via a meeting with a "commission for the dissuasion of addiction". In practice, most cases end with no sanction. Portugal also expanded access to treatment, health and social services with positive results.

*Importantly, we did not find evidence that any of these alternative measures consistently increased the use of drugs.*

## HOW THE MODELS STACK UP

Each approach has its own advantages and drawbacks. Depenalisation, for example, is easy to implement and lets police use their discretion in deciding who to arrest. But this may lead to discriminatory enforcement, as black people are often far more likely to be stopped, arrested and punished for drugs.

Decriminalisation requires legal changes to be made. Some may argue that it leaves authorities without legal opportunities to intervene in undesired activities, such as public drug use. But these can still be banned



by separate rules. Indeed, possession of cannabis has been formally decriminalised in New York State since 1977, but it has still been an offence to have the drug “in public view”, leading to hundreds of thousands of arrests for low-level drug offences, again falling most heavily on people of colour.

But decriminalisation also brings the potential for health, social and criminal justice benefits, by reducing stigma surrounding drug use – a known barrier to treatment and harm reduction – and improving employment prospects and housing stability. It can also reduce the burden on police and courts. In Portugal, the extra spending on health services was offset by savings in the criminal justice system and other benefits, meaning the overall social cost of drugs fell.

### NO MODELS LEAD TO INCREASED DRUG USE

Importantly, we did not find evidence that any of these alternative measures consistently increased the use of drugs. A study of over 100,000 teenagers in 38 countries did not show higher rates of drug use in countries with more liberal approaches. Recent decriminalisations in five US states produced big reductions in arrests but no apparent increase in cannabis use among young people.

As countries look for ways to implement UN recommendations to avoid criminalising people for using drugs, they will need to consider these different options carefully. They will, as Ireland has found, need to adapt them to their own legal, social and drug use contexts.

They can do so with a fair amount of confidence that removing the harms of punishment is not likely to increase drug use. But, given some models bring greater long-term gains, there is merit in arguing that governments ought to be bold.

### DISCLOSURE STATEMENT

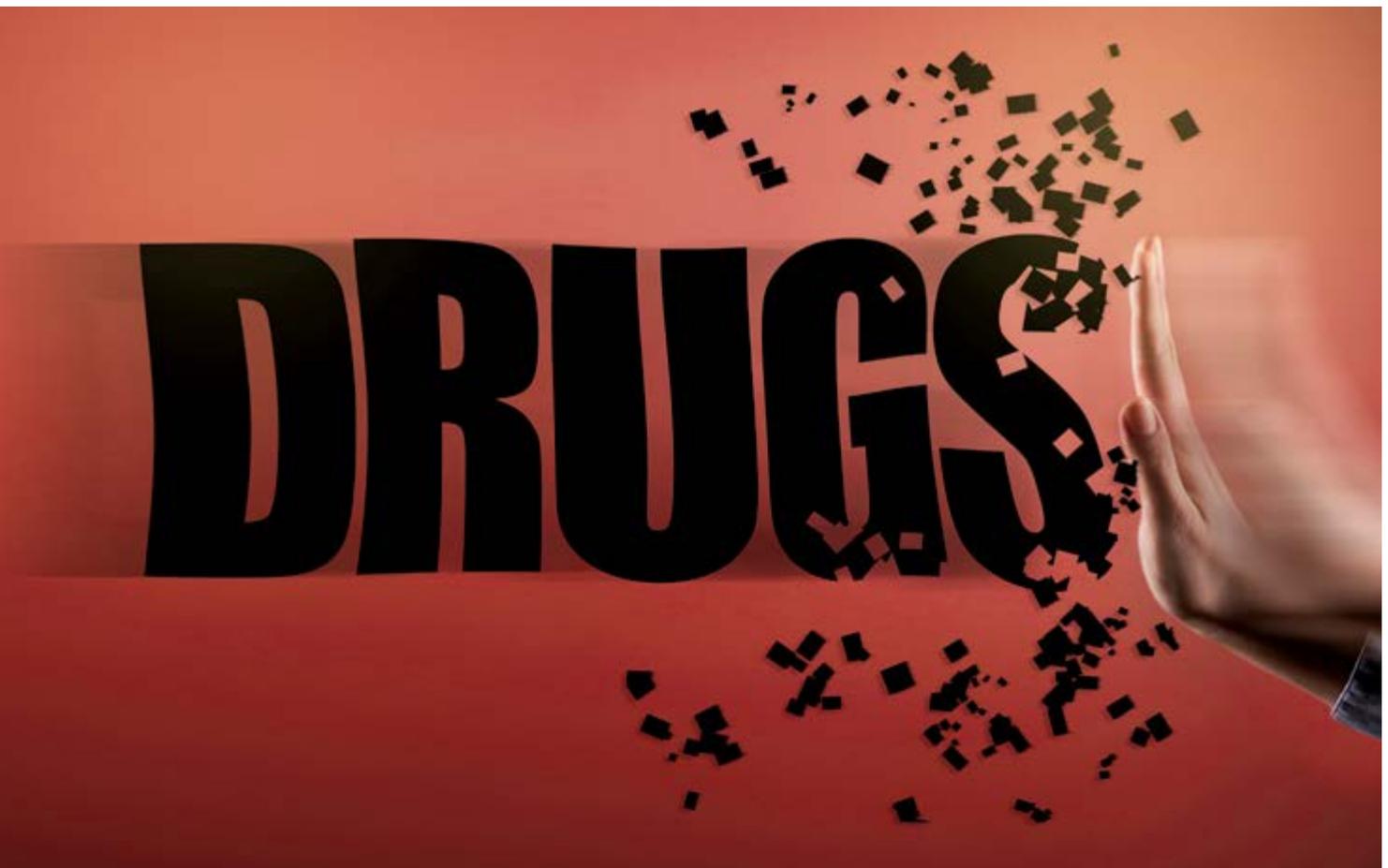
Our review was funded by the Department of Justice and Equality and the Department of Health of the Republic of Ireland. Caitlin Hughes has received funding from the Australian Research Council, National Drug Law Enforcement Research Fund, Australian Institute of Criminology, and federal and state Governments (Commonwealth, ACT, WA) and the Irish Government. She undertook this research while working at the National Drug and Alcohol Research Centre which receives funding from the Australian Government, and she remains a visiting academic at this centre.

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## THE CONVERSATION

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# MEDICALLY SUPERVISED INJECTING CENTRES: DISPELLING THE MYTHS

The primary aim of a medically supervised injecting centre (MSIC) is to tackle health risks associated with using drugs on the streets as well as introducing drug users to services and support. Evidence to support the existence of centres is overwhelming yet a lack of understanding of the purpose is easily lost amidst misinformation in the media, according to the [Alcohol and Drug Foundation](#)

**Medically supervised injecting centres have three clear goals:**

1. To provide an environment for safer drug use
2. To improve the health of drug users
3. To reduce public disorder.

A medically supervised injecting centre does exactly as the name suggests. The staff in the centre ‘supervise’ episodes of injecting drug use that would otherwise happen somewhere else – often in public, laneways, public toilets or next to schools. The absence of a designated place to inject will not stop someone from injecting, regardless of drug type.

All MSICs acknowledge that injecting any drug is inherently ‘unsafe’ however the practice can be made ‘safer’ if supervised by a trained professional in a controlled environment.

MSICs do not supply drugs. Clients arrive at the



## DRUG INJECTING AND HARM

- Unsafe injecting practices were responsible for 0.5% of the total burden of disease and injuries in 2015.<sup>1</sup>
- People who inject drugs experience considerably poorer health outcomes than others who use drugs.<sup>2</sup>
- In 2018, the most commonly reported injected drugs were:
  - Methamphetamine (48%), up from 33% in 2014
  - Heroin (26%), decreasing since 2014 (31%).<sup>3</sup>
- Between 2014 and 2018, the prevalence of HIV among people who inject drugs remained low and stable (1.4% to 2.1%).<sup>3</sup>
- In 2019, 45% of respondents to the Illicit Drug Reporting System interviews (IDRS) had experienced an injection-related health problem in the last month.<sup>5</sup>
- Proportion of needle and syringe program survey respondents reporting receptive sharing of needles and syringes increased, from 16% in 2014 to 18% in 2018.<sup>5</sup>
- Of the population aged 14+, 1.6% reported injecting a drug in their lifetime; 0.3% reported injecting a drug in the past year in 2016.<sup>4</sup>
- The proportion of respondents reporting reuse of needles and syringes (including the reuse of one’s own syringes) increased from 21% in 2014 to 26% in 2018.<sup>3</sup>
- In 2018, 45% of people who inject drugs had been exposed to Hepatitis C, a significant decline since 2014 when it was 54%, and the lowest level since data were collected in 1995.<sup>3</sup>

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centre with pre-purchased drugs. MSICs do not support drug dealing – selling, buying or sharing drugs is prohibited within a centre. Staff do not assist a client to inject their drug of choice. Instead staff are present to supervise the injection of the drug and to ensure that there is immediate access to emergency medical care in the event of an overdose and to support the drug user after injection has taken place.

The medically supervised injecting centre in Kings Cross, Sydney reports a mix of drug types used in the facility. In 2015, heroin only made up 41% of all injections. Amphetamines, which includes methamphetamines or ‘ice’, made up 18% of all injections.

As more than one million injections have taken place since the MSIC in Sydney opened its door, a conservative estimate would suggest that may have included more than one hundred thousand injections of amphetamines. *The Australian* newspaper reports that despite injections of methamphetamine increas-

ing from 268 in January 2012 to 1212 in June 2017, rates of abuse and aggression are decreasing.

The very nature of the centre allows for the drug user to remain in the centre in a calm, safe space post injection. There is no evidence, anecdotal or otherwise, that use of methamphetamine under the supervision of trained professional health workers aligns with the concerns being addressed in the local media.

In October 2017, the Victorian government passed legislation to open a MSIC in North Richmond, a suburb that has a high level of drug use and tragically high numbers of overdose deaths. Many concerns have been expressed regarding the location of the centre being close to a primary school.

These are legitimate concerns and worthy of being expressed. Children should not be exposed to trauma on their daily walk to school. However, the current situation in Richmond sees primary school children, kindergarten children and families being exposed to

## INJECTING CENTRE SAFETY FACTS

- More than 1 million injections have been supervised in Sydney’s Safe Injecting Facility with no fatalities occurring since the centre opened in 2001.
- Research by the University of Sydney (released November 2017) into the safety of the Uniting Medically Supervised Injecting Centre found that more than 1 million injection events have occurred with no fatalities.
- The Uniting Medically Supervised Injecting Centre (MSIC) has operated in Sydney’s Kings Cross since 2001, providing health facilities and support to people who inject drugs.
- The research has found the MSIC supervised more than 1 million injections between 2001-2016 with medical intervention required on less than 10% of occasions.
- This covers periods of changing drug availability and use, including increased methamphetamine use, pharmaceutical opioid use and more recently the emergence of the highly potent pharmaceutical opioid, fentanyl.
- Lead researcher Associate Professor Carolyn Day says the results prove the effectiveness of the facility in providing a safe environment for clients and assisting users in accessing education and other health services.
- The service also provides clients with education and referral to counselling and rehabilitation services. Each interaction with a client represents engagement which would not otherwise have taken place.
- Safe injecting facilities operating around the world have been shown to reduce overdoses, decrease the transmission of blood-borne viruses, and provide access to treatment programs.

Source: University of Sydney, (News release, 14 November 2017), *1 million injections and no fatalities*. Sourced from <https://sydney.edu.au/news-opinion/news> on 26 November 2019.

an open drug using scene daily. Many families and children in the area have already been exposed to drug use, discarded injecting equipment and many have borne witness to tragedy. Discarded injecting equipment is regularly found in the playground of the primary school.

This is unacceptable and must be addressed. And now it finally is. By the establishment of a medically supervised injecting centre. The establishment of the centre is not the only solution to solve drug-related concerns but it is a significant step as part of an overall approach.

*All medically supervised injecting centres acknowledge that injecting any drug is inherently 'unsafe' however the practice can be made 'safer' if supervised by a trained professional in a controlled environment.*

The supervised injecting centre will reduce the discarded needles in the playground, it will reduce the likelihood of primary school children being exposed to drug using, it will reduce the open drug using scene. This is based on fact. There are over 220 peer reviews papers that show facilities like this work.

Media reports early in 2018 that all drugs of dependence will be allowed in the centre, including methamphetamines, generated a great deal of noise and misinformation. The drug of choice used within the centre does not change the purpose of, or the impact that the centre will have on the lives of drug users or the wellbeing of the community. Feeding the hysteria surrounding crystal methamphetamine only contributes to further stigmatisation of the people who are using it – and we know that stigma is a major reason people don't seek help.

## EDITOR'S NOTE

The medically supervised injecting room opened in North Richmond on 30 June 2018 as a two-year trial.

An independent panel is reviewing the medically supervised injecting room during the two-year trial period.

After considering the evidence collected by the panel during the trial, a decision will be made on whether the service should continue at North Richmond Community Health.

Opposition to the centre and moves to stop the trial well before any impact can be measured will only increase the harms (including stigmatisation) associated with injecting drug use in Richmond and will result in more deaths and greater harms in the Richmond area.

The medically supervised injecting centre is good public health policy and deserves bipartisan support.

If we don't have a centre in Richmond people will continue to die. And they will die in public places for school children to witness. People will still inject a variety of substances. Injecting equipment will continue to be found in the playground of the local school. Residents will still witness overdoses and have to provide emergency first aid to people on their doorstep. And school children will continue to witness the tragedy that is severe drug dependence.

This life-saving, public health intervention should not be at risk due to misinformation and moral panic whipped up by incorrect reporting and a lack of basic understanding of what the centre exists for in the first place.

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## CHAPTER 3

# The pill testing debate

## What is harm reduction and why is it important at music venues and events?

### A FACT SHEET FROM THE ALCOHOL AND DRUG FOUNDATION

The principles of harm reduction accept that no matter the rigour of messaging around the individual risks and dangers of substance use, there will always be people who take or experiment with substances. As such, it is important to ensure that individual harms associated with substance use are minimised wherever possible.<sup>1</sup>

Many people who use drugs recreationally do so only on occasions, and this use is often determined by the environment they are in. Music events, such as festivals, live concerts, Electronic Music Dance Events (EMDE's) and raves are often popular environments for substance use.<sup>2,3</sup>

The types of settings and environments people are in often influences the types of substances they consume.<sup>4</sup> Stimulant and psychedelic recreational drugs such as MDMA and ecstasy, are among those typically consumed at music events.<sup>5</sup>

#### DRUG USE AT MUSIC EVENTS

People who frequent music festivals in Australia report higher levels of illicit drug use than those seen in the general population. A 2011 survey of festival goers found at minimum 52% had used illicit drugs at least once, 25% of which had done so in the previous month, compared to 42.6% and 15.6% respectively in the general population.<sup>6,7</sup>

Strategies that promote zero tolerance on drug use at music events, such as significant police presence, sniffer dogs, and random drug searches are not necessarily stopping festival goers from consuming drugs.

This is supported by a recent study from the National Drug and Alcohol Research Centre, which surveyed a group of people who regularly attend festivals.

Approximately 70% stated that police presence does not deter them from using illicit substances at music festivals.<sup>8</sup> Higher rates of consumption also indicate that patrons may be at increased risk of adverse events and harm.<sup>9</sup> It also suggests they are potentially immune to the general messaging around the risks of drug use and that more targeted harm reduction information may be more effective in this population.<sup>10</sup>

#### THE PILL TESTING DEBATE

The screening of illicit drugs for harmful substances (known as 'pill testing' or 'drug checking'), has been sanctioned for a number of years in countries like The Netherlands, Austria, Belgium and Switzerland.

No Australian jurisdictions endorse pill testing, however a number of recent deaths at music festivals has sparked a national debate, prompting public calls on state and territory governments to introduce illicit drug testing facilities at major public events along with trained healthcare support staff.

A range of experts including scientists, doctors and policymakers assert that current anti-drug strategies are not working, and that a new harm reduction approach is needed. Calls for state-funded pill testing services have been supported by the Australian Greens, members of the Australian Labour Party and the Australian Medical Association, among other health professional bodies.

To date, state governments have resisted the official introduction of pill testing services, instead maintaining a tough criminal justice stance on illicit drugs.

Source: The Spinney Press

#### CHARACTERISTICS OF SUBSTANCE USE AT MUSIC EVENTS

##### Illicit drug use

The types of substances consumed, and the way in which they are taken at music events and festivals, also carry risks. Drugs such as ecstasy and MDMA are commonly consumed by attendees of music events.

The risks associated with the consumption of these substances include:

- High body temperatures
- Dehydration
- Increased heart rate and blood pressure
- Anxiety
- Irrational behaviour
- Visual and auditory hallucinations.<sup>11</sup>

Some of these effects can lead to behaviours such as excessive water consumption, which can be fatal – especially in first-time users.<sup>12</sup>

The effects of these drugs can also be exacerbated by the festival environment, with attendees consuming in larger amounts to keep their energy levels up, coupled with elevated activity levels. Environmental factors such as heat and sunstroke can lead to further overheating and dehydration.<sup>13</sup>

Many of the risks can be addressed or moderated by harm reduction strategies. Access to educational resources such as *Text the Effects* cards, hydration stations and chill out spaces can help.

### **Alcohol use**

Alcohol is also widely consumed at music festivals. Alcohol licencing information will provide organisers with service guidelines and restrictions around alcohol consumption at these events. Organisers should also be aware of the impact that alcohol consumption can have on individuals who are also using other illicit substances.

Alcohol is a depressant, and when combined with stimulant drugs such as ecstasy, MDMA and amphetamines it often results in the effects of either or both substances being masked, leading to increased consumption and higher risks of overdose.<sup>14</sup> Alcohol can also increase the dehydration risk associated with ecstasy use.<sup>15</sup>

Ensuring that staff are aware of these risks and are monitoring patrons' alcohol consumption is important. Appropriate communication between staff members is also essential to ensure that all are informed and aware of any high-risk individuals.

### **Substance identity and purity**

The other stand-out issue at music festivals is that the potency and purity of substances can be questionable. While this is always a risk when taking substances,

it tends to be more common in environments where demand is high. Substances such as LSD, MDMA and ecstasy can be substituted with a range of different chemicals and can contain synthetic versions of the intended substance, which have much more serious risk profiles than more traditional illicit substances. This type of substitution has been demonstrated in international trials, and in a recent pill testing trial at a music event in Australia.<sup>16</sup> Consumption of these chemicals has correlated with overdose in some cases.<sup>17,18</sup>

### **Drug use and event environments**

Research has demonstrated that the environment in which drugs are consumed can often dictate the impact that consumption will have on the individual, and their behaviour toward others. Studies have demonstrated that no matter the type of substance taken (including alcohol) violent, aggressive or anti-social behaviour is more common in environments that do not promote cohesion. Physical characteristics of environments that have been demonstrated to be linked to aggressive or anti-social behaviour with substance use are poor ventilation, unclean conditions, negative attitudes of staff, management and security, and a lack of 'chill out spaces' or areas that provide a comfort and respite.<sup>19,22</sup>

### **Benefits of harm reduction at music events**

There are many benefits to engaging in harm red-

Strategies that promote zero tolerance on drug use at music events, such as significant police presence, sniffer dogs, and random drug searches are not necessarily stopping festival goers from consuming drugs.



uction strategies at music events.

Harm reduction strategies in these environments have significant reach. They target a broad sub-set of the population that is often immune to general health warnings about drug use, and as a result tend to be at higher risk of harm.<sup>20,21</sup>

This is important as many people, especially young people, experiment with recreational drugs for the first time at these events. Harm reduction interventions at music events also provide an important opportunity for education and awareness around the risks associated with recreational drug use. This may potentially disrupt drug use paths, as education and awareness has been demonstrated as an important factor in moderating risky behaviour. These interventions present an opportunity to potentially influence the frequency, intensity and risks associated with future drug use in individuals.<sup>22</sup>

Engaging in suitable and evidence-based harm reduction strategies should be a priority for venue and event owners, managers and organisers, as the negative reputational consequences of adverse events such as overdose can cause substantial financial, legal and regulatory burden.<sup>23</sup>

## HARM REDUCTION STRATEGIES

Harm reduction strategies at music events are numerous and diverse. They range from the provision of water stations and free water bottles at events, to providing 'pass outs' or chill out and sanctuary spaces. They can also include engaging with expert organisations, who provide harm reduction information services and pill testing. The more that is done to address harm reduction at events, the more successful the outcomes are.<sup>24</sup>



## Chill out and sanctuary spaces

Environmental approaches to harm reduction focus on changing the social and physical environment and offer management and organisers an approach to harm reduction that is built in to the design of events.

They focus on creating spaces (often called chill out or sanctuary spaces) offer respite from the event, providing a quiet, calm, comfortable and shady space for patrons to relax. These might also be areas that provide hydration and food and can also be a good opportunity to provide health promotion information to patrons that address key issues specific to the event environment, such as information on common substances taken at these events and information on how to care for friends who might be using substances.

Chill out spaces are also key areas in which to engage in peer education interventions. Peer education about substance use and harm at music events is an effective way of reducing immediate harm, and potentially reducing future substance use.<sup>25</sup> Peer-to-peer education teams are often the first point of call for patrons experiencing distress and are of critical importance to ensure that individuals seek and obtain the treatment needed.<sup>26</sup>

Chill out spaces should be clearly signposted and marked on festival and event maps and information about them should be shared in programs and promotional material.<sup>27</sup>

## Peer education programs

DanceWize is a peer education program run by Harm Reduction Victoria and NSW Users and AIDS Association (NUAA). It is volunteer-led and operates at dance parties, festivals, nightclubs and events.<sup>28</sup> DanceWize provide judgement-free chill out spaces where patrons can access accurate and credible information about drug and alcohol related harm, through both face-to-face discussion and resources, and support services. Volunteers are first aid-trained, though patrons that need medical attention are referred to onsite health providers, such as St John Ambulance. Event organisers can contact Harm Reduction Victoria to request the presence of DanceWize at their events.

save-a-mate is a health program run by Australian Red Cross, that provides peer-to-peer information services in urban, rural and remote areas. Trained volunteers utilise chill out spaces to identify and support people who are experiencing adverse reactions to substances.<sup>29</sup> Event organisers can contact save-a-mate via Australian Red Cross.

## Healthcare and first aid providers

St John Ambulance provide onsite healthcare and first aid services at events around Australia. St John team members are specifically trained to address issues that may arise from substance use at these events and can provide advice as well as medical treatment or assistance if needed.<sup>30</sup> Event organisers can contact St John Ambulance to request a service quote.

## Staff and security training

Ensuring that festival staff and security are trained appropriately to deal with people who might be taking substance is important, as the attitudes of staff and security at events has been shown to be key in reducing the potential for anti-social or aggressive behaviour as a result of substance use.<sup>31</sup> Staff should also be trained to recognise the signs and symptoms of overdose, and how to appropriately address these situations.

The Penington Institute runs overdose awareness and first aid courses around Australia, more information is available on their website.

## POTENTIAL STRATEGIES

### Pill testing

Pill testing is becoming increasingly common at music festivals and events around the world, and pill testing organisations and not-for-profits currently provide services throughout Europe, the US and Canada.

A recent trial in Australia demonstrated positive results, showing that only 43% of the substances tested contained significant amounts of the substance that the patron expected, the other 57% containing significant levels of other chemical agents.<sup>32</sup> Around 40% of patrons who engaged in the pill testing trial chose to moderate their behaviour as a result of these findings, either stating that they would take less of the substance or would not take the substance at all.<sup>33</sup>

Pill testing stations also provide another outlet for the dissemination and reiteration of harm reduction messaging. While this trial has shown positive impacts on substance use within the event environment, there is still significant legislative and political debate about the use of pill testing on a broader scale in Australia.

History has demonstrated that no matter the level of deterrence-based policy that is implemented around substance use at events, there will still be a proportion of people who consume substances. This results in an increased risk of harm, including potential overdose, at these events.

Harm reduction strategies play a key role in reducing the adverse impacts of substance use at these events. Evidence-based methods should be a focus of event organising and planning to reduce harm associated with substance use.

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# Toxic cocktail of booze, drugs key cause for medical care at festivals

Four in five Australian music festival attendees that seek medical help are consuming an average of 15 standard drinks when using drugs, finds a new report. By Chanel Bearder for RMIT News

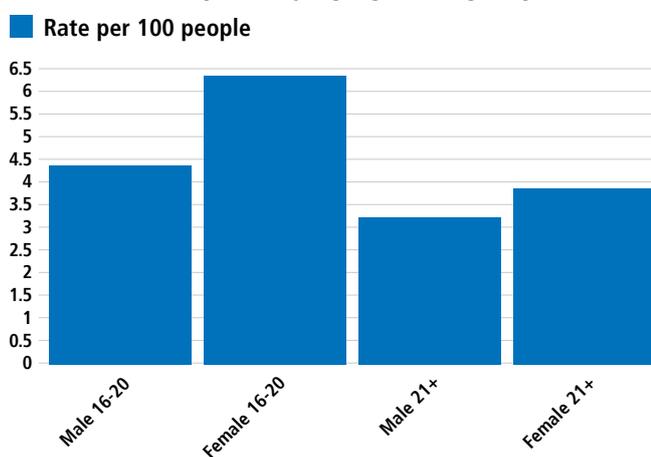
Between December 2018 and March 2019, there have been a series of drug-related deaths at Australian music festivals. These deaths have highlighted a gap in community knowledge about how people use drugs like MDMA or LSD and whether they actively seek out emergency medical treatment in time.

Using data from the *Global Drug Survey*, RMIT Vice-Chancellor Research Fellow Dr Monica Barratt assessed the responses from over 4,000 Australian festival goers to better understand the circumstances surrounding emergency medical care following drug use.

*“Four in five people who sought medical help said they had been drinking alcohol, with most reporting they were ‘already drunk’ before taking MDMA.”*

While it was not surprising that people were consuming alcohol when taking drugs, Barratt said the

## Rates of emergency medical treatment following alcohol consumption by age/gender group



average amount of alcohol consumed exceeded what people may expect.

“Festival goers who reported seeking medical help most often did after heavy drinking,” she said.

“Four in five people who sought medical help said they had been drinking alcohol, with most reporting they were ‘already drunk’ before taking MDMA.

“What’s surprising is the median number of standard drinks consumed was 15 over a five-hour drinking session when medical help was sought.

“That amount is three times over the limit recommended by the National Health and Medical Research Council guidelines to reduce the risk of alcohol-related injury.”

The report also found young women between the ages of 16 to 20 were particularly vulnerable to experiencing acute harm from drinking alcohol and other drugs and were most likely to seek medical help.

## Top five drug types that cause Australian festival goers to seek emergency medical treatment

Drug type	Any EMT	Any use	Rate per 100 people	Number of EMT episodes	Number of use episodes	Rate per 1,000 episodes
Alcohol	186	4,326	4.30	259	n/a	n/a
Cannabis	23	2,392	0.96	33	226,977	0.15
MDMA	51	2,044	2.50	61	32,706	1.87
Cocaine	11	1,639	0.67	14	19,346	0.72
LSD	17	1,146	1.48	18	7,541	2.39

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Barratt said this vulnerability may reflect lower body weight, differences in how they take the drug and how much of it, or physiological and hormonal variations in susceptibility to drug-related harm.

While most participants used alcohol and other drugs without incurring serious risks of harm, 6% of festival goers (280 people) reported seeking emergency help.

*“The median number of standard drinks consumed was 15 over a five-hour drinking session when medical help was sought.”*

Although 6% may not seem like much, what is concerning about this minority says Barratt, is majority of that 6% ended up in hospital.

“Of them, two thirds – or almost 190 people – reported seeking emergency medical treatment following the consumption of alcohol,” she said.

MDMA and LSD were the illegal drug types most likely to result in medical assistance.

Barratt said the report found mixing or taking large amounts of drugs, and not knowing the content or strength of illegal drugs were common reasons festival goers reported seeking help.

“Respondents who took MDMA were further asked whether they had tried to find out about the content and purity of their MDMA before consumption at the last emergency treatment event,” she said.

“Over half of people surveyed had not tried to understand the make-up of the drug.

“Those who did try to find out content and purity information did so by talking to friends who had already taken it, checking websites and online forums.”

Barratt said drug and alcohol use at festivals was a complex issue and the risk from taking any substance cannot be reduced to zero.

“To reduce risks, we should increase access to safe spaces and education such as DanceWize that provide non-judgmental support and education,” she said.

“On-site forensic drug testing services and brief interventions that engage festival goers to reconsider their drinking practices are also warranted.

“In a society where drug-taking will occur, regardless of what policy or policing measures are in place, aspiring to zero harm for those who use drugs as opposed to zero tolerance to using drugs is a far better solution.”

The *Australian music festival attendees who seek emergency medical treatment following alcohol and other drug use: A Global Drug Survey data report* was prepared for the New South Wales coronial inquest into drug-related deaths at music festivals.

Reproduced courtesy of RMIT University.

Bearder, C, RMIT News (17 July 2019). *Toxic cocktail of booze, drugs key cause for medical care at festivals*. Retrieved from [www.rmit.edu.au](http://www.rmit.edu.au) on 8 August 2019.



# STAY OK AT MUSIC FESTIVALS

Safety tips courtesy of [Your Room](#), a joint website initiative by NSW Health and St Vincent's Alcohol and Drug Information Service

Music festivals are the highlight of the calendar. You're psyched to be seeing your favourite artists, hanging out with mates, meeting new people and having an awesome experience. To make sure the fun doesn't stop for you and your mates, it's important to know how to party safe and stay OK.

## ULTIMATE FESTIVAL EXPERIENCE = PREPARATION

**P**reparation is paramount to the ultimate festival experience. Planning for what could happen in the event you or someone else needs help because of alcohol or drug use is just as key as your wardrobe, bum-bag game, road trip playlist, phone and other essentials.

## PRE-FESTIVAL SAFETY CHECKLIST

### Make a plan with your mates

Make a plan with friends about what you'll do in an emergency. Here are some tips for what to discuss:

- Before the event talk about when you want their help, like if you start to feel:
  - Hot and can't cool down
  - Rigid muscles, tremors or spasms
  - Clenched jaw or gurning
  - Confusion, disorientation or frightened
  - Difficulty walking
  - Severe agitation, panicky, paranoid or anxious
  - Lightheaded/dizzy or have a bad headache
  - Vomiting repeatedly
  - Breathing fast or having trouble breathing
- If you've had a bad experience (or they have) in the

past, share what happened including the feelings and symptoms, so you both know the signs to look out for

- You won't get into trouble for getting help. Make sure you all understand that getting help is really important and you won't get into trouble with the police or be judged for seeking medical help
- Even if you think it's not serious, if you feel unwell get checked out, or if someone tells you they're feeling unwell – believe them and get help fast.

### Have a contact strategy

Charge your phone fully before you leave and remember to check your phone regularly during the event. Stay with your mates wherever possible, and agree on a physical meeting point if you get lost. Some people use live GPS location-tracking apps, coordinate outfits or use big brightly coloured props so they're easier to find.

### Plan to stay cool

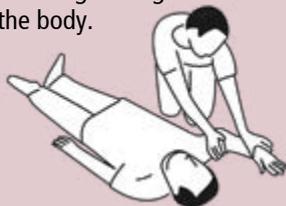
If you're dancing outdoors and/or taking MDMA it can be very easy to overheat as the drug interrupts your body's cooling down mechanism, meaning your body will create more heat than it can get rid of. Here are some tips for keeping cool:

- If you're dancing, cool down every so often – chill out tents and zones are perfect for this and are usually not far from the action
- If the sun's out or the temperature's high, find some shade and cool off as much as possible. Wearing a hat, sunglasses and sunscreen when the sun's out is obviously a must.



## RECOVERY POSITION

**Figure 1:** Kneel by the person. Raise the arm closest to you and place the arm out at a 90-degree angle to the body.



**Figure 2:** Place the other hand under their cheek, to support their head.



**Figure 3:** Lift the leg furthest away from you and place their foot on the floor.

**Figure 4:** Using their knee as a lever gently pull the person onto their side, towards you.

Tilt the head back and ensure airway is open and clear.



### Track your water intake

It's important to have access to drinking water and drink regularly, but not too much. Taking MDMA, alcohol and other drugs increases your risk of heat-stroke, especially at outdoor events. Remember these water safety tips:

- Too little water can be dangerous because dancing, walking, and being in the sun causes you to lose water through sweating. If you're drinking alcohol, that'll make you need to pee (urinate) more than usual, which leads to even more dehydration
- Be careful not to drink too much water, this is especially the case for people who've taken MDMA. Drinking too much water can disrupt your electrolyte balance. If your blood becomes too low in important salts it's a life-threatening situation
- Sip, don't gulp to avoid disrupting your balance of electrolytes. Slowly drink (sip) 500ml over an hour if you're dancing and 250ml per hour if you're not moving around, even if you're not thirsty (A regular water bottle is around 600ml and a large plastic cup at a festival is around 375ml).

### Food matters

Fill your body with healthy food before any event where you'll be outdoors, on your feet for long hours or drinking alcohol or taking drugs. It's smart to eat well and hydrate before taking any kind of drug or drinking alcohol.

### Mind your mood

Alcohol and other drugs like MDMA affect serotonin levels in your brain, a chemical responsible for regulating social behaviour like empathy and optimism. Using MDMA causes the release of large amounts of serotonin which depletes your reserves, making you feel bummed out (depressed, confused or low) after the high. Be aware that it can take anywhere from a few days to a week or two for your serotonin levels to return to normal.

### Learn the recovery position

Make sure you know how to put someone in the recovery position if they become unconscious, this prevents them from choking on vomit or fluid and helps to keep their airway clear.

If someone falls unconscious ask someone else to get help fast and put them in the recovery position. Stay with them and make sure they are breathing and have a pulse, if you know how to check. View the recovery position diagram above.

Watch this save-a-mate recovery position video demonstration for further instructions: [www.facebook.com/redcrosssaveamate/videos/10160741221015654/](http://www.facebook.com/redcrosssaveamate/videos/10160741221015654/)

### Check the festival map

Check the map before and at the event so you know where the medical tent and peer support/chill out tents are. Look out for the peer support volunteers (crowd carer/crew) – they can help if you're feeling unwell, need to chill or want some advice on how to stay safe.

Whichever festival you're heading to, peer support organisations are there for you! Look out for the following groups:

- DanceWize NSW  
[www.dancewizensw.org.au/patron](http://www.dancewizensw.org.au/patron)
- save-a-mate | Australian Red Cross  
[www.facebook.com/redcrosssaveamate](http://www.facebook.com/redcrosssaveamate)
- Red Frogs  
<https://redfrogs.com.au/programs/music>
- ACON Rovers  
[www.acon.org.au/what-we-are-here-for/alcohol-drugs/#acon-rovers](http://www.acon.org.au/what-we-are-here-for/alcohol-drugs/#acon-rovers)

### Know the risks

Check out the risks of all sorts of drugs and alcohol by browsing the A-Z of Drugs for in-depth detail: <https://yourroom.health.nsw.gov.au/a-z-of-drugs/Pages/a-z-of-drugs.aspx>

### Further reading

- Drug safety and overdose  
<https://yourroom.health.nsw.gov.au/getting-help/Pages/Drug-safety-and-overdose.aspx>
- The law and long-term drug problems  
<https://yourroom.health.nsw.gov.au/getting-help/Pages/Law-and-problems.aspx>

ADIS and NSW Health (October 2019). *Stay OK at music festivals*. Retrieved from <http://yourroom.health.nsw.gov.au> on 25 October 2019.

# Pill testing as a harm reduction strategy

In this Ted Noffs Foundation blog post, [Matt Noffs](#) explains how testing can help counter some of the risks associated with consumption of illicit drugs

Harm reduction measures aim to reduce the risks associated with illicit drugs and create a more informed environment surrounding drug consumption, ultimately improving the welfare of the community. Whilst we do not see any one, single, harm reduction measure as the holy grail, regulating certain measures such as pill testing programs would give users more information, and may lead to them deciding not to consume a potentially dangerous substance.

## THE SCIENTIFIC APPROACH

There is no way of knowing the contents of a pill or capsule simply by looking at it<sup>1</sup>. While various online drug forums such as *Pill Report* have compiled a database of pills and their contents based on anecdotal evidence, this is far from a fool-proof strategy. A pill testing program can benefit recreational drug users by scientifically testing and revealing the contents of the substance they are intending to consume<sup>2</sup>. An individual can then make an informed decision as to whether or not they will use the drug.

Pill testing programs have added benefit to societies and governments by obtaining precise information about the composition of the black market, monitoring trends and patterns in drug use, and identifying which demographics use these substances and who is at risk<sup>3</sup>.

## WHAT PILL TESTING CAN SOLVE

Pill testing is a step towards regulation as it can actually have an effect on the black market. Products found

to contain dangerous substances via pill testing can become the subject of warning campaigns, leading to their removal from the market<sup>4</sup>. If governments endorse a pill testing program in their jurisdiction, that would allow them to have a measure of control and regulation over the illicit drug market, which is extremely difficult under prohibition<sup>5</sup>.

Policies of prohibition have proven to be ineffective in reducing drug-related harms, and are causing negative interactions between young people and the police<sup>6</sup>. Meanwhile, international evidence suggests pill testing services are having a positive effect in educating young people about harm reduction<sup>7</sup>.

Considering Australia ranked highest for adulterated, and more 'dangerous' ecstasy pills<sup>8</sup>, it must follow that Australian recreational drug users would have an increased risk of experiencing adverse reactions, including effects of drug toxicity, hospitalisation and death. A string of deaths at Australian music festivals over the past few years emphasises this<sup>9</sup>, and highlights that extant policies of prohibition within Australian jurisdictions are not preventing these deaths. The increased presence of emerging psychoactive substances (EPS) is of great concern, as they often mimic the effects of drugs such as ecstasy and LSD yet do not contain chemicals associated with either drug<sup>10</sup>. The risks to public health presented by these drugs could be mitigated if they were able to be tested on the spot.

Traditional methods of controlling drug use come at a large cost to governments and the taxpayer. Amongst people aged 16-24, hospitalisations from ecstasy use have almost doubled in the period between 2010 and 2015, from 413 to 814<sup>11</sup>. If pills are tested and discarded if found to be adulterated, drug-related hospitalisations would reduce, lives would be saved, and young people can be educated about safer drug use.

Another comparison point is that of police drug dogs. Currently, Australians spend \$1 million per jurisdiction to maintain drug dog programs<sup>12</sup>, yet these programs have been found wanting. In 2014, there were 14,869 searches across NSW as a result of a drug dog indicating the presence of illicit substances on a person. Three quarters of those searches, or 11,043, turned up no drugs<sup>13</sup>. This is a waste of time and resources. A pill testing program is less than one tenth of this cost<sup>14</sup> and, as this article outlines, has had a positive impact where it has been introduced.

From a research perspective, pill testing can provide invaluable information about the emergence and decline of certain substances present on the drug scene<sup>15</sup>. This is important, particularly given the increase in new, untested psychoactive substances such as synthetic forms of MDMA, cannabis and LSD, which are marketed to mimic the effects of mainstream drugs but whose



effects are unknown and could be far more dangerous, as they are packaged and sold with no indication of their contents<sup>16</sup>.

Data from pill testing can contribute to an enhanced monitoring of these substances, and increase the effectiveness of governments' response by providing them with accurate knowledge from which to create warning campaigns around new, potentially lethal substances<sup>17</sup>.

## PILL TESTING DOES NOT CONDONE DRUG USE

Critics will say that pill testing sends the wrong message by deeming some illicit substances "safer" than others, and that harm reduction advocates should be focusing on prevention in the form of providing resources about the health risks associated with recreational drug use.

However, advocates have repeatedly stressed that pill testing does not condone drug use, that the overarching aim is to reduce the negative impacts associated with drug use by creating awareness about drug effects and side effects, whilst recognising that people will take drugs regardless of the laws in place to criminalise them.

Moreover, many young recreational drug users do not access traditional drug care services<sup>18</sup> making it hard to directly convey health risks to them. Pill testing programs tap into this demographic by establishing a direct presence within the context of drug use – festivals and clubs. Crucially, there is evidence to suggest that pill testing does not increase incidents of drug use, and may actually reduce it<sup>19</sup>.

## TOWARDS A FUTURE OF HARM REDUCTION

Harm reduction services such as drug checking do not inevitably lead to legalisation<sup>20</sup> and can exist alongside both the current prohibitive drug policies in Australia and any future amendments towards regulation. Pill testing is not the ultimate solution, rather one part of a harm reduction strategy. And it has shown to be effective. In Austria, one study showed 50% of those who had their drugs tested changed their consumption choices based on the results<sup>21</sup>. The ideal would be to have a number of harm reduction measures in place at a festival, including pill testing.

Advocates would like to see pill testing as part of a routine approach to safety at festivals<sup>22</sup>, and hope to achieve it as soon as possible. Another important aim of a legitimate pill testing service is having it work in collaboration with a multitude of other organisations, such as research institutes, hospitals and policymakers<sup>23</sup>, to create stronger drug policies and safety strategies.

Given the inevitability that people will use drugs, regardless of their legal status, and that the responsibility of governments and police is to ensure the safety of the community, regulating drug use must go hand-in-hand with harm reduction. If Australian governments are serious about reducing the amount of drug-related deaths at festivals, they must support a proper exploration of harm reduction strategies. In the case of pill testing, a comprehensive trial to assess its benefits would allow society to make a fully informed decision about its merit.

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# Drug experts say yes. Many politicians say no. What's the evidence for pill testing?

*The aim of pill testing is to warn against harmful or unexpected ingredients, and to arm people with more knowledge, according to this [ABC Health & Wellbeing](#) report by Olivia Willis*

It's becoming something of a sombre routine: a young person dies from a drug overdose at a music festival, calls for pill testing are ignited, calls are summarily rejected, and we wait until another young person takes a gamble with their life – and the gamble doesn't pay off.

Earlier this month, 19-year-old Callum Brosnan died of a suspected overdose after attending the Knockout Games of Destiny dance event in Sydney.

It's the third death brought on by a suspected drug overdose at a music festival since September, and according to media reports, the tenth in the last five years.

Following the teenager's death, New South Wales Premier Gladys Berejiklian extended her condolences to the young man's family but said her government would not change its stance on pill testing.

One of the main concerns about pill testing is that it may provide people with a "false sense of security", and therefore lead to an increase in drug-related harm.



"Unfortunately, we know that pill testing won't work because it will give people the green light to take substances which in the end could still kill them," she said.

But drug and medical experts reject this claim – and say pill testing leads to a reduction in the harms associated with drug use.

A new study published today backs this idea, too (more about that later). So how strong is the case for introducing pill testing in Australia?

## Firstly, what's the point of pill testing?

Pill testing, also known as drug checking, is a service that provides people with information about the content of illicit substances.

The idea is that individuals armed with more knowledge about drug composition and purity are able to make more informed decisions when it comes to drug taking.

Unlike pharmaceutical drugs, recreational drugs are unregulated, meaning the quality and strength of substances vary widely. This can sometimes lead to drug contamination, which can cause poisoning, or unintentional overdose, when people are unaware of the strength of the drug they are consuming.

According to the Alcohol and Drug Foundation:

*"Drug checking services tend to have three main goals: to prevent people from using especially dangerous or contaminated substances, to communicate safer-use messages, and to improve the users' factual knowledge about substances and risks".*

Despite controversy in Australia, pill testing is not a new idea. It first emerged in the early 1990s in the Netherlands (where it is now part of national drug policy), and services are routinely available in several European countries, including Switzerland, Austria, Germany, Spain and France.

Pill testing is an approach to harm reduction (one of the three pillars of Australia's National Drug Strategy), and research shows young people are largely in favour of it.

## How does pill testing actually work?

Drug testing encompasses a range of testing facilities and capabilities – from informal DIY testing kits to advanced pharmacological analysis.

To understand how it might work in an Australian setting, let's focus on Australia's first and only trial of pill testing, which happened at the Canberra Groovin' the Moo festival in April.

1. When a person first enters the pill testing area (set up in the festival's health tent), they are met by a "harm reduction worker". This person explains the pill testing process and advises the patron that there is no safe level of drug consumption, said David Caldicott, an emergency doctor and senior lecturer at the Australian National University. "You are advised even before anything starts that if you want to be 100 per cent certain about not being hurt by drugs, you should not use any drugs," said Dr Caldicott, who led the trial.
2. Next, the patron hands over a pill (or capsule or powder) to a chemist who photographs and weighs the substance, and explains that the test results apply only to the test sample (which will be destroyed in the testing process).
3. The sample – which may range from a thin scraping to an entire pill – is analysed using an FTIR spectrophotometer. This detects substances by passing an infrared beam through the sample and checking the result against a library of 30,000 substances.
4. The chemist labels the sample with one of three classifications: *white* – the substance is what the person anticipated; *yellow* – the substance is different to what the person anticipated; or *red* – the substance is known to be associated with increased harm/multiple overdoses/death (or the machine is unable to identify it, suggesting the drug is new).
5. This information is relayed to the person by a medical practitioner who outlines the potential dangers of each substance (that includes those identified a 'white' result).
6. The person is directed to a drug and alcohol counsellor who provides information about the risks of consuming the substance identified, and ways they can reduce their risk (e.g. not taking the substance, or taking a smaller dose).
7. Before leaving the tent, the person is advised of an "amnesty bin" in which they are able dispose of any drugs they have on them.

### Won't this kind of testing encourage drug use?

One of the main concerns about pill testing is that it may provide people with a "false sense of security", and therefore lead to an increase in drug-related harm.

"What would be horrific would be if you had such a regime, something was deemed safe, and you have multiple deaths as a result," Ms Berejiklian said in September.

But Dr Caldicott said this is a fundamental misunderstanding of how pill testing works.

"You will not be told at any stage that your drug is safe," he said.

Prior to the testing process, each person is advised (and required to sign a legal waiver confirming they understand) the test does not provide evidence of drug purity, safety, dosage, or information about how they



will individually respond to the substance being tested.

"We advise people that it's not a medical consult ... we don't know enough about them to tell them whether it is safe for them or not," Dr Caldicott said.

It has also been suggested that introducing pill testing at music festivals would lead to "an increase in drugs and a greater rates of death and greater harm to our society".

But Alison Ritter, a drug policy expert from the University of New South Wales who co-authored a global review of drug checking services in 2017, said there is no evidence to support this claim.

"We know that it doesn't produce an increase in drug use ... and there's no evidence of harm associated with pill testing," said Professor Ritter.

Both Professor Ritter, director of the Drug Policy Modelling Program at UNSW, and Dr Caldicott said pill testing was about targeting people who already have the intention of consuming illicit substances – and helping to mitigate their risks.

It's a view backed by the Alcohol and Drug Foundation: "Drug checking does not promote illicit drug taking, and people who choose to get their substances tested have already purchased their drug with the intention to use them."

### Research shows pill testing can reduce harm

Despite concern about pill testing increasing the appeal of illicit substances, research shows it can lead to less drug taking, and help people consume drugs in a safer way.

"What's clear from the results of the services operating [in Europe] is that people make different choices based on the results of the testing – some choose to put their drugs into an amnesty bin, others choose to take half as much as perhaps they thought they would," Professor Ritter said.

In the US-Australian study published today in the *Drug and Alcohol Review* journal, 54 per cent of ecstasy users surveyed said they were less likely to use ecstasy again if they learned their ecstasy contained ‘bath salts’ (synthetic cathinones) or methamphetamine.

Similarly, an evaluation of the UK’s first pill testing trial found one in five substances tested at the festival was not what people expected, and among people mis-sold substances, two thirds chose to hand over further substances to be destroyed.

Lead researcher Fiona Measham, a professor of criminology at Durham University, said by identifying toxic and potentially lethal contaminants, the pill testing service was able to reduce drug use and “therefore reduce drug-related harm”.

“There was a 95 per cent reduction in hospital admissions that year when we were testing on site,” Professor Measham told ABC Radio Sydney.

She added that pill testing provided an opportunity for healthcare workers to engage in a dialogue about health and harm with a group of young people who don’t usually access drug and alcohol services.

In April, at Australia’s first pill testing trial, 42 per cent of people who brought drugs for testing reported that their drug consumption behaviour would change as a result of the testing.

Dr Caldicott said in addition to reducing harm at an individual level, pill testing services are able to obtain valuable information about what drugs are circulating on the black market, which can be used to tailor public health alerts and assist law enforcement.

“One of the biggest problems in Australia right now is the diversity of the drug market,” he said.

He said new drugs were emerging at such a rate that it was possible the test would not recognise some substances, in which case, they would be given a ‘red’ classification.

## Pill testing a ‘pragmatic response’ to drug use, experts say

Australians are among the leading consumers of ecstasy in the world – 2.1 million of us report having used the drug at least once. Research shows that in NSW between 2010 to 2015, hospitalisations from ecstasy use nearly doubled among people aged 16-24.

“We’ve got 20 years of attempts at prohibition, and now a demographic which is largely immune to this approach,” Dr Caldicott said.

He said in order to reduce harm, we needed to treat drug use as a health issue – not an “ideological” one.

“Pill testing moves the debate from being ‘just say no’ to ‘let’s talk about this’ ... to a non-judgemental, health-based discussion about drug use.”

Professor Ritter said although pill testing wouldn’t be a panacea to illicit drug use, it would offer a “pragmatic response” to “the reality that young people use drugs, and will continue to use drugs”.

“It’s not going to prevent all harms – not taking drugs is the safest option, clearly,” she said.

“But I don’t think encouraging young people not to do drugs is mutually exclusive from offering pill testing ... you can do both things at once,” she said.

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Willis, O (21 December 2018). ‘Drug experts say yes. Many politicians say no. What’s the evidence for pill testing?’, *ABC News*. Retrieved from [www.abc.net.au/news](http://www.abc.net.au/news) on 8 August 2019.

## DIY PILL TESTING

- DIY drug testing kits are sold legally in Australia from around \$8 for a single test, and are increasing in demand, even though the drugs consumers would be testing remain illegal.
- These DIY tests are known as reagent chemical tests. Reagents are chemicals that react with a small sample of the drug being tested by changing colour. The best known reagents are marquis, mandelin and mecke. The colour change on a chart that comes with the kit indicates what might be in the drug.
- Reagent testing is rudimentary and unsophisticated; it can identify potential fatal adulterants in ecstasy such as PMA and Nbome. However, although a test might show that a sample contains MDMA (ecstasy), the sample could also contain other dangerous chemicals. This is greatly complicated by the hundreds of new drugs which have come onto the market in recent years.
- Reagent testing would also struggle to identify very high purity MDMA, as well as novel psychoactive substances.
- Pill safety advocates claim that when reagent testing is accompanied by quality harm reduction literature, some of the risks associated with the tests could be mitigated. And if consumers understand the test’s limitations, it may still be of some use.
- But while reagent testing might give some users pause for thought, it does not provide healthcare experts with any of the granular data about the Australian market which is being obtained in other countries.
- Given the clear limitations of DIY reagent testing, many are advocating for more sophisticated lab-based technologies, such as infrared spectroscopy (used in the trial at Canberra’s Groovin’ the Moo Festival in 2018), which can quickly identify all known chemicals and indicate their purity.

Compiled by The Spinney Press

# PILL TESTING AND NATIONAL DRUG STRATEGY – REDUCING HARM OR NORMALISING HARMFUL PRACTICES?

The call for pill testing, sadly, has very little to do with 'saving lives' and much more to do with the 'drug use normalisation' enterprises of the pro-drug lobby! [Drug Free Australia](#) explains its opposition to harm reduction approaches like pill testing.

The National Drug Strategy, not only scrutinised and lobbied for, but signed off by all parties, continues to follow UNODC prescriptions and proscriptions of best practice for drug policy with its three-pillar platform.

Demand reduction is now the first and foremost pillar, followed by supply reduction, then finally, for those caught (not seeking to join the) tyranny of addiction, there is harm reduction – the primary purpose is not to keep users using, but reduce and help them exit drug use!

The latest National Drug Strategy (NDS) 2017-26, now puts demand reduction as the priority!

*The strategy states that: "Harm minimisation includes a range of approaches to help prevent and reduce drug related problems ... including a focus on abstinence-oriented strategies ... [harm minimisation] policy approach does not condone drug use." (page 6)*

*"Prevention of uptake reduces personal, family and community harms, allows better use of health and law enforcement resources, generates substantial social and economic benefits and produces a healthier workforce.*

*Demand reduction strategies that prevent drug use are more cost-effective than treating established drug-related problems ... Strategies that delay the onset of use prevent longer term harms and costs to the community." (page 8)*

So, how does the process of pill testing contribute to these three pillars, and where does it legitimately fit under this protective legislative framework, and mandate?

## CERTAINLY NOT UNDER DEMAND REDUCTION!

Pill testing actually utterly undermines, and is contrary to, demand reduction. Pill testing/checking actually validates the pursuit/seeking out of illicit psychotropic toxins, for one reason only, to 'enhance one's party experience' (not the tyranny of addiction). Bring your illegally obtained and very harmful substances to a public event. We, approved by government, will test your poison to see if it is the poison you ordered, and if the contents of the drug complies with your agreed illegal purchase, then permit you to use this drug!

## CERTAINLY NOT SUPPLY REDUCTION

The aforementioned applies here too. Pill testing actually endorses and encourages the supply chain,

and actively contributes to the drugs being not only 'acceptable', but further available and accessible!

Supply continues to exist when demand is increased/encouraged and the market/consumer is easier to access. Pill testing certainly 'lubricates' that market engagement.

## CERTAINLY NOT HARM REDUCTION

In its truest protective form, harm reduction can never be about endorsing, or more, enabling, equipping and empowering ongoing drug use. Every drug-taking episode is a health- and life-threatening/diminishing exercise, and any interpretation of a policy that actively empowers and equips easy use of drugs is not only bad practice, it's arguably culpable!

When we start implementing policy based, not with best practice of prevention and reduction in mind; but purely on the basis of conduct/behaviour, then we are in trouble. Understand this is conduct, not of addicts, rather it is deliberate and considered behaviour of informed, product-aware, self-aware and disposable income-equipped 'adults' with rebellious, careless or wantonly 'F-you', law breaking attitudes.

Again, when best protective practices are jettisoned at the whim of propaganda, emotive mantras, or even 'net community benefit' equations, then we end up 'educating' the community (particularly the careless voluptuaries or hedonists) that self- and community-harming conduct is 'inevitable' and therefore we need to support it!

Understand, with no other self- and community-harming behaviour are such concessions made, and we wonder why this tacit permission model isn't decreasing harms! The best way to decrease harms is to decrease drug use – that's what the National Drug Strategy is all about!

Delaying or denying uptake and seeking to facilitate the reduction of drug use is the NDS priority. It is not supposed to endorse, enable, equip or empower the increase of drug use! Permission models drive demand, and that's what pill testing is being hijacked for, by the pro-drug advocates to drive demand to drug use 'normalisation' ends.

The gatekeepers of health and wellbeing in our communities at a governance level are supposed to be politicians and policymakers, using the evidence-base and agreed-upon strategies (i.e. National Drug Strategy) and interpreting it for reduction of, not permission for, drug use. It would appear such poor interpretations of policy in the hands of people who are supposed to protect and provide best health and wellbeing options to the community are due primarily to ignorance of the platform, or the intimidation of pop-culture noise – nearly always driven by a bullying and noisy minority.

## SO, SIMPLE QUESTIONS FOLLOW

1. Do responsible governments and healthcare architects want to protect from harms (not just seek to hopefully minimise them). Will endorsing demand and supply of illicit drugs via pill testing add to another endorsed drug-taking episode?
2. Will pill testing/checking provide/encourage an environment that will enhance or diminish capacity, agency and productivity of the citizen?

If that's not enough, then policy around *disease management* is also vital in this arena. When it comes to the epidemiology of a disease, treating physicians look to a number of factors, including the agent of contagion. They look to manage, negate and prevent these agents from spreading. Illicit drug use dependency has now been widely touted as a 'non-communicable disease' (NCD). Therefore treatment principles remain the same – the containment, cessation and future prevention of this disease.

### **Two key factors must be addressed if any sort of positive health outcome is going to be achieved ...**

- Susceptibility factors of the patient
- Exposure factors to the patient.

## SO, MORE SIMPLE QUESTIONS FOLLOW

3. Do responsible governments and healthcare professionals want to increase or decrease susceptibility and exposure to the potential of drug addiction?
4. Will pill testing/checking increase or decrease exposure and susceptibility to the potential for drug addiction?

### **Governments should aim to ...**

- Protect their citizens from harm.
- Provide environments that enable its citizens to reach their full productive potential.

*Any legislation must be filtered through these two foundational principles and the tough questions asked of any proposed introductions or amendments that may breach these principles.*

Gus Jaspert the Deputy Director of UK Home Office speaking at the 3rd World Forum Against Drugs in Sweden, 2012

5. Will pill testing lead to a now publicly-endorsed 'altered state' that will enable/empower poor decision making on both safety and sexual practice that can lead to further burden of disease?

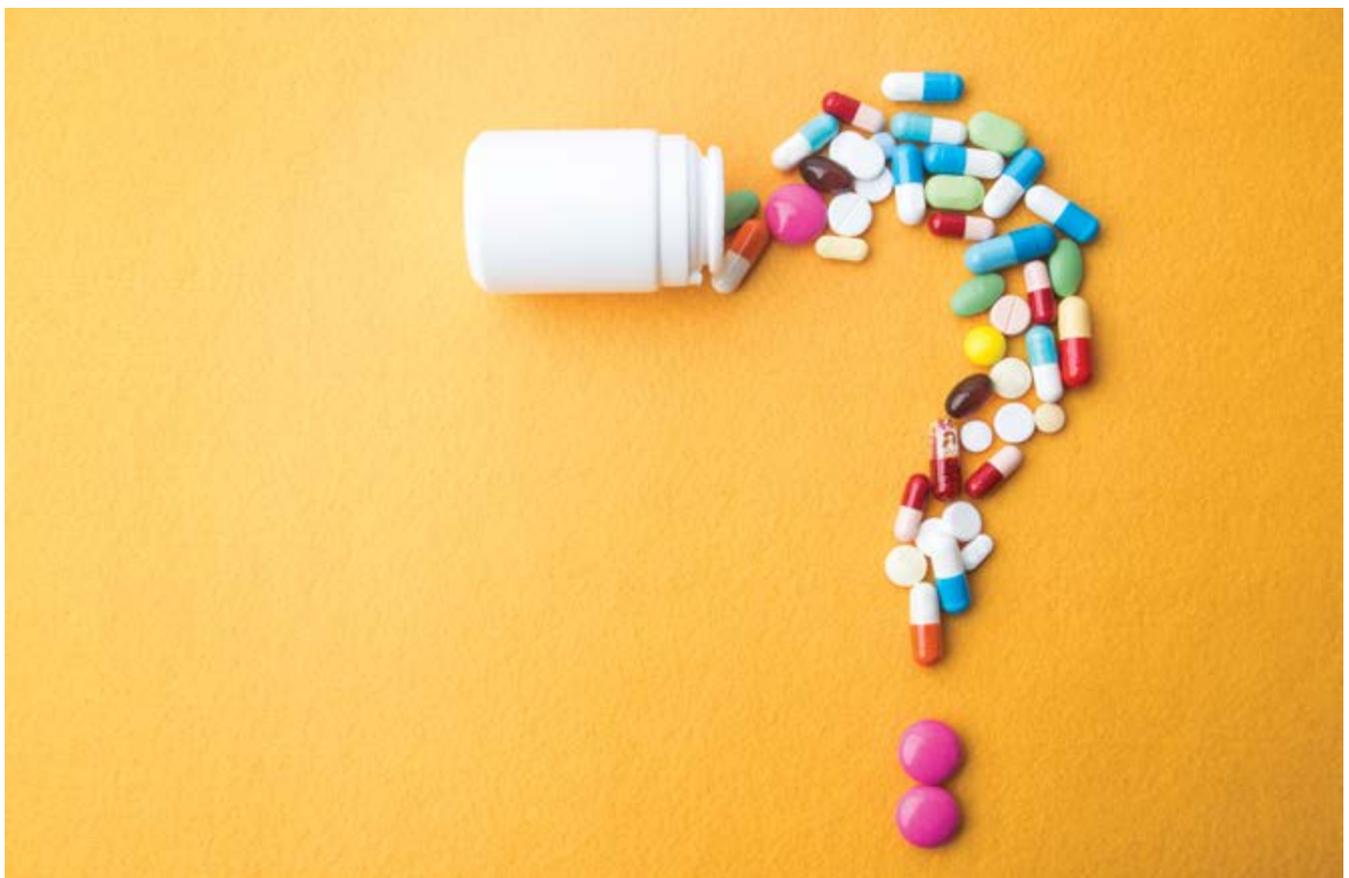
We will not even go into the impact/influence such permission measures will have on children, families and the wider community ... Again, every drug-taking episode, and every permission in play, *only adds* to the overall harms to family and community fabric.

### **IT IS TIME TO #PREVENT DON'T PROMOTE**

For more watch *Pill testing goes against national drug strategy: The Dalgarno Institute* – interview with Shane Varcoe: [www.skynews.com.au/details/\\_5836663610001](http://www.skynews.com.au/details/_5836663610001)

Written by Shane W. Varcoe, Executive Director, Dalgarno Institute (Coalition of Alcohol and Drug Educators).

Drug Free Australia/Dalgarno Institute. *Pill Testing and National Drug Strategy – Reducing Harm or Normalising Harmful Practices?* Retrieved from [www.drugfree.org.au](http://www.drugfree.org.au) on 8 August 2019.



# SIX CLAIMS ABOUT PILL TESTING – AND WHETHER OR NOT THEY’RE TRUE

As the debate about whether to introduce pill testing continues, Olivia Willis from [ABC Health & Wellbeing](#) takes a look at some of the biggest claims made by politicians, experts and commentators this year – and whether their claims check out.

The pill testing debate seems louder than ever, and with festival season in full swing, it’s unlikely to quieten down any time soon.

Yesterday, calls to introduce pill testing services at music festivals were renewed after a 19-year-old woman died from taking a unidentified substance at the FOMO music festival in Sydney at the weekend. The young woman’s death followed that of a 20-year-old Melbourne man who died of a suspected overdose at a music festival in Victoria, and a 22-year-old Brisbane man who died after taking an unknown substance at a music festival in New South Wales.

The festival goers are among six young people believed to have died from drug taking at Australian music festivals in the past five months.

As the debate about whether to introduce pill testing continues, let’s take a look at some of the biggest claims made by politicians, experts and commentators this year – and whether their claims check out.

## CLAIM 1: PILL TESTING LEADS TO MORE DRUG USE

In early January, Liberal MP and ACT shadow Attorney-General Jeremy Hanson told *RN Breakfast*: “What the evidence says to us is that pill testing will actually lead to increased [drug] use.”

Similar comments were made by Queensland Police Union president Ian Leavers in an interview on *Sky News*: “I believe the condoning of illegal drugs will lead to more deaths.”

But drug policy expert Alison Ritter, who co-authored a global review of drug checking services in 2017, told the ABC there was no evidence to support this claim.

“We know that it doesn’t produce an increase in drug use ... and there’s no evidence of harm associated with pill testing,” Professor Ritter said.

In fact, research shows pill testing can lead to less drug taking, and help people consume drugs in a safer way.

“What’s clear from the results of the services operating [in Europe] is that people make different choices based on the results of the testing – some choose to put their drugs into an amnesty bin, others choose to take half as much as perhaps they thought they would,” Professor Ritter said.

The results of the UK’s first pill testing trial published last month found one in five substances tested was not what people expected, and among people mis-sold substances, two thirds chose to hand over further

substances to be destroyed.

Researchers in the United States, Austria, Germany and Australia have made similar findings: people who use pill testing services are less likely to consume drugs if they are advised the drugs contain harmful substances.

## CLAIM 2: A QUARTER OF PEOPLE UNDER 30 ARE USING DRUGS

In a recent interview on 3AW, leader of the Reason Party and pill testing supporter Fiona Patten said the ‘just say no [to drugs]’ message was not being adhered to by young Australians.

“We know that probably a quarter of the population under 30 is experimenting with drugs at the moment,” Ms Patten said.

According to the Australian Institute of Health and Welfare, Ms Patten’s claim checks out. The 2016 National Drug Strategy Household Survey found 28 per cent of people aged 20-29 had used illicit drugs in the past year (compared to 16 per cent of the general population). Cannabis was the most commonly used drug, followed by ecstasy, cocaine and methamphetamines.

## CLAIM 3: PILL TESTING CREATES A FALSE SENSE OF SECURITY

NSW Deputy Premier John Barilaro recently wrote in *The Sydney Morning Herald* that pill testing was a “regime designed to give your loved ones and their friends the green light like to take an illicit substance at a music festival”.

It’s a concern shared by NSW Premier Gladys Berejiklian, and Victorian Health Minister Martin Foley, who recently said “advice from Victoria Police tells us it can give people a false, and potentially fatal, sense of security about illicit drugs”.

But David Caldicott, an emergency doctor and senior lecturer at the Australian National University, said concerns about pill testing providing “quality assurance” to drug users demonstrated a lack of understanding of how pill testing works.

“You are advised even before anything starts that if you want to be 100 per cent certain about not being hurt by drugs, you should not use any drugs,” said Dr Caldicott, who led Australia’s first pill testing trial in Canberra in 2018.

“You will not be told at any stage that your drug is safe,” he said.

In Australia, prior to the testing process, patrons are advised (and required to sign a legal waiver confirming they understand) the test does not provide evidence of drug purity, safety, dosage, or information about how they will individually respond to the substance being tested.



Once they are provided with the results of their drug test, patrons are directed to a drug and alcohol counsellor who provides information about the risks of consuming illicit drugs, and ways they can reduce their risk (such as not taking the substance, or taking a smaller dose).

#### **CLAIM 4: PILL TESTING CAN'T DETECT NEW SYNTHETIC DRUGS**

You might have heard that the type of pill testing being proposed at Australian music festivals is unable to detect the presence of dangerous new synthetic variants.

It's a claim that was recently made during a pill testing discussion on the ABC, and again by toxicologist Michelle Williams in *The Sydney Morning Herald*: "...the testing will not inform the person that their tablet may also contain novel psychoactive substances such as NBOMe – a deadly synthetic hallucinogen".

In Australia's first pill testing trial, a technology known as infrared spectroscopy was used to check drug samples against a library of 30,000 chemical compounds.

Dr Caldicott said although the machine is unable to identify the exact nature of every new drug, it is able to detect the presence of unknown substances – and immediately red-flag these samples.

At the Canberra trial, chemists detected the presence of two potentially lethal substances, one of which was believed to be NBOMe.

"We don't have to give it a name – we can say this is something new and dangerous," he said.

When I spoke to Dr Williams, she said although she wasn't opposed to pill testing, she still had some

concerns about the "detection limits" of the current technology.

"Given new and emerging drugs are typically far more potent, can the device detect them at the level that's going to have harmful effects?" she said.

According to Pill Testing Australia, infrared spectroscopy is a "highly discriminatory method".

Dr Caldicott said while it is technically possible the machine may not detect particular substances at very low levels, it was unlikely substances at such levels would be harmful to people.

"Our colleagues in analytical chemistry require perfection. We require technology that is safe and changes people's behaviour. That's our criteria," he said.

#### **CLAIM 5: PILL TESTING DOESN'T CONFIRM DRUG PURITY**

In early January, Queensland Liberal MP Andrew Laming tweeted his opposition to pill testing at music festivals, saying "only HPLChromatography in hospital labs tells you dose; and dose is what mostly kills users".

It's a concern shared by forensic toxicologist Andrew Leibie, who recently told *The Australian* that "on-site pill testing doesn't answer how much ecstasy is within the drug".

Dr Laming and Dr Leibie are right that pill testing technology used at Australian festivals is (at least for now) unable to provide exact information on the purity or doses of ingredients in the drugs presented.

Instead, the technology provides information on what the ingredients in the drugs are and gives a "qualitative indication" of purity, including what substances are predominant in the sample, Dr Caldicott said.

“We can identify major compounds and minor compounds and their relationships,” he said.

When asked whether he was concerned the technology couldn't identify exact drug purity, Dr Caldicott said “not at all”.

“If we were providing a safety or quality guarantee, we would be worried. But our baseline is: you probably shouldn't be consuming this,” he said.

“We're pretty careful to talk about dose ... every single test is contextualised to the individual about what it is and what the harms could be.”

Dr Caldicott rejected the idea that laboratory-grade technology is what's required to give people the information they need about drug safety and potency.

“That approach is thinking about it in the context of prosecuting somebody, but we're thinking about it in the context of changing somebody's behaviour. So, it's quite a different bar,” he said.

### **CLAIM 6: THERE'S NO EVIDENCE PILL TESTING SAVES LIVES**

Two weeks ago, NSW Premier Gladys Berejiklian said her government would consider pill testing “if there was a way in which [they] could ensure that lives were saved”.

*Pill testing technology used at Australian festivals is (at least for now) unable to provide exact information on the purity or doses of ingredients in the drugs presented ... Instead, the technology provides information on what the ingredients in the drugs are and gives a “qualitative indication” of purity, including what substances are predominant in the sample.*

“But there is no evidence provided to the government on that,” Ms Berejiklian said.

Speaking on ABC TV's *The Drum*, Alex Wodak, president of the Australian Drug Law Reform Foundation, said demonstrating a clear reduction in deaths from pill testing was a real challenge.

“All these kind of interventions, like medically supervised injecting rooms, like needle syringe programs ... are very difficult to evaluate,” Dr Wodak said.

“We can't do a randomised control trial – which is the standard way we evaluate most new clinical interventions – because they're either inappropriate or not feasible for this kind of change in environment.”

Dr Caldicott agreed, and said choosing not to introduce pill testing on this basis demonstrated “a lack of understanding of scientific principles”.

He said other indicators of pill testing benefits could and should be used as evidence.

“We know that where pill testing occurs, fewer people use drugs, and fewer people use mixtures of drugs,” he said.

“Those are independent risk factors for overdose and death. So, we can stop the things that lead to death.”

In September, the Premier established an expert panel to improve safety at music festivals, but ruled out pill testing for consideration.

Harm Reduction Australia president Gino Vumbaca said the evidence for pill testing is “being ignored”.

“I think it's a bit disingenuous of the Premier to now say, ‘give me the evidence’, when she set up a taskforce that specifically excluded evidence being presented or discussed,” Mr Vumbaca said.

“To not even have the ability to sit down and discuss this with ministers is a fairly sad indictment of public discourse and policy.”

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Willis, O (15 January 2019). ‘Six claims about pill testing – and whether or not they're true’, *ABC News*. Retrieved from [www.abc.net.au/news](http://www.abc.net.au/news) on 8 August 2019.

# Testing festival goers' pills isn't the only way to reduce overdoses. Here's what else works

Prohibition doesn't work to reduce either harms or drug use – but what does?

Nicole Lee and Monica Barratt consider a range of harm reduction strategies

The NSW inquest into recent drug deaths at music festivals is due to start this week. So focus is turning to how to make music festivals safer by reducing drug-related incidents. We know that prohibition doesn't work to reduce either harms or drug use. But what does?

## HOW DO DRUGS CAUSE HARM?

Most illicit drugs used at festivals, including ecstasy (methylenedioxymethamphetamine or MDMA), started out as relatively benign pharmaceuticals.

MDMA is most commonly implicated in drug-related harm at festivals. Fatal and non-fatal MDMA overdoses are usually a result of high-purity MDMA, dangerous contaminants, or environmental factors such as overheating or drinking too much or too little water. So to reduce harms we need to address all these problems.

## WHAT DOESN'T WORK

Police presence, random drug searches and drug detection dogs don't deter drug use and may increase harms. Yet they are common at festivals and come at a substantial financial cost to festival goers, which has to be covered in the price of the ticket.

People who go to festivals say that police presence doesn't discourage them from taking drugs; and

there are many documented cases of people taking multiple pills at once to avoid searches and sniffer dog detection, which increases the risk of overdose.

*When police dogs are present, people are more likely to buy drugs inside the festival rather than risk detection by carrying drugs in. This means they are more likely to buy from unknown sources, which increases their risk of harm compared with buying from a trusted source.*

Publicly, the police focus is on drug dealing, but the reality is that most people who are arrested at festivals are people who use, rather than sell, drugs. NSW police reported that, at Sydney's 2019 Field Day Festival, of the 28,000 people who attended, there were 155 drug-related arrests: 149 for possession and 6 for supply.

When police dogs are present, people are more likely to buy drugs inside the festival rather than risk detection by carrying drugs in. This means they are more likely to buy from unknown sources, which increases their risk of harm compared with buying from a trusted source.

Decriminalising illicit drugs would significantly reduce harms and allow festival police to focus on public safety issues, such as antisocial behaviour and public drunkenness.



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## WHAT WORKS

There are already effective harm reduction strategies in place at festivals.

These include:

- Presence of peer-led organisations, like DanceWize, which provide harm reduction information and support
- Emergency services and first aid
- Chill out spaces
- Availability of cool clean water
- Good ventilation in indoor spaces, and
- Staff and volunteer training in responding to drug-affected people.

## PILL TESTING DIRECT TO CONSUMER

On-site pill testing, which identifies the content and purity of drugs brought in by festival goers, also includes contact with a health professional to provide a brief intervention, that can include advice about risks of taking drugs and harm reduction information. Festival goers are always told that it is safest not to take drugs at all.

Brief interventions from a health professional can reduce risky drug use among young people. But without a way to offer an intervention, most young people who go to festivals will not come into contact with a health worker to receive that information.

Some Australian police, politicians and policymakers are reluctant to consider pill testing at festivals. That may be because, so far, only on-site, direct-from-consumer testing has been offered as a viable way of reducing harm.

Some people have concerns about the idea of accepting and testing illicit drugs direct from the people using them, given that they are still illegal.

But there are many other ways of pill testing that can also reduce harm.

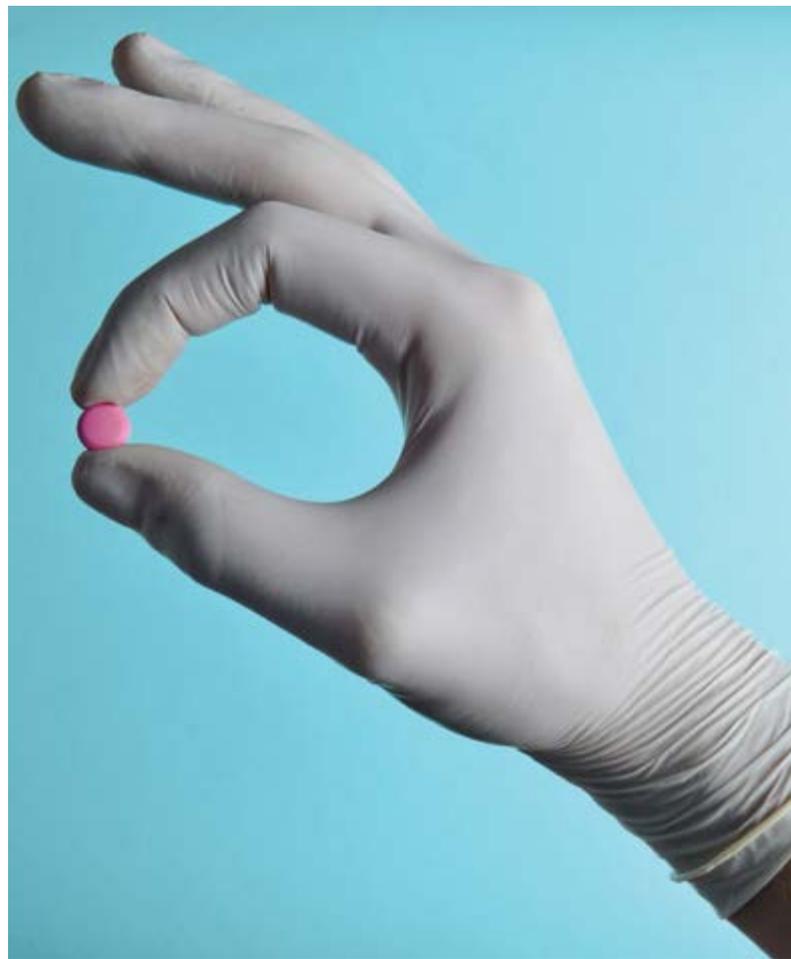
## TESTING OF POLICE-ACQUIRED DRUGS

We could also test drugs on-site that have been seized by police, acquired from emergency services after an incident or surrendered in amnesty bins.

This approach has been used at a number of festivals in the UK since 2013. When a potentially problematic drug is identified during the festival, an alert is issued on-site through social media usually within hours, to alert others who may have bought drugs from similar batches.

As well as potentially reducing harm for people who use drugs, these alerts mean police are better able to monitor the local drug market; on-site paramedics, first aid and outreach workers are better informed about drugs in circulation, helping to improve responses; and according to the UK testing facility, medical services report having more confidence in dealing with presentations because of the alerts.

This approach is not as effective in reducing harms as direct-from-consumer testing. That's because it doesn't include contact with a health professional who can offer a brief intervention, and the information



about pill contents doesn't go direct to the people intending to use them.

But if testing of police-acquired drugs is combined with real-time alerts about potential problem drugs to festival goers, it can still reduce harms.

## OFF-SITE TESTING

Testing of pills brought in by festival goers can also occur off site before the festival. It works the same way as onsite testing, and includes brief intervention, but operates away from the festival site. It's the primary model used in The Netherlands.

*We will never completely eliminate drug use at festivals but we can make them safer by implementing what we know works and stopping what we know doesn't.*

Off-site testing removes the need to change the way the drugs are policed at festivals, so may be more acceptable to some. If both off-site and on-site testing are implemented, testing services will have greater reach and be more effective in reducing harm.

## TESTING DRUG PURITY

The only official pill testing that has been undertaken in Australia has been at Canberra's Groovin' the Moo in 2018 and 2019. The on-site facility tested samples provided directly by consumers and identified the drugs present. But they could only estimate the

purity of drug powders and did not measure the dose of MDMA in the pills.

High-dose MDMA has been implicated in a number of the recent festivals deaths. Knowing the dose may help reduce overdoses from MDMA pills because people can choose to take a smaller amount of the drug if they know the strength is high.

*It's normal for young people to take risks. Whether you agree with drug taking or not, our young people don't deserve to die just because they have taken drugs.*

The Loop UK has developed a method of more accurately measuring the dose in MDMA pills, which could help reduce the harms associated with high purity. The process does not require any specialised equipment and is performed on-site by trained chemists. At this year's Parklife Festival the organisation identified high-strength pills and sent out warnings.

### UNDERSTANDING DRUG USE AT FESTIVALS

We also don't really know how many young people use drugs at Australian festivals and how much they use. Most of what we know is from anecdotal reports. There's probably differences between festivals.

We know both festival attendance and illicit drug use hit a peak among people in their 20s. So more research on how common drug use is at festivals and the kinds of drugs people use would help inform better and more targeted harm reduction policies.

We will never completely eliminate drug use at festivals but we can make them safer by implementing what we know works and stopping what we know doesn't. It's normal for young people to take risks. Whether you agree with drug taking or not, our young people don't deserve to die just because they have taken drugs.

### DISCLOSURE STATEMENT

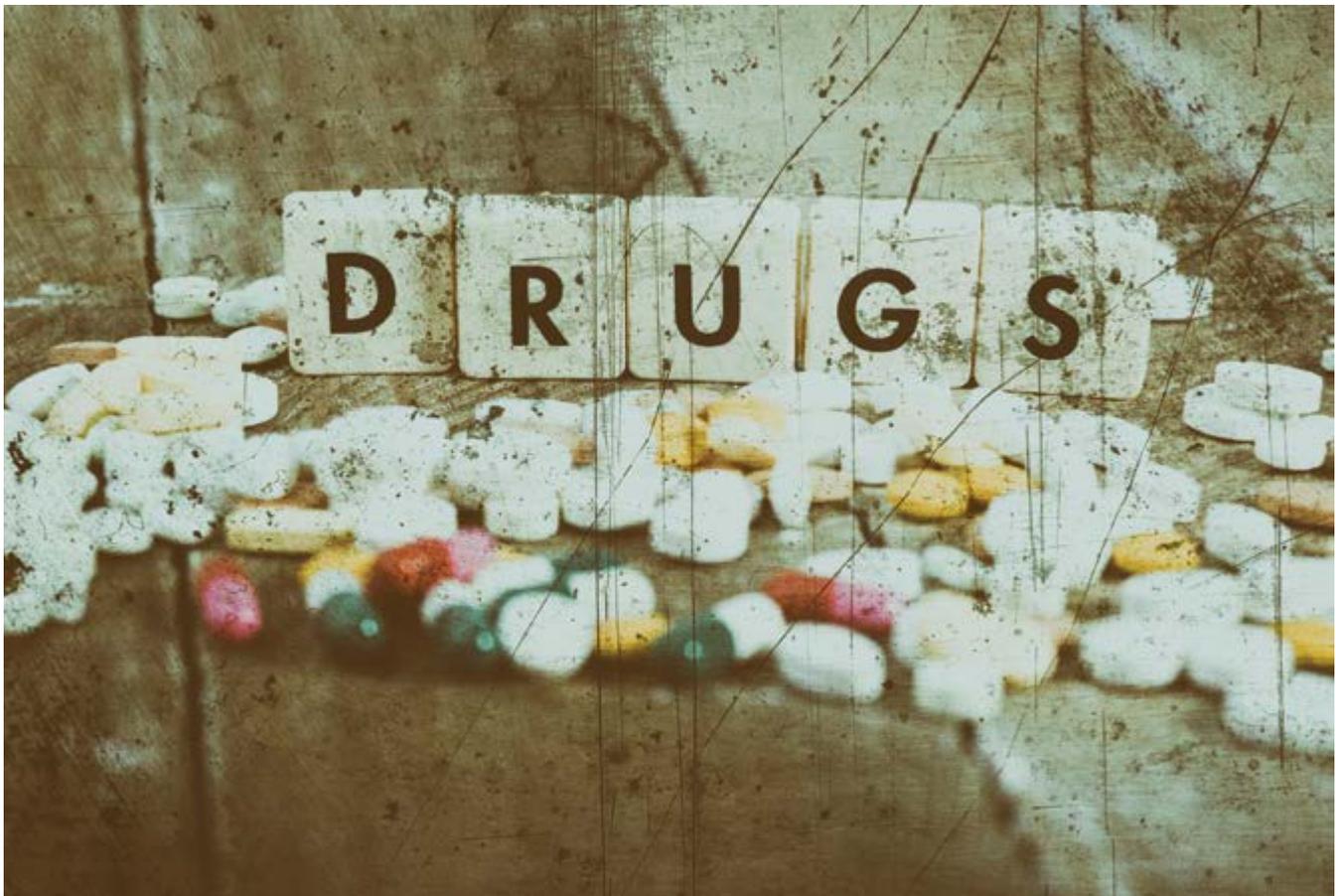
Nicole Lee works as a paid consultant in the alcohol and other drug sector. She has previously been awarded grants by state and federal governments, NHMRC and other public funding bodies for alcohol and other drug research. She contributes volunteer time to The Loop Australia. Monica Barratt receives funding from the National Health and Medical Research Council, the Marsden Foundation (NZ) and the National Institutes of Health (US). In addition to her academic research role, she volunteers as Director of Research at Bluelight.org and as Victorian Strategic Engagement Coordinator at The Loop Australia.

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## THE CONVERSATION

Lee, N, and Barratt, M (8 July 2019). *Testing festival goers' pills isn't the only way to reduce overdoses. Here's what else works.* Retrieved from <http://theconversation.com> on 8 August 2019.



# EXPLORING ISSUES

## WORKSHEETS AND ACTIVITIES

The Exploring Issues section comprises a range of ready-to-use worksheets featuring activities which relate to facts and views raised in this book.

The exercises presented in these worksheets are suitable for use by students at middle secondary school level and beyond. Some of the activities may be explored either individually or as a group.

As the information in this book is compiled from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Is the information cited from a primary or secondary source? Are you being presented with facts or opinions?

Is there any evidence of a particular bias or agenda? What are your own views after having explored the issues?

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## MULTIPLE CHOICE

Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of the next page.

- 1. According to the National Drug Strategy Household Survey (2016), what percentage of Australians aged 14 years and over have illicitly used a drug at some point in their lifetime?**
  - a. 13%
  - b. 23%
  - c. 33%
  - d. 43%
  - e. 53%
  - f. 63%
  
- 2. Which of the following categories does cannabis belong in? (Circle all that apply)**
  - a. Depressants
  - b. Party drugs
  - c. Hallucinogens
  - d. Opioids
  - e. Stimulants
  - f. Analgesics
  
- 3. Common after effects from a drug-induced 'comedown' can include which of the following symptoms? (Circle all that apply)**
  - a. Flatness
  - b. Exhaustion
  - c. Feeling depressed
  - d. Shakes
  - e. Sweats
  - f. Dizziness
  - g. Nausea
  - h. Feeling hungry
  - i. Fatigue
  - j. Feeling fresh
  - k. Sleepy/unable to sleep
  
- 4. Which of the following are harm reduction intervention strategies? (Circle all that apply)**
  - a. Diversion programs and caution schemes
  - b. Needle and syringe programs
  - c. Law enforcement campaigns
  - d. Opioid pharmacotherapy treatment
  - e. HIV education/information, testing and counselling
  - f. Medically supervised injecting facilities
  - g. Promotion of illicit drug use
  - h. Mandatory sentencing of offenders
  - i. Overdose prevention interventions
  - j. Legal and regulatory frameworks
  - k. Peer education programs
  - l. Drug detection sniffer dogs
  - m. Chill out and sanctuary spaces at festivals



## MULTIPLE CHOICE

### 5. Match the following terms to their correct corresponding descriptions.

- |                      |   |
|----------------------|---|
| a. Abstinence        | 1. Policy that promotes the idea that 'no drugs' or 'no drug use' is the aim of education and intervention activities.  |
| b. Controlled use    | 2. Treatment goal of moderation (cutting down) as opposed to abstinence.  |
| c. Demand reduction  | 3. Refraining from using drugs.   |
| d. Harm minimisation | 4. Preventing uptake and delaying onset of use of alcohol, tobacco and other drugs; reducing misuse of these substances in the community; and supporting people to recover from dependence through evidence-informed treatment.   |
| e. Harm reduction    | 5. Activities that aim to disrupt the production and supply of illicit drugs; may also be used to impose limits on accessibility and availability of legal drugs such as legislation regulating sale of alcohol and tobacco to people under age of 18.  |
| f. Prevention        | 6. Refers to measures that prevent or delay the onset of drug use as well as measures that protect against risk and prevent and reduce the harms associated with drug supply and use.   |
| g. Supply reduction  | 7. Policy that aims to reduce the impact of drug-related harm within society, and acknowledges that drug use exists and will continue to.   |
| h. Zero tolerance    | 8. Underpins the National Drug Strategy; aims to promote better health, social and economic outcomes for community and individual; includes preventing anticipated harm and reducing actual harm from licit and illicit drugs through demand reduction, supply reduction and harm reduction strategies. |

### 6. Respond to the following statements by circling either 'True' or 'False':

- |  |              |
|--|--------------|
| a. Methamphetamine is the most commonly used illicit drug in Australia.  | True / False |
| b. The most common drug class identified for drug-induced deaths over the past decade is opioids.  | True / False |
| c. In cases of long-term use, ecstasy/MDMA is linked to memory loss, depression and anxiety.   | True / False |
| d. Alcohol causes the most overall harm of any drug in Australia.  | True / False |
| e. Depenalisation involves legal changes so that it is no longer a criminal offence to possess illicit drugs for personal use.   | True / False |
| f. Diversion is when people found to be in possession of illicit drugs are sent to education sessions, treatment or social services instead of being charged and prosecuted. | True / False |

## MULTIPLE CHOICE ANSWERS

1 = d; 2 = a, c, e; 3 = a, b, c, d, e, f, g, i, k; 4 = a, b, d, e, f, i, j, k, m; 5 = a = 3, b = 2, c = 4, d = 8, e = 7, f = 6, g = 5, h = 1; 6 = a = f (Cannabis is the most used illicit drug, NDHS 2016), b = 1, c = 1, d = 1, e = f (Depenalisation is where the crime remains in law, but the police stop imposing penalties for some people), f = 1.

- Drugs can be categorised by the way in which they affect our bodies: depressants – slow down the function of the central nervous system; hallucinogens – affect your senses and change the way you see, hear, taste, smell or feel things; and stimulants – speed up the function of the central nervous system (Department of Health, *Types of drugs*). (p.1)
- In 2016, 8.5 million (or 43%) people aged 14 and over in Australia had illicitly used a drug at some point in their lifetime. This includes cannabis, ecstasy, meth/amphetamine, cocaine, hallucinogens, inhalants, heroin, ketamine, gammahydroxybutyrate (commonly known as GHB), synthetic cannabinoids, new and emerging psychoactive substances, and the misuse of pharmaceuticals (namely, painkillers/analgesics and opioids, tranquillisers/sleeping pills, steroids and methadone or buprenorphine) (AIHW, *Australia's Health 2018*). (p.3)
- In 2016, there were 1,808 drug-induced deaths, equating to 1.1% of all deaths – the highest number of drug-induced deaths recorded over the past 20 years (*ibid.*). (p.6)
- The majority of people never use drugs, but it is important for people to know how to assist someone if a drug-related emergency happens. Drugs are unpredictable; they can affect people in different ways. As there is no quality control for illegal drugs there is no way of knowing their content or strength (Positive Choices, *Helping someone who has taken an illegal drug*). (p.10)
- Harm reduction strategies identify specific risks that arise from drug use. These are risks that can affect the individual who is using drugs, but also others such as family members, friends and the broader community. Harm reduction strategies encourage safer behaviours, reduce preventable risk factors and can contribute to a reduction in health and social inequalities among specific population groups (Department of Health, *National Drug Strategy 2017-2026*). (p.13)
- The International Harm Reduction Association defines harm reduction as the policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs (Harm Reduction Australia, *What is harm reduction?*). (p.16)
- Harm reduction interventions include: needle and syringe programs; medically supervised injecting facilities; opioid pharmacotherapy treatment; outreach services; HIV education/information, testing and counselling; brief interventions (aimed at harm reduction); overdose prevention interventions; legal and regulatory frameworks; peer education programs; diversion programs and caution schemes; and chill out and sanctuary spaces at festivals (The Spinney Press, *Forms of harm reduction*). (p.17)
- Drug-related offences take up a lot of the resources within Australia's criminal justice system. In 2016-17 law enforcement made 113,533 illicit drug seizures and 154,650 drug-related arrests (Nicole Lee & Jarryd Bartle, *History, not harm, dictates why some drugs are legal and others aren't*). (p.18)
- In a 2010 study, experts ranked 20 legal and illegal drugs on 16 measures of harm to the user and to wider society. This includes health damage, economic costs, and crime. Overall, alcohol was the most harmful drug. MDMA (ecstasy), LSD and mushrooms were among the least harmful (*ibid.*). (p.18)
- There is no evidence a prohibitionist approach to drug law has reduced the supply of illicit drugs. Instead, it has increased organised crime and acted as a barrier for people seeking help (*ibid.*). (p.19)
- Despite what many people think intuitively, the evidence from numerous studies is that drug laws have minimal or no effect on levels of illicit drug use. Punitive laws do not reduce drug use and liberal approaches do not increase drug use (Dr Alex Wodak/Australia21, *How can making drugs easier to access save lives? 10 FAQs about drug law reform*). (p.20)
- Medically supervised injecting centres have three clear goals: to provide an environment for safer drug use; to improve the health of drug users; and to reduce public disorder (Alcohol and Drug Foundation, *Medically supervised injecting centres: dispelling the myth*). (p.27)
- Safe injecting facilities operating around the world have been shown to reduce overdoses, decrease the transmission of blood-borne viruses, and provide access to treatment programs (*ibid.*). (p.28)
- The screening of illicit drugs for harmful substances (known as 'pill testing' or 'drug checking'), has been sanctioned for a number of years in countries like The Netherlands, Austria, Belgium and Switzerland. No Australian jurisdictions endorse pill testing, however a number of recent deaths at music festivals has sparked a national debate, prompting public calls on state and territory governments to introduce illicit drug testing facilities at major public events along with trained healthcare support staff (The Spinney Press, *The pill testing debate*). (p.30)
- A range of experts including scientists, doctors and policymakers assert that current anti-drug strategies are not working, and that a new harm reduction approach is needed ... To date, state governments have resisted the official introduction of pill testing services, instead maintaining a tough criminal justice stance on illicit drugs (*ibid.*). (p.30)
- Police presence, random drug searches and drug detection dogs don't deter drug use and may increase harms. Yet they are common at festivals and come at a substantial financial cost to festival goers, which has to be covered in the price of the ticket (Nicole Lee & Monica Barratt, *Testing festival goers' pills isn't the only way to reduce overdoses. Here's what else works*). (p.48)

## **Abstinence**

Refraining from using drugs.

## **Addiction**

Physical and psychological craving for drug/s and related behaviours. The process of addiction is progressive and chronic. Addiction is more commonly referred to as psychological and physical dependence.

## **Binge**

An episode of intense (concentrated) or excessive alcohol or drug use. A prolonged binge is called a 'bender'. Heavy drug use over a limited period of time can result in intoxication and sometimes overdose.

## **Controlled use**

Drug treatment goal of moderation (cutting down), as opposed to abstinence.

## **Demand reduction**

Involves preventing the uptake and delaying the onset of using alcohol, tobacco and other drugs; reducing the misuse of these substances in the community; and supporting people to recover from dependence through evidence-informed treatment. Initiatives include: information and awareness campaigns, education and early intervention, restrictions on the marketing and advertising of tobacco, alcohol and prescription drugs, drug treatment programs, programs focused on building protective factors and social engagement.

## **Dependence**

When a person has a strong desire to take drug/s and cannot control their use despite its harmful effects.

## **Drug abuse**

This term is subjective, pejorative and often has little relative meaning. It is more useful to look at patterns and problems of drug use. Alternative descriptions include AOD-related harm (alcohol and other drugs); risky patterns of use; and dependent use.

## **Drug-related harm**

Any adverse social, physical, psychological, legal or other consequence of drug use that is experienced by a person using drugs or by people living with or otherwise affected by the actions of a person using drugs.

## **Harm minimisation**

This policy underpins the National Drug Strategy and aims to promote better health, social and economic outcomes for the community and individual. Harm minimisation includes preventing anticipated harm and reducing actual harm from licit and illicit drugs through a comprehensive approach to drug-related harm involving demand reduction, supply reduction and harm reduction strategies. It takes into account three interacting factors: the individual, the environment/setting and the drug(s).

## **Harm reduction**

Policy that aims to reduce the impact of drug-related harm within society, at an individual and community level. It includes reducing physical and social harms

associated with drug use, encompassing the prevention of disease, death, incarceration and isolation. It acknowledges that drug use exists and will continue to, and therefore focuses on promoting harm reduction methods.

## **Illicit drug**

Drug whose production, sale or possession is prohibited; alternative term is 'illegal drug'. Classification of legal status varies over time according to social attitudes and legislation.

## **Licit drug**

Drug whose production, sale or possession is not prohibited. 'Legal' drug is an alternative term.

## **National Drug Strategy**

Framework of policies and programs aimed at preventing and reducing the uptake of harmful drug use and minimise the harmful effects of licit and illicit drug use in Australian society. The NDS adopts a comprehensive approach, which encompasses the use of both licit and illicit drugs.

## **Overdose**

Results from the ingestion of a drug(s) that exceeds a person's tolerance. The result may include acute psychosis (e.g. amphetamines) or potentially life-threatening effects (e.g. respiratory depression with opioids).

## **Party drugs**

A term that loosely groups drugs used in the pub, club, party and rave scenes. Includes stimulants such as amphetamines, MDMA (ecstasy), GHB and ketamine. Individuals who use party drugs often take other drugs (e.g. alcohol, antidepressants, benzodiazepines, cannabis).

## **Polydrug use**

The simultaneous or sequential non-medical use of more than one drug.

## **Prevention**

Within the context of the National Drug Strategy, prevention refers to measures that prevent or delay the onset of drug use as well as measures that protect against risk and prevent and reduce the harms associated with drug supply and use.

## **Psychoactive drugs**

Refers to any chemical substance which when taken into the body, alters mood, cognition and behaviour. The term 'drug' usually includes tobacco, alcohol, pharmaceutical drugs and illicit drugs. It also refers to other substances that have psychoactive effects such as solvents.

## **Supply reduction**

Activities that aim to disrupt the production and supply of illicit drugs. It may also be used to impose limits on the accessibility and availability of licit drugs such as legislation regulating the sale of alcohol and tobacco to people under the age of 18.

## **Zero tolerance**

A policy that promotes the idea that 'no drugs' or 'no drug use' is the aim of education and intervention activities. This contrasts with the policy of harm minimisation.

## Websites with further information on the topic

Alcohol and Drug Foundation [www.adf.org.au](http://www.adf.org.au)  
 Australia21 [www.australia21.org.au](http://www.australia21.org.au)  
 Australian Drug Law Reform Foundation [www.adlrf.org.au](http://www.adlrf.org.au)  
 Australian Institute of Health and Welfare [www.aihw.gov.au](http://www.aihw.gov.au)  
 Department of Health [www.health.gov.au/health-topics/drugs](http://www.health.gov.au/health-topics/drugs)  
 Drug Advisory Council of Australia [www.daca.org.au](http://www.daca.org.au)  
 Drug Free Australia [www.drugfree.org.au](http://www.drugfree.org.au)  
 Drug Help (Department of Health campaign) [www.campaigns.health.gov.au/drughelp](http://www.campaigns.health.gov.au/drughelp)  
 Drug Policy Australia [www.drugpolicy.org.au](http://www.drugpolicy.org.au)  
 Drug Policy Futures [www.drugpolicyfutures.org](http://www.drugpolicyfutures.org)  
 Families and Friends for Drug Law Reform [www.ffdlr.org.au](http://www.ffdlr.org.au)  
 Harm Reduction Australia [www.harmreductionaustralia.org.au](http://www.harmreductionaustralia.org.au)  
 Harm Reduction Victoria [www.hrvic.org.au](http://www.hrvic.org.au)  
 National Drug and Alcohol Research Centre [www.ndarc.med.unsw.edu.au](http://www.ndarc.med.unsw.edu.au)  
 Pill Testing Australia [www.pilltestingaustralia.com](http://www.pilltestingaustralia.com)  
 Positive Choices [www.positivechoices.org.au](http://www.positivechoices.org.au)  
 ReachOut [www.au.reachout.com](http://www.au.reachout.com)

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