Students for Sensible Drug Policy: Edith Cowan University



ALTERNATE APPROACHES TO DRUG POLICY IN WESTERN AUSTRALIA

SSDP ECU | 2019

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Students for Sensible Drug Policy: Edith Cowan University

Would like to take this opportunity to formally address;

Honourable Alison Marie Xamon, Member of Legislative Council
Honourable Samantha Helen Rowe, Member of Legislative Council
Honourable Aaron Stonehouse, Member of Legislative Council
Honourable Michael Mischin, Member of Legislative Council
Honourable Colin Stephen de Grussa, Member of Legislative Council

And others involved in this committee.

An introduction…

Students for Sensible Drug Policy: Edith Cowan University (SSDP ECU) is the only West Australian representation of SSDP Australia, a not for profit organisation that seeks to empower the youth voice in the drug policy debate. SSDP Australia has a large presence in the eastern states, where the organisation has teamed up with various MP's and organisations such as Unharm, Dancewize, Australian Drug Observatory, the Greens and the Reason party, and were part of the STA-SAFE consortium responsible for Australia's first pill testing pilot at Groovin the Moo in Canberra. While the issue of drug policy reform is one that touches Australians of all ages, SSDP ECU has chosen to focus on the impact of current drug policy on students and young people aged under 30 as this group is far more likely to use illicit drugs than any other age group (Australian Institute of Health and Welfare, 2017), while three in ten (27.8% N=28,286) 14-19 year old's nominate alcohol and other drugs as one of the most important issues that young Australians face (Mission Australia youth survey, 2018).

International evidence (e.g., see; Morgan, Noronha, Muetzelfeldt, Feilding & Curran, 2013; Nutt, King, Saulsbury & Blakemore, 2007) has consistently shown that legislation regarding illegal drugs is inconsistent with the potential harms associated with these drugs. For example, drugs such as LSD, MDMA, DMT and psilocybin have been shown to have a low potential for causing harms associated with their acute and chronic toxicity. Yet these drugs remain Schedule 9 illicit drugs within the *WA Misuse of Drugs Act 1981*. As such, we recommend pragmatic amendments to the *Misuse of Drugs Act 1981*, that ensures that the degree of regulation placed over a drug is directly proportional to its potential to cause harm to individuals and society.

Such amendments would emphasise understanding and compassion that embraces a harm reduction approach to drug policy. Most governments have relied on punitive supply and demand reduction measures to mitigate the risks associated with drug use with minimal harm reduction services provided, often in the form of a counselling service. While these measures are indeed a necessary precaution, the resources allocated to supply and demand reduction far outweigh that which is given to harm reduction services in Western Australia, where the burden of illicit drug use largely falls within the jurisdiction of the West Australian Police Force.

SSDP would like to see the implementation of evidence-based approaches to drug policy in Western Australia, in which more resourcing is provided to harm reduction interventions and preventative measures that have been shown to have strong returns on investment with less resourcing provided to supply control strategies that have been shown to have limited efficacy and do not provide a good return on investment. We believe these changes need to be made collaboratively with politicians, police, the wider community and most importantly, young people.

Early last year Fiona Patten initiated the parliamentary inquiry into drug reform in Victoria. The cross-party law reform, road and community safety committee released its Inquiry into drug law reform in March 2018 – the most comprehensive examinations of harm minimisation in Australian history. The Law Reform, Road and Community Safety Committee, Inquiry into Drug Law Reform report was tabled with 50 recommendations put forward by the committee. We believe that many, if not all these recommendations are positive steps in creating just laws that will seek to improve the lives of people who use drugs, their families and society as a whole. A successful precedent has already been set by many countries, including Portugal, Norway, the Czech Republic, Switzerland and the Netherlands, who have changed their approach towards public health in respect to drug use.

This report will be broken down into subsections focusing on the more traditional drugs of choice for young people; Cannabis and MDMA or Ecstasy, as well as touching on traditional psychedelics such as LSD, Psilocybin (Mushrooms) and DMT, and the issue of new and emerging or novel psychoactive substances (NPS) that have been reported to cause significant harm.

Cannabis

Cannabis law reform has been the front-runner of drug law reform worldwide because the harms associated with cannabis use have been found to be grossly overestimated and related to propaganda campaigns that emerged during the inception of USA's war on drugs. Further, the harms associated with the criminalisation of cannabis have been shown to be greater than the harms associated with use of the drug. This has led to a range of reforms ranging from decriminalisation, medical use and regulation of recreational markets.

Cannabis is reported as being the most widely used psychoactive drug in Australia. More than 10% of Australians report using the drug in the last 12 months and 35% report they have used the substance in their lifetime (Australian Institute of Health and Welfare, 2017). Interestingly, 65% of people who use cannabis report sourcing their drug of choice from a friend rather than a drug dealer. This suggests that most people who use cannabis do not see themselves as participating in a criminal activity (Australian Institute of Health and Welfare, 2017).

Additionally, cannabis is widely used to self-medicate (or cope) with various forms of mental health issues, such as depression and anxiety and is notably more common in areas that offer medical cannabis treatments (Sarvet et al., 2018). Although medical cannabis is available to patients in Western Australia, the acquisition of a prescription for its use is convoluted and ultimately restricted to patients with a terminal illness or experiencing debilitating diseases such as epilepsy. The previously cited data suggests then, that there is a large demographic of people self-medicating with cannabis for simple cases of mood disorders and anxiety without the proper supervision of a medical professional. SSDP ECU is concerned that since many of these conditions are experienced by youth involved with university studies, career pursuits and family issues, young people are at risk of being criminalised for their use of medical cannabis and accessing an unregulated product. In turn, this could lead these individuals' conditions to exacerbate and ultimately could lead to higher rates of dependence.

WHAT ABOUT CANNABIS CLUBS?

An alternative approach to the polarising, wholly restrictive or free cannabis market is the establishment of Cannabis Clubs. Cannabis Clubs refer to services operated by a collective of community members who cultivate cannabis for their own consumption with no motivation for profit, which seek to provide a safe environment in which medical cannabis patients, or otherwise, can source a variety of cannabis products varying in potency and administration method, such as the dispensing of edibles, tinctures and oils (Feldman & Mandel, 1998). Such a service found its infancy in San Francisco but has since seen Cannabis Clubs form in Belgium, Spain and Uruguay (Cerdá & Kilmer, 2017). Individuals seeking to source cannabis from a Cannabis Club would first require membership, which

would ensure those using the service would be properly vetted and screened before gaining access to the product.

The benefit of such clubs is twofold. On the one hand it removes the need for people who use cannabis to approach the black market, crippling criminal syndicates revenue streams; and on the other hand, the nature of being a legal collective provides a sense of community involvement for people who use cannabis who previously have been ostracised from the larger populace. For details regarding the social benefits of the San Francisco Cannabis Club, see Feldman & Mandel (1998).

The cultivation of cannabis for individuals can be logistically difficult since it requires an extensive knowledge of horticulture as well as the space to yield sufficient crops and the ability to be able to properly identify contaminants such as mould. Cannabis Clubs offer a place where like-minded individuals can pool their knowledge, resources and collectively provide a product that is sufficient for the needs of regular cannabis users.

While the cannabis plant has been increasingly decriminalised and even legalised in such jurisdictions as Canada, Uruguay and Mexico, Australia appears to be clinging to a rigidly structured medical model which shuts out a majority of otherwise law-abiding citizens who use cannabis, forcing them to turn to the black market where there is much less red tape precluding their access to cannabis. Although a regulated legal cannabis market would be a welcomed sight for most of the cannabis using community, SSDP understands that such a model is far from becoming a reality in Australia.

RECCOMENDATIONS

Based on the evidence described above and SSDP's commitment to pragmatic policy change, we provide the following recommendations for cannabis law reform in a stepped approach. That is, the first recommendation would be the easiest to implement, while the final recommendation would be difficult to implement, though is increasingly supported by evidence as reducing harm to individuals and the community.

1. **Wider access to medicinal cannabis and for a greater amount of conditions.**

   This would divert those using the drug for medical reasons away from law enforcement and the black market.

2. **Decriminalisation of cannabis for personal use.**

   This would further reduce the impact current punitive measures have on individuals seeking to use the drug for recreational purposes and would ensure that already at-risk individuals would not have their potential futures ruined by incurring criminal charges for what is essentially a personal choice. Cues for this type of legislation can be taken from the recent private members bill introduced by Labor backbencher Michael Pettersson in the ACT.

3. **Establishment of community Cannabis Clubs**.

   This would do much to mend the divide between people who use cannabis, law enforcement and those that hold the view that cannabis users do not contribute to society as a whole. Additionally, it would initiate the demise of the black-market trade of cannabis.

4. **Government regulated legal cannabis market.**

   This would ensure that adults wanting to experiment with the drug would have a reliable source separate from the black market, where the revenue gained from the sale of cannabis could go toward other law enforcement, educational and health-related activities. However, pricing on such a market would need to remain competitive, and even undercut, current black-market prices to be effective.

MDMA (Ecstasy)

In Australia, 11% of people aged 14 and older have used MDMA in their lifetime. This might seem like an alarming number of Australians that have used the drug. However, research regarding how harmful the drug actually is remains contentious. Some studies appear to highlight the neurotoxicology of MDMA to both serotonin, dopamine and noradrenaline transporters, while also suggesting that acute toxicity (overdose) has detrimental effects on the thermoregulatory system, endocrine system and cardiovascular system (Moratalla et al., 2017). It has been argued however, that MDMA is often consumed unintentionally alongside other drugs (such as methamphetamine) which can trigger its toxic effects (Kish et al., 2010) and studies that have been conducted on animals involve doses far above normal human consumption (Bright & Williams, 2018). It is also important to note that there has been no correlation to the use of MDMA and a depleted brain structure in terms of volume, dispelling the myth that ecstasy use causes brain damage (Kish et al., 2010). There have also been suggestions by the same papers condemning MDMA, that some of the neurotoxicity it causes to neuro-transporters may be reversible (Moratalla et al., 2017). Further, when provided to clinical populations on several occasions, MDMA has been found to have no detrimental effects. This has led to the FDA approving large international multisite clinical trials for MDMA-assisted psychotherapy for Post-traumatic Stress Disorder (PTSD) in 2016 (Bright & Williams, 2018).

Additionally, dependence to MDMA is reportedly quite low with most people stopping use in their 20's (Mueller et al., 2015). Mueller and colleagues also note that MDMA use is often "incidental" and "transient" for most people and in their review found that only 15% of people who choose to use MDMA are heavy regular users. With the toxicity of MDMA that appears to be low, and with low rates of dependency, the harms associated with MDMA use appear to have been overstated. Coupling this poor evidence with new and emerging evidence for its efficacy in assisting treatment resistant mental health conditions and its perception as a 'dangerous party drug' seem somewhat unfounded (Bright & Williams, 2018).

MDMA has seen a resurgence in research in the last few years with a focus on its application in conjunction with exposure therapy to treatment resistant PTSD (Amoroso & Workman, 2016; Bright & Williams, 2018; Sessa, 2017). MDMA stimulates the release of serotonin, oxytocin, prolactin and cortisol which enhances empathy and trust whilst overriding negative feelings and thoughts normally associated with traumatic experiences allowing an individual to fully engage in the often re-traumatising nature of exposure therapy (Amoroso & Workman, 2016; Wagner et al., 2017). This chemical reaction also brings about persistent and lasting changes in trait openness and decreases in neuroticism which have been sustained up to 45 months after treatment (Wagner et al., 2017). It would appear many of the benefits of this drug to society and the individual are yet to be explored.

Given the psychopharmacological and psychological effects of MDMA, it is clear why so many young people appear to defy the sanctions placed on this drug and choose to consume it regardless. Coming of age and learning about one's self is a large part of young people's lives and the consumption of MDMA and ecstasy appear to soothe the angst many young people feel when socialising in high energy situations such as nightclubs and music festivals. Anyone who experiments with these drugs do not do so with the intention of overdosing on MDMA or consuming an adulterated product that has been sold to them as MDMA. Most young people know what their limits are when it comes to using MDMA. Yet we still see deaths occurring, apparently from overdose, at music festivals across the country.

Reports indicate Australian ecstasy could be the most dangerous in the world (Palamar & Barratt, 2018). Australian ecstasy often contains adulterants such as methamphetamines and countless novel psychoactive substances (NPS). In the past 8 years over 800 new drugs have been identified worldwide, many of which have been found in Australian samples of ecstasy. Examples of these include N-ethylpentylone, which was identified at Australia's first sanctioned pill testing trial at Canberra's Groovin The Moo festival. Most of the ecstasy overdoses that have been reported in the past few years have been due to such adulterants rather than MDMA itself. The prevalence of NPS's in Australia is on the rise with clusters of patients presenting to hospital emergency departments with symptomatic sympathomimetic poisoning from unidentifiable NPS's (Barratt, Bruno, Ezard, & Ritter, 2018). However, there is also international evidence suggesting that the purity of MDMA is increasing and samples of ecstasy from the Groovin The Moo festival pill testing trial found samples containing up to 250mg of MDMA in a single pill. This is significant since 500mg of MDMA (or taking two of these pills) could lead to an MDMA overdose. The introduction of pill testing services for those who choose to use MDMA would provide a much-needed screening process that would alert consumers to these unwanted adulterants and pills that contain dangerous amounts of MDMA.

PILL TESTING

Pill testing involves using lab grade analytical equipment that determines the chemical content of drugs that consumers would otherwise not know about. In doing so, the purpose of pill testing is to provide people with education about the harms associated with their drug use and assist them to make a more informed choice about their use of drugs. In turn, this has been demonstrated to reduce the use of drugs by people who use pill testing services and significantly reduce the amount of harm experienced by people attending festivals. One UK study found a 95% reduction in ambulance transfer rates to hospital from a festival following the introduction of a pill testing service (Measham, 2018).

On-site pill testing services at music festivals and at least one fixed site service in the CBD would introduce a point of first contact with medical professionals for at risk users. Protocols have already been developed by members of SSDP: ECU that could be

refer them on to the appropriate treatment services, depending on their level of need. A copy of the Risk Appropriate Brief Intervention for MDMA (RABI-M) protocol and A Brief Intervention Protocol for Festival Goers have been attached to this submission as examples of possible intervention initiatives that could be implemented alongside pill testing services in Australia to reach young people who may not otherwise engage with traditional alcohol and other drug services (see Appendix A and B for details).

While pill testing services present an opportunity to educate consumers, the stigma currently associated with using these substances may be a sufficient deterrent for youth to engage with such a service. That is, it is a common fear that once an individual has utilised a pill testing service, police (undercover or otherwise) may be waiting to pounce on a now known drug user. The fear of persecution and ending up with a tarnished record and therefore limited career prospects is one that is justly warranted in the current social environment in WA. Decriminalisation of MDMA for personal consumption would dispel these fears as it would turn police attention away from the people who are using these drugs, and towards those that are illegally manufacturing and selling them.

DOES PILL TESTING INCREASE DRUG USE?

Simply put, there is no evidence to suggest this to be true. There are 31 pill testing services operating worldwide, which have shown that drug use does not increase following the introduction of pill testing (Brunt, 2017).

REGULATING MDMA

A government regulated MDMA market where consumers could source their product from a pharmacy, for example, would be the ideal alternative approach to reducing the harms associated with the drug, SSDP: ECU acknowledges that this is far from becoming a reality in the current political and social environment. As such, a stepped approach is also recommended to allow policy makers and the wider public to catch up to the way of thinking and partying of the current youth generation.

SSDP Australia and SSDP ECU believe that:

- Pill testing reduces drug harms and does not increase drug use, producing benefits for both people who use drugs and the broader community.
- Pill testing is consistent with state and national drug policy, as outlined in Australia's National Drug Strategy.
- Community and political opposition to pill testing typically ignores research evidence illustrating the effectiveness of pill testing. Further delaying public access to this resource undermines the capacity of alcohol and other drug treatment providers to reduce drug-related harms.
- Countries with access to pill testing have avoided batches of drugs containing lethal substances, while these same batches have caused harms in countries without access to pill testing. "Drug-checking services, by

executing warning campaigns, can cause hazardous drugs to be quickly removed from the market" (Brunt, p. 13, 2017).

RECCOMENDATIONS

1. **Decriminalisation of MDMA for personal use**.

   This would reduce the stigma young people face from using these drugs. The maximum quantity of product that an individual may have for personal use can be modelled on current policy for intent to supply (3.5 grams).

2. **Implementation of fixed site and festival pill testing services**.

   Should decriminalisation not become reality, a 'tolerance zone' around services where police do not arrest people for drug related crimes should be negotiated.

3. **Implementation of online pill content reports**.

   This would allow people who use MDMA but are not confident in approaching pill testing services to still get the necessary information about the current state of the drug market in WA.

4. **Legalising of MDMA for research and treatment purposes.**

   Psychedelic medicine and other emerging treatments need to be considered in this inquiry. This includes consideration for novel research and emerging treatments with potential to assist individuals with mental health concerns.

Preventative Measures

SSDP recognises that once an individual is engaged in substance use, harm reduction practices are our best line of defence. However, SSDP also recognises that by delaying the onset of substance use by just a few years there could be significant lifetime health and social benefits (Foxcroft & Tsertsvadze, 2011). A growing body of evidence demonstrates that substance use is prevalent during adolescence, with age of first use negatively correlated with the risk of developing substance use disorders (SUD) in adulthood (Levy et al., 2014; Merianos & Barry, 2017). Accordingly, the lifetime burdens that substance use can have on the individual, as well as health and social services, suggests there is a crucial need for early intervention and prevention with a universal Screening, Brief Intervention and Referral to Treatment (SBIRT) model for substance use among adolescence (Teesson, Newton, & Barrett, 2012). However, Australia currently has no SBIRT protocol for substance use in secondary and high school settings. A universal objective developed by members of SSDP: ECU outlines a preventative brief intervention protocol for substance use amongst youth, dubbed the Youth Intervention and Prevention Protocol for Students (YIPPS), it targets at risk youth in Australian high schools with the aim of prevention and/or delayed onset of substance use as an added measure of protection from harm and subsequent dependence (see Appendix C for details).

Conclusion

To conclude, the re-imagining of Western Australia's drug policy is one that should be implemented sooner rather than later and would be welcomed by the silent majority of people who use drugs – young people. With the rise of the psychedelic renaissance over the last 20 or so years, and the current pill testing debate occurring all over the country, the time is ripe for reform in this sector. While drugs such as LSD, MDMA and Psilocybin are undergoing extensive research across the world, Australia is missing out due to the current stigma's associated with illicit drugs. This is unfortunate for many up and coming students who may wish to carry out this research, right here in their own country.

The range of recommendations listed in this submission - decriminalisation, Cannabis Clubs and pill testing – are pragmatic and based on extensive evidence collected over many years and from many countries. Comprehensive preventative measures must be deployed within a practical time-frame in high school settings. Prohibition has done little to prevent many of the harms associated with drug use and has led to the creation of NPS's that are often more dangerous than the drugs they seek to mimic.

We hope that you will take the same time and care that we have, when looking into the research that has been presented here. We look forward to engaging and discussing these highly important issues with you in the future.

Students for Sensible Drug Policy: Edith Cowan University.

Joe Panaia	President
Becky Black	Secretary
Natalia Hazel	Treasurer

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Appendix A

The Risk Appropriate Brief Intervention for MDMA Protocol (RABI-M Protocol): An Intervention Initiative External to Primary Care

Joseph Panaia

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Unit Code: ADS2356

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Submitted: 1/10/2018

The Risk Appropriate Brief Intervention for MDMA Protocol (RABI-M Protocol): An Intervention Initiative External to Primary Care

Pill testing at music festivals has been implemented in other parts of the world as an effective harm reduction measure that targets people who use drugs at a crucial moment just before the point of consumption and has been praised by both users and experts alike (Day et al., 2018; Sande & Šabić, 2018; Hungerbuehler, Buecheli & Schaub, 2011). However, the opportunity to provide a brief intervention at this highly influential point in time to potentially at-risk users has largely gone unnoticed in Australia. This report details an evidence-based intervention that could be implemented alongside a proposed pill testing site at a music festival in WA, the Risk Appropriate Brief Intervention for MDMA (RABI-M)

Drug use in Australia is prevalent with 43% of Australians over the age of 14 having used an illicit drug in their lifetime ("National Drug Strategy Household Survey 2016", 2017). Although the use of MDMA or 'ecstasy' has been gradually declining since 2004 ("National Drug Strategy Household Survey 2016", 2017) it remains in the spotlight as the dangers associated with its use go on largely unaddressed, with several deaths at music festivals being attributed to the drug in the past (Kaye, Darke & Duflou, 2009). On average, nationally, 2.2% of Australians used MDMA in the last 12 months with people in their 20's having the highest rate of use ("National Drug Strategy Household Survey 2016", 2017). Within Western Australia however, that number rises to 3.2%, the highest in the country ("National Drug Strategy Household Survey 2016", 2017). Additionally, the most prevalent (90%) form of MDMA in Australia is a pill ("National Drug Strategy Household Survey 2016", 2017), which has the potential to contain any number of dangerous chemicals, usually new psychoactive substances or 'research chemicals', as filler material (Giné, Espinosa & Vilamala, 2014). Recent Australian

research by Day et al., (2018) showed that 54% of drug users at a music festival would be highly likely to use a drug checking service. The potential of such a program to be a point of first contact, is obvious.

This data shows the need for an effective but brief intervention protocol that targets young people who choose to use MDMA at music festivals. The use of the screening, brief intervention and referral to treatment (SBIRT) model for reducing illicit substance use has been used extensively in the past, though one group of researchers suggest the evidence base for its efficacy is inconclusive (Young et al., 2012). By following the SBIRT model, the implementation of this protocol and the subsequent data that follows would contribute a valuable Australian perspective to this body of research.

Like other early intervention protocols developed in Australia (Bright & Williams, 2016), this brief intervention delivers personalised *feedback* that grants self-autonomy and instils a sense of personal *responsibility* whilst also *advising* change. It offers a *menu* of choices that ideally, will be delivered by skilled clinicians able to reflect a high level of *empathy* and offer treatment options that promote an individual's *self-efficacy*. This framework is otherwise known as the FRAMES model (Bright & Williams, 2016) and its philosophy was used to guide the creation of this protocol.

RABI-M Protocol

Participants and Setting

Participants would consist of individuals attending a music festival that choose to use an on-site pill testing service. This would ensure the intervention is targeted only at the relevant population; those who are already planning to use MDMA. Participants would be ensured of

their anonymity and asked as a pre-requisite for the service, only to complete an online 'MDMA use survey'.

It is essential that practitioners of the RABI-M protocol be skilled clinicians with at least some experience in formalised alcohol and other drug treatment. This ensures that the appropriate level of empathy and engagement with participants remains authentic to the tools used in the protocol.

Psychoeducation

A psychoeducation package is utilised in the delivery of this protocol. It will include informational brochures on harm reduction, facts and figures about MDMA use in Australia informed by the National Drug Strategy Household Survey, and information and contact details for different rehabilitation and alcohol and other drug services around Perth. In this package participants will also receive a printout of their personal screening results (see Appendix A for reference).

Screening

Online screening tools have been shown to have some efficacy at reducing the amount of alcohol consumed per session in university students (Gajecki et al., 2014; Kypri et al., 2014) so utilising a similar tool with MDMA in a pill testing scenario outside of primary care may yield positive results. "Drugs Meter" is a website home to several drug usage apps (including MDMA meter) that simultaneously act as a screening and data collection tool (Winstock, 2018).

'MDMA meter' is a comprehensive and interactive tool that quizzes a user on different elements of their MDMA consumption. While doing so, it delivers consciousness raising advice around drug use, including advice on how to handle sex on drugs, pictures of dosage sizes, information surrounding criminal penalties, an estimate on lifetime expenditure and advice on

the effects of mixing different drugs. It provides a personalised readout of how a user's data compares to completed results of over seventy-thousand entries, while localising relevant information down to the individual's state (Winstock, 2018). The data readout from the survey is simple and easy to understand. It provides details such as the national average use, use adjusted for life risk factors (such as prescription medications and family history of mental illness), quantified lifetime usage reports, and a unique ID number (see Appendix A). This ID number can then be used by participants to re-sit the application and track their progress based on previous results.

As well as providing this data, the MDMA meter also incorporates an assessment of the problems an individual may incur from their drug use in the form of the Drug and Alcohol Problem Screen (DAPS). The DAPS was developed specifically by drugs meter for use in their screening tools and is informed by clinical experience and a range of research instruments and diagnostic guidelines used in the addiction field (Winstock, 2018). It scores from 0 to 50 and effectively creates four categories; controlled use (0-10), problematic (11-20), hazardous (21-30) and harmful (31+). Upon receiving a score from the questionnaire, the user is presented with information about how their drug use may be impacting their lives as well as advising to take breaks from use and appropriate advice on how to cut down (see Appendix B for details). This number also acts as a base reference point to compare to at follow up.

The psychometric properties of the DAPS are yet to be assessed, so utilising this tool in a research setting with individuals already using MDMA can lend significant data as to its accuracy, validity and efficacy as a screening tool for problematic drug use.

Brief Intervention

Controlled Use

People who use the service that return a DAPS score of ten or less will be considered in the "controlled use" category. Intervention initiatives for these individuals will be as simple as a read out of their pill content attached to a wristband (for emergency worker reference) and the psychoeducation package.

Problematic, Hazardous and Harmful

For those with a DAPS score of above ten, they will be assessed using the Contemplation ladder which has been applied to various behaviour change models extensively since its invention (Bright & Williams, 2016; Biener & Abrams, 1991). This data will then be used to assess the level of intervention that is appropriate for the individual ensuring that the first two stages of the Trans-Theoretical Model (TTM) of change are acknowledged and the known mechanisms at work can be adhered to (Prochaska, DiClemente & Norcross, 1992). That is, individuals in the pre-contemplation stage of the TTM do not perceive their behaviour to be problematic and do not respond well to interventions to change behaviour, while those in the contemplation stage are beginning to feel thoughts of ambivalence towards the behaviour and will benefit from a client centred brief intervention that boosts their self-efficacy for change (Miller & Rollnick, 2012; Prochaska, DiClemente & Norcross, 1992).

Contemplation

For contemplators experiencing ambivalence, motivational interviewing (MI) has been regarded as an effective and robust technique that enables an individual to retain their sense of personal autonomy which then becomes the source of their intrinsic motivation to change (Miller & Rollnick, 2012). MI has been implemented across a wide array of mediums and so long its

client focused spirit is retained, its application in a festival setting should pose no issues (Jiang, Wu & Gao, 2017; Walker et al., 2017; Lundahl, Kunz, Brownell, Tollefson & Burke, 2010). As well and as part of their brief MI session, contemplators will also be offered goal setting advice pertinent to their DAPS score and their personal motivations for change, psychoeducation and the results of their pill test on a wristband.

Pre-contemplation

As stated previously, individuals in the pre-contemplation stage do not benefit from attempts to persuade behaviour change (Bright & Williams, 2016; Prochaska, DiClemente & Norcross, 1992). Therefore, pre-contemplators using the service will first be offered consciousness raising advice to help them become aware of the potential risks posed from their level of MDMA use. This advice will further be informed by the data collected from the MDMA meter and DAPS screening tools, ensuring the information delivered to the individual is personalised and relevant to their level of progression through the stages of change. If attempts at consciousness raising are successful and the individual moves into the contemplation stage, the practitioner can then address the individual as such. If an individual remains pre-contemplative, they will only be offered their pill test results on a wristband and the psychoeducation package.

Referral to Treatment

As previously stated, part of the SBIRT model is referral to treatment. As such, part of this intervention protocol will address the potential need to refer some participants to treatment services. As well as having access to contact information of treatment services in the psychoeducation package, participants indicated as having patterns of hazardous or harmful use (score above 20) should be directly alerted to this information. Depending on the severity of their score, participants can be informed as to the level of treatment they may find helpful and the

wide availability of treatment services available in the state. However, it is important that a practitioner does not push a participant to engage with a treatment service, this ensures that the elements of MI and the FRAMES approach to brief interventions are respectfully adhered to.

Follow up

Participant follow up will be entirely driven by the individual participating. As MDMA currently carries criminal penalties, participants will not be required to leave any contact details behind but offered the option to do so for a 1 week follow up phone call. Also, due to the nature of the screening tools used by this protocol, participants can re-assess themselves at any stage in the future to gauge their progression through behaviour change. This tool and the data it carries then becomes an asset for any health worker that the individual chooses to engage with in the future. This leaves participants free to choose from a menu of options available to them, which enables the responsibility to change to remain theirs.

The RABI-M protocol outlined in this document details a client centred and evidence-based approach that adheres to the SBIRT and FRAMES models of intervention. For a detailed flow chart of expected outcomes, see figure 1. This framework can be adapted for use with alcohol and other drugs via the other screening tools available at the drugs meter website should its application prove effective. To determine efficacy of the protocol and its technologies, a randomised control trial assessing the protocol's follow up rate will ensure the parameters of the intervention are able to be adjusted sufficiently.

In conclusion, the RABI-M protocol is designed to engage with at risk individuals using MDMA who may not have approached treatment services in the past. Through the administration of a contemporary and interactive screening tool, participants of the service will gain a

personalised and structured insight into their MDMA usage. Potentially problematic users are identified while also allowing the freedom of choice to engage with treatment services to remain with the individual. This protocol should be considered as an intervention strategy that is offered alongside pill testing services in Western Australia.

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RABI-M protocol flowchart:

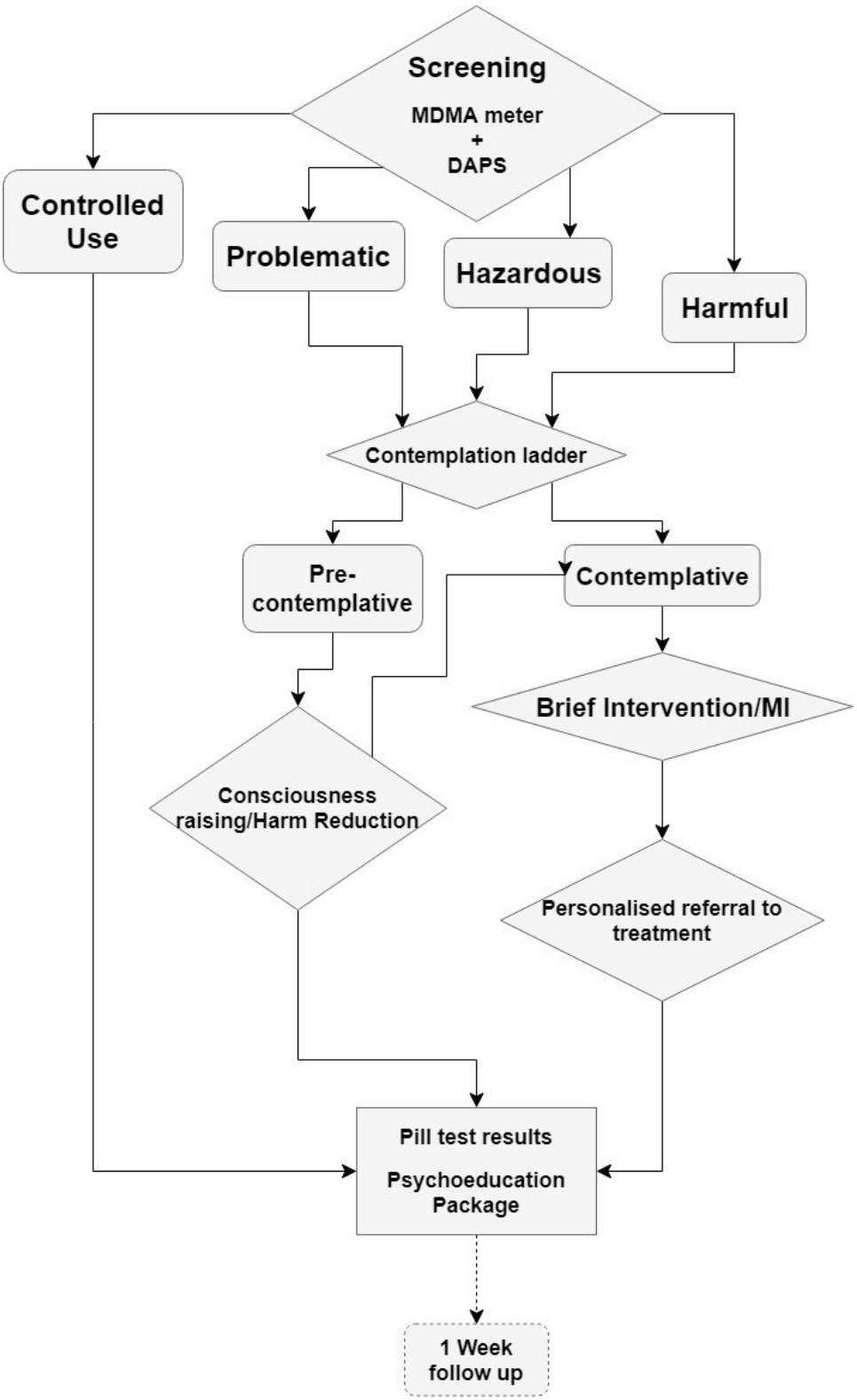


Figure 1.

Appendix A

print this page

Your drug usage: A summary

MDMA use

Your use compared to others	:	Very low
Your use with risk factors	:	Average (middle 20%)
DAP Score	:	10
Your use last visit	:	In the top 10% of users†

† risk adjusted score

Reviewing your MDMA use



Where you thought you were

Based on amount, how you measure up to others

How you measure up adjusted for your individual risk

Your lifetime usage: **18.00 gm**

Your lifetime spend: **5,400.00**

Last year **3.5%** of your country's population used mdma

Thank you for submitting your answers, they are completely anonymous and will be integrated into our database

By submitting your data you are adding to the drugs meter database to help other people and make our dataset bigger and more accurate, and it means you can return to drugs meter to compare your results

Use this unique ID number the next time you complete drugs meter and we can compare that visit with your previous (ie this) visit

10-00-05-68-41

Check us out at www.drugsmeter.com

Appendix B





Problems from MDMA use

The questions you have just answered are known as the Drug and Alcohol Problem screen (DAP) and is a score from 1 to 50. Based on the answers you have given your DAP score is **37**

Find out how the DAP worls at the bottom of the page

0. Based on what you have reported to us you do not appear to have a problem with this substance

1-10. Based on what you have reported to us your use of this substance appears to be controlled and not impacting too negatively upon your health and well being

No level of use however is without the risk of acute harm. If you want to keep your risk of substance related harm low, try not to increase how much you use or how you use it

11-20. Based on what you have reported to us, your use appears to be causing you some problems in at least some areas of your life

Think about how your use is impacting upon you and think about taking a break or cutting down for a while and see how you feel. See the drugs meter tips for cutting down and safer use

21-30. Based on what you have reported to us, your use appears to be causing you problems and impacting negatively upon your life.Your responses are similar to those seen in people who are at risk of developing dependence. You should try and give yourself a break and see how you feel in a couple of weeks

See the drugs meter tips for cutting down and safer use. If you cannot cut down we suggest you seek some help. Some useful links to local UK directories of drug, alcohol and counselling services are given on the drugs meter website

31+. Based on what you have reported to us, your use is causing you significant harm and impacting negatively on your health, relationships and functioning. You may be dependent on this substance. If you want to stop, don't do it suddenly . Cutting down gradually over a week or two will make your withdrawal symptoms less intense. Go to the tips for cutting down in the drugs meter. If you cannot cut down we suggest you seek some help. Some useful links to local UK directories of drug, alcohol and counselling services are given on the drugs meter website

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For a more complete explanation of how and why we developed the Drug Associated Problem score and what it means please click here.

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Appendix B

Brief Intervention: Protocol for Festival Goers

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ADS2356: Interventions Initiatives

Stephen Bright

Submitted: 1/10/2018

Brief Intervention: Protocol for Festival Goers

According to the National Drug Strategy Household Survey in Australia, between 2013 and 2016, the average age of first use was between 18-21 years, with reported use of four most common used substances: cannabis, meth/amphetamines ecstasy and hallucinogens (Australian Institute of Health and Welfare [AIHW], 2017). In 2016, in the last 12 months, substance use was the highest amongst people ages 20-29 years (AIHW, 2018). In Australia alone, 1.6 million people in 2013 reported being a victim of an illicit substance-related incident and this increased in 2016 to 1.8 million people (AIHW, 2017). Illicit substance use is associated with risk factors that interlink with the individual, family, friends, and the community (AIHW, 2018) and can lead to the cause of diseases, disability and death. Approximately one in five deaths are substance related (Department of Health [DOH], 2004) and 1,808 substance-induced deaths were reported in 2016 (Australian Bureau of Statistics [ABS], 2018). These statistics convey the major health issue regarding substance use and the innocent lives lost from both accidental overdoses (71.3%) and suicidal overdoses (22.7%) (ABS, 2018). To prevent the increase of these statistics amongst young people and substance use, a harm minimisation approach could be implemented to raise consciousness and awareness around risky substance use and deter dependence. Substance use for young people is commonly experimentation (e.g. at parties or festivals), depending on their curiosity and peer groups (Bonomo & Bowes, 2001) and has been found young people are less likely to develop dependence when they are experimenting.

A brief intervention (BI) protocol will take place at an upcoming festival in Australia: Listen Out (Perth, Western Australia). The brief intervention will utilise the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model (Babor et al., 2007) with the elements developed by the Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy (FRAMES) model (Miller & Rollnick, 2012). The BI protocol will be in a marquee at the festival, with couches, low lights and calm music to ensure the individuals are in a relaxing environment. The protocol will identify young peoples (aged 18-28 years) substance use with the Drug Use Disorder Identification Test (DUDIT) (Berman et al., 2003). Peer Based Harm Reduction, Western Australia (PBHR) is a non-for-profit organisation that utilises a harm reduction approach, by raising awareness and providing education and support, to minimise harm to individuals involved in substance use (PBHR, 2018). This

organisation can grant funding for the protocol and provide their highly trained staff to assist at the festival. Students from Addiction Studies in second year from Edith Cowan University (ECU) will volunteer to help as staff and aim to engage and encourage people to take part in the brief intervention protocol. Students for Sensible Drug Policy (SSDP) executives will provide funding from the ECU Guild and assist in the sausage sizzle provided.

Understanding the SBIRT Model

SBIRT is an integrated framework that is utilised to prevent substance related risks (Babor et al., 2007). A review of SBIRT in the management of substance use, demonstrated efficiency within a clinical setting, in reduction of heroin and cocaine use (Bernstein et al., 2005). A single session of motivational interviewing and a self-help book portrayed reduction in amphetamine use (Baker et al., 2005); and general practitioners utilised a brief intervention strategy (letters and consultations) to reduce major benzodiazepine use (Bashir, King & Ashworth, 1994). The common research within a clinical, primary care setting is useful, however, there is a lack of evidence within a non-primary care setting: festivals.

The Protocol for Festival Goers: Participants and Setting

When recruiting staff, PBHR is robust within this area. PBHR utilise a peer-education approach by reducing the harm associated with substance use (PBHR, 2018). Five professionals from PBHR will carry out the BI and screening in the marquee because they are professionals and reliable within the drug sector. Approximately five volunteer students from ECU in Addiction Studies will also help staff the protocol. The five volunteer students will be chosen through a personality test: The Five Factor Model by McCrae & Costa (1987) and those with high scores in openness, agreeableness and extraversion will be chosen as the right candidates. The volunteer students from ECU will stand outside the marquee (two people) and influence young people to have a chat and try the BI in the ‘chill out zone’. The other students, (three people) will walk around the festival and advertise the ‘chill out zone’ to those that look in need of a rest and a calming environment. The SSDP executives will provide funding for the sausage sizzle and cupcakes through the ECU Guild. The five executives will help set up the front of the event and entice young people by giving away free food and non-alcoholic drinks. Prior to the festival, all the staff will undergo First Aid as a health and safety precaution.

The Protocol for Festival Goers: Screening Tool

Berman et al. (2003), developed DUDIT, as a brief screening tool to identify recent substance use and patterns of the substance use. The screening tool consists of an 11-item self-report questionnaire, for individuals to report their recent substance use (within the past year) and can identify at-risk substance use (Hildebrand, 2015), through three focus areas: frequency of substance use, physical and psychological issues related to substance use and symptoms of dependency to the substance (Matuszka et al., 2013). The DUDIT has nine questions that are scored on a Likert scale "…on 5-point scales ranging from 0 to 4, and two are scored on 3-point scales with values of 0, 2, and 4. Thus, total scores range from 0 to 44, with higher scores suggestive of a more severe drug problem." (Voluse et al., 2012, p.23).

Studies have utilised the DUDIT psychometric tool in detox and impatient units in Sweden (Berman et al., 2003) and was further reviewed in a less severe substance use setting with outpatient and residential treatments in the United States (Voluse et al., 2012). The study consisted of random selection from two treatment programs in South Florida (outpatient substance treatment and residential substance treatment). The participants were classified into three groups: outpatient substance users (M = 30.66 years) (n = 35), residential substance users (M = 41.51 years) (n = 79), or a combination of alcohol and substance use from both treatment programs (M = 43.21 years) (n = 39) (Voluse, et al., 2012). The results used a receiving operating characteristics (ROC) curve to establish the test sensitivity and specificity of the study and concluded a high sensitivity score of .90 and specificity score of .85, (Voluse et al., 2012). These results convey the test reliability and validity of the DUDIT scale for substance treatment programs.

Another study utilised the DUDIT scale and focused specifically on young people in Hungary at two electronic dance events (Matuszka et al., 2013) and examined the internal consistency, reliability and the validity of the tool. The participants were randomly selected through every fifth person and the results examined the young people were at risk of two prominent substances: cannabis (92.1%) and amphetamines (55.3%) (Matuszka et al., 2013). The study used Cronbach's Alpha coefficient to test the consistency and resulted in 0.88 for the young people at risk of substance use (Matuszka et al., 2013). The ROC curve was also used to establish the sensitivity and specificity of the DUDIT test and resulted in 0.95 for sensitivity and 0.81 for specificity (Matuszka et al., 2013). These results conclude the consistency, reliability and validity of the DUDIT tool within a dance event environment and

targets young people. However, to our knowledge shown through prior research, this study has not been examined in Australia for young people within a festival setting and critiques the gap within the literature, respectively.

The Protocol for Festival Goers: Brief Intervention

The FRAMES model explains effective BI's through six fundamental elements (Miller & Rollnick, 2012). The BI should cover individualised personal ***F****eedback,* with ownership of personal ***R****esponsibility,* autonomy and encouragement of self-efficacy, whilst providing ***A****dvice* to change. To pursue change, the individual is offered a ***M****enu* of options with the clinician providing ***E****mpathy* and support for the individuals ***S****elf-efficacy* (Miller & Rollnick, 2012).

Components of the FRAMES model has been utilised for young people within an Adolescent Cannabis Check-Up (ACCU), with personalised feedback and provision of advice to aid an in-depth assessment of the young peoples' behaviour around cannabis use (Martin, Copeland & Swift, 2005). The personalised feedback occurred one week after the assessment and resulted in significant results; 96.9% thought the clinician was moderately or extremely helpful and 86.9% believed the personalised feedback was helpful (Martin et al., 2005), and within the 90-day follow-up, 78% of individuals reported reduction in their cannabis use.

The protocol for festival goers is accompanied by pre-existing early intervention protocols, to ensure the BI is effective for the young people. The BI will be delivered in a "chill out zone" within the festival, so the individual and the peer-based educator can have a relaxing, non-judgemental and non-pressured conversation about their substance use, using the screening tool (DUDIT) (Berman et al.,2003).

The Protocol for Festival Goers: Referral to Treatment

The DUDIT totals to a score of 44 and the scoring is classified different between male and female (Berman et al., 2003). If a male scores less than 6 and a female scores less than 3, this is a low range at-risk score and consists of a minimal intervention (1-hour session). Basic education is provided to reduce harm and it is believed they can posit change themselves. The basic education provides an understanding about water consumption: if a person is active, drink 500-600ml of water per/hour, if a person is not active, drink 250ml of water per/hour (AIHW, 2017). Other basic education is around knowledge on staying safe: being with

trustworthy friends, having a phone to contact emergency if needed, taking breaks from dancing and avoiding polydrug use.

If both genders score up to 25, this is a mid-range at-risk score from substance use. The Contemplation Ladder constructed by Biener and Abrams (1991) is used at the mid-range and high-range of at-risk, to determine their stage of change. A minimal intervention (1-hour session) and harm reduction strategies: The Four L's: Liver, Lover, Lifestyle and Law (adapted by Roizen) (DOH, 2004), are put in place to provide knowledge and cognitive strategies to flow through the stages of change.

If both genders score above 25, this is a high-range at-risk score from substance use. The individual is referred to a counsellor for 4-5 sessions (1-hour sessions) of BI. The counsellor will determine their stage of change using the Contemplation Ladder (Biener & Abrams, 1991) and assist movement in the stages of change. Triggers will be assessed for substance use and how these can be avoided. Setting goals is a main priority in these sessions, up to follow-up. The individuals at the mid-range level are given an incentive ($50 Coles voucher and a SSDP goodies gift bag) to return to follow-up within 1 month of the screening and 1-hour session of minimal intervention. The individuals at the high-range level are given the same incentive to return to follow-up within 3 months of the BI sessions.

The Protocol for Festival Goers: Follow up

These follow-up times have been chosen in accordance to the individuals' stage of change. Those at high-risk are assumed to be involved in the 4-5 sessions of BI and be in contact with a professional. The focus on their stage of change, is most likely situated around the contemplation to preparation stage (Prochaska, Norcross & DiClemente, 2013). Whereas the mid-range will only attend a 1-hour session and is most likely assumed to posit pre-contemplation stage (Prochaska et al., 2013).

Summary

In summary, the BI protocol for young people within a festival setting, has acknowledged the gap within the research in Western Australia, in relation to screening for substance use within this population and setting. The SBIRT model and elements of the FRAMES model interlink with one another, to provide an in-depth understanding about the process of screening and BI. The DUDIT psychometric tool is utilised for this protocol as it has shown feasibility and reliability through previous research within this population. The BI

protocol chosen, is going to allow for screening for patterns and frequency of use, to determine whether an individual posits at-risk in the low-range, mid-range or high-range of substance use. The gap within the research implies this brief intervention protocol chosen, will be feasible within a primary care setting and could potentially assist festival goers. Through screening individuals, health professionals can provide knowledge around substance use and utilise harm reduction strategies to prevent hazardous risk associated with the individual's substance use within a festival setting.

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Appendix C

Youth Intervention and Prevention Protocol for Substance Use: A Universal Objective

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ADS2356: Addiction Studies Intervention Initiatives

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30/01/2019

Youth Intervention and Prevention Protocol for Substance Use: A Universal Objective

A growing body of evidence demonstrates that alcohol and other drug (AOD) use is prevalent during adolescence, with age of first use negatively correlated with the risk of developing substance use disorders (SUDs) later in life (Levy et al., 2014; Merianos & Barry, 2017; Reyna & Farley, 2006; Winters & Kaminer, 2008). More specifically, AOD use during adolescence increases exposure to neurotoxic processes that can impact the cognitive development of complex, higher-order reasoning and processing (Brown et al., 2008). According to Brown et al. (2008), adolescent AOD use potentiated risky behaviours, disrupted social and academic maturity, and exacerbated physical and mental health concerns throughout life. Hence, the lifetime burdens that AOD use can have on the individual, as well as public health and social services, suggests there is a crucial need for an effective early intervention and prevention protocol for AOD use among the adolescence population (Teesson, Newton, & Barrett, 2012).

It is recognised that a significant percentage of individuals initiate AOD use throughout their secondary high school (SHS) years. In 2014, more than 23,000 Australian secondary students were surveyed for substance use. A staggering 68% of students aged 12 to 17 years reported drinking alcohol in their lifetime; 39% of 17 year old students had used tobacco products, 19% of all students had used inhalants; 18% of students reported the use of tranquilisers for non-medical purposes; two percent of students reported the use of amphetamines, performance enhancing drugs, opiates, and cocaine; and whilst only three percent of all students reported ever using ecstasy and hallucinogens, this proportion increased to six and seven percent respectively for students aged 17 years (White & Williams, 2016). In summation, the SHS setting provides an opportunistic window in which to initiate a universal Screening, Brief Interventions and Referral to Treatment (SBIRT)

program that could delay or prevent the onset of AOD use and minimise the risk of developing SUDs later in life.

A universal SBIRT protocol involves screening an entire population within a specific setting to identify individuals at risk with AOD use, and to deliver brief intervention (BI) and referral to treatment (RT) as required (Bright & William, 2017). Research developments in the United States of America (USA) have reported on the primary strength of universal SBIRTs in SHS settings. Maslowsky, Whelan, Moberg, and Brown (2017), demonstrated the potential for school-based SBIRTs to prevent or delay the onset of AOD use in adolescence, when AOD use is recognised as being most harmful to cognitive development. This was further evidenced in a systematic review conducted by Foxcroft and Tsertsvadze (2011), that reasoned by delaying the onset of substance use by just a few years in adolescents could have significant lifetime health and social benefits.

There is extensive research to support SBIRT protocols for substance use in primary health care settings (Gryczynski et al., 2015; Howard, Fry, Chan, Ryan, & Bonomo, 2018; Pilowsky & Wu, 2013; Levy et al., 2014). However, despite high rates of substance use and an increased risk associated with the development of SUDs among adolescence, the proportion of adolescence that seek primary care treatment remains very low (Reavley, Cvetkovski, Jorm, & Lubman, 2010). Wells, Horwood, and Fergusson (2008), reported that 96% of young adults presenting with AOD problems did not seek help because they did not believe they had a problem, and of those more than a quarter believed they could help themselves. This suggests that an effective program is needed to assist our youth in understanding and recognising the stages associated with AOD use and the subsequent development of SUDs. For this reason, the Youth Intervention and Prevention Protocol for Substance Use (YIPPS), Resilience is Ours' Challenge (ROC) has been developed. Suitably, the SHS provides a practical setting to deliver SBIRT for substance use in adolescence.

Primary research on the effects of universal school-based SBIRT for AOD use in the adolescent population is necessary in Australia. Future research should incorporate the development of randomised control studies to measure the effects of YIPPS on prevention and intervention, and delayed AOD use in this population. Success of the YIPPS program in the SHS setting, could provide protection measures for future students entering the higher education settings where again, despite high rates of AOD problems among students', treatment is rarely sort (Caldeira et al., 2009).

Development of Youth Intervention and Prevention Protocol for Substance Use (YIPPS)

A structured universal SBIRT protocol was developed as an early intervention for AOD use in SHS settings. The protocol was named the Youth Intervention and Prevention Protocol for Substance Use (YIPPS). The objective of YIPPS was to delay or prevent onset of AOD use in individuals with existing thoughts of AOD use in near or distant future, and to minimise the harm and prevent SUDs developing in adolescence and adulthood.

Participants and Setting

Recruitment. YIPPS is directed toward all students enrolled in Australian SHS education. For this protocol youth is defined as all students or adolescents aged between 12 and 18 years.

The development of the Resilience is Ours' Challenge (ROC), otherwise referred to as the ROC- ON challenge will be presented to all students to encourage unity and commitment to healthy challenges among peers. A dedicated website will be developed to allow students to engage and participate in Social and Emotional Learning (SEL)/resilience programs, challenges and events.

Informed Consent. Following standard consent practices for school-based interventions, an opt out consent form will be posted or emailed to all parents of students

aged 12 to 14years. Mature consent would be obtained by students aged 14 to 18 years (Maslowsky et al., 2017).

Staffing. In collaboration with the Australian Departments' of Health and Education, and Edith Cowan University (ECU), a two-year initiative program will commence to incorporate AOD studies and treatment practices into nursing, psychology, and social workers degrees. A practical program will be developed that provides the opportunity for up to 20 high achieving third year nursing students and social work students to assist with the delivery of the YIPPS program into Australian SHSs. This will provide for two YIPPS teams to be actioned, with each team consisting of a minimum of six nurses and 4 social workers. This practical program will provide initial training on the CRAFFT screening tool, and strategies necessary for delivery of the YIPPS program. Maslowsky et al. (2017), determined that the use of paraprofessionals provided a cost-effective means to deliver SBIRT programs to large populations whilst providing a valuable practical opportunity for these higher education students. Additionally, a high proportion of undergrad students are young adults and studies indicate adolescence are more likely to relate to younger interviewers, and thus divulge personal information and AOD use (Maslowsky et al., 2017). Older candidates would still be utilised; however, it is important to include a proportion of young adults in each YIPPS team.

The school psychologist is the leading mental health expert in the school environment and together with school nurses will take a senior role in the YIPPS program. It is crucial that the Department of Education and the Department of Health up-train all school psychologists and nurses to ensure effective delivery of all aspects of the YIPPS strategies such as, BI, harm reduction approaches, cognitive awareness building, MI and SEL/resilience programs.

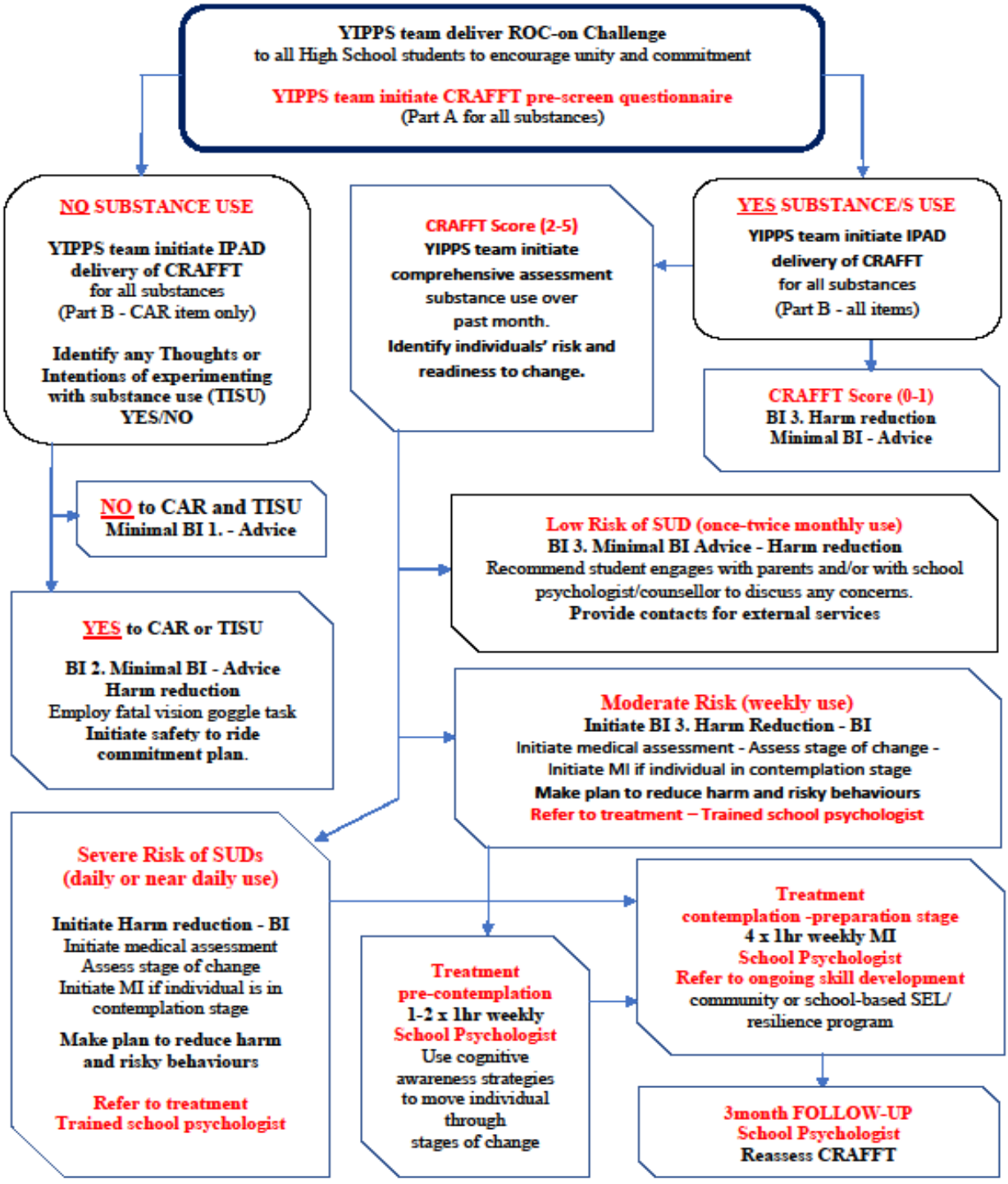
Screening Tools and Tasks

CRAFFT screening tool. The CRAFFT (Car, Relax, Alone, Friends/Family, Forget, Trouble), is the most widely used and developmentally appropriate screening tool for AOD use in adolescents (Maslowsky et al., 2017). CRAFFT is a 6-item mnemonic scale. A pre-screen questionnaire was initiated to determine previous or anticipated AOD use. "All students were asked the Car question of the CRAFFT ("Have you ever ridden in a CAR driven by someone (including yourself) who was 'high' or had been using alcohol or drugs?"). Students who reported using any alcohol or drugs were asked the remaining CRAFFT questions". "Do you ever use alcohol or drugs to Relax, feel better about yourself, or fit in?; Do you ever use alcohol or drugs when you are by yourself, Alone?; Do you ever Forget things you did while using alcohol or drugs?; Do your family or Friends ever tell you that you should cut down on your drinking or drug use? Have you ever gotten into Trouble while you were using alcohol or drugs?" (Maslowsky et al., 2017, p. 5). Each "yes" answer =1 point. A CRAFFT score of zero to one indicated low risk AOD use. A CRAFFT cut off score of two or higher was considered optimal to identify AOD-related problem. Mitchell et al. (2014), conducted analysis that recently validated the CRAFFT against DSM-V (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) substance use diagnostic criteria. "At the CRAFFT score of 2, sensitivity and specificity for problem use or any DSM5 SUD were 0.79 and 0.97, respectively, whereas sensitivity and specificity for SUD were 0.91 and 0.93, respectively" (Mitchell et al., 2014, p. 378). A detailed summary of YIPPS universal protocol utilising the CRAFFT can be viewed in Figure 1.

Fatal vision goggle task. Fatal vision goggles provide a practical experience and understanding of how alcohol and marijuana will impact ones' ability to function whilst under the influence of these substances (Alcohol & Drugs Innocorp, 2018). The objective of utilising the fatal vision goggle task is to create a memorable, interactive task that will arm individuals with the power of foresight to allow them to make more safety conscious choices.

Figure 1: Youth Intervention and Prevention Protocol for Substance Use (YIPPS)

Universal SBIRT in High Schools



Brief Intervention (BI)

As seen in Figure 1. the YIPPS BI protocols are structured to incorporate the underpinnings of the Trans-Theoretical Model (TTM) of change (Prochaska & Velicer, 1997). The TTM of change theorizes that an individual with SUDs will move through five stages of change from pre-contemplation to maintenance according to that individual's readiness to engage in behaviour change. The precontemplation stage of change represents a stage when the individual does not recognise their behaviour as problematic, while those in the contemplation stage of change experience inconsistencies, or cognitive dissonance between their beliefs and their behaviour (Bright & William, 2017). The following BI's are structured to work with the individual at their presenting stage of change.

BI 1. Minimal BI, advice. Identifying individuals' self-efficacy and own motivations used to avoid substance use. Focus on praise and positive reinforcement for maintaining healthy behaviours that promote abstinence. Provide further support and information on student groups, SEL programs, and activities that support and develop effective resilience skills for students to maintain healthy abstinent behaviours.

BI 2. Harm reduction. In addition to BI 1. provide feedback and information on the effects and harms associated with psychoactive drug use. Employ relevant fatal vision goggle task for alcohol and/or cannabis use. Make a safety to ride commitment plan with the individual.

BI 3. Harm reduction with minimal BI, advice. In addition to BI 1. and BI 2. Identify individuals' ambivalence and/or own motivations to reduce and avoid substance use. Recommend students abstain from substance use. Provide feedback and information flyers on harms associated with psychoactive drug use and the effects on social and psychological development. Emphasise risk avoidance and harm minimisation.

Referral to Treatment

Individuals presenting with immediate health issue should be referred to the school psychologist to determine if further external treatment services are required. Otherwise, treatment is to be undertaken by the school psychologist with treatment plan to be determined by the individuals' assessment of risk and stage of change. Individuals presenting in pre-contemplation will receive one-two, one-hour weekly sessions with the intention to influence the individual's cognitive awareness to assist them to move them through the stages of change. Individuals presenting in contemplation stage of change will receive four-six, one-hour weekly MI sessions with the school psychologist.

Referral to ongoing skills development through community or school-based SEL/resilience programs are to be extended to the individual to further support and develop effective resilience skills necessary for individuals to maintain healthy abstinent behaviours.

Follow-up

To assess if the individual has moved forward with initial plan to reduce risky behaviours and/or AOD use, individuals that have progressed through the YIPPS program will be invited by the school psychologist to be reassessed with the computerised CRAFFT tool three months after last treatment session.

Conclusion

AOD use is prevalent in the adolescent population and Australia currently has no effective universal SBIRT in place to reduce the likelihood of developing SUDs later in life. The YIPPS universal protocol extends from USA initiatives and studies that have demonstrated how the implementation of a universal SBIRT in SHS setting for the early intervention and prevention of AOD use is both warranted and necessary. Delaying the onset of AOD use and reducing the harms associated with early drug use can have far reaching health and social benefits for the individual and public health care services. Thus, indicating feasibility in implementing the YIPPS and ROC-ON Challenge into the SHS setting. In line

with research developments in the USA, the Australian Departments' of Education and Health should be encouraged to explore the implementation of the YIPPS Universal ROC-ON Challenge into Australian SHSs. This protocol extends on previous studies that focus on reducing the risk associated with developing SUDs through early intervention in adolescence.

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