LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE DRUGS OF DEPENDENCE (PERSONAL USE) AMENDMENT BILL 2021

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

Members:

MR P CAIN (Chair)
DR M PATERSON (Deputy Chair)
MR J DAVIS

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 9 JULY 2021

Secretary to the committee:
Dr D Monk (Ph: 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

WITNESSES

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Amended 20 May 2013

The committee met at 1.01 pm.

EGERTON-WARBURTON, PROFESSOR DIANA, Fellow, Australasian College for Emergency Medicine
LOOI, ASSOCIATE PROFESSOR JEFFREY, Board Member, Australian Medical Association (ACT) Ltd
SOMERVILLE, MR PETER, Chief Executive Officer, Australian Medical Association (ACT) Ltd

THE CHAIR: Good afternoon, and welcome to this public hearing of the Select Committee on the Drugs of Dependence (Personal Use) Amendment Bill 2021. The committee wishes to acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of the city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

During today's proceedings we will hear evidence from medical and legal experts, the Alcohol, Tobacco and Other Drug Association, and the Australian Federal Police Association.

Please be aware that the proceedings today are being recorded and will be transcribed and published by Hansard. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if you could please state, "I will take that as a question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

At the moment we have in personal attendance Mr Somerville, a representative of the Australian Medical Association, and two on the phone—Associate Professor Looi, representing the Australian Medical Association, and Professor Egerton-Warburton, representing the Australasian College for Emergency Medicine. Do you have any comment to make on the capacity in which you appear?

Prof Looi: I am Associate Professor and Head of the Academic Unit of Psychiatry and Addiction Medicine at the Australian National University Medical School. I am speaking in my capacity as a board member of AMA ACT.

Prof Egerton-Warburton: I am a Fellow of the Australasian College for Emergency Medicine and a member of the Public Health Committee.

THE CHAIR: Please be aware that today's proceedings are covered by parliamentary privilege, which provides protection to witnesses but also obliges them to tell the truth. The provision of false or misleading evidence is a serious matter, and all participants today are reminded of this. Please ensure that you have read and understood the pink privilege statement. Mr Somerville, is that the case?

Mr Somerville: Yes, that is the case. I have read it and I understand it.

THE CHAIR: Professor Looi, have you read and understood the pink privilege

statement?

Prof Looi: Yes, I have.

THE CHAIR: Professor Egerton-Warburton, have you read and understood the pink privilege statement?

Prof Egerton-Warburton: Yes.

THE CHAIR: I invite each of you, if you so wish, to make an opening statement of up to five minutes. Peter, we might start with you, if you want to do that.

Mr Somerville: Chair, Professor Looi will make an opening statement for the AMA.

THE CHAIR: Jeffrey, would you like to proceed to make an opening statement on behalf of the AMA?

Prof Looi: Yes, thank you very much. I would also like to acknowledge the custodians of the land on which we meet today, the Ngunnawal people, and pay our respects to their Elders, past, present and emerging. I thank the committee for the opportunity to appear today and give the views of the AMA ACT on the important matter of decriminalisation of drugs of dependence.

By way of introduction, I am a psychiatrist working in the public and private sectors for approximately 20 years. I am Associate Professor and Head of the Academic Unit of Psychiatry and Addiction Medicine at the ANU Medical School. I appear, as indicated, as a board member of the AMA ACT.

The decriminalisation of illicit substances raises difficult issues. The community is concerned that we should treat them seriously and conscientiously. The medical profession is part of the community and cannot stand aside from that discussion; indeed, we wish to play a part in it.

Our primary position, in the context of the current bill, is that we support a harm minimisation approach to the use of illicit substances. While supply reduction has historically received the majority of government funding, there appears to be increasing acceptance, particularly in the community, of focusing more resources on demand reduction and decreasing harmful use. We support this. However, there are significant caveats, and I would go so far as to say that I have concerns on behalf of the AMA that some of these aspects significantly, and perhaps dramatically, put the cart before the horse.

It is essential that early intervention, treatment and rehabilitation are present for a comprehensive health approach to drugs of dependence, including decriminalisation, comprising but not limited to: care and support in the emergency department; access to acute addiction medicine and mental health services, as well as community addiction medicine and mental health services; and, importantly, support for our GPs in providing care of patients in the community. Furthermore, if we want to plan for more innovative models of care, it will always be underpinned by adequate resourcing, staffing and infrastructure, of which presently we do not have sufficient levels.

To give you some specifics on that, in the ATT public treatment and rehabilitation services work for addiction medicine and psychiatry, clinicians try to deliver a high-quality service, but frequently struggle to meet the levels of demand that they face, because of this unsustainable under-resourcing, understaffing and lack of infrastructure. This under-resourcing, combined with culture issues identified in the Canberra Health Services culture review, lead to an environment where recommendations to increase resources and funding do not have a response at best, and perhaps the other types of responses are not there. This has understandably led to reticence as well as a sense of frustration that bona fide concern and repeated recommendations can have no useful outcome.

In this context, it is essential that additional funding will be required for drug and mental health related services in the ACT, and we will need to carefully examine how we better integrate our drug and mental health related services with acute health care such as the emergency department and alternative funding models, particularly for general and primary care.

The key issues are better integration of care for all stakeholders involved, from the acute hospital system through to the community, and the support of patients being cared for in the main by their GP, in the absence of the levels of addiction medicine and psychiatry services that we would want for our population.

We need to base resourcing of addiction medicine and mental health and allied health services on a comprehensive plan that includes population ratios of practitioners, understanding of service models, requirements for acute, non-acute inpatient and community outpatient services, as well as broad community health services.

I will give a brief summary of the numbers of services. In relation to specific addiction medicine services, we have presently in the ACT, to the best of my knowledge, four addiction medicine specialists, one of whom is a psychiatrist. For the staffing and support of the detoxification unit, that means, for the addiction medicine specialists who cover that, a one-in-three roster. For the population of Canberra, which was last estimated at 430,000, that is one addiction medical specialist for 100,000 people. This is clearly a level about which we should be concerned.

We have better figures from the Canadian Psychiatric Association of the psychiatric services that are needed. To underline why they are needed, in discussions with colleagues in psychiatric services, it can be the case on the weekend and after hours that 30 to 40 per cent of the beds in our high dependency unit are occupied by patients suffering from psychosis in relation to methamphetamine abuse, which leads them to be psychotic and often highly aggressive. Our colleagues in the emergency department can give you more direct information about that, but the staffing levels about which we are concerned, similarly with medical specialists in psychiatry, are the Canadian Psychiatric Association's baseline recommendations—and that is without taking into consideration service models—that we should have 65 psychiatrists for our population; that is, 15 per 100,000 people.

Currently, our staffing for psychiatrists is 55 at the establishment level, and our staffing levels currently sit at 45 with substantive, and 10 of these being provided by

locum services. With respect to significant vacancies in this regard, five to seven are in the forensic mental health services, where many of the people with addiction medicine problems would be encountered. That is a sketch of some of the shortfalls there. I am not a specialist in relation to the nursing workforce, so I cannot speak specifically on that, but that gives some idea of the lack of specialist support.

In relation to bed numbers, my colleague from the Australasian College for Emergency Medicine is better able to discuss this, but we certainly have issues with bed flow or patients that have dual diagnosis, with both psychotic symptoms and addiction medicine problems combined, raising concerns for themselves, their families and those caring for them. We have constant problems with the level of capacity in relation to bed flow, having sufficient beds to care for people with acuity of conditions, with a substantial overlap of addiction medicine problems, including substance abuse, such as methamphetamines in particular as well as amphetamines and other psychotropic agents which are subject to the bill.

THE CHAIR: Thank you, Jeffrey. We might go to questions now. We will spend the next 10 minutes or so just with the AMA. We will then give you, Diana, an opportunity to make an opening statement, and we will spend 10 minutes or so with you, if that is acceptable.

I have a substantive question, Jeffrey, to you or to Peter. Thank you for your paper and for the two recommendations on the theme of what Jeffrey just spoke about. I am very interested, and the committee is very interested. The bill, as it stands, has been presented to the Legislative Assembly. The next legislative stage will be to have a debate on the bill and whether it passes into law. Do you have a recommendation on the merits of the bill as it is now written?

Mr Somerville: Chair, we have not gone to the technical aspects of the bill as such; rather, we have gone to the principles that we see that lie behind it. That is based on, essentially, our expertise in regard to these issues. There are others who will look at those technical aspects. We have assumed that that process would be similar to the legalisation of small amounts of cannabis legislation, where there were amendments to that bill which would have put into the proposed legislation the technical implementation of the matters that we raised in the context of that debate. We have not approached it, and they are the reasons why.

THE CHAIR: You do not really have a view on whether the bill should pass in this present form? That is not a criticism; I am just asking you—

Mr Somerville: Yes, we have not considered that; rather, we have taken a more general approach to this submission and the process.

DR PATERSON: Thank you very much for your submission. I was interested to hear you talk about models of integrated care because this is something that has come through with a lot of the families that we spoke to yesterday—the comorbidity, the drug issue versus mental health issue. There seem to be two different systems that people access, in respect of either/or. There does not seem to be much integrated care or many options for people. In terms of your understanding of other jurisdictions, or even internationally, can you point us to a jurisdiction that does integrated care very

well in respect of mental health and drug addiction issues?

Mr Somerville: I might leave that for Jeff.

Prof Looi: I was also trying to consider the statements about the bill. The caution I would have with the bill is checking the dosages for the personal possession limit, because I have not had the opportunity to calculate the risk consequences of the amounts proposed in the bill. I would think that is a crucial issue. With respect to two grams of methamphetamine listed for personal usage, consumption of that amount may be very deleterious if it is taken in one go.

Without wanting to belabour that point, in relation to Dr Paterson's question about the jurisdictions in which this is done well, most of the jurisdictions that provide more integrated alcohol and drug services with mental health have adequate resourcing of both the addiction medicine and the psychiatric services. As to where that is in Australia, that would be of relative concern, because most of the jurisdictions around Australia struggle with under-resourcing and adequate funding of services. In the states there is provision of services with addiction medicine, but all of that complexion is affected by the managed care system there.

Addiction medicine, as it stands as a specialty, is very limited. I understand from my colleagues who work in addiction medicine that there are only 216 specialists in Australia; the numbers are very low. The specialty is not well developed outside USA and Australia. There is not a lot of comparative data in other jurisdictions to go on. That is why having some better resourcing initially might allow us to build better models of care. I apologise if that lacks the specifics that Dr Paterson wishes to hear about.

DR PATERSON: That is all right.

MR DAVIS: I am sympathetic to the view that general practice is one of the best places for a health consumer to receive good, ongoing care. In your report you cite that 87.8 per cent of Australians see a general practitioner once a year, which leaves 12.2 per cent who do not. We do know that, in large part, that is due to a financial barrier, and the intersectionality between people who are illicit substance users and financially struggling is quite high.

Could we dive a little bit deeper into your second recommendation about that round table where we look at alternative funding models? What conversation has your sector or your organisation already been having about, for lack of a better word, concessions that the industry may be prepared to accommodate going forward to ensure that those people seeking to recover from substance abuse can receive care through a general practice?

We know bulk-billing rates are very low in the ACT. We have recently lost a health cooperative. I am flagging my initial concern that if we are trying to promote those with problematic substance use to go to a general practice, we are already seeing some evidence that suggests there is a financial barrier as to why they are not accessing general practice. Could you reflect on that a bit?

Prof Looi: It may not be the case that it is specifically financial barriers in terms of the people that are not able to present. There may be people that are suffering from comorbid psychiatric illness. Many of the people that we care for in the public mental health services do not have a GP because of some of the health inequities that you have described. It is not necessarily the resourcing thereof, but because of their illness they are reluctant to access a GP. Often the trust can only be built with the mental health services and, to some extent, with addiction medicine services, because our addiction medicine colleagues are much less well staffed.

I am not trying to shy away from the question about the financial aspect. It is not something that I currently have expertise on in GP funding, because I am a psychiatric specialist. The AMA can take the question on notice in relation to that, Mr Davis.

Mr Somerville: The bulk-billing rates in the ACT say nothing about who gets bulk-billed. They are the lowest in the country, but they do not say who walks into a general practice and gets bulk-billed. You will find that in most general practices who privately bill, or bill gaps in the ACT, they will bill selectively people who come before them; that is, many practices will bulk-bill children, parents of children who accompany the child, and health care cardholders. It is not quite as straightforward as saying we have a very low measure of bulk-billing in this territory, which we do, and it can be improved. It is one of the things we are interested in helping with, but it says nothing on its own.

Some of the people we talk about will already be bulk-billed in those practices when they show up. The difficulty, though, is that it is private medicine that operates in general practice. And you are right; we have just seen the National Health Co-op go into voluntary administration for various reasons. The fact is that a general practice needs to run and operate, particularly a high-quality general practice that does not operate on six-minute appointment slots.

This is the sort of trap. There have been other answers that have emerged. The Interchange Co-op in Tuggeranong, run by Dr Clara Tuck Meng Soo, is an answer to this. In fact, I think Dr Su has made a submission as part of a group, which talks about between 30 and 40 per cent of opiate replacement patients in the territory actually being seen in that practice. In a way, the public services in that area have been privatised.

There are a range of different ways that the system reacts to dealing with the sort of patients that you are talking about, Johnathan. It is not quite as straightforward. In a sense, we are saying that that work is already being done. If we are going to look at alternative funding models then we will look at how we can build on, at least potentially, one of the models that is out there. We already have a second model, which is, of course, Medicare. That depends on, if you like, the decision of individual general practitioners as to who is bulk-billed. We can supplement all of that; that is your opportunity to sit down and talk with the various stakeholders about how we can supplement it.

We cannot point to a particular model, although we have advocated in the past for the use of vouchers or the use of funding to NGOs to enable people—their clients and others—who they recognise would benefit from connection with a general practitioner

to access those GP services, for example. That is the sort of thing, and it is why we made that suggestion about a broad-based round table.

THE CHAIR: Diana, we will come to you now. Do you want to have the opportunity to make a five-minute opening statement?

Prof Egerton-Warburton: Yes, I will make a brief statement. I am an emergency clinician. I would also like to acknowledge the traditional owners of the land on which I am speaking today, the Wiradjuri people, and pay my respects to their Elders, past, present and emerging, and to any other Indigenous people at the committee hearing today. I do this particularly because of the high burden of disease from alcohol and drug issues that the Indigenous population has, while recognising that they actually, as a group, use less of these drugs than the general population, but there is a high burden of harm associated with it.

I would like to acknowledge the fact that the College for Emergency Medicine is supportive of decriminalisation and harm minimisation approaches to drug use. We look to the success of overseas models in reducing overall resources and overall harm in relation to that.

In our submission we highlight a number of issues, and I will touch briefly on some of them. In terms of data collection, we recommend that there is part of a national minimum dataset for non-admitted patients to include alcohol and other drugs. This would be a particularly powerful intervention in the ACT if you are considering any policy or legislative changes because it would allow you to measure the actual harm effect, rather than the use effect, of any public policy or legislation changes.

Along with asking questions, emergency physicians are keen to offer screening and brief intervention and referral to treatment. We acknowledge the issues raised by the AMA in terms of the actual ability to be able to do that. While emergency physicians are generally in favour of these measures, they do feel overwhelmed, and they need more resources to be able to do the screening and brief intervention.

We acknowledge the fact that there is an absence of evidence for the benefits of these, in a lot of aspects, but there is some evidence that suggests a small population benefit. Given the large numbers of people presenting, with up to one in 10 people being alcohol related and up to three per cent of attendances at ED being methamphetamines, to name just two drugs, that is a big opportunity.

We would also like to emphasise the need for the integration of AOD services within the general practice, in the ED and in the broader community. The ED offers an opportunity to commence that integration service. There are national models that have this integrated service in the ED, which includes mental health, social work, AOD specialists and peer support workers working side by side. In a lot of the community consultations that I have been involved in, I hear a lot of frustration from people about the difficulty of wrong doors and not being able to have an integrated service.

We do support decriminalisation. While not having expertise on the technical aspects of the bill, overall, the college does support the decriminalisation approach that the bill takes.

I would note that, in emergency departments in the ACT, there are limited physical spaces in terms of de-escalation rooms and spaces for patients with acute psychosis while waiting for admission to inpatient services. This creates a potent recipe for violence and aggression towards emergency department staff. We know that up to nine out of 10 emergency clinicians, doctors, nurses and other healthcare workers have experienced AOD-related violence and aggression in their workplace in the preceding year. A lot of the reason for that is inadequate spaces to care for these people.

There are frequently situations that would have been dealt with in a law enforcement situation and the patients are now, appropriately, brought into the emergency department, under a medical model. But the infrastructure available in the emergency department is not conducive to the management of these patients in a safe way for the staff. Thank you for the opportunity.

THE CHAIR: Thank you, Diana. You will have a chance to add to your commentary. The committee would like to ask some questions. Many of the submissions, even ones today, suggest that the priority should be getting ACT's health service and drug support agencies functioning much more effectively before the step envisaged in the bill is taken. Do you have any comment on that, noting your in-principle support for decriminalisation?

Prof Egerton-Warburton: That issue was not raised in our support and our broad canvassing of my colleagues in relation to this. I do not really feel that I can give an answer. From a personal perspective and in my role as an emergency physician, I think that this will result in reduced presentations in terms of law enforcement. We do not know what the effects will be on acute health services—whether that will be reduced or increased. It is hard to judge which should come first.

DR PATERSON: Thank you very much, Diana. That was very interesting. With respect to data collection, the submission says that there is a lack of appropriate diagnostic codes for acute recreational drugs. Does that mean the international codes are not relevant to the Australian drug setting? Is that what that means?

Prof Egerton-Warburton: I would have to take that question on notice because the codes are not an area of my expertise.

DR PATERSON: Okay. When you are talking about the harm, and data collection on the harm, for example, with alcohol, is that someone who has fallen and injured themselves—

Prof Egerton-Warburton: Yes. What I can tell you is that if people do pure coding-based research studies, it suggests that 0.1 per cent of ED attendances are due to alcohol-related harm. Our research would suggest it is about 10 per cent of presentations. Many of them would be coded as injuries, psychiatric presentations or any number of things, but the alcohol harm is not captured. With respect to any opportunity to influence policy, you cannot measure the direct effect without complex research methodology or laborious one-on-one processes. The College for Emergency Medicine supports the idea of adding alcohol harm and potentially other drugs to the

national minimum dataset.

I know that a number of jurisdictions, including Queensland and Northern Territory, have done this. It provides them with a powerful opportunity to measure any effects when they intervene. If you are considering any intervention, make sure that you have the ability to measure what the effect of it is; that is key.

MR DAVIS: I have a couple of quick questions to clarify my understanding of recommendation 6. In recommendation 6, you say that health professionals can offer assertive interventions. We heard some evidence yesterday from parents who were advocating for involuntary rehabilitation. Can I confirm how you would describe assertive interventions and whether that relates to involuntary rehabilitation?

Prof Egerton-Warburton: I do not think that would relate to involuntary rehabilitation.

MR DAVIS: What do "assertive interventions" look like?

Prof Egerton-Warburton: It might be better to use the term "proactive interventions" and "integrated proactive interventions", rather than "assertive". It is not suggesting any compulsion.

MR DAVIS: Does the College for Emergency Medicine have a position on the merits of involuntary rehabilitation?

Prof Egerton-Warburton: I would have to take that question on notice. It has been discussed, anecdotally, and I do not think it is supported. As to whether there is actually a policy position, I would have to check.

MR DAVIS: My last follow-up regarding that theme of questions around interventions is this: recommendation 6 goes to the point of rehab. Some of the other testimony we heard from parents yesterday was that, on the whole, they did not feel that the children they were supporting had access to rehabilitation services for a long enough length of time to get the care that they needed. Is that what we are getting to here in recommendation 6? Is it that there are not enough places or is it that, because of the pressure on the system, once we get people in they are not spending enough time in these programs?

Prof Egerton-Warburton: I am not qualified to answer that question, because I do not work in the ACT and I am not in addiction medicine. The previous witnesses may be in a better position to answer that question.

THE CHAIR: Does the AMA have positions on anything that was just raised?

Prof Looi: The AMA had expressed an opinion. I will deal first with Mr Davis's question about mandatory treatment. In some Australian jurisdictions—and this is speaking to what we submitted—there are interesting provisions in some states for mandatory treatment if you are deemed to have severe dependence. However, there is a lack of evidence that there is substantive efficacy, particularly in the long term, of compulsory residential or other treatment. Therefore there are unresolved questions

about the efficacy of mandatory treatment programs. Our position would be that we could not necessarily recommend it.

In relation to my colleague Diana passing on to us the question in relation to provision of care for younger people, Mr Davis's question, that is why we emphasise that, while recognising and respecting the views of the Australasian College for Emergency Medicine that they are agnostic about some matters in relation to this, we believe we have a lack of capacity for enough clinicians to see people within an adequate time and for long enough to provide ongoing care. These are the consequences of—and I emphasise this is a common theme—under-resourcing, understaffing and lack of infrastructure. People try and do the best they can, absolutely, and care very much about the community. But, with resources as they stand, it is just not possible to provide the level of care that people need. This is the foundational and basic issue.

While respecting and understanding the community's wishes and the evidence, as my learned colleague has presented, about decriminalisation, we still have a basic resource problem. Whether there is an increase or a decrease, we still have this issue at the baseline. I appreciate that it is not necessarily in the direct terms of reference, but you did ask about drug treatment and rehabilitation services. The existing baselines are very low. We do not have specific addiction medicine services for younger people, because there are only four addiction medicine specialists. The child and adolescent psychiatry services would assist that. They still have relatively low levels of numbers overall, like the rest of the mental health services.

THE CHAIR: Thank you so much. There is no doubt that we could spend the whole afternoon with either of the groups. We do appreciate your submissions and the time that you have given to attend the hearing. On behalf of the committee, I would like to thank you for giving evidence today. The secretary will provide you with a copy of the proof *Hansard* of today's hearing when it is available, to check for accuracy. Could you please liaise with the committee secretary to provide answers to questions taken on notice.

Short suspension.

EDMONDS, MR PAUL WILLIAM, Member, Criminal Law Committee, ACT Law Society

KUKULIES-SMITH, MR MICHAEL, Chairperson, Criminal Law Committee, ACT Law Society

GOONETILLEKE, MS ANUSHA, Program Manager and Senior Solicitor, Canberra Community Law

THE CHAIR: Good afternoon, Anusha. You are giving evidence via telephone link. At the moment we are awaiting representatives of the ACT Law Society, so you are lucky to be first off the rank. Please be aware that today's proceedings are covered by parliamentary privilege, which provide protection to witnesses but also obliges them to tell the truth. The provision of false or misleading evidence is a serious matter, and all participants today are reminded of this. Please ensure that you have read and understood the pink privilege statement. Is that the case, Anusha?

Ms Goonetilleke: Yes, it is.

THE CHAIR: For the record I acknowledge that Michael Kukulies-Smith and Paul Edmonds have taken their seats. Do you have anything to say about the capacity in which you are appearing today?

Mr Kukulies-Smith: I am the Chair of the ACT Law Society Criminal Law Committee, and I appear in that capacity. I am also a private practitioner in Canberra, but I appear in the Law Society's capacity.

Mr Edmonds: I am the vice-chair of the Criminal Law Committee of the Law Society. Like Michael, I am also a lawyer in private practice. I am appearing in an official capacity for the Law Society.

THE CHAIR: Could each of you confirm that you have read and understood the pink privilege statement?

Mr Kukulies-Smith: I have, thank you.

Mr Edmonds: Yes, thank you.

THE CHAIR: With two organisations represented, we will allow Canberra Community Law to have the first part of our session, which will entail the opportunity to provide an opening statement of up to five minutes duration, then questions from the committee. We will then hear from the ACT Law Society representatives. Without being too formal about it all, we will enter into a free exchange of ideas, questions and answers.

Anusha, thank you again for the submission from Canberra Community Law. Do you have an opening statement that you would like to present?

Ms Goonetilleke: I do. Thank you for the opportunity to comment on this bill. I am speaking to you today on behalf of Canberra Community Law. By way of background, Canberra Community Law is a community legal centre which provides free legal

advice and assistance to people in the ACT with low incomes. This includes in the areas of tenancy, public housing, social security and disability discrimination law.

One of our programs is Street Law, an outreach legal advice service that assists people who are experiencing or at risk of homelessness, with their legal issues. It is from this position that we offer our view on the draft bill today.

Canberra Community Law supports the bill in principle and the intention behind it, to follow the trajectory set by the Drugs of Dependence (Personal Cannabis Use) Amendment Act in adopting a public health attitude towards drug use, to divert drug users at the first point of contact to appropriate services and avert prosecution. However, we would like to use this opportunity to suggest some key changes.

Many of our clients have complex circumstances, including physical and mental disability, exposure to abuse, trauma, family or domestic violence. Many of these clients are at risk of substance abuse and exposure to the criminal justice system. This can contribute to a cycle of recidivism, financial instability and homelessness. We believe the bill could be improved to reduce these risks and produce better outcomes for our clients.

As outlined in our written submission, one of our current concerns with the draft bill is the proposed penalty for a personal possession offence. Of course, we support the reduction to one penalty unit. However, we strongly believe that a one-size-fits-all approach will disproportionately affect those on low incomes and experiencing homelessness.

Our experience with clients who use drugs is that they commonly accrue multiple infringement notices, fines and charges for minor poverty criminal offending. A $100 fine for a single possession offence makes up 32 per cent of the weekly JobSeeker income for a single person with no children.

We believe that a best practice approach is one which provides alternative ways to manage penalties, much like the road transport act. The act operates through a system of infringement notice offences, allowing the recipient 28 days to pay this penalty by paying it in instalments, applying for a waiver or entering into a work and development program.

I would like to reiterate our support for the ACT's move towards a public health approach to drug use. We have also seen support for a health-based approach to personal drug possession in many other submissions, including by ACT Health and the Alcohol Tobacco and Other Drug Association ACT.

To support these services, we recommend that the ACT government use funds raised from the simple drug offence penalty to help fund rehabilitation services in the ACT. This should, of course, be complemented by other funding commitments.

The current policy on homelessness in the ACT does not align with the health approach to our clients who engage in drug use. Clients who are sleeping rough or are in temporary accommodation struggle to receive effective drug treatment and are preoccupied with trying to find a safe place to reside and can feel hopeless in their

situation, which can direct them to drug use. We believe that the aspirations of this bill would be best supported by a housing first approach for people experiencing homelessness and receiving a simple drug offence notice. Once a house is secured, individuals are supported by support workers to engage in rehabilitation efforts such as drug and alcohol treatment, which is intended to assist the person to sustain their housing tenancy and reintegrate into the community. This offers a more suitable and effective approach to reduce the societal harm of drug use arising from people experiencing homelessness because it is supportive and holistic in its approach.

In conclusion, criminalisation of possession of drugs of dependence affects the most vulnerable members of our society. As a service that deals firsthand with people who experience homelessness, family violence and financial hardship, we appreciate the impact that criminal enforcement has on real lives.

We submit that the penalty for possession of a drug of dependence, although reduced, should be substituted with other measures such as community work and development programs and waivers of penalties. Funding should be focused towards rehabilitation services.

Canberra Community Law has made its recommendations in the context of the bill's impact on people experiencing homelessness and financial disadvantage. We deal with these clients every day and we see the detrimental impact that enforcing penalties has on vulnerable offenders. Our recommendations do not just support the needs of vulnerable drug users; they address the broader needs of the ACT community, law enforcement, healthcare services, and the purposes of the bill itself.

From a public health perspective, shifting the focus from criminalisation to support services reduces stigma and barriers to vulnerable people seeking support, allowing us to address the core issues driving drug abuse, rather than taking a surface-level approach. A greater focus on support and community education empowers people to access the support they need without the fear of criminal consequences. To reduce personal and public risk associated with drug use, we must adopt a health-centred and people-centred approach to tackle the issues at its core.

THE CHAIR: Thank you very much. I note in one of your recommendations, on page 2, you recommend that the ACT and commonwealth governments enter a memorandum of understanding to mitigate in some way what would be a conflict with the commonwealth Criminal Code.

Putting on a very strict legal hat at the moment, and an appreciation of the rule of law, one component being that a legal system should not be able to be trumped by a superior one, which does create problems for administrators of that law, are you content that a memorandum of understanding would protect the ACT community from the possibility of criminal sanctions under the commonwealth code?

Ms Goonetilleke: I would have to take that question on notice.

THE CHAIR: Thank you. Dr Paterson?

DR PATERSON: Thank you very much for your submission. With your Street Law

program, what proportion of your clients would have drug problems?

Ms Goonetilleke: I am not sure whether we have a breakdown in terms of the questions that we ask our clients when we do our intake, as to how many have drug problems, unfortunately. It would be only anecdotal. I would not be able to comment. We do know that a percentage of our clients experience issues around drug use. Unfortunately, we do not collect data around that.

MR DAVIS: I have a couple of quick, clarifying questions that I am sure are assumed but it is good to have them on the record. Your clients do not ever pay for your service in any way, do they?

Ms Goonetilleke: No, it is a free legal service.

MR DAVIS: In the conclusion statements in your submission, you make a recommendation that the government should direct funds raised from the payment of infringement penalties under the bill to funding rehabilitation services. I am interested in exploring that concept further. Are you aware of any other way that either the ACT government or any other subnational governments directly fund services in such a clear-cut way from infringement notices, from fines, under service provision?

Ms Goonetilleke: No, I am not aware of that. I could take the question on notice and get back to you on that.

MR DAVIS: That would be great.

THE CHAIR: Anusha, I am sure we will have the opportunity to have a freer exchange once we get past the slightly more formal part. I will invite the ACT Law Society reps to make up to a five-minute opening statement.

Mr Kukulies-Smith: In terms of the Law Society's position, we have provided a written submission that outlines some of our concerns. In summary, although the society supports harm minimisation and a therapeutic approach in dealing with drug users, we also have concerns as to whether this bill will genuinely assist in diverting those individuals in ways that they are not already diverted by police in relation to offences.

We have concerns in relation to possible health impacts of decriminalisation, particularly in terms of the quantities that are being considered. We would regard the quantity that has been specified as being effectively with reference to what is a trafficable quantity under the commonwealth legislation. The limits have been set to match those. Paul will talk in more detail about some of those issues. That is a level at which it can be presumed that a person has the matter for trafficking at law. The Law Society queries why that figure has been used as the bright line between where decriminalisation starts and where criminalisation at the level of trafficking would commence on the other side of that bright line.

With respect to ice, the Law Society is very concerned about the inclusion of that drug in relation to this bill. We have cited a paper from the AMA, the Australian Medical Association. In that citation that we have provided, the AMA make it very clear that

that is a drug that should not be regarded as a recreational drug. They go through the health reasons. It is beyond the expertise of the Law Society to go into those health reasons as to why that is the case. We do note that, anecdotally, in the court system our members frequently come across individuals charged with some very serious offences, where it is quite clear that they are acting outside their "normal" behavioural patterns as a result of the consequences of the consumption of ice.

Those offences include, from my own personal experience of cases, cases in which some very serious family violence offences have been committed due to the side effects of an individual experiencing psychosis from taking ice in quantities far less than quantities being suggested in this legislation.

We also have concerns that we raised previously in relation to cannabis, in relation to the interplay between commonwealth and territory legislation. Whilst there have not been any prosecutions under commonwealth legislation in respect of cannabis, we suggest that, from a legal standpoint, the issue remains unresolved. It would seem that, from a practical standpoint, given the general hierarchy that is assumed between the drugs that are now under consideration, relative to cannabis, the prospect of that issue arising seems greater in relation to these drugs than perhaps in relation to cannabis.

Finally, in relation to cannabis, we note that it is possible, after having initially obtained seeds, for an individual to maintain their own supply, effectively, at levels that are now permitted under the legislation that was passed last year. But that is not the case for any of the drugs here. For the drugs that are being considered in this bill, it should be recognised that the reality is that, at their source, they will have to be sourced from organised crime figures, almost invariably. They may be some steps removed from the individual user, but, from a legal standpoint, it would be naive to assume that anything otherwise is the case in relation to these drugs. Their source is from organised crime, almost universally, be they outlaw motorcycle gangs, drug cartels et cetera. That is the source of these drugs.

The Law Society, in terms of quantity—and that is our primary concern—raises whether the bill effectively allows an undue amount of support or is setting the bar too high in relation to where the change in policy and treatment should be, from a legal standpoint. Paul will now address some more specific legal concerns in relation primarily to the quantity issue.

Mr Edmonds: Firstly, I confirm that the Law Society's overall position is in support of the harm minimisation approach. Further, it is clear to the Law Society that the intentions behind this bill are laudable. The concern that the Law Society has, however, is that the bill may have the opposite effect to what is intended. Specifically, if passed, it may increase harm to certain drug users rather than reduce it.

In terms specifically of the so-called personal possession limits set out in the bill, further to what Michael has indicated, it is clear from both the explanatory statement to the bill and the public comments made by the member who introduced the bill that the upper limits of the personal possession limits have been set solely with reference to what is considered a trafficable quantity at commonwealth law. Whilst it is clear to the Law Society that that is an attempt to avoid a constitutional issue of inconsistency between commonwealth and territory law, the concern that the Law Society has is that

it is otherwise a somewhat arbitrary upper limit to set when, presumably, what should be considered in terms of a personal possession limit is, firstly, what might be considered a relatively safe small quantity of some of these substances and, secondly, what would be considered a quantity consistent with personal use and not consistent with trafficking, which is to say the selling of such substances.

To give a further practical example of what these quantities mean, in case any members are not aware of this, if evidence has not already been given in this regard, take the example of the proposed limit of two grams of cocaine. That is the equivalent of approximately 20 lines of cocaine. It is respectfully submitted that that is not personal use; that is potentially a large number of people at a party all partaking in consumption of cocaine or it is a quantity that a drug trafficker might be expected to have in their possession. Again, we are talking about more than $1,000 worth of cocaine, if we are talking about two grams, to give an example.

In addition to that concern about quantity, the Law Society is of the view, based on the best medical evidence, including from the AMA, that there is, in short, no safe quantity of methylamphetamine, that it is a substance that potentially should be excluded from this bill. The criminal justice system sees every day serious offences of violence, as Michael has touched upon. Many of those cases involve people who are suffering from a psychosis caused by consumption of methylamphetamine or other drugs.

In short, the Law Society's position is that, whatever proposal might become law in relation to other illicit substances, hopefully with a lower limit than what is currently proposed, it would be sending the wrong message and dangerous from a medical point of view to decriminalise any quantity of methylamphetamine.

THE CHAIR: I have a question on that very theme. Would you support the bill if the quantities were reviewed according to personal use, with ice excluded?

Mr Kukulies-Smith: We would still observe that there is the issue to be resolved with the commonwealth; that still remains. Otherwise, assuming that that issue could be resolved, the Law Society believe that would be an appropriate approach to harm minimisation. As to what the appropriate levels are, the Law Society regard that as more of a medical question than a legal question in terms of consideration of safety et cetera.

DR PATERSON: I refer to another submission that deals with the issue of the commonwealth Criminal Code. It says that the High Court of Australia has determined that the Criminal Code does not attempt to "cover the field" of drug laws in Australia. Further, it says that the Criminal Code allows for the exercise of discretion in the choice of law under which users may find themselves prosecuted. It also states that the commonwealth DPP has issued a charging guideline that, where matters are investigated by state or territory police, the charges that are ultimately laid would normally be those of the state or territory. The submission also states:

> Under Commonwealth law, amounts above the threshold are deemed to be trafficable quantities. However, this is not the case in the ACT, where the threshold for trafficking is considerably higher …

For example, in relation to heroin. Given those views coming from another submission, I am interested in your response to that.

Mr Kukulies-Smith: Firstly, can I ask whose submission it is?

DR PATERSON: It was the ANU Drug Research Network, and it is on page 12 of their submission, on the harmonisation of laws.

THE CHAIR: The submissions that have been provided to the committee are published on the committee website.

Mr Edmonds: Thank you for the question, Dr Paterson. Firstly, the concession would have to be made that neither Michael nor I are constitutional law experts. In an attempt to deal in a broadbrush way with the comments that have been raised, firstly, it would be accepted that the potential inconsistency arguments in relation to this bill, save in respect of methylamphetamine, which I will come back to, perhaps are not as significant an issue as the recent effective legalisation of cannabis. That is partly because, under this bill, the various substances referred to would still remain illegal to possess. To that extent there is no inconsistency, obviously, with commonwealth law.

However, in respect of methylamphetamine in particular, it appears that possibly there has been an oversight by the legal officer advising the parliamentary draftsperson in respect of the bill, because whilst a trafficable quantity for methamphetamine—more commonly referred to as speed—is two grams in commonwealth law, the trafficable quantity for methylamphetamine—which is commonly referred to as ice—is in fact three-quarters of one gram. The territory bill would be directly inconsistent with that limit set by commonwealth law.

More broadly, though, the Law Society is not submitting that this bill is doomed to fail a constitutional challenge. All that the Law Society is saying is that it should not be thought necessarily that just because the recent cannabis laws have not been challenged in the High Court, that that is, in effect, some sort of guarantee or precedent that this bill will be immune from challenge. That is all that the Law Society is saying in that regard.

Mr Kukulies-Smith: The other point is simply a practical one, which is that the ACT has the unusual position where our police force is the Federal Police force. It is different from every state and territory in the country in that regard. It is not just a question of the territory's power; it is also a question that individual police officers, taking their oath, are taking their oath in respect of commonwealth law, as well as ACT law. Where there is a conflict, my understanding is that the AFP have raised that issue both in relation to the cannabis bill and in relation to this bill, for that reason. That is a unique position that is a functioning part of constitutionality and it is also a function of the practical realities of our circumstances as a territory and who provides our policing.

There is another issue in relation to that. From what I understood, the part of the submission that was just read to us was talking about the commonwealth DPP; it is not true in respect of commonwealth offences in the ACT. There are some of those

that are controlled by the ACT director as well, and charged in that field. There is an interplay between both, although the ultimate authority at law does rest in a commonwealth charge, with the commonwealth director. Again, there is an interplay between agencies that is, in part, created because of our unique circumstances.

As Paul indicated, it is not something that the Law Society is saying is foredoomed to fail, but it is certainly something that the Law Society is saying is worthy of consideration in terms of the details and the specific example that Paul has given about the apparent drafting error in respect of the quantity of methylamphetamine. That, with respect, the Law Society would suggest is a very significant problem. In cases above that, at 0.75, between there and two grams, it would be highly likely to be challengeable.

MR DAVIS: Reading from your website, it says:

> The Society's role in the ACT community is to represent, advance, and defend the interests of an independent legal profession in the ACT.

In that context, while you have cited a number of medical examples, I want to reserve my line of questioning specifically for that theme. Can I ask you the same clarifying question that I asked Anusha? The legal profession that you represent would, in almost all cases, charge for their services; is that correct?

Mr Kukulies-Smith: Well—

MR DAVIS: I am sure there are outliers, but more often than not?

Mr Kukulies-Smith: They work for money. As to whether that is privately paid or whether that is legally aided, in a criminal law context, it depends on the individual law firm, lawyer and circumstances of individual cases.

MR DAVIS: I appreciate that my point is spicy. I will ask you to reflect on it, because why I feel quite challenged, as someone working on this committee who will provide advice to government, is that I have two groups of reputable legal professionals with two very different takes on the bill. It would seem that the core difference between the two bodies is whether or not their clients are charged for services. I would ask you to perhaps reflect on that a little bit and maybe put my mind at ease, given that there seems to be such a core difference between two groups.

Mr Kukulies-Smith: One of the major differences would be that one is focused principally in this regard on courtroom law. Another is providing more generalised legal services than simply courtroom law. The Law Society in this regard is largely talking about, and the members whose views are expressed relate to, the court process and lawyers such as Paul and I, who appear in court. Experience is not limited to—and whilst you have asked me to limit it purely to legal, it is, with respect, extremely naive to think that the law is other than about people and about people's behaviour.

To try and suggest, as your question does, that you can separate those two is a complete misapprehension of what the law is and what the law does, and a very concerning one, with respect. We come across the individuals. We see the

photographs of the individuals who are self-harming as a result of this. We see the photos and hear the testimony of the individuals who are the victims of violent crimes as a result of this. We bring that experience, as well as some issues in relation to apparent drafting errors et cetera, from a black-letter-law point of view. It is both aspects.

We also come across clients who are struggling, and it is true that people can end up in the revolving door of the court system on a whole range of charges, be they drugs, minor street offences et cetera. It is for that reason that the Law Society supports harm minimisation. It is for that reason, in answer to Mr Cain's question before, that the answer was yes, we support the bill, if the amounts were changed. It is about those amounts; as Paul said, we appreciate that two grams, for example, of cocaine is 20 lines.

That is not a question of law that it is 20 lines; that is a matter of fact that it is 20 lines. It is a fact that will be lost on many members of our community because they do not engage with the criminal justice system themselves, because they are law-abiding citizens who do not come across that aspect. Criminal lawyers come across that side of society. We deal with that in court; we have those practical understandings that are not a function of the law per se but are a function of interaction with the law.

THE CHAIR: Anusha, is there anything else that you would like to add, having heard our questions and the Law Society's responses?

Ms Goonetilleke: No, there is nothing further that I wish to add at this stage. Thank you for the opportunity.

DR PATERSON: I have a question in respect of what you are saying about what you observe—that it is relatively uncommon for drug users to come to the courts charged only with drug possession. I am not 100 per cent around what the criteria are to be a participant in the alcohol and drug court. You say that possession of drugs is normally charged alongside criminal offences such as burglary, assault and drug driving. In respect of those offences, is there anything that could be done in terms of the drug court? You have talked about someone with quite serious offences, such as assault. Is there anything that you see could be done better in that space ultimately to support people in getting off drugs?

Mr Kukulies-Smith: The Law Society is very supportive of the drug court. The drug court is a very good initiative and the types of examples you have just given would render a person eligible for referral to the drug court. There are obviously criteria at law to be met, but they would be in the relevant category to seek a referral, and it comes down to judicial officers as to whether that referral is made.

The Law Society would strongly support the expansion of the drug court. At the moment it applies in a Supreme Court context—for the more serious offences. If more funding was made available and it could be expanded to cover the full range of offences in the territory, the Law Society would be very supportive of that, but we understand that it is effectively a funding issue. There would need to be some legislative change to reflect the expansion. The Law Society would be wholly supportive of that change. We regard it as a very positive addition in recent years to

our legal framework.

Mr Edmonds: It is clear with respect to what is partly behind that question—again, it is accepted that the intention behind the bill is to divert drug users from the criminal justice system to rehabilitation, counselling et cetera. It is partly for that reason that the Law Society would note that if this bill becomes law, the bill alone, without a substantial increase in funding for rehabilitation programs, will not have the desired effect. It is all very well to divert a number of people from the court system, and the Law Society's view is that it is probably quite a small number of people. Again, many persons who come into contact with police under the influence of drugs will be charged with other offences, not simply possession of drugs. If that is the focus, there needs to be further funding.

I would also like to add something to Michael's response to Mr Davis's question. Lest it be thought that the Law Society, or certain members of the Law Society, have some sort of self-interest in maintaining the prohibition on these drugs, far from it; the Law Society's perspective would be that if this bill becomes law, the potential is for a significant increase in some crime, which would indirectly assist lawyers such as Michael and I, who represent people charged with criminal offences.

I apprehended that that may be an unstated premise to the question that had previously been put. I accept that there are quite different legal perspectives from the private profession, represented in part by the Law Society, and those from the more public sector, including Canberra Community Law. But the Law Society does not see any significant reduction in the numbers of people being charged with criminal offences, apart from just possession of an illicit substance, if this bill becomes law.

THE CHAIR: We will close this session. On behalf of the committee, I would like to thank you all for giving us your evidence today. The secretary will provide you with a copy of the proof transcript of today's hearing when it is available, to check for accuracy. Please liaise with the committee secretary to provide answers to the questions you have taken on notice. We will have a 15-minute break.

Hearing suspended from 2.29 to 2.45 pm.

BOWLES, DR DEVIN, CEO, Alcohol Tobacco and Other Drug Association ACT
McDONALD, MR DAVID, Consultant, Alcohol Tobacco and Other Drug Association ACT

THE CHAIR: Welcome to the select committee's inquiry into the Drugs of Dependence (Personal Use) Amendment Bill. Do representatives of the Alcohol Tobacco and Other Drug Association wish to say anything about the capacity in which you appear?

Dr Bowles: ATODA is the peak body for specialist alcohol and other drug services in the ACT. My professional background is largely in epidemiology. I bring to my role at ATODA a firm commitment to promote people's health.

Mr McDonald: I am a social scientist. Primarily, I do research evaluation and policy analysis at the interface of criminal justice and population health.

THE CHAIR: Thank you. Please be aware that today's proceedings are covered by parliamentary privilege, which provides protection to witnesses but also obliges them to tell the truth. The provision of false and misleading evidence is a serious matter and all participants today are reminded of this. Please ensure that you have read and understood the pink privilege statement.

Mr McDonald: I have.

Dr Bowles: I have.

THE CHAIR: Thank you both. Do you wish to make an opening statement? We have about five minutes available for that.

Dr Bowles: Thank you for inviting us to speak with you today. I am grateful to all of you for approaching this issue so constructively and with open minds. While the committee has heard a diversity of views about the bill so far, I have been really gratified to hear the widespread support from both sides of the debate about the quality of Canberra's alcohol and other drug services.

I have been in my role for only about a year, so I cannot take any credit for that good work, but let me echo these sentiments about the wonderful work of the sector. The work is emotionally demanding, intellectually complex and often very poorly remunerated. That is not for the three addiction specialists. I mean the other 300 people in the sector, just to be clear. More than any other sector, though, in the AOD sector that I have been a part of, people are in it because they genuinely want to help other people.

ATODA's members have clear insights into the harm that alcohol and other drugs can cause to health, to families and to society. Our members help people who use alcohol and other drugs to reduce these harms or to treat dependence every day. It is my members' core business. Our members also understand that most people who use alcohol and illicit drugs are not harmed by them or that these harms are minimal. For instance, every time we consume a glass of alcohol, we are slightly increasing our

cancer risk. Similarly, many people who use illicit drugs do so in a way that is not problematic for health or for the people around them.

It is notable that there is such high-level agreement about the virtues of the bill from the organisations that made submissions. By my count, 38 were in favour, with only two or three clearly opposed. I think this reflects the strong community sentiment against custodial sentences for people in the ACT, as demonstrated by the results of the March 2021 YourSay community panel conducted by the ACT government. This found that 15 per cent or less of the population favours any kind of detention, including weekend detention, for possession of any kind of drug for personal use. That proportion drops to just seven per cent of support for incarceration for possession of hallucinogens, ecstasy or cocaine.

Eighty-five per cent of community agreement about anything is remarkably high. Those for and opposed to the bill agree on a lot. At a time when politics can sometimes be acrimonious, I think it is really important to highlight and celebrate the things on which we agree. Everyone knows drugs can cause harm, but people are fundamentally divided on what will happen to drug use rates if possession of small amounts of drugs is decriminalised.

The data are complex, with a lot of information from many jurisdictions, including overseas, Australia and, indeed, right here in the ACT. The data are complex, but the conclusion is simple. There is no reason to think that decriminalising drugs in the way outlined by this bill will increase drug use. This is why the three groups of academic experts that made submissions to this inquiry about the bill were unanimous in their support for it. That is what the data say.

Some advocates of decriminalisation could focus on certain data and argue that decriminalisation will substantially decrease drug use. Similarly, advocates for a drug-free approach can be highly selective in the data sources and the time frames that they analyse, to show that drug use increases with decriminalisation. That side, in my opinion, need to work a little harder. Occasionally, they are especially creative about the time frames they use, but they can do it. The data are complex enough that you can always fudge it.

Nevertheless, an intellectually honest assessment of the evidence is that implementation of this bill is not likely to change the amount of drugs that are consumed in the ACT. A story about drug harms, though, is a different one. Decriminalising drugs can substantially reduce harms, even when the amount of drug use does not change. People naturally want to protect their own health, and if they are not constrained by needing to keep an illicit activity secret, they are better able to look after their own health. For instance, people are more willing to obtain and carry sterile injecting equipment.

The bill is a powerful aid also to reducing stigma. We know that stigma is one of the primary reasons that people do not seek help for drug use if it becomes problematic. In the testimony from parents yesterday, the sense of shame that their children felt for taking drugs was all too evident, and the tragedy was all too evident. This bill is a huge step to reduce that shame. I should add that other measures that government takes in parallel to partial decriminalisation are an opportunity to amplify the harm

minimisation effects of the bill. In essence, making alcohol and other drug services more readily available promotes harm minimisation.

I note there was a previous question from the chair around the sequencing of decriminalisation and enhancing AOD services. I might briefly address that by saying that enhancing services is going to amplify the effects of decriminalisation. Already the AOD sector is highly performing, if drastically underfunded. We have surveys of how happy people who use alcohol and other drug services are. More than 92 per cent are satisfied with the service they received.

There are a number of other statistics showing that clear majorities of those people also experience improvements in other health areas, even dental health. Because the enhancement of their lives that comes from engaging with the AOD services is so useful, they are able to better engage with other elements of the health system, or because the AOD services are, in fact, helping to arrange interaction with the health system. In an ideal world, we would have started to enhance the sector through increased funding several years ago. Now, in an ideal world, increased funding would commence right now. But if we cannot have increased funding, this bill is still worth passing.

There are several amendments that, in our view, would substantially enhance the bill, which we have detailed in our submission. I will briefly explain them. The first is to expand and future-proof the list of drugs included in the bill. The current list of drugs in the bill includes both prohibited drugs and schedule A drugs. We think this list should be expanded, basically, to include all the drugs which people use or may use in the future, the drugs for which people seek assistance and the drugs for which people are arrested. The implications of each of these criteria are spelled out in our submission.

Secondly, we should ensure that police provide information on drug treatment and harm reduction with every simple drug offence notice. It is essential, as is clear from the testimonies of many of the families yesterday, that in decriminalising drugs the government would be pivoting from seeing drugs as primarily a criminal issue to primarily a health issue. The best way for government to convey that message to people who use drugs is to make sure that every time the police come into contact with someone who is using drugs they get information about treatment and harm reduction services that are available here. It is also the best way to encourage people who might need help to get that help.

Thirdly, like many others, we believe there should be an alternative to the fine associated with the SDON. As has been noted before, many people who experience drug dependence are not financially well off and would find a $100 fine highly burdensome or, in some cases, even unpayable. That could lead to the sorts of interactions with the criminal justice system that this bill seeks to avoid. We suggest that a person charged with an offence has the option of attending an alcohol or other drugs service for an information session in lieu of a fine. I want to emphasise that this would not be mandatory treatment. I should note that my sector has a clear conflict of interest on mandatory treatment. Can you imagine: we would be getting so many more people. We are against it. On the one hand, it would be financially advantageous for the sector, but the evidence is quite clear that mandatory treatment does not work.

If a person does not want help with an alcohol or other drug issue then having them talk to someone or receive other treatment is not going to be helpful. That person has to want to make that change in their life.

A fourth alteration would be to collect data that enables evaluation of the bill's impacts. The effects of this bill will be watched closely by the rest of Australia. Making evidence-based decisions about illicit activities is difficult due to their covert nature, inhibiting the creation of reliable information for legislators like you and policymakers who support you. As elaborated in our submission, information on drug use, drug arrests and drug treatment in the ACT has received relatively little investment and is insufficiently robust. For instance, we are unaware of any specific effort to collect baseline data to measure the effects of the 2020 partial legalisation of cannabis.

Such information would be of obvious use to you now, I would suggest, and inform many other policy decisions. I want to emphasise, though, that there is a reasonable amount of evidence about the passage of that bill, its effects, and whether or not it led to increased cannabis use. And the answer is it did not. Anecdotally, though, it did lead to increased treatment-seeking behaviour for cannabis. We have heard many stories of people who have maybe had an issue with cannabis for decades coming forward because finally they could do it without that shame and fear of prosecution. I can tell you that, but having quantitative data would make me more persuasive, wouldn't it? Collecting information with the passage of this bill would be really helpful.

We also recommend increasing the personal possession limits in the bill. The personal possession limits set out in table 170 of the bill do not actually reflect the quantities of drugs that people routinely buy at one time and have in their possession for personal consumption. When I do my grocery shopping, I try to do it all in one go for the week. I am not very organised, so it rarely works out, but I do not go to the grocery store before preparing each meal. Similarly, drug users do not buy a single dose of drugs each time they want them.

As it happens, internationally groundbreaking work has occurred right here in the ACT. It finds out how many drugs people buy and have in their possession at one time, not for the purpose of distribution but just because they are going to use them themselves. I guess the question is: would we rather wrongly convict some people of the very serious crime of drug distribution/trafficking, or would we rather let some people get away with the same crime? In Australia, we have agreed that it is better to err on the side of letting some guilty people go free, because we acknowledge the awesome power of coercion that the state has.

THE CHAIR: Dr Bowles, many of the things that you are going to say, I suspect, can be in answer to questions from the committee.

Dr Bowles: Yes.

THE CHAIR: We will just throw some questions to you. It is not terribly formal and different ones will add supplementary questions, but I will certainly be passing to each of my committee members for a substantive line of inquiry. Something that came

up this afternoon and was in my mind was that the bill, if passed, would create a conflict with commonwealth legislation. That is obviously of concern to some. Secondly, at the moment the only source for these hard drugs is criminal activity. Do you have any comment on both of those issues?

Mr McDonald: On the second one, I was a little surprised by the evidence given just a few moments ago where it was stated that somebody who, for example, wanted to cultivate cannabis would have to get seeds from organised crime. What we know very clearly from research, both in the ACT and other parts of Australia, is that most people get most of their drugs from their friends or trusted low-level dealers.

THE CHAIR: My query was about the drugs listed in the bill, not cannabis so much.

Mr McDonald: I just referenced cannabis because that was raised previously. Most people accessing most drugs get them from their friends or low-level dealers whom they know and trust. A relationship is built up with those low-level dealers, who essentially become friends or people that they know, and, as I say, trust. Obviously, at a certain point these drugs come through organised crime networks. But that is far removed from the people who would potentially be charged with possession of small quantities.

With regard to the matter of the commonwealth legislation, we are not lawyers and we do not have technical knowledge about that. I noted recently the reference you made to a group of my colleagues at ANU who prepared that submission. I know very well the source of the legal information in it. That is quite persuasive but, not being legal people, we do not have specific technical constitutional solutions to suggest.

Dr Bowles: The only thing I would add is that, while there is concern about how the two laws interact, to my knowledge, there is nothing about this amendment to the bill that creates anything new in law.

THE CHAIR: Thank you for your evidence and opinion.

DR PATERSON: Thank you very much for your submission. One of the submitters this afternoon, I think, is going to talk about MDMA and potentially focus on that. I think it is the AFP Association. Even the submission before from the Law Society was talking about singling out methamphetamine. They would consider it an appropriate bill for all the other drugs, just not methamphetamine. You are alcohol, tobacco and other drugs. Yesterday afternoon one of the family members really highlighted how alcohol is as much a drug and alcohol is the main problem in emergency rooms. I am interested in why it is important that this bill captures all drugs, or drugs that we know and general street drugs, rather than singling out particular drugs.

Dr Bowles: I would start by observing my agreement with one of the previous speakers, noting that alcohol is a drug, indeed, as is tobacco. In fact, according to the AIHW, the total burden of disease across Australia for all illicit drugs put together is around two per cent. Alcohol is about five per cent. Tobacco is about double that again. Tobacco, far and away, is the most dangerous drug, if you look at the burden of disease. I recognise that there are community perceptions around ice and it being particularly dangerous. What I would suggest is that, philosophically, this bill is

shifting the government's view of drugs from being a criminal matter to a health matter. It seems to me to be illogical to say, "Well, something is really unhealthy so we're not going to shift our view to being a health view." In fact, it should be the opposite, surely.

I am aware of the trial proposition in the AFPA's submission. I note that their submission suggests that we trial both cannabis and MDMA. We have been trialling cannabis decriminalisation for about two decades and, in fact, adding MDMA, which is a relatively small proportion of total drugs, seems unlikely to yield a whole lot of new information. Usually, when you have a trial, you are doing that so you can elicit new information. We already have 20 years of data about what happens when we decriminalise cannabis. This may be my ignorance, but I just do not understand what additional information we would be hoping to gain by decriminalising MDMA.

I think also there is a really important point about messaging. Other speakers have talked about the messaging that this bill will give to the community and how that can be enhanced. Let me say, on behalf of my sector, that we will be very happy to work with the government to get out messaging about what this bill does and does not do, like legalise drugs, and also about why the bill has come about.

Let me also say that the messaging ought to be, "We are decriminalising drugs because if you have a problem with drugs, we would rather see you getting treatment than in prison." Saying that for only some drugs and not the most harmful drugs, or what are perceived as the most harmful drugs—I should correct myself—makes that messaging a lot more difficult.

On some level it is easy to say, "Why don't we have a trial? A trial is a safe option." I think that for the community there are real drawbacks. Additionally, there is the increased harm that people will experience with unnecessary interactions with the criminal justice system. The police are public servants. It was very evident from their written submission that they are highly professional and that if the government says, "Please do this," they will do their absolute best. They are professionals; they will handle it. I cannot speak to the operational challenges they might have, but I would ask you to weigh up whatever operational challenges they put forward with what I view to be the clear harms of having a trial or staggering this.

Mr McDonald: I think that part of the difficulty in getting our minds around this issue of covering all drugs, or pulling some out to be dealt with separately, reflects different perceptions of the objective of the bill or the broader societal goals that people who support decriminalisation are seeking to achieve. For many of us, and I am sure for the proposer of the bill, the starting position for all this is that the current penalties are disproportionate. Of course, it is a breach of human rights law if the penalties are disproportionate to the actual offence. At the United Nations level, over the last three or four years they have moved to explicitly write into global drug policy that criminalising possession and use is disproportionate and that applying criminal penalties is disproportionate. The highest levels of the United Nations drug system have now officially given guidance to all nations to decriminalise all drugs. There is no sense of singling out either those that are the least problematic or the most problematic, because of the deep underlying principle about the disproportionality of criminal penalties for these very minor activities.

MR DAVIS: There seems to be agreement from most individuals and most organisations that have made written submissions to the committee that decriminalisation of small amounts of drugs for personal use would be a good thing. That seems to be the majority view. However, the submission presented from Drug Free Australia seems to be the clear outlier. Like your submission and like many others, it cites a whole range of facts. It puts me, and I am sure other members of the community, in a bit of a compromised position to try and deduce which are the authoritative facts. Can you explain the difference?

Dr Bowles: As I said in my opening submission, we agree with Drug Free Australia that drug use is harmful. Some people on both sides of the debate have strong pre-existing beliefs on this. There are some diehard libertarians who believe that government could not possibly do anything useful in people's lives. They will view drug data from that lens and conclude, consciously or unconsciously, that instances like Portugal show that decriminalising drugs radically reduces drug use. Similarly, people on the other side with strong preconceptions can, consciously or unconsciously, view the data that way. We have gone through the evidence that Drug Free Australia provided in some detail because we think that it may have been skewed in that way. If the chair will permit this, I have printed copies of pages 44 and 45 of their evidence with some elements highlighted—if you would permit the distribution of that?

THE CHAIR: Sure.

Dr Bowles: Thank you. Ironically, this comes from a section where they are going through the data themselves and critiquing the data used by Uniting, a church-based organisation. They indicate that, with decriminalisation in the ACT, drug use spiked, or cannabis use spiked. Then they have a graph. My reading of that graph is that drug use, or cannabis use, was going up quite dramatically between 1988 and 1991. No data were then collected until 1993. My reading of that graph is that decriminalising cannabis did not increase cannabis use at all. In fact, the cannabis use was on a steep rise and that probably continued through 1991. We do not know for sure because the data are not there.

What else is really interesting is that this graph excludes people who have never tried marijuana before. If you were looking to see what decriminalisation does to the community use, why would you exclude people who have never used cannabis before? It would not be a good measure. I note that this graph ends in 1996, so we cannot really see what happened. Then we go to the AIHW information and the most recent data from the AIHW.

THE CHAIR: Can you clarify where on this page we should be following you?

Dr Bowles: It is no longer on this page, because that is the end of Drug Free Australia's submission on that. My apologies for not making that clear. I went separately to this, to the 2019 household drug survey by the AIHW. I looked at all people 14 and up who had used cannabis in the last 12 months, because that was the most readily available and the best data nationally. The national average is 11.6. The ACT has the lowest rate at 10.5. South Australia, which is also impugned by Drug Free Australia for its decriminalisation policies, has the second lowest rate. To be

scrupulously honest with the statistics, the 10.5 per cent of the ACT is probably partly due to the fact that we are more affluent, our people are less traumatised and fewer are seeking solace in drugs. That is part of it. But, clearly, the national data show that the ACT has the lowest cannabis use rate and South Australia has the second lowest. I understand people get passionate about that and that that can distort their views of the data. I am afraid that may have happened to the people at Drug Free Australia. That is one example. There are others, but I will not take up the committee's time with that.

Mr McDonald: I might remind you that Drug Free Australia made some claims about what has happened in Portugal as a result of decriminalising all drugs there. Their claims and the data they presented are totally at odds with those published by the European Monitoring Centre for Drugs and Drug Addiction, which is the official European Union drugs monitoring organisation. It has concluded year after year that Portugal's levels of drug use and drug-related harm have fallen markedly and are very low by EU standards. The facts presented by them are totally at odds with what is presented by DFA.

Dr Bowles: Just to add on the Portugal issue: if you are interested, I can send you an article which specifically addresses controversy or alternative interpretations of Portuguese data called "A resounding success or a disastrous failure: re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs".

THE CHAIR: Please do. We are open to submissions until 30 July.

THE CHAIR: I have a different line of question. Perhaps you can clarify something that I thought you said in your opening, Devin. You said that there was widespread support for the quality of drug and alcohol support in the ACT and then a little later you said that the alcohol and drug support services were performing very highly. I must admit that at yesterday's hearing in particular we heard from families who had very unfortunate personal stories. I would suggest—and I am happy to be corrected—that their view was not that, but that there just was not enough there to help them deal with their unfortunate situation.

Dr Bowles: That is a fantastic question. I think much of it comes down to the difference between what happens to someone when they are in treatment in one of the alcohol and other drug services versus what happens when they are waiting, or when they have decided that they are no longer interested in treatment for a little while. I think many of the families yesterday had loved ones who were struggling with both alcohol and other drug issues and mental health issues. Those situations are especially complicated. That is an area in particular where I think the ACT needs substantially more investment.

People talk about integrating those services. Some level of integration is useful, but there are many different interpretations of what that means. I would commend to the committee a report by 360Edge. Professor Nicole is the first author on how that can best be done. I think the system works well if you are in it. Our waiting time is too long, absolutely. The gold standard is that if someone wants treatment for alcohol and other drug issues, they should get it right then. Often they have chaotic lives and that window of desire and ability to seek treatment does not stay open forever.

Many people would have other substantial responsibilities, including caring responsibilities. They cannot just say, "I'm going to do nine months of residential rehab right now at any given time." There might be a window when that is okay, but if the waiting list is four months long, that window may have shut. It is fair to say that when people get into the system, it works well, but there are a number of lines of evidence that suggest that it is radically underfunded.

The best national reporting on this is that AOD services nationally would need to at least double to meet demand. Secondly, ATODA produces a survey. It is a snapshot of people who use alcohol or other drugs and are in one of our treatment services. It is a census; it is once a day. We look at the waiting times on that for residential care. They are egregiously too long for far too many people.

There is a third data source that shows funding has largely remained constant. We have good evidence from the national minimum dataset on episodes of care for residential care, and they have remained largely flat over many years. At the same time, those services have seen a sharp increase in other services, such as outpatient services. The clear reason for that is that services desperately want to help people, but they struggle with limited budgets. So when someone says, "I need your help. Please, what can you do for me?" they do not say, "Wait for six months," they say, "We can see you once a week. We can see you once a fortnight until that time." The graphs are in our submission. They really paint a picture of a sector that is doing its very best under really trying circumstances. I hope that explains the apparent contradiction.

THE CHAIR: That has clarified what I thought you had said. Thank you.

DR PATERSON: I was wondering about mass media campaigns, more broad public health campaigns. That was one of the things that were discussed yesterday that would be needed and that really deters people from drug use. You have outlined in your submission that it can work to really stigmatise people and reduce the number of people seeking treatment. In terms of general public education, what do you propose or what does the evidence suggest is more appropriate than mass media campaigns?

Dr Bowles: There are a limited number of mass media campaigns that have had some utility, but there are also some that have actually been harmful. Getting it right is pretty difficult. The same is true with education. There have been some recent educational developments in Australia that have been proven to work well in helping to educate young people about the risks of drugs, not using a "just say no" sort of approach but being realistic about it.

As an aside, most people who are going to initiate drug use are adolescents. It is rare for a 50-year-old to initiate drug use if they have not before. So targeting that group is very effective and empowering that group is very effective. We note some research in our submission and we suggest modelling education programs that might be rolled out on those.

As an aside, I think shifting from criminalisation to a health issue is really good at influencing adolescents. The idea of doing something illegal might seem sort of attractive if you are 17. But the idea of having a health condition—I do not know

whether any of you have known adolescents with chronic health conditions. They typically go to great pains to say, "I'm just like everybody else. This is not an issue for me." They do not want to have health issues.

I think that would be the best investment, really. With mass media campaigns, if it is on TV, most of the viewers are not at risk of initiating drug use. So you are wasting a lot of the bang for your buck. Mr Cain, I know you have much more experience in education than I do and will no doubt have your own views on the importance of educating young people.

MR DAVIS: I have been interested in the language that you were using, particularly in your opening statement, around people who use drugs. Just to clarify, would it be fair to say that if we actually include all of the drugs that are legal and all of the drugs that are currently illegal, the majority of Canberrans are probably drug users in that sense?

Dr Bowles: I suspect the statistics would bear you out very strongly, yes.

MR DAVIS: I thought so. I am interested in talking about those drugs that we have, for a range of reasons, already deemed socially acceptable—alcohol and tobacco in particular. I am interested in the efficacy that you can speak to of treating someone's problematic relationship with either alcohol or tobacco at the same time as treating their problematic relationship with drugs that are currently illicit. Anecdotally, it has been put to me that complementary supports would not be very useful, but I would be interested in your take. Further to that, do you think that, as a government, we are currently doing enough to limit the health impacts of tobacco and alcohol?

THE CHAIR: Dr Bowles, I might let you take that on notice, if you do not mind, because it sounds like a substantive inquiry.

MR DAVIS: Fair enough.

THE CHAIR: If you are happy to take that question on notice?

Dr Bowles: I will.

THE CHAIR: Thank you. On behalf of the committee, thank you for giving us your evidence today. The secretary will provide you with a copy of the proof transcript of today's hearing, when it is available, to check for accuracy. Could you please liaise with the committee secretary to provide answers to questions that you have taken on notice? And thank you for volunteering to do so.

Short suspension.

CARUANA, MR ALEX, President, Australian Federal Police Association
PETERSON, MR MATTHEW, Legal and Industrial Relations Manager, Australian Federal Police Association
ROBERTS, MR TROY, Media and Government Relations Manager, Australian Federal Police Association

THE CHAIR: Good afternoon. I welcome representatives from the Australian Federal Police Association. Please be aware that today's proceedings are covered by parliamentary privilege, which provides protection to witnesses but also obliges them to tell the truth. The provision of false or misleading evidence is a serious matter, and all participants today are reminded of this. Please ensure that you have read and understood the pink privilege statement. Could you all affirm that that is the case.

Mr Roberts: Yes.

Mr Peterson: Yes.

Mr Caruana: Yes.

THE CHAIR: Troy, Matthew and Alex have affirmed that. Thank you so much. I think you have been advised that there is an opportunity to provide an up to five-minute opening statement; is that something that one or—

Mr Caruana: We are mindful that it is late in the afternoon, so we will take the opportunity to get straight into it, save to say that we thank you for the opportunity to speak to the committee. We think it is important that our members have quite a large stake and their voices are heard.

THE CHAIR: It is okay to drop your mask if there is difficulty. If you feel you are having difficulty speaking or hearing any of us, please let us know. We are able to drop the mask for that purpose. Each of the committee members—myself, Peter Cain as chair; Dr Marisa Paterson as deputy chair; and Mr Davis as the third committee member—will be asking you substantive questions on your submission or on other submissions that have come to our attention. We might invite your comment on those, and then any of the members can ask supplementary questions, but otherwise we will just move down the line. It will be a fairly free exchange, I am sure.

So, thank you. I note you make reference, as well, to the ACT Policing submission, so thank you for that reference. That helps us to see your views in conjunction, and the like, with one another. One thing that has come up particularly this afternoon is the concern that the bill, if passed, would be in conflict with the commonwealth legislation and possibly leave people open to prosecution under commonwealth law, but not ACT law. Secondly, an observation was made that, unlike, I guess, the cannabis decriminalisation approach, where people can grow a cannabis plant, the only source for these illicit drugs at the moment is criminal activity. Do you have any thoughts about that and whether that touches on the merits of allowing this bill to pass?

Mr Caruana: We have a couple of comments, and I will refer to Matt, the legal and

industrial relations manager, to touch on anything that I miss. In relation to the commonwealth legislation, we note that the commonwealth legislation trumps the state legislation, and it kind of puts our members into a conflicting position, where they have sworn an oath to uphold the law, and all of the law. That includes the commonwealth law. So, arguably, it would be at their discretion whether or not they could or would charge. Even under the current decriminalisation laws for cannabis, it is at their discretion. I will be honest; there are police officers out there that will charge members if they are caught with cannabis, under the current legislation. That being said, it does not mean that it is not workable, but it does leave our members in a position where they are conflicted and potentially open to scrutiny from internal affairs, ACLEI and the other bodies that do scrutinise them. Matt, did you want to touch on that?

Mr Peterson: Certainly I think there are difficulties around the precarious position it leaves some of our members in. They swear or affirm their allegiance around undertaking the duties of their office in relation not only to ACT law but obviously to federal law as well. One of the key functions of the AFP is obviously the upholding of federal law; it does put them in a very precarious position, not only in terms of dealing with people that may come on their radar but ultimately in relation to what their obligations are in discharging the functions of their office.

Mr Caruana: In relation to the question about obtaining the drugs through nefarious means, I guess, that is a major concern. We can use Operation Ironside as an example of the amount of drugs being used to facilitate funds, or to grow funds through or for organised crime. We know that organised crime uses drugs as an easy win for money. Those drugs or that money then goes to supplement other crimes like people trafficking, child exploitation, sexual slavery, terrorism et cetera. So, by decriminalising drugs in the ACT you are going to be bringing those players in that game to Canberra, or essentially people will be paying to get a stake in that market.

Let us be honest here; organised crime is like a business and everybody is going to want a piece of that business. After it has been decriminalised in Canberra—as we have seen anecdotally with the cannabis—people will want a stake in that business here in Canberra. So, how do we do it? In that instance, I do not know how you do it without compromising or potentially compromising some of the other laws around supply and trafficking.

THE CHAIR: I just have two quick questions to follow up on my own. Have there been any commonwealth prosecutions with respect to possession of small quantities of cannabis?

Mr Caruana: In the ACT?

THE CHAIR: In the ACT.

Mr Caruana: Not to my knowledge.

THE CHAIR: Are you concerned that, given the character of these proposed decriminalised drugs, that that will raise the prospect that the commonwealth may actually act?

Mr Caruana: Yes, definitely. I will be honest; we will be lobbying the commonwealth to act because a lot of those drugs, we would say, are not socially acceptable and they would not pass the pub test. You could argue that in Canberra cannabis was socially accepted, and it would pass the pub test. However, if you question the average punter down at the pub about whether they would find it acceptable that someone was carrying around X amount—two grams or one gram—of ice, after seeing what ice can to do somebody and the after-effect of what a person on ice can do to somebody else, the majority of people would say, I suggest, that it is not acceptable.

DR PATERSON: Can I challenge you on the idea of social acceptability? Shouldn't we be making policies and laws based on evidence rather than just general appeals to the public? I guess a lot of the submissions that we have had actually say that decriminalising these drugs would lead to a reduction in use, not an increase.

Mr Caruana: I would have to see the statistics and scrutinise the data on that. Certainly, the evidence that I have seen—and we are looking at the countries and other states that have decriminalised it—indicates that there is a severe increase and then there is a drop in use for the people that live in that area or in that country. In Amsterdam, for instance, they have changed, or they are changing, their laws. There was a steep increase in drug use when they decriminalised and then they had a slow gradual fall amongst people who lived in Amsterdam. What they did find is that drug tourists were moving in and coming in to experiment with drugs. That created another problem, where people who were unfamiliar with the drugs, and did not know the drugs, were using them inappropriately—or overdoing it, let us say—and putting a bit of a burn on their health system. So, they now either are, or are about to, change the laws to stop that drug tourism from occurring.

DR PATERSON: Yes. But it is legalisation, not decriminalisation, in Amsterdam. Right?

Mr Caruana: I agree; but it is essentially the same beast.

DR PATERSON: I would challenge that too. I have another quick supplementary question. You said that you would lobby the commonwealth government if this did pass. Why? We read another submission earlier, which outlined that the commonwealth DPP had said that, basically, it is up to the states to legislate and that it would be incredibly rare for them to intervene in that. I just wonder why you would lobby if a state had the jurisdiction to make the law and the commonwealth was comfortable with that.

Mr Caruana: We do not feel that the ACT currently has the infrastructure in place to adequately support members that are going through drug addiction. There is not the infrastructure there, so the impost on ACT Policing members would be significantly increased. At the moment, there has not been, or there are not, any single-use charges for drugs in Canberra. There has not been. At the moment, police officers are using their discretion, and 99 per cent of the time—Troy, as a serving police officer, can attest to this—they are dissuading the public from using drugs by saying, "You've got a choice. We can charge you for this or we can put this in the bin and don't use it

again." So there is that. However, there is no formal opportunity to send them to a dissuasion, education or therapy session to dissuade them, to educate them and to take away their want to use the drugs. There is not that option, mandatory or otherwise, for them to send them there. So, until we have the infrastructure here in Canberra, in our opinion, it would be putting the horse before the cart.

Mr Roberts: I will just add something there. As part of our job as representatives of the AFP membership, we have to look after them, as well. There is this threat, or outcome, where if someone does not uphold the commonwealth legislation, they could be opened up to a PRS investigation. We do not want to see our members lose their job. What do we follow? Do we follow the state or territory model, or do we follow the commonwealth model? That is another reason we would be opposing it.

DR PATERSON: I guess my substantive question would be around what you are saying about how police already use their discretion. Your submission talked about them having to carry around scales and measurement devices and that type of thing, whereas they did not actually mention that, to my knowledge, as an issue in that ACT Policing submission. At the moment they do not seem to have an issue with that discretion with regard to cannabis, so I am just wondering where the difference is?

Mr Caruana: We raised that when cannabis came up.

Mr Roberts: Yes. We do not know what is in a bag. It could be sugar, it could be salt, it could be meth, it could be ice. Officers on the road are not drug experts. It is pretty obvious what a bud of cannabis is. It is not always obvious what a white powder or a grey powder is, or what a pill is. A pill of MDMA could be 90 per cent MDMA, or it could be 90 per cent rat poison; we do not know.

DR PATERSON: When you talk about your trial for MDMA—and some of the other submissions that talked about separating out methamphetamine—would the logic be that you could not tell them apart and you do not have drug testing facilities on police, so it would be better to decriminalise all drugs, as the bill outlines, rather than have specific kinds of drugs out of that?

Mr Caruana: Our position is not to decriminalise all drugs. Our position would be to maintain the current legislation as it is and give the police additional powers to divert members of the public who have a health issue when it comes to drugs, to an alternative option, whether that is the Ted Noffs Foundation—I will use Ted Noffs as an example—or a similar type of arrangement. However, if there is an order for them to attend those facilities, there has to be a mechanism to ensure that they attend and if they reoffend. We feel that to achieve the goal as a health issue, or to minimise harm, we can do it under the current legislation if the ACT invests more money in the health services and then follows the current model and formalises it. Give the police the powers to divert those people to those relevant health services and collect the data. Let's see if it works. Let's test it; let's check and make sure it is working.

We say in our submission that MDMA might be a good option. We picked that because it is probably one of the less harmful drugs out there. We also picked that because it is probably one that young people are using more prolifically. So, if there was an option for us to test it, that would be where we would be able to get good data

from. We could take that data and extrapolate that and go, "For this particular drug, we have trialled it and it is working, so maybe there is a case to decriminalise." However, without sufficient data and without sufficient evidence to back up the claims that decriminalisation reduces the stigma, and therefore people are going to get help, we cannot support that bill.

MR DAVIS: I have, I guess, a quick line of questioning so that I can get my head around the broader context in your submission. It goes to the point you were making before, Alex, about that pub test. I think most Canberrans would describe the police force as "conservative"—I put it in inverted commas—or would describe police officers as conservative. But you have raised a surprising amount of—again, I will put it in inverted commas—"progressive" points. You are supportive of the ACT government moving to pill testing. Frankly, I was even surprised to see that your organisation would support moving to some form of decriminalisation for, specifically, MDMA. Would that be a fair assessment up to this point?

Mr Caruana: Yes, for a trial purpose—because without the data, we do not know. If it does not work, we can; if it works then we can expand from it.

MR DAVIS: Of course. I definitely sympathise with views that you have put through your submission. Would it be fair to say that the biggest challenge is that when a police officer comes in contact with somebody using drugs, they do not feel confident there is a place for them to go, or a service to which they could be referred? I suppose I am moving to the broader philosophical challenge here. If the government were able to assure your members that there was going to be adequate investment in the services provided so that officers could refer drug users to services, and if the government were able to assure your members that an appropriate relationship had been established with the commonwealth so as not to put them in the compromised position you articulated, would there be a broader philosophical opposition to the principle of decriminalisation?

Mr Caruana: We would have to look at the data because it still brings in the question of where those people are getting the drugs from. We do not want to see organised crime getting a foothold in Canberra. This is not a political point, but we have the lowest number of police officers per capita in any state in Australia, so we are already stretched in ACT Policing. If organised crime started moving in here to capitalise on that business opportunity, it would certainly put our members at risk. Also, if we did start to see a steep increase in drug usage and our members were starting to get injured because of, let us say, ice rages et cetera, then we would have to make sure that there are safeguards in place to roll that back and to make sure that we now take a harder approach because the softer approach has not worked. We would have to see the specifics of it. Philosophically it is possible, but we would want to see what the details were.

Mr Peterson: I could just expand on that in two ways. Obviously, there are the policy commitments around funding regarding the health service, intervention services and things like that. The second is obviously what is in the proposed bill. The proposed bill, as I read it, does not afford the powers for police to recommend somebody go into, or be pushed into, a particular support service. So, certainly, there are things within the bill that could be provided to allow our policing members to direct people

into the services they need. The bill fails to do that, as I read it, in any substantial respect.

MR DAVIS: Could I ask a very naive question? Do police currently have the authority in any other area to direct anyone to a service?

Mr Caruana: In mental health they might, but it is under the direction of a doctor.

Mr Roberts: It is normally backed by a court order. So we could take someone into custody on mental health grounds, under a green slip under the Mental Health Act, but to keep someone in long-term care and treatment, then, yes, it is a court order.

MR DAVIS: So what you would be advocating for is something very different to how police have historically operated, where you have either not arrested somebody and charged them with a crime, or—and this would create something entirely different—you would want some obligations on the person you have apprehended or are dealing with, to be able to take them, I imagine, forcibly, against their will to—

Mr Roberts: Police have a duty of care. When talking to anyone on the side of the road, regardless of whether they are intoxicated or suffering mental health, there is a duty of care, and you still have to transition that duty of care. Police officers are great front-liners, but, because they are so stretched on the road, we cannot provide the ongoing care. So we need those diversions and those programs in place to know that, once we have found them, they are safe; we have diverted them—that they are actually being looked after; that it does not take three months or six months to get someone into a treatment program. It needs to be now.

Mr Caruana: In our submission we refer to the Portuguese model as an example. I am not suggesting that they are the gold standard; other people are suggesting that they are the gold standard. However, what they did in Portugal, to my understanding, is that they built these health services first, before they changed the legislation. And they built a commission or a committee on the side so that the police divert the members of the public—the people with the health issues—to that committee. So the police do not actually make that decision. The police say, "Here is an order for you to appear to a panel," and the panel makes a decision. And that decision could be anything from, "You can't attend a nightclub," "You cannot go out at night after 7 o'clock," to applying fines and/or inclusive of attending this rehabilitation health clinic et cetera.

But they had the health infrastructure in place and people were able to be diverted by the police officers before they decriminalised. The police had the discretion to do that before the decriminalisation and before any of the legislation was changed, and that was proved effective at the time. We do not have that data here in Canberra, or here in the ACT—that we are going to have the health services in place that are suitable to transition someone. Because, let us face it, a heroin addiction does not require a 10-day solution; it is an addiction for life, generally.

So we need a longevity of funding for a long period of time. We need to make sure that there is funding in place before we change the legislation, that the police are given the appropriate powers, we would suggest, to go to a committee to make that

decision or to a panel or some other body. Police have found this person. They have admitted to them that they have a problem. They go to this panel and the panel makes a decision on what happens to them next. But that panel cannot make that decision and divert them to a health service if there is not a health service.

MR DAVIS: Can I just ask a final supplementary question on that. It is about something that you said earlier, Alex. I will challenge you just a little bit on one assertion that you made. Accepting your hypothesis that the ACT does not have enough police officers—and that is probably a conversation for another day but let us accept it for argument's sake—would you not imagine that most Canberrans would prefer that the limited or stretched resources of police officers be invested in tackling drug trafficking and the outlaws that are selling these drugs to vulnerable consumers, rather than police being focused on the individual consumers of small amounts of drugs?

Mr Caruana: I would agree, and I will also say that that is the strategy for ACT Policing. The strategy is not to tackle the small consumers; it is to police the traffickers. So, as we said earlier, very few, if any, members are charged with single-use possession or small possession. In some instances, even with large quantities, people have not been charged; they have managed to find a way out of that. So, yes, I agree with what you are saying; the AFP's resources are being spent to deal with the traffickers and they are not being put onto the users. It is safe to say that when that user is having an episode—domestic violence cases, child abuse cases et cetera are generally drug or alcohol fuelled—ACT Policing will get to step in. I will be honest with you; there are a lot of mental health cases which are drug induced. Troy, I do not know if you want to tell the story about the person you picked up several times in one day, because we did not have the health services.

Mr Roberts: For the guys on the ground it can be a bit of a revolving door. You are on an eight-hour shift; your first job in the morning may be a welfare check or something where you have a drug user. They are not in the best state, so you take them into custody and transfer them to hospital. You go out to the station and a couple of hours later you get, "Can you please go back to that house because such and such has returned." There needs to be that option where you cannot keep on doing the cycle. The cycle needs to be broken somehow. I agree that the watchhouse is not the best place for that person but then we cannot keep on putting them into that health treatment system and have them getting spat out to repeat their behaviour.

Mr Caruana: And if the option is for them to leave, they are going to leave. They do not want to feel as though they do not have an option. Then it becomes a revolving door and then AFP's resources are being wasted picking up these people. There is no saving in decriminalising drugs because the public would still be going through that revolving door.

THE CHAIR: Do one of you want to make a final statement to conclude this hearing?

Mr Caruana: Yes. We are all for the harm minimisation, and we understand that this is what this bill is essentially trying to achieve. It is trying to minimise the harm in people and change the narrative away from drugs being seen as a bad or a dirty thing

so people can seek help if they want or that they need. Certainly, we agree with that. We feel as though that money could be spent in educating people better as to what the ramifications are of putting this substance in your body—what may happen—and people can make their own decisions from there. Having a penalty for using drugs has a dissuasive effect. It does dissuade people from doing it.

I heard earlier presenters say that young people will try to challenge the system. That is correct, young people will, but the vast majority are scared of going to jail, are scared of getting a criminal record, so more people are worried about the ramifications if that might happen. I am not suggesting that if somebody makes a poor decision and takes one ecstasy tablet when they are 18, they should be punished for that for the rest of their lives and are not able to get a meaningful job et cetera. I think that there is a balance that can be had, and I certainly think that that can be done without challenging the legislation and that that can be done by building a stronger health system and giving police additional powers to divert these members that are suffering these health problems into those therapies—into those alternative means—to get the help that they need.

Mr Roberts: Just to follow up on what Alex said, I think there is a bit of a missing space here. At the end of the day, it is not a police officer that convicts someone; it is actually the court. So let the police do their job. A lot of possession offences are secondary offences. People come to police attention after committing a more serious offence. So why can't some sort of framework be looked at where the police still do their job—they still put the brief up—and the court can prove but not convict? That is an option that the court has open today.

They can do that right now. So, I am just wondering, has that been explored more as an agreement with the courts? You still comply with the legislation and the commonwealth legislation, so you remove that PRS angle. What the court decides, the police will wear. They have to wear it; it is a court decision. As I said, it is not the police officer's job to convict someone.

THE CHAIR: Thank you for coming to the hearing today and for your submission. The secretary will provide you with a copy of the proof transcript of today's hearing when it is available, for you to check for accuracy. Could you please liaise with the committee's secretary to provide answers to questions you have taken on notice. I am not sure there were any, anyway.

I would like to thank all the witnesses for their constructive approach to our hearing today and for making their expertise available to the committee for the purpose of this inquiry. This hearing is now closed.

The committee adjourned at 3.58 pm.