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

WEDNESDAY, 21 JULY 2021

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

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

All witnesses making submissions or giving evidence to committees of the Legislative Assembly for the ACT are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution.

Witnesses must tell the truth: giving false or misleading evidence will be treated as a serious matter, and may be considered a contempt of the Assembly.

While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 1.38 pm.

HENDRY, MS BRONWYN, CEO, Directions Health Services
STEPHENS, MS STEPHANIE, Director, Service Delivery, Directions Health Services

THE CHAIR: Good afternoon and welcome to this public hearing of the Select Committee on the Drugs of Dependence (Personal Use) Amendment Bill. The committee acknowledges the traditional custodians of the land we are meeting on, the Ngunnawal people, and the committee acknowledges and respects their continuing culture and the contribution they make to the life of the city and this region. We also acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event either in person or online. During the proceedings today we will hear evidence from Directions Health Services, Drug Free Australia and Hepatitis Australia.

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," and this will help the committee and witnesses to confirm from the transcript questions taken on notice.

I welcome first of all representatives of Directions Health Services. 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 information is a serious matter and all participants are reminded of this. Please confirm that you have read and understood the pink privilege statement.

Ms Hendry: Yes, I have.

Ms Stephens: I have.

THE CHAIR: I think you were advised that there was an opportunity to make an opening statement of up to five minutes. Is that something you would like to do?

Ms Hendry: I would like to do that.

THE CHAIR: Please, proceed, Bronwyn.

Ms Hendry: I thank the committee for your consideration of our submission and the opportunity to present today. Firstly, I acknowledge the traditional owners of the land on which we meet, the Ngunnawal people, pay my respects to their Elders and ancestors past, present and emerging, and thank them for their continuing custodianship. I also pay my respects to the Ngambri people and other represented Aboriginal and Torres Strait Islander nations. We value the contributions of diverse cultures, identities and lifestyles made to our region and the richness of our society.

Directions provides a very broad range of drug and alcohol services in the ACT and surrounding regions in New South Wales. Our services range from harm minimisation services, such as the ACT needle and syringe program, through to counselling and case

management groups; withdrawal services; day and residential rehabilitation; and primary health services for vulnerable people impacted by past or current AOD use, mental health and other complex health conditions. Our services are available for individuals impacted by their own use, regardless of their goals for reducing or maintaining their substance use. We also provide counselling and support for family members and friends impacted by someone else's use, whether or not the person they are concerned about is willing to seek help, and this support is critical to their wellbeing.

Similar to the majority of submissions received by the committee, Directions strongly supports a health-first approach to drug use. In our experience the longer term harm from criminalisation of drug use can far outweigh the harms people experience from the drug use itself. Whilst illicit drug use is prevalent in our community, with 43 per cent, or roughly nine million people in the current population having used an illicit drug in their lifetime, drug dependence disproportionately impacts disadvantaged and vulnerable groups—for example, people who have experienced trauma, people with mental illness and people with cognitive impairment. Regrettably, Aboriginal and Torres Strait Islander people are also disproportionately impacted. Consequently, the harm from criminalisation of drug use disproportionately affects these vulnerable groups.

In effect, we add to their trauma through contact with the criminal justice system, possible incarceration and a criminal record that impedes their recovery and reduces their opportunity for participating meaningfully in our society. Perhaps more importantly, criminalisation creates a deterrence for people to seek help, due to concerns about the legal consequences, the embarrassment and shame they feel, and the stigma and discrimination they experience.

I think we would all be aware that the stigma and discrimination of people who use drugs is pervasive in our community. Sadly it is as evident in health and community support services as it is in other sections of our community. For example, we know people who have problematic drug use are often self-medicating trauma and/or mental illness. However, it is very difficult for them to access mental health treatment.

As we have heard in previous presentations, the common responses received by people who use drugs and who are trying to access mental health services, including when we refer them ourselves, is that it is a drug and alcohol issue, not a mental health issue, or that people need to stop using drugs first, which they are unable to do unless their mental illness and psychological distress are treated. This creates an obvious catch-22 for which there is currently little prospect of escape. People who use drugs are also poorly treated by other mainstream health services, regardless of their health needs, and tend to avoid accessing services unless it is an emergency. Consequently they experience very poor health outcomes and significantly reduced life expectancy.

Homelessness is another significant issue. It is virtually impossible for people who use drugs to get access to emergency housing through OneLink or to get the sort of permanent housing that would support their recovery.

Harms from criminalisation and from lack of access to treatment not only serve to entrench disadvantage over an individual's lifetime, they also entrench disadvantage for future generations, with families, and particularly children, negatively impacted by

the consequential unemployment, poverty and reliance on the welfare system, homelessness and the trauma of removal into the child protection system.

From a purely economic perspective, the costs of these avoidable consequences are far in excess of the cost of reorienting our system towards a health-first approach and providing better access to treatment and support. However, it is critical that when people do reach out for help the service system is able to respond.

Directions is by far the largest provider of community-based treatment and support services in the ACT and, like all other AOD agencies, our services are too stretched. Over 100 new clients seek access to Directions counselling services each month in the ACT. Our staff are working very hard to provide timely support, to call people back within two days and to offer an assessment within a week. Unfortunately, a lot can happen in the space of a week, and we lose people in that time. We do offer a walk-in service for people in crisis and provide interim support. However, people still need to wait to access ongoing treatment. Because we are too stretched we are not able to provide each person with the optimal treatment 'dose'—by 'dose' I mean the treatment intensity or frequency that we know will get better outcomes. For example, we provide counselling services to over 2,000 Canberrans each year. In order to try and provide services to as many people who reach out to us as possible we can only offer a weekly counselling appointment, at best, for people in really high need and usually only fortnightly or monthly appointments.

That is a very different treatment dose compared with what our teams can provide in surrounding New South Wales regions. In the towns in which we are based we can offer multiple contacts per week and a much higher level of community support. As a consequence, our New South Wales clients get demonstrably better outcomes.

In summary, whilst we have outlined in our submission a number of things to be considered in relation to the bill, including alternatives to the proposed fines and referrals to treatment services, today I also highlight two important points. It is clear that criminalisation is not an effective deterrent for illicit drug use and, in other jurisdictions where decriminalisation has been implemented, the evidence shows that it does not increase problematic drug use. Most importantly, it actually reduces stigma and discrimination and increases the likelihood that people will seek help.

Finally, I think it is worth noting that the bill is in line with current community attitudes. The vast majority of Australian people, including the majority of Canberrans, support non-criminal actions for drug possession. In the national drug household survey, around 88 per cent of people surveyed supported non-criminal sanctions. They supported a caution or warning, referral to treatment, or a fine, with only 12 per cent indicating support for correctional measures such as community service or prison. Similarly, in the most recent survey 57 per cent of Australians supported fixed site pill testing. Support was even higher in the ACT, with around 70 per cent supporting pill testing at designated sites.

As a community, we also support more of the current resources being directed to treatment, harm reduction and education, and less towards supply reduction and law enforcement, which currently receive two-thirds of the resource allocation in this area.

THE CHAIR: What will happen now is that we will each take a turn to ask what we call a substantive question, but that does open the opportunity for supplementary questions from anyone on the committee. It is pretty much an opportunity for an exchange as well. I would like to touch on something that I did not feel was addressed and is certainly important to some of our submitters. It is more from the legal side of things and, forgive me, I am a lawyer; so I think I go there as well. Would you like to comment on the issues that would be raised if the bill is passed? It would be in conflict with the Commonwealth Criminal Code, which would create a dilemma for AFP police. Also the fact is that at the moment, unlike tobacco and alcohol, the only source for these illicit drugs would be criminal activity.

Ms Hendry: I think that is true. There is the conflict with the commonwealth legislation. But that has not proved to be problematic so far. And one would hope that a negotiated response to that could be agreed. Yes, by their very definition they are illegal and procured from illegal sources, including what I have referred heard referred to as organised crime. That is the case now. Decriminalisation is going to make absolutely no difference to that situation.

It may actually assist if we have supported drug checking, for example, where we can identify where drugs have been adulterated with dangerous substances, and that will influence what people are actually trafficking, as well as what people are taking. That is another harm reduction strategy but the source is still the same, regardless.

THE CHAIR: I know the police associations would feel that there is a real challenge for their members in that—as opposed to the cannabis possession, which is easy to identify—some of these substances are not easy to identify, let along their weights. There are very real administrative as well as legal challenges for them. Have you got any other comment on that?

Ms Hendry: I think the ACT Health submission was interesting in that regard in that they recommended that mixed weights of drugs be used. If all drugs are covered by the decriminalisation, by the amendment bill, then what a drug is actually is not nearly as relevant. Obviously you need to weigh it. We can test drugs to see what is in them. We certainly have the technology to do that. But if mixed weights are used rather than pure weights then that creates fewer barriers to the police and to law enforcement.

THE CHAIR: That would create a greater sense of whether they have someone who has got an amount in excess or not. They just would not really be confident unless they could test on the spot, which is apparently a challenge for them?

Ms Stephens: Testing, if you have access to the equipment, can be quite immediate. Maybe that is something that could be explored. But I would think there is a return in time, effort and process in taking the bill for the police—the nature of their relationship with the public changes, the prosecutions and the legal pathways, as well as the administrative burden on the police force would also be reoriented into a different relationship.

MR DAVIS: You spoke to the current arrangement around the decriminalisation of cannabis. No doubt there have been a number of individuals that your organisation provided service to when that legal change changed their relationship with your

organisation, with the justice system or even with the substance itself. Mr Cain rightly highlights some of the challenges that other submitters have suggested to us, including the Police Association, about conflicts with commonwealth law. On the ground, in the service provision area that you work in, how have you seen that MOU between the police force and the commonwealth work out, practically, around the decriminalisation of cannabis? Have you seen challenges around that that could be challenges for us in the decriminalisation of other substances, if that makes sense? It was a bit of a preamble but I think you see I am getting at.

Ms Hendry: We have not seen any that I am aware of.

Ms Stephens: No, nothing comes to mind.

Ms Hendry: No. I know the drug driving laws are still problematic in that respect. But we have not had any information that the conflict between the commonwealth law and the ACT law has been problematic.

DR PATERSON: Thank you so much for your submission. We have had a few submissions on the difference between AOD services and mental health services, the lack of crossover and what came first, 'the chicken or the egg' type of thing, and that people cannot get into mental health services at the hospital if it is drugs. I am interested to know your thought about this and where you see limitations on things that could be improved in respect of supporting people more broadly.

Ms Hendry: We have long been advocating for an integrated primary health level of mental health and AOD service that can treat both those conditions concurrently by the one agency and people do not ping-pong between one section of the health system and another section. Then we need better integration at the specialist level, as well, with mental health and drug and alcohol services. Structurally they are under the same umbrella, so to speak, but that is about as far as the integration goes. To get the best outcomes for people we definitely need to be able to treat mental illness and drug and alcohol use simultaneously. And we need services that can do that.

MR DAVIS: I do not want to verbal your submission. But just to set some context, would it be fair to summarise it as support for the principles of decriminalisation but with a whole bunch of opportunities and challenges around making sure the right services are in place? I think that would be a fair way of describing it in summary when there are all those challenges.

I want to speak to one particular part of the bill and get your perspective, which is the infringement notice. There has been an awful lot of conjecture about whether there be an infringement notice or not and, if there should be, how much should that infringement be? Putting that to one side, let us work on the assumption that there will be, and it will have some monetary value. The suggestion has been put that one thing the government should do is ensure that 100 per cent of the funds collected from the payment of those infringement notices are redirected, dollar for dollar, into services. You have obviously presented in your submission the need to urgently fund the expansion of existing services. I wonder if you have a position on that and if you would reflect on, I suppose, the challenge of government to fund everything that needs to get funded. What would your position be on a model like that?

Ms Hendry: I do not have a position about where the money comes from, I have to say.

MR DAVIS: That is for us to figure out. Is that right?

Ms Hendry: That is right. I think part of our submission is that we hope there are alternatives to fines, because the most disadvantaged people will continue to be disadvantaged by fines. People who are just using drugs recreationally and have an income are not going to be severely financially disadvantaged by whatever fine that is in the bill. But the most vulnerable people will be. I am hoping that there will be fewer fines and more diversion to treatment and more referrals for harm reduction services. I would not really want to bank on the fines paying for the additional treatment services.

MR DAVIS: That is fair. Has that been your experience so far with the decriminalisation of cannabis? In your experience, have police officers chosen to refer to services like your service as opposed to putting out infringement notices?

Ms Stephens: I do not have any strong data to confirm that, but anecdotally yes. That reduced stigma just helps people to engage in services more regularly, and having that motivation really reduces barriers to engaging in help-seeking.

MR DAVIS: Were the government to fund equal to what you identify you need, one of the challenges I observe—and tell me if you think I am wrong—in healthcare provision more broadly is just the recruitment of suitably trained staff. I wonder if you could speak to the challenges. Do you feel confident, as an organisation, that if funding were to be provided you would be able to recruit and retain staff?

Ms Hendry: We are currently pretty fully staffed. We do not have vacant positions generally for long. We have had one psychologist position vacant for a little while because they are particularly hard to recruit. But we do not normally have trouble recruiting staff. We are getting to the point where we probably need to pay them a bit more because they are getting poached by other areas. But I do not really have an issue with that.

I also would not want you to think that we predicate our support for the bill on increased treatment services. We support the bill regardless.

MR DAVIS: That is an important clarification.

Ms Hendry: We support the reduction in harm that people experience from their interaction with the criminal justice system, regardless of whether we get increased resources for treatment.

DR PATERSON: On support for families, do you run services to support families? How can we do that better?

Ms Stephens: Absolutely. We are one of the few providers who provide counselling and group support to family members, regardless of whether the person whose substance use they are impacted by is engaged with us or not. We offer a peer support group, which we were discussing a little earlier, where people can provide mutual

support, share stories and feel a sense of connection in being able to talk about something that at the moment is so stigmatised. For us, it is really around being accessible.

When a family member reaches out for support often it is preceded by something occurring, whether it is a crisis or new information, and being able to reach out for support that is non-judgemental, welcoming, not pressured on a particular outcome, is not about making anything in particular happen but is really around their wellbeing, and what is going to be best for their family.

Ms Hendry: And how they can best support the person they are concerned about. Your natural reaction, including my own, is not necessarily the thing that will be most helpful. And it is such a stressful situation for families that it is really great if they can actually get some objective advice about some of the strategies they could use.

MR DAVIS: Just to clarify on the subject of parents and carers and friends of those who use drugs, the committee has heard evidence from a number of people who advocate for involuntary rehabilitation. Can I confirm what your organisation's position is on involuntary rehabilitation?

Ms Hendry: We do not have an official position on it. My background is in mental health, so I am very familiar with involuntary treatment. I think perhaps in extreme cases there may be some value in keeping people safe for a period, but it does not actually have demonstrated efficacy in the long run and it does have the risk of alienating people from treatment services.

We cannot take that approach now anyway, and it is certainly not what we are advocating for, because our approach is really the opposite to that. It is that we will see you, we will provide individual counselling, we will provide case management support even if you cannot see a way to reducing your drug use, we will support you with some other things and some harm minimisation strategies. And we found that is a better way of engaging people than involuntary treatment.

But I do understand the arguments that some of the presenters have made about people really not being in the position to consent and make good decisions for themselves, and I think that is where the mental health system and the AOD system at that specialist level need to work much more closely together so that we can actually keep people safe when they are in really a very precarious position.

Ms Stephens: Program outcomes, client outcomes show that if you work with motivation, you make things timely, you make things accessible and if people can have a positive, strength-based experience of treatment, they are more likely to have positive outcomes but also to engage again if they need to.

DR PATERSON: There has been a bit of concern in the submissions around methamphetamine being included in this. We had a really interesting submission—and I felt it was an interesting way of positioning things—from ATODA who said, "If you are going to shift things from a criminal lens to a health lens you cannot then say, 'Pick the drug that is worst for your health and we are going to put that over there and everything else here'." Given your experience in working with people who are

experiencing effects from a vast array of drugs, legal or not, I am interested to know what your views on that are.

Ms Hendry: We certainly do not have the view that any illicit drug should be excluded from this bill. I think the harms are relative to individuals. Some drugs that we consider softer drugs can end up causing harm to some people. Some people manage what we call harder drugs and manage to function quite well in our community. I think really you cannot discriminate based on a particular drug.

The premise is that if you decriminalise then you increase help-seeking. We would want to increase help-seeking for the people that are most compromised by methamphetamine use. We would not want to exclude them and leave them stigmatised and less able to access treatment. I think it would have the opposite effect.

THE CHAIR: On behalf of the committee, I thank you for giving your evidence today. 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. I do not believe there were any questions on notice. I thank you so much again for coming and giving us your evidence.

Ms Hendry: Thank you.

Ms Stephens: Thank you so much.

Short suspension.

CHRISTIAN, MR IAN GARY, Research Director, Drug Free Australia

Evidence was taken via teleconference—

THE CHAIR: I welcome Drug Free Australia to present its evidence to us today. Please be aware that today's proceedings are covered by parliamentary privilege—Mr Christian, this is really for your knowledge—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 confirm that you have read and understood the privilege statement that the secretary has sent to you.

Mr Christian: Yes, I have.

THE CHAIR: Thank you. Do you wish to make an opening statement of up to five minutes?

Mr Christian: Yes.

THE CHAIR: Please proceed.

Mr Christian: Rather than making a statement, I want to pose a number of questions for your committee, or subcommittee. I want to start with Australian attitudes to the drugs the bill wants to decriminalise, be it the hard drugs, heroin, ice, speed, cocaine. Ninety-nine per cent of Australians do not give their approval to the regular use of heroin, ice and speed; for cocaine, 97 per cent do not give their approval; and, for ecstasy, 96 per cent do not. These are the drugs you want to decriminalise in this bill.

My first question is: with these high rates of disapproval, would Australians want fewer drugs in their society or would they want more drugs in their society? I think the answer is unequivocal. We know that they want less drug use. Australians do not approve of drug use, because drugs present unacceptable harms for others. We put that in our submission very clearly—they harm a whole constellation of people around each user—the user themselves, their partner, their children, who are the most vulnerable of all, the children's grandparents, their siblings, their friends, their workmates and other road users.

My second question is: how can this inquiry be sure that everyone out there thinks that drugs present unacceptable harm? It is a good question to be asking. We know that we have harm reduction programs for illicit drugs. In actual fact, that is international nomenclature; it is in the name that they are harm reducing. We spent tens of millions each year between 2000 and 2009. We spent $243 million on needle programs alone, and that does not include all the other harm reduction programs we have. We would not do that if the harms of these drugs were entirely acceptable. They are unacceptable, and that is an unequivocal fact.

My third question is: would Australian voters want their legislators to increase drug harms in their society through the legislation or decrease the harm? I think the answer to that one is clear. My fourth question is: will this bill increase the harms of drug use or will it decrease the harms for ACT citizens, who are Australians like any other and who answer the survey just like all other Australians? For some years, the answer to

that was a little speculative but it is no longer, because we have empirical data on the table.

Portugal had a 59 per cent increase in drug use over 16 years under decriminalisation, a 59 per cent increase in overdose deaths and a 60 per cent increase in use for high school minors. In California, they decriminalised all drugs in 2015. I have a survey in front of me, which came out about a week ago, which shows that 40 per cent of those surveyed want to leave the state to go to other states, citing drugs and homelessness as the main reason, and that the homelessness goes with the drugs. Decriminalising these drugs increased the use and harms in both of those places. That is exactly what ACT citizens, according to the survey, do not want.

My fifth question is: why is this bill being moved forward when we know the answer to all of these questions? Decriminalisation will increase drug use, which Australians do not want. Why are we even talking today?

This bill is based on two fictions. First, the Uniting Church came out and said, "We must fight for users' rights," but there has never been an enabling of a right to use drugs. Nobody has ever heard of it, other than the people who use drugs who think that they have a right to use drugs. They do not—not in the United Nations; not anywhere in the world. There is no such right.

The second fiction is that convictions harm users—that it is a terrible thing, convictions harming users. In actual fact, users cause unacceptable harms for other people and the community. Everyone accepts that, but that is why we have harm reduction programs. We have already covered that ground. They harm others in the same way as someone who steals from somebody else harms the other person. Nobody in their right mind would say that a conviction for stealing harms the thief; neither does it for drug users.

THE CHAIR: Thank you. I am just going to stop you there. You will have plenty of opportunity to respond to our questions and make your other points. We were keen to give you an opportunity for up to five minutes to state your broad position. We will be taking it in turns to ask you a substantive question that each committee member has in mind. This will be a little tricker with the phone connection as other members may come in with a supplementary on the theme, so to speak, so bear with us. Please make sure that you have understood a question that is being asked and ask us to clarify or to speak a bit louder if that is needed.

In your opening statement you touched briefly on the failed Portugal model. We have had many submissions that speak in completely opposite terms in that the Portugal model is an example of how well decriminalisation of illicit drug works. In a short big picture response to that, I am interested in your views.

Mr Christian: I have seen the comments by Dr Bowles. He is so wrong. Just to correct that, I have sent the European monitoring centre data to you by email for your records. I will ask the chair to table that, and it should be able to be distributed at some stage. You will see that it is the actual data that we are using. Dr Bowles was entirely wrong; he was entirely mistaken. We are using nothing but the EMCDDA data from Portugal; we are using the official data.

Nobody can make out that a 59 per cent increase in drug use is a good thing. In Australia, we decreased our drug use. On the same drugs that they measure in Portugal, we decreased drug use by 42 per cent when we had "tough on drugs" between 1998 and 2007. How can anybody think in glowing terms of Portugal when they have an increase in drug use? That is not what Australians want. We know from the surveys that we do not want increased drug use.

But decriminalisation is going to deliver that—a 59 per cent increase in overdose deaths and a 60 per cent increase in use by high school minors, and they are not even meant to be using drugs, under any regime. These all need to be factored in. These are the facts. You have lots of activists who have all grouped together to put in hundreds of submissions and they are all based on error. It does not make it right; numbers do not make anything right.

THE CHAIR: Thank you. Dr Paterson has a substantive question.

DR PATERSON: You have not mentioned addiction once. I struggle with that, because we are looking at alcohol and tobacco, for example, which are also addictive substances. We do not view someone who does not stop drinking or smoking, as you said in your example, as a criminal.

Mr Christian: Yes.

DR PATERSON: I am interested in your views if a person who is addicted to a drug is seriously struggling, because you have not mentioned it once.

Mr Christian: It has been the subtext of every comment I have made. Everything here is addressing addiction and nothing but, in actual fact. As I remember, the community, especially around 2008, were wringing their hands in New South Wales. They were having summits about alcohol use in teens and so on. Here we are wringing our hands about how much damage alcohol and tobacco do and here we have something that wants to decriminalise and increase the use of a whole plethora of other drugs. That does not make sense at all. We have enough trouble with the drugs which are legal already. Why would we make it easier to use the other drugs?

DR PATERSON: The argument would be that you have services in place that support people. If you can reduce the addiction or address the addiction with the individual then you will reduce the harm more broadly.

Mr Christian: That is the ambulance at the bottom of the cliff. The problem with the harm reduction programs is that they do not work. I can send you this and give you every piece of evidence for it. Needle exchanges do not work; they do not do what they are meant to do. They do not protect people from HIV or hepatitis C, and neither do methadone programs keep users from criminality or overdose deaths. I have got that from the best reviews in the world—Cochrane collaboration and the Institute of Medicine in the US, who were very pro needle exchange, I might say, when they started out.

DR PATERSON: Do you really think, though, that the fact that these drugs are illegal has helped the situation?

Mr Christian: Yes.

DR PATERSON: Do you think things are getting any better?

Mr Christian: Yes. The fact that they are illegal means that we do not use them like alcohol, which is 80 per cent. We used to have 90 per cent at one stage using alcohol. At worst, 13 per cent, I think in 2007, were using illicit drugs in that year as against big figures and we used to have 65 or 70 per cent of our society using that drug. We actually gave you a survey question which said, "If drugs are illegal, does that keep you from using them?" Thirty-two cent of people said, "Yes."

DR PATERSON: They are probably not the ones using them though.

Mr Christian: That is in our submission.

THE CHAIR: Thank you for the other material you have mentioned. I am just confirming that we have your other emailed material. That will be taken as evidence.

Mr Christian: Can I just add something? I think you have to go to a document called "The Truth on Portugal". It is referenced and linked to in our first submission, submission A. It shows the prior years, so you can get all of the data. It has screen shots of the official report that goes from Portugal to the European monitoring centre. Between the two things I have given you, you can back up everything that I have stated about Portugal. The activists are wrong.

DR PATERSON: We have heard from the police association; we have had submissions from police. They have said that no-one has gone to court for single-use possession of drugs. At the moment it is police discretion; they have been using their discretion to address this. Basically, we would be working within the same system, but we would be seeking to improve the services and supports for people and referrals to these services. Ultimately, we are not changing what happens on the ground, but we might be offering people a better outcome.

Mr Christian: This is why our drug use has gone up since 2007, when "tough on drugs" finished. Our overall drug use has gone up 30 per cent in that time. It is because we have chosen to do lots of work with our policing, with our prevention intervention. I should say that particularly. We really need to be doing better. We can go back and we can do something about what Australians want. They want less drug use. We can do it. Tough on drugs—we know exactly what to do. I made that point in the third submission. We know exactly what works. We can do it and we can bring our drug use down significantly, rather than having it continue to go up and up.

THE CHAIR: Thank you. We have no further questions from the committee, but I would like to give you a couple of minutes to make a statement, if you would like to do so.

Mr Christian: I think it is important to recognise that we have a really compassionate answer to all of this, especially when people are saying we do not want conviction. They do not have to have a conviction. That is already how it works. We have drug

courts in Australia. People go to treatment. They are given the choice of going to treatment and, if they do, there is no conviction. So the community get what they want. We know that they want less drug use, so they get what they want. The user gets no conviction if he goes off to treatment rehab. This is the best of all possible worlds. Drug courts work if a conviction is a possible reality and they will not work unless a conviction is possible.

THE CHAIR: 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. Thank you for your time.

Short suspension.

ANLEZARK, MR JOSHUA, Executive Officer, Hepatitis ACT Inc

Evidence was taken via teleconference—

THE CHAIR: Welcome. Do you have anything to add to the capacity in which you appear?

Mr Anlezark: I have lived experience as a person who has used and injected drugs, and I have been a client to alcohol and other drug services in the ACT.

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 confirm that you have read and understood the privilege statement that the secretariat sent to you.

Mr Anlezark: I have read and understood the privilege statement.

THE CHAIR: Thank you. Ordinarily, we would have a written submission and we would have been able to prepare ourselves for this hearing. I confirm that you have not lodged a written submission.

Mr Anlezark: I have not.

THE CHAIR: We will be relying then on an opening statement of up to five minutes. It is then up to us, as committee members, to ask you some questions that have perhaps been raised by other submitters. Would you like to make an opening statement?

Mr Anlezark: Yes, I would. Hepatitis ACT is a community-based hepatitis organisation, predominantly funded by ACT Health. We celebrate our 25th anniversary this year. We deliver a comprehensive range of hepatitis B and C related information and training, advocacy, support, and referral services. We work to prevent viral hepatitis transmission. We support morbidity and mortality quite critically to minimise the related personal and social impacts of viral hepatitis. That is important because our major transmission route for viral hepatitis is through injecting drug use. It is estimated that there are 2½ thousand people living with hepatitis in the ACT, only 14.2 per cent of whom are engaged in care.

In 2017, there were 138 new hepatitis C notifications, with 85 per cent attributable to injecting drug use. For that reason, we are very interested in needle and syringe program activities. We are a secondary needle and syringe program service under the contract for Directions. We also work in custodial settings and alcohol and drug treatment services.

I guess one of the key things I want to highlight to the committee is the massive impact of stigma on people who use drugs and on people who live with blood-borne viruses, and how this can be a barrier to living proficient lives and accessing the health services they need. It can be complex and multi-layered from injecting drug use stigma to the stigma of having a blood-borne virus. By removing stigma and negative attitudes or prejudice against people who use drugs, there is an opportunity for them to be seen as

something other than a drug user or other than just someone living with a blood-borne virus. Too often the service system can only apply one lens; you cannot see people as their whole selves. It was mentioned in one of the earlier witness statements today that drug use is often symptomatic. It is a problem in itself, but it is not necessarily the root of the problem. If problematic drug use is to be addressed properly then we need to be able to get past seeing someone through a stigmatised lens and see them as a whole person.

Currently, Hepatitis ACT is running a program with the Canberra Alliance for Harm Minimisation and Advocacy to get people at risk of contracting hepatitis C tested and on treatment. These are very hard to reach communities. They are distrustful of medical services. They feel the impacts of stigma. By providing non-judgmental services in a safe community setting, we have been able to put 39 people through peer education programs that increase harm minimisation behaviours, as well as getting a large number of them tested and on effective antiviral treatment for their hepatitis C, meaning that they can clear it.

I also want to mention some of the other submissions that Hepatitis ACT supports. We support in full the submissions made by the Canberra Alliance for Harm Minimisation and Advocacy, the Alcohol Tobacco and other Drug Association of the ACT, Directions Health Services, and Meridian. Particular elements that we support include: the removal of fines; diversion to treatment and education as a first response; a supervised injecting facility in the ACT, with peer support available; an increase in community-based and community-operated needle and syringe program outlets, covering the geographical spread of Canberra, including an increase in the number of primary NSPs; widespread rollout of peer distribution of take-home naloxone, which is an opioid antagonist; and increased funding for treatment services, including additional funding for innovative service responses and pilot programs. That is my opening statement.

THE CHAIR: Thanks for that. Are you intending to lodge any written material?

Mr Anlezark: I am willing to if there is a question on notice.

THE CHAIR: We will be drawing a line in the very near future about accepting material. I am just putting you on notice, so if you could answer that question as soon as possible.

Mr Anlezark: Certainly.

THE CHAIR: The committee will eventually be in a position where we will be saying no more submissions will be accepted.

Mr Anlezark: Understood.

THE CHAIR: Thank you. I want to touch on something that has been brought up by a few, and you have not touched on it so much, and that is the conflict with the Commonwealth Criminal Code and the challenging place that that puts ACT Policing in. They themselves have said that it will be a bigger challenge than with the cannabis bill that was introduced in the last Assembly. Do you have any comment on that?

Mr Anlezark: This is about changing drug laws in relation to how they impact on people's lives. It is not about challenges or conflicts that may exist between jurisdictional or federal legislation. Certainly, they have got to be worked through. I would probably echo what Bronwyn Hendry from Directions said earlier today; there have not been too many tensions. Successful implementation of this bill will present many challenges across the whole service system, but that does not mean we should not do it.

DR PATERSON: In relation to the 85 per cent of people living with hepatitis being injecting drug users, I think the community is quite aware of injecting drug use. I am interested in methamphetamine injecting drug use. In terms of that 85 per cent, what percentage would you say would be methamphetamine?

Mr Anlezark: I would not be able to tell you that. I can take it on notice and look at the data. It would depend on whether that is captured by the person completing the testing and shared with the surveillance team in ACT Health. From the top of my head, opioids still remain the largest injecting drug. I know that there are significant levels of methamphetamine injections in the ACT.

DR PATERSON: I would be interested to know, if you have further information, about the differences in drug use and the differences in drug injecting use. For example, does someone using methamphetamine use more syringes? I guess I am going to education. Do you need to target education in the community to different drugs?

Mr Anlezark: Most definitely. The messages really need to be that the number of pieces of equipment required would depend on how much that person was using and at what frequency. If I were developing the message, I would certainly be encouraging people to take more equipment than they thought they would need. There are plenty of ways for that to be safely disposed of if they no longer require it. With hepatitis transmission, it happens through reusing the needles. I certainly support anything that meant that every time someone injected a drug they did so with a clean needle.

DR PATERSON: Thank you.

MR DAVIS: I know you come before the committee with a lot of professional experience in your role currently and your role immediately past. If you are comfortable, I would be interested in asking you a question about your personal experience as a consumer of some programs here in Canberra.

Mr Anlezark:. I am happy to do that. If not, I will stop.

MR DAVIS: I am just interested in your reflections as someone who, as you have pointed out, has been a consumer of a range of services from a range of organisations. Government is tough in that you have to prioritise things. If you were in our place, what would you prioritise as the first area that needs immediate investment, from your personal experiences?

Mr Anlezark: Based on that personal experience, it would be making sure that you are able to engage with people at the point they are ready to engage for problematic substance use. That window can be very, very small. It is really acute and the best thing

is to get contact there. Despite eventually being able to access great services, I had to wait quite a while and waned in between wanting to do it and not wanting to do it. The thing that got me through was that I was able to advocate really strongly for my needs and keep pushing and pushing. But for people that are disenfranchised by the health system, or by any system, they do not feel they have the capacity to do that. It is almost like privilege played a part in being able to keep myself safe.

MR DAVIS: That makes sense. You are not the first person to put it to this committee that there is usually a very small window—

Mr Anlezark: Yes.

MR DAVIS: if I can paraphrase it—when the person using drugs needs to access services. What, in your opinion, does a best practice model look like when a person self-identifies and makes contact with a service? What do they need in that moment?

Mr Anlezark: They need to feel heard and understood about what the issue is. They need to have a clear way forward and some expectations that can be quantified, communicated and managed. You have got a resource-tight environment in terms of treatment services and they need to know people are going to stay engaged and demonstrate a commitment to wanting to get help. You pull them back regularly to see how things are progressing. I think there would be a great opportunity for ongoing engagement, either one-on-one or in groups, to have that available in the lead-up to the service that you are accessing.

MR DAVIS: Thank you.

DR PATERSON: Are the rates of hepatitsis going up?

Mr Anlezark: We are not quite sure because the available data from last year has been delayed. We are certainly not hitting our elimination targets in the national hepatitis C and hepatitis B strategies. These are targets for the virtual elimination of hepatitis in Australia. We are progressing against them, but not as quickly as we need to in order to meet those targets.

DR PATERSON: You were saying that there are a lot of people living in the community that have not reached out for help. What would you say would be ways we could better try to reach those people?

Mr Anlezark: Make testing and treatment community based, free and easy—obviously there is a clinical component to it—and led by people with lived experience who understand it. From a purely hepatitis lens, it is about getting tested and treated. That can reduce rates of passing it on. If someone is clear, there are education opportunities to prevent reinfection. I guess the key message is to go to where the people are. If there are signs identifying locations, that is one initiative. Whether it is a hep C testing treatment option in Tuggeranong or Gungahlin, you are fitting into a bigger clinical setting.

THE CHAIR: Would you like to make a closing statement?

Mr Anlezark: No, thank you.

THE CHAIR: On behalf of the committee, I 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 you have taken on notice? I thank all witnesses today for assisting the committee. This hearing is now closed.

The committee adjourned at 2.45 pm.