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

THURSDAY, 29 JULY 2021

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

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 20 May 2013

The committee met at 12.32 pm.

TONGS, MS JULIE OAM, Chief Executive Officer, Winnunga Nimmityjah Aboriginal Health and Community Services

THE CHAIR: Welcome to this public hearing of the Select Committee on the Drugs of Dependence (Personal Use) Amendment Bill. The committee wishes to acknowledge the traditional custodians of the land that 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 region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today.

During today's proceedings we will hear evidence from a range of witnesses, including organisations that provide drug treatment services. 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.

To start off our afternoon, I welcome the representative of the Winnunga Nimmityjah Aboriginal Health and Community Services.

Ms Tongs: Thank you. As well as being the chief executive officer of this organisation, I am a proud Wiradjuri woman.

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 pink privilege statement.

Ms Tongs: I have.

THE CHAIR: There is an opportunity for witnesses to make an opening statement of up to five minutes. I note that we do not have a published submission from you, so I assume that you would like to take that opportunity.

Ms Tongs: Absolutely; thank you. I would like to commence by acknowledging the traditional owners of the land, the Ngunnawal and Ngambri people, and pay my respects to their elders, past and present. I would also like to thank the committee for the opportunity to give evidence today.

As we all know, First Nations people are massively over-represented in the justice system in the ACT, including the AMC. We also know that a very large percentage of First Nations people who go to prison are sent there as a result of drug-related crime and their addiction to drugs.

I agree that drug law reform is well overdue. We simply have to recognise that drug addiction must be treated as a health issue and not a justice issue. This requires a complete rethink of our drug laws. My major concern arises because of the circumstances that my people live in. They are people living in severe disadvantage.

I am sure you would appreciate that my people, First Nations people, are over-represented across all of the systems in the ACT—corrections, child protection, homelessness, and the list goes on. This and other aspects of the lives of First Nations people give me cause for concern.

As far as I and the Aboriginal community are concerned, our number one priority in relation to illicit substance use is the need for an Aboriginal-specific community-controlled and managed residential drug and alcohol rehabilitation facility. I find it concerning how the focus is on a particular substance, a drug of dependence, when people with addictions will use any illicit drug, prescription drugs and alcohol.

We all know that there have been missed opportunities over decades to address drug-related issues, and we are still here today discussing what needs to be done to stem the high rates of addiction. Addiction is a health issue, not a corrections issue, and governments of all persuasions need to step up and provide the leadership required to stem the devastating impact that addiction through the use of illicit and prescription drugs is having on our community. Drugs do not discriminate.

THE CHAIR: Thank you, Julie. Each of us will have a turn to ask what we call a substantive question, which will give the other committee members an opportunity to ask something related to that question, a supplementary. Each of us will certainly take the opportunity to ask something of substance.

With the earlier change in the law, which basically decriminalised the possession of cannabis, are you able to tell us what you feel was the impact on First Nations people of that change, this one being similar, obviously with a different list of illicit products?

Ms Tongs: What concerns me is that, with the amount for personal use, it is geared towards the middle class—professionals and people who manage their substance intake. But if you have people with serious addictions, all you are doing is setting them up to fail again. People think, "It's legal now." They do not understand that it is only a small amount that is legal. Rich people can pay for it; poor people can't, so poor people steal to feed their addictions. Others can go to work, they can function and they can do all of that. We see that, later on in life, addictions will catch up with you, no matter what walk of life you come from.

THE CHAIR: Do you have any feedback on when the cannabis decriminalisation was implemented? Did that have any particular impact on the First Nations community in Canberra?

Ms Tongs: It did, for the people that can use responsibly, but not for the disadvantaged and marginalised.

DR PATERSON: Thanks for your submission and for being here today. You referred

to an Aboriginal and Torres Strait Islander residential facility. I would like to understand how important cultural safety is in the delivery of alcohol and drug services to Aboriginal people in the ACT.

Ms Tongs: It is hugely important. I spent 14 years of my life on the committee for the Ngunnawal Bush Healing Farm. That was meant to be an Aboriginal-specific residential drug and alcohol rehab. We were told, after we had done all of the tendering and everything, that the purpose of the land had been changed and we were not able then to deliver that service. That had a huge impact on our community. I cannot help thinking and wondering about how many people we might have been able to assist to come through that, if that had come to fruition. But it did not, and now we are back to square one.

Prisons are not rehabs. The problem is that, for a lot of First Nations people, there is all of that historical trauma. Being born into poverty, with colonisation, dispossession and the stolen generation, all of those things have led people into, firstly, the child protection system and, from there, into juvenile detention and prison.

The sad part about it is that when the AMC was built, it was intended to do a lot of things, and particularly to reform the way that justice was served here in the ACT. With Alexander Maconochie, that prison has not lived up to his name. I feel gutted that it has become more of a bloodbath, in that people are coming out way worse than when they went in. Their criminal behaviours are becoming more and more violent. That is because they are in lockdown all the time. Some of them that are first-timers are locked up with pretty hardcore men. Also, addiction causes other issues on the outside. The thing is that, when you run up a drug debt, somebody has to pay for it. Often it is the family; or, when they get out, they have a debt that has to be paid back.

There are a lot of things that are not right. Without proper leadership—good, strong leadership—we will never change anything. That is why people vote for politicians, and that is why we have governments. We expect people to lead. But if there is no leadership or if there is weak leadership, nothing will ever change, because all we do is go around in circles.

My mob want people that they can trust. Their case managers out there are corrections officers. They do not trust the corrections officers because they are the ones that turn the key on them. At the end of the day, they need to be autonomous services so that they have people that they can trust, and so that they can talk about the things that have happened, what they want to do and what they want to achieve when they get out. Without that, what hope do they have?

THE CHAIR: Regarding the lost facility that you mentioned earlier, what has been the government response to your questions? Why did you lose out, and what are we getting instead?

Ms Tongs: The week before last, I visited a site in Watson with a couple of Winnunga board members, the chairperson and the deputy chair. They have shown us another site where we could possibly build a residential rehab. It is a good site, but for how long do we have to wait? I do not have another 14 years to wait, and nor do my people. We needed that a long time ago, and now we are starting all over again.

Winnunga wants no involvement if they keep doing to us what they do. We put in tenders; we follow the proper processes and, when we get to the end of the line, we are told, "No, we're going to give it to a mainstream service." That does not work for my people. When people start to realise that all that they do is fail us, it is not about failing me; it is about failing the people that need those services.

THE CHAIR: That is the health minister, is it, in this case?

Ms Tongs: Yes, the health minister. Also, mental health is a big, underlying factor in all of this. People self-medicate, and the drug is a symptom, not the problem. You need to start to address that unresolved historical trauma. Also, when you are incarcerated, there are terrible things that happen to the women and men in there. We need to start to address that and rip the scab off. We have to get on with it and do something; otherwise I will be long gone and people will still be sitting here and talking about the same old thing.

There has to be some common ground between all of the political parties so that they really want to do something, because a lot of people in this community are struggling. Canberra is a very middle-class community that does not see disadvantage like we see disadvantage. I think that a lot of the problem is that, unless you have lived it, and unless you have been subjected to racism and discrimination, and you have lived in poverty, or you have had an addiction, you really do not understand it or get it.

MR DAVIS: I want to get your thoughts on drugs in AMC, specifically. The Justice Reform Group made a submission in which they talked about the impact of criminalisation on Aboriginal and Torres Strait Islander people. They said:

> … their exposure to drug related harms is increased while in prison, due to boredom, discrimination and lack of appropriate or adequate health care.

I am interested in your thoughts about what corrections and justice health should be doing specifically to reduce drug harm in the AMC.

Ms Tongs: Winnunga is the other player in the AMC. Winnunga is in there, and that came about because of Steven Freeman, the young Aboriginal man that died in custody from a methadone overdose in 2016 and the inquiry that was done by Philip Moss. He was also assaulted in 2015. He had only been in the prison for three hours, and he was in intensive care for six days.

One of the recommendations of the Moss inquiry was for Winnunga to go in. We thought that Winnunga on the outside would be Winnunga on the inside, because of the continuity. They are our clients on the outside, so it makes sense that they are our clients on the inside.

We had to push really hard to get in there and provide a service. When we did get in there—I think it was in 2019—they did not have a room ready for us. They actually gave us David Eastman's old cell for our doctor to work from. They put our nurses over near the library. There is a lot of distance in between. There was a podiatry chair in the room next door to the cell where we run our clinic and they did not want to

move it. It took me 18 months to get them to move the chair. They said it was a fixed chair, but actually it was not.

We get a lot of pushback. We have done some really good stuff, but as soon as we start to do good things, they change the days, we cannot have the room or we have to book a room. With justice health and corrections, it has not been easy for us, but we are still in there, and that is the most important thing. And we are not going anywhere. We are going to stay there, and we are going to make sure that our clients get the services that they deserve. I do not understand why it is such a big issue, when we could do really good work in AMC if everybody just got over themselves and looked after us.

There are a lot of mainstream people in there. My priority is my people. I thought that, with Winnunga going in there and providing a gold-star service, that would help to push up justice health and make others perform in the way that we do. But it has not been like that. I am not prepared to share the risk, because it is a very risky environment. A lot of what they do is paper based. We run an electronic system, plus we have access to psychiatrists and psychologists. We have a forensic psychologist who went in there and tried to run programs; now it is one on one.

I went out there a few times when we were talking again about a residential rehab. I was making real progress; then they changed the days and they split the group. It makes it very difficult. Then COVID hit and everything was in lockdown. There is no physical contact, and families are falling apart. They are looking for other avenues. Drugs run freely in jails; you will not keep drugs out of jails; it is as simple as that. If you cannot keep them out of Goulburn, what hope do you have of keeping them out of AMC? We have to live with that, but we need to provide opportunities to give people a choice—whether they want to use or not. They make home brew. Maybe they could run a pharmaceutical company. They are very clever. They could be scientists, if they put it to good use, because they make their jail brew and all of that.

When you lock people down and keep them locked down for a very long time, and there are only two of them in a cell, it is a real tinderbox. That is why we are seeing what we are seeing out there. It is because a lot of the women and men just are not coping. I think that is really sad.

MR DAVIS: At the moment, do your services at the AMC remain located in two separate places? You said the nurses were over here and the doctors were over there.

Ms Tongs: Yes.

MR DAVIS: Would it be fair to say—I do not want to verbal you—that you would find it easier to deliver these services if you were co-located at the AMC?

Ms Tongs: Yes, absolutely.

MR DAVIS: There is something else that I would like to get your opinion on. Going back to that quote from the Justice Reform Group, they said that the reasons were boredom, discrimination and a lack of appropriate or adequate health care. Appropriate or adequate health care is a big problem and discrimination is a systemic

problem, but it seems kind of jarring to see boredom there. In your experience, as someone delivering services in AMC, what kinds of services could we, or should we, be running that would alleviate at least that boredom part of the challenge?

Ms Tongs: There are no work opportunities. Doing the washing for the pod or the cottage or sweeping the floor is not a job. That is part of what we do every day. That is part of your living skills. They have to do proper physical work. They have to be able to get training.

With respect to other prisons around the country, I met with the general manager of Junee, a private prison, probably 12 months ago. Some of those fellas go off to work at the abattoir. They keep their family on the outside while they are in jail because they are earning an income. They are building houses for homeless people. There are lots of opportunities. It is not like we do not have land out there. There is a lot of goodwill in the community for people to go in and be able to assist. But it is all about power and control. There needs to be a balance between that power and control and health and wellbeing.

In my mob, too, the racism is what they cop every day from the officers and other inmates, and that is really sad. This is 2021. We are talking about a lot of other things that have changed, particularly with gay rights and that sort of stuff; yet my mob are still the most downtrodden, and we are the first Australians. Why is that? It is not like we have a huge population. If there were 750,000 politicians, families, doctors and other people that were facing the same issues as us, I am sure it would have changed. People need to look in the mirror and have a good look at themselves. At the end of the day, we are all human beings, and some just have not had the opportunities that others have had.

THE CHAIR: On the bill itself, does your organisation support the bill that we are actually inquiring into?

Ms Tongs: Any change—but it has to go further. You either decriminalise or you do not. All we are doing is tinkering around the edges, and for the people that are other than the people that really need greater reform around this.

DR PATERSON: With the drug court, if there was a residential facility, how would facilitating referrals from the drug court to a residential facility happen? I do not know whether any Aboriginal people have gone through the drug court yet.

Ms Tongs: There have been a few, but there has not been a huge success rate because it is very intense, and people do not have the level of resources in our community to be able to do it.

DR PATERSON: Supporting that process and the outcomes of that court process would be something that we could look into?

Ms Tongs: I do not necessarily think that we need it. If we had our own residential rehab, we would do everything at Winnunga, anyway. The courts could say, "We're referring you to Winnunga," instead of putting people through all of that. That would be a better option for my mob.

THE CHAIR: Thank you so much, Julie. 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 transcript of today's hearing, when it is available, for you to check for accuracy. I do not believe you took any questions on notice. We do appreciate your testimony today.

LEE, PROFESSOR NICOLE, Chief Executive Officer, 360Edge

Evidence was taken via telephone.

THE CHAIR: Good afternoon, Professor Lee. Thank you for giving evidence via telephone link. Could you tell us about the capacity in which you appear?

Prof Lee: I am the CEO of a specialist alcohol and drugs consultancy called 360Edge. I am also an adjunct professor at the National Drug Research Institute. I am appearing today with my 360Edge hat on, mainly drawing on my academic experience.

THE CHAIR: Thank you for giving up your time to appear before us. 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.

Prof Lee: I have read it, and I do understand the privilege statement.

THE CHAIR: Professor Lee, it is the practice to provide each witness with an opportunity to make a five-minute opening statement. Do you wish to do that?

Prof Lee: Yes, I do. I did send through a set of notes that may be helpful to follow up, if you have those. I want to use my opening time to highlight a couple of key ideas that run through the detail of the submission that I made.

The first point is that, historically, the prohibition approach has done very little to curb drug use. It is pretty evident now that we need to take a new approach. I believe that that approach needs to be focused on reducing harm, at the core. I want to give an example more broadly than the ACT, to demonstrate this point. I want to talk a little bit about the use of methamphetamine in Australia. If you have those slides in front of you, you will see that the National Drug Strategy survey data shows the proportion of the population that use methamphetamine. We are seeing that, in the last 20 years, it has significantly decreased, from a high of about 3½ per cent of the population to its current level of about 1.3 per cent. It is actually at its lowest point since we started measuring.

The second piece of data is the wastewater data. It shows the volume of drugs per population. They reported an estimate of volume, not prevalence, so it cannot tell us how many people are using; it just tells us how much is being used. It could be a small number of people using a huge amount or a large number of people using a very small amount each. That also shows ups and downs, but generally overall a decrease since 2016. This is important because, although we have seen a decrease in use, we have seen an increase in methamphetamine-related harm. We have seen an increase in treatment visits, hospital visits and drug-induced deaths, among other things.

I want to compare that to another stimulant drug that has gained popularity in Australia, which is cocaine. It is a similar drug to amphetamine, with a shorter

half-life. It has been on an upward trajectory since 2004. It is well and truly at its highest level since we have been officially recording. In fact, since 2013 it has overtaken methamphetamine in the percentage of the population using it, by far. It is now at around four per cent.

When you look at the harm indicators, if we take the proportion of treatment episodes as an example, there is not an increase in harm indicators, despite the huge increases in use. We have a situation, in this example, where methamphetamine use is decreasing but harm is increasing. On the flip side, cocaine use has increased, without the harm indicators.

My point is that drug use is really only an issue because of the potential harm it causes. We should be focusing directly on harms and how to reduce those, rather than using use as a proxy for reducing harm.

The second point I want to make is that most people are under the impression that drugs are illegal because they are dangerous, but it is actually the other way around. The approach that we have been taking, mainly a prohibition approach aimed at eliminating drug use, has completely failed. There are no real benefits that have been demonstrated from the criminalisation of drugs. It has just increased the harm. That is the opposite of what we want to do.

More specifically to the ACT, we have had a natural experiment for the last 25 years or so, because in the ACT cannabis has been decriminalised for nearly three decades. When that happened in 1992, it did not increase the number of people who were using cannabis. In fact, it has been slowly decreasing over that time. In the ACT it has been decreasing at a faster rate than in the rest of Australia, which demonstrates that decriminalisation and what some people might think of as liberalisation of drug laws do not necessarily result in an increase in use, and in any case an increase in use does not translate to harm, necessarily.

As I outlined in my submission, the experience in Portugal has also shown that decriminalisation can actually decrease harm. It is not that it just does not have an impact, but it does actually decrease harm. We know that there have been increases in treatment uptake, and a reduction in HIV deaths and early uptake by teenagers—a whole range of harm indicators have gone down as a result of decriminalisation. Those two ideas demonstrate the value of treating it as a health and human rights issue rather than a criminal one, and moving right away from that criminal model.

We also know that the treatment system in Australia is chronically underfunded. We do know that, for every dollar that is spent on treatment, we save about $7 in costs to the community. Based on the evidence, it is worth shifting our view of drugs from a criminal justice lens to a health and human rights one.

THE CHAIR: Thank you so much. I have a short, specific question. Some submissions—again, this is probably in the minority—have alerted us to the rather obvious fact that, unlike alcohol and tobacco, and cannabis in the ACT which can be grown in someone's backyard, the source of all of these substances is criminal activity, so there is a criminality still attached to the supply. Does that affect at all your thinking about this bill?

Prof Lee: The reason why there is criminality attached to these drugs is precisely because they are a criminal offence, so that logic may need to be flipped around. The reason why the criminal element engages in producing those drugs is that they are criminal. If they were better regulated, we would not have that criminal element.

Decriminalisation is quite a different thing. All that is proposed with decriminalisation, with any type of model, is removing the criminal penalties so that people who use drugs are not harmed as much as they are currently in terms of the criminal justice system.

THE CHAIR: If the bill is passed, it would still be a criminal offence to possess a quantity just above the current prescribed threshold in the bill, so that, under the bill, criminality would still be there, in this drug environment, but only for quantities above certain amounts. Does that affect your view?

Prof Lee: I think it is an important first step in a rethink about our drug laws in Australia. The very first step is to ensure that people who are abusing a range of drugs, mostly recreationally, and not experiencing huge harm are not additionally harmed by having criminal records.

DR PATERSON: Apart from decriminalising these drugs, with specific reference to methamphetamine, what would you say is the next best after that? What else could we be doing to reduce methamphetamine harm?

Prof Lee: That is a really good question. The first thing is to decriminalise those drugs early on, in strong support of that, because the criminalisation of drugs increases stigma towards people who use drugs. In particular, in the majority of the media coverage, a significant amount of this stigma is associated with methamphetamine use, despite the fact that more than 70 per cent of people use very occasionally and are not the stereotypical user that you see in the media. I think that the stigma attached is very significant, because we know that stigma stops people accessing help when they need it. Decriminalisation has a number of knock-on effects regarding people being able to access treatment.

MR DAVIS: I am interested in the role of drug and alcohol sector organisations in providing education to school students on harm reduction. Your submission discusses the ineffectiveness of lecturing young people on drug harm. Can you tell us why that approach is not effective and what an effective approach might look like?

Prof Lee: We have a lot of research that supports how to do good drug education in schools. We know that sending people who are recovered users into schools is unhelpful. We know that sending police into schools is unhelpful. What does work best is for drugs to be discussed in amongst the health curriculum in school and for it not to be a lecturing approach to telling kids how bad things are.

The reason why those types of interventions with ex-users, police and those kinds of people going into schools is ineffective is that young people do not see the world in the same way that an adult does. We would maybe see the terrible consequences regarding getting into trouble with drugs, and think, “That is something I don’t want

to do." It has been demonstrated in research that, when we do that, kids actually have more interest in using drugs. Paradoxically, that happens, but we have to follow the evidence, and the evidence is that lecturing kids and having ex-users and police go into schools is counterproductive.

In Australia, we have two or three well-developed drug education programs for schools that follow best practice, that are integrated into the program and that have been evaluated, and we should be focusing on and using those.

MR DAVIS: Your submission also strongly rebuffs some other evidence that the committee has heard about the use of broad-scale public health campaigns. You argue that these campaigns have been found to increase drug use, if they are focused on the fear-based messaging that you spoke about. How would you suggest that the committee, and subsequently the government, approaches public health campaigns on drug use?

Prof Lee: We know from research in other areas, and also in the drugs area and aligned areas, that fear messages tend to turn people's attention off the message. Particularly for low-prevalence issues, for things like methamphetamine use, which is only 1.3 per cent of the population, it is not the most effective way to get messages across, with a broad brush. Again, we need to follow the evidence. We have the evidence and we know what works in this area. We need to be providing targeted messages to the right group. We need to be evaluating properly.

One important thing to remember is that knowledge of a campaign does not equal behaviour change. That is clearly shown in much of the psychological literature. We need to be measuring and aiming for impact in terms of behaviour change, not just having someone see the campaign and asking what they think about it.

MR DAVIS: I have one last question, specifically regarding the school campaign. You mentioned a couple of best practice models. I do not have your submission in front of me. Are they ones that you have included in your submission, with reference to some of the best practice?

Prof Lee: Yes, there are references to some of the best practice. The major one is called Climate Schools. That was developed at the National Drug Research Institute, at the Matilda centre, which has now moved to Sydney university. That has had a lot of research that supports its use; it has had a lot of development time. The other one is called SHAHRP. That was developed at the National Drug Research Institute in WA.

One of the problems is that doing good school-based drug education is expensive. It is not funded and it is not really required by the schools. They just have to do something, so they tend to do the least expensive, bare minimum. We should be providing funding for schools to be able to implement best practice drug education in schools.

THE CHAIR: Professor, did you mention some slides that you thought we had available, or just your submission?

Prof Lee: Yes, I did send them through this morning and David Monk said that he had passed those on to you.

THE CHAIR: They came through this morning, obviously, so we have not had a proper chance to look at those, but we will certainly look at that in light of your testimony here.

Prof Lee: Thank you. They add some details on the graphs and numbers that were in my opening statement.

DR PATERSON: In your submission, right at the end you state:

> … the current proposed legislation definitions of 'personal use' do not align with the evidence-based definitions that are already in place in the ACT, and this should be reviewed.

What do you mean by that?

Prof Lee: In the current proposed legislation, as I understand it, the definition of personal use for many of the drugs would be lower than the current definitions of personal use that are being used in the ACT. Those definitions of personal use that already exist in the ACT have been developed after a significant amount of research, and they are what we might think of as evidence-based. They have been really well thought through and well developed. I believe that the current proposed legislation should be using the existing definitions of personal use, not the lower amount that is currently in the proposed legislation.

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

Prof Lee: I do not have anything further to add, apart from my opening statement and my submission, other than to say that we have a real opportunity here to think differently about drugs and to make a real impact on the reduction of harm.

THE CHAIR: Thank you. I have been able to call up your slides. They give a little bit more detail regarding your substantive submission. I just want to assure you that we do have those to look at in more detail later.

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 transcript of today's hearing, when it is available, for you to check for accuracy. I do not believe you took any questions on notice. Thank you very much for giving up your time and for providing your submission.

Prof Lee: Thanks for the opportunity to appear today.

STEVENS, DR ADELE, Member, Health Care Consumers' Association
TITO WHEATLAND, DR FIONA, Member, Health Care Consumers' Association

THE CHAIR: Good afternoon. We are resuming our inquiry, and I call representatives of the Health Care Consumers' Association. Welcome, and 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 confirm that each of you have read and understood the privilege statement that the secretariat sent you?

Dr Stevens: Yes, I can confirm that.

Dr Tito Wheatland: Yes, I can confirm that too.

THE CHAIR: Thank you both. Would you like to take the opportunity to make up to a five-minute opening statement?

Dr Stevens: Yes. We would like to do that. I begin by acknowledging that we are meeting here on the land of the Aboriginal people—the Ngunnawal and Ngambri—and that ownership has never been ceded.

The Health Care Consumers' Association support this bill, but we see decriminalisation as just part of the picture. As we have said in our submission, additional alcohol and drug services are going to be needed, and I think a number of people have already testified about the inadequacy of the services. That is particularly important if we are going to have the police divert to alcohol and drug services—at the moment they do not do that at all—so it would be a new way of doing things and we would need alcohol and drug services. I think I heard the witness from the police association talk about the three times that he took someone to the hospital. So if you had some way of getting into alcohol and drug services, I think it would be of use to the police.

The other thing that has become clear is that we need a joint alcohol and drug mental health service. It seems to be that people get tossed from one to the other, and that is something we have seen. Another thing the Health Care Consumers' Association would like to make clear is that we are supportive of the government initiatives so far in the area of pill testing and also the early work on the creation of a supervised injecting service. We see those things as part of a parcel we need to do better on in this field.

I will move on to more detailed comments about the bill and a need to review the personal use amounts. We go shopping at the supermarket once a week; you do not want to go shopping every day. My experience with people who use illegal drugs is that, on the whole, you do not go shopping for your daily use; you go shopping for a week. On the submissions regarding talking to the alcohol and drug sector, I think our last interviewee spoke about reviewing, and also about the danger of just sticking to talking about legislation about these specific drugs. We need to be able to be more flexible in the future.

The Health Care Consumers' Association are concerned about reducing harm. We are in the health field and we work as consumers of the health service. We see the benefit of consumers having a say in legislation. Both of us have worked with a number of friends and relatives who have used illegal drugs. We recognise that the majority of people who use illegal drugs do not cause any harm, just like with alcohol. Most people who use alcohol do not cause any harm. I will leave Fiona to say a few words because of her legal expertise.

Dr Tito Wheatland: The important thing in the harm minimisation element of it, which we think is the priority, is that with recreational use in particular the biggest harm at the moment comes from criminalisation of that use. The other one is about supply. I will talk a bit further about supply issues later because it seems to me that, both for people who are suffering from addiction and for people who are recreational users, if you do not have some quality in relation to the supply of the drugs, you will end up having an unmeasurable risk of harm each time someone uses drugs.

I looked at what happened in the federal government because of the federal-state issue, and through some other mechanism I came up with the Narcotic Drugs Amendment Bill in 2016 that the federal government passed. That was basically to allow the medicinal use of marijuana and actually control the supply. So this has already been done by the commonwealth government. It is not the same commonwealth government now—it was under Turnbull's governance—but the bill was passed and it looked at the government as a regulator of supply in relation to medicinal use and to opt to take that for all of the states as being their role.

It seems to me that if we sat down using Julie's methods of a yarning circle type of thing, where we could talk with the Federal Police and other groups like that, we could look at how that might be managed to avoid harm to people. The worst option would be that we make the law change and then someone who thinks they are still covered by our law then gets prosecuted under the federal law. That is a risk that is worthwhile taking seriously and looking at ways of how we might address that.

The other way of addressing it possibly would be through substituting for the illegal drug supply the use of prescriptions of similar drugs that have the same sort of efficacy. That would be another way of having authorised use under the federal legislation, where you are talking about some of those drugs. That is a separate issue completely, that supply quality issue. One of those is designed to deal with the federal issue at the same time, which is by prescription.

The other thing we should be looking at is why people are using any of the drugs of addiction. Some of it is about what makes that transition between recreational to addictive use and some is about what are some of the reasons that people take drugs. That knowledge allows us to have better interventions then. If it is about experimentation then pill testing is a really useful thing. If it is about disconnection and feeling that life is crap at the moment—there can be a bit of that, particularly with COVID at the moment—then a different set of skills is needed to look at how you help people to get some of the skills to deal with it and look at things that are making them feel disconnected from everyone and society and feeling that they need to withdraw into a place that is not real. Another one looking at decision-making and

learning decision-making skills. A lot of people are choosing not to use drugs, so what makes that difference and how can we teach skills to people about that? That is all about looking at why people are using and what skills you might need to not use.

THE CHAIR: Adele, you mentioned that police do not have the power at the moment to divert someone they find in possession of one of these substances to a support agency. What do you think of the idea of simply giving the police that power and the option then sits with the alleged possessor to say, "Okay, I'll go to the justice system," as opposed to, "I'll go to a support service"?

Dr Stevens: That would be an excellent option for the consumers. They need to have choice, and that would be a good start.

Dr Tito Wheatland: It probably needs to be informed choice, though, if you end up with a criminal record. I think a lot of people at the moment who intersect with that system do not necessarily understand that it means they might not be able to get a public service job; they might not be able to work for a whole lot of different agencies.

THE CHAIR: The point of my question is that you are almost giving them the opportunity to make a decision right there and then.

Dr Tito Wheatland: As long as they know what the consequences of that decision are. That is all I am saying.

DR PATERSON: I am fascinated by your discussion about the supply of drugs, because it seems a very radical idea. You think about cannabis and there is increasing discussion about LSD, psilocybin and MDMA for medical intervention. I guess it is getting to that way. If it is regulated and it is for medical use and to tackle addiction, what do you do about recreational use? That is a harder aspect of drug use. Could you talk more about your thoughts on that?

Dr Tito Wheatland: I have thought about it, and I have not got a concluded view yet. I do not think that the commonwealth would be all that keen on taking the PBS into that area. I have not thought through whether you can actually do something that is less than the PBS but still legalises it. That is what some of the countries that have decriminalised it have done, and they do it through prescriptions. In Switzerland and places like that, you go along to a treatment facility to get it, even though you are using it like that. I suspect sometimes people look after those ones and take them away for when they want to—I do not know.

It does not stop that, but at least you know that whatever they are taking has not got Ratsak laced in it, for example. They could pay not the PBS subsidised price, but it would be done through a pharmacy, which is what is being done where the TGA has approved vaping liquor that contains nicotine, to make sure that it is regulated and that the supply is clean. You can only do it two ways after 1 October, and one of those is to go to a pharmacist. You get the prescription from a doctor and the doctor provides you with advice about the safe use. Then it goes to the pharmacy and the pharmacy dispenses it and you pay. But I do not think it is subsidised.

At the other end of it, if you import for use then you have to get approval, using the

TGA process. I know it is looking a little left field in one sense, but it is another way of thinking about how we authorise the use of some things in some of those other areas. It might be worthwhile looking at.

DR PATERSON: Especially if there are increased public health messages about cocaine being laced with something. That seems to be happening more and more.

THE CHAIR: That really is something I do not think we have heard before. Creative thinking at work. That would obviously be a change much bigger than the bill anticipates—and that anyone in discussion that we have heard so far anticipates. Given that that is not going to happen in the next six months or so, yet the bill may well be presented to the parliament in the next six months, do you still support the bill, given the things you have said?

Dr Tito Wheatland: I support the decriminalisation element of the bill because I think that only bad things happen from it.

THE CHAIR: In light of your comments about being inconsistent with commonwealth law?

Dr Tito Wheatland: As I said, there are only two ways to deal with it. One is to talk with the Federal Police, and they have two choices. One is the discretion not to prosecute and the other is to prosecute. You need to know where you stand and to tell people, when we put the bill forward, that this is where we stand. It creates another level of risk, at the moment, for people. If you are convicted under a federal drug offence then that will be more of a difficult issue when you want to go to America, for example—if we ever travel again.

MR DAVIS: I am going to take it in a completely different way: your submission highlights the disproportionate impact that alcohol and other drug use has on people of social and economic disadvantage. I am curious for you to reflect on the implications of the $100 fine that the bill suggests be imposed and what health and wellbeing implications you think that may have on some of those social and economically disadvantaged if it were to go ahead in that way.

Dr Stevens: I did mean to mention this in the opening statement, because it is an important issue. We are strong supporters of diversionary or other systems. We have had some talk here about fines, and you could do things other than fines. Presently, under Access Canberra, if you have fines for illegal drug use or driving offences you can sign up to do a payment plan. That is one of the ways we now have, and I know people who use those because they do not have the money, because they are on a Centrelink payment or JobSeeker. But there are some people whose lives are so disorganised that that does not even work. So we need to look creatively at what are the options.

Dr Tito Wheatland: We look at it and think, "Oh, it's 100 bucks," but some of the disempowered and those not economically in a good position can't pay that sort of thing even when you are doing a payment schedule. I have just helped a friend enter a scheme of arrangement for unpaid traffic fines. He has to take $41 a fortnight out; that is the minimum you can organise over the telephone. If you go in, you can do it as

$10. While $41 a fortnight does not sound a lot, if you are on the basic Centrelink payment for people under 20 it is quite a chunk. He is coping with it by living in a car somewhere. He has to pay his fine to keep the car, but he does not have to pay rent. There is an understorey of Canberra society where we do not have much of a handle on what it is like to be living in that place.

It is complicated by the fact that quite often they are very disconnected. They are also wanting to live a different sort of life, so they take drugs because of that. Sometimes they have mental health issues. That group will still use drugs, so the fine is not going to do anything except add to their poverty. My view would be to not have a fine-based option but have some capacity to refer. The bottom line is that if you are trying to minimise the impact of the harm of drugs, one wonders why you have a fine at all.

DR PATERSON: Drug driving is a complex issue and you have a reference to it in your submission from 2021, so it is very new. I guess we will increasingly get testing that will be able to measure cognitive impairment for these types of drugs, but I am interested in your views on this.

Dr Stevens: We need to start looking at this issue. For one thing, we should be looking at prescribed medical cannabis. If you use that you can be caught for drug driving, yet if you use methadone it is okay. I think that because cannabis has been part of the illegal drug system, we have not really started to look at that. It just got left as an illegal drug and therefore illegal drug driving. Evidence is now showing that impairment for medical users is about four hours. For recreational users it is about five hours for not much use, versus about seven hours for heavy use.

There was a court case in the Lismore Magistrates Court where someone had been told by a police officer that if you do not use for a week you will be okay. He then did that and was caught with cannabis in his system nine days after using. The magistrate was in a difficult position because there was no leniency; that is the law. They did not have the ability to change it. It is very, very, difficult.

We need to start looking at drug driving laws. They have only been in for about 10 years. I was working in the drug and alcohol field in the 1980s and 1990s, when we worked on the proposal to have a supervised injecting service, and we did not have any drug driving laws then. What I am seeing now is that, although we have decriminalised cannabis in a way, we have got drug driving laws which are putting people back into the criminal justice system, which was not the case in the 1990s.

There is no evidence that the road toll has been reduced by the drug driving laws, whereas the laws for compulsory seatbelts and for alcohol did make a difference to the road toll. I know you cannot do anything; it is not part of your terms of reference. But I would like you to consider another step, following on from this, which is that we really need to look at our drug driving laws and how they are criminalising ordinary recreational users and people who are on medical cannabis.

Dr Tito Wheatland: It would be useful if we had an agreed guideline or anything under the legislation regarding the half-life of the drug in your system and we had some evidence base to it.

DR PATERSON: It goes back to your point that if it is not regulated then you do not know what you are taking, so you cannot legislate it.

Dr Stevens: The difference is that people in Canberra have been growing their own cannabis for quite a while.

THE CHAIR: Do you think that there is merit in the idea of doing a more thorough review to cover some of the gaps you have both identified, versus letting this bill pass and just seeing what happens?

Dr Stevens: I have a problem with that, in that "not now" often means no, and I feel we really need to start moving ahead. I think these changes are very minimal. We did not have any problems with cannabis. I will be very surprised if we have any problems with this very minimal step in decriminalisation. One of the best things of this inquiry is to point out some of the other problems with the systems, and we need funding for those systems to improve them.

THE CHAIR: Is there anything either of you would like to say in closing?

Dr Tito Wheatland: I think we can look at some of those outside-the-box ideas that we have presented to you so that maybe we can move ahead a bit further. In relation to the other thing you suggested, which is a bigger review, looking at all those broader questions, I think that that would be great. I just would not make the passage of this bill contingent on that.

THE CHAIR: Thank you for giving us some of your time. On behalf of the committee, thank you for giving us your evidence. 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.

Hearing suspended from 1.55 pm to 2.45 pm.

HANSFORD, REVEREND SIMON, Moderator, Uniting Church, Synod of NSW and ACT

MAIDEN, MS EMMA, Head of Advocacy and Media, Uniting Church, Synod of NSW and ACT

Evidence was taken via telephone.

THE CHAIR: Welcome to Simon Hansford and Emma Maiden from the Uniting Church, Synod of New South Wales and the ACT. 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 confirm that you have each read and understood the privilege statement that the secretariat sent to you.

Rev Hansford: I have indeed.

Ms Maiden: Yes, I have.

THE CHAIR: It is our practice to give witnesses an opportunity to make up to a five-minute opening statement. Is that something you wish to take up?

Rev Hansford: We had each hoped to make a statement. Speaking on behalf of the church, thank you for your time today, Chair. Our concern with this is that at the core of the gospel is an understanding that we love God and we love our neighbour. Of course, the challenge of that is that loving our neighbour who we like is quite easy and loving our friends and our family is quite straight forward. But what is difficult for us often is that we are encouraged to think about our neighbours too as those people who are outside us, people who are not like us—people who are foreign or difficult or criminals or simply find themselves in hard times. We find them hard to like—the extraordinary kinds of people.

At the core of the gospel, the question of loving God and loving our neighbour advises us that the people who are drug dependent are not easy to love or easy to like. More of a surprise for us, in actual fact, is that people who are drug affected are often not strangers to us but just like us—they are often members of our family and our friends. So in talking about this issue, about drug dependency, about care, about decriminalisation, we are not talking about some people far away from us but people who are near to us—people who we know, people we love, and people who are part of our family and community.

The Uniting Church has been involved for some time in issues of drug care and drug treatment. The injecting centre in Kings Cross is part of that situation. We have consulted with social and health and legal and policing throughout this conversation for several years now, so we come to this conversation not uninformed or inexperienced.

The gospel which the church holds dear is about the ministry of Jesus Christ, but the wholeness of life, the wholeness of a person—not just treating an issue or an event but

treating people as whole people. That healing is not just about physical healing but about social, emotional and community healing.

The challenge for us in this issue is that so much criminality and blame and accusation is part of this issue. We want to argue that the best way of treating this is as a social and health issue and not as a criminal one. We are arguing, too, that restoration of those who are drug dependent, of caring for them and providing them with connection and community is at the heart of the church's understanding of the gospel and who they are. Our invitation to this conversation about drug dependency and decriminalisation is to see people as human beings and not simply as a problem to be solved.

Ms Maiden: Uniting New South Wales and ACT is the service and advocacy arm of the church in New South Wales and the ACT. We also lead a campaign called Fair Treatment, which is a partnership of over 60 health and legal organisations supporting and campaigning for two things—the decriminalisation of the possession of small amounts of drugs for personal use, as well as the expansion of treatment programs.

In that capacity we have written a discussion paper about decriminalisation and what a decriminalised legal system might look like. We applied our values as a faith-based organisation to all the different legal questions that need to be resolved in making that decision, as well as the principles of good lawmaking.

We concluded that we were attracted to a model that is a comprehensive decriminalisation model, one that applies to all drugs, does not apply civil sanctions, has a combination of alternatives to sanctions, removes eligibility criteria and abolishes the threshold of quantities. This recommendation is very close to recommendation 11 of the ice inquiry from the New South Wales parliament.

We make the observation that the bill before the ACT parliament is not the comprehensive model that we favour, but we certainly acknowledge that it brings the ACT closer to this preferred model and that, with increasing treatment and work to reduce stigma, it will have a significant benefit to the community and improve lives.

We also want to note that there is strong public support for non-criminal responses to the possession of drugs and that any system needs to be designed to reflect the fact that only a small proportion of people who use drugs go on to develop a dependency. Therefore, most people that use drugs are ordinary people going about their day-to-day lives.

We are concerned that current laws create barriers to treatment. We want to say strongly that treatment works, and the more we can connect people who need and want treatment to that treatment the better our society will be.

THE CHAIR: Thank you both. Some of the submissions have touched on the practicalities of implementing the bill as it currently reads. For a policeman in front of an individual in possession of one of these substances, for example, if it is two grams of cocaine or under, they would not be issued with a criminal sanction, but if it is over that amount then they would be. Have you had any thought about the administration of the bill as it currently stands, in its implementation?

Ms Maiden: Yes, we do have concerns about the nature of these threshold quantities. Obviously wherever they are set there is always going to be the potential that somebody that possesses the drugs just for their own personal consumption is categorised as a dealer or a supplier and therefore attracts criminal sanctions. So they are quite arbitrary.

We recognise that it would be a big leap for jurisdictions in Australia, but we support the abolition of threshold quantities and moving to a system that requires more comprehensive proof of someone being a drug dealer or a drug supplier. That kind of approach operates in numerous jurisdictions around the world, where there would be scales, bags, large amounts of cash and unexplained income et cetera. That would be the kind of evidence that police would have to bring to prove that someone is a supplier or a dealer. We think that system is more in accordance with principles of good lawmaking in that it does not have that kind of reverse onus of proof. That is certainly our preference.

As a stepping stone to that, we think it is time to review where these current lines and threshold quantities are drawn. There has not been a lot of work on that. There are criticisms that those thresholds include the whole substance, which is not necessarily the whole active ingredient and that, therefore, unfairness can arise due to that issue.

We recognise that threshold quantities are a current part of our system. If that is the way the ACT decides to go, it is the way the law currently operates and there are different sanctions depending on what side of the line you fall. That is quite arbitrary. Certainly, reviewing those threshold quantities would be a good first step and then in the longer run abolishing them and moving towards a system that is more consistent with our other legal principles.

THE CHAIR: Given your perspective, why bother criminalising suppliers if ultimately they are in the business of supplying to people who want to use it for personal consumption?

Ms Maiden: What we are saying is that people who use drugs are not bad people, and you have heard Simon talk about that before.

THE CHAIR: But are you saying suppliers are?

Ms Maiden: We do not support the decriminalisation of the act to supply or traffic drugs—

THE CHAIR: And that is where I fail to see the logic for your position.

Ms Maiden: I think it is because, for certain people, the issue of being supplied with those drugs creates huge problems for them as individuals. We do not seek to judge that individual for using those drugs or in certain circumstances becoming addicted to those drugs. But we do think there is a role for society to have criminal sanctions against those that seek to profit from that. Our position on this comes from a resolution of the church that was made five years ago. It gave support for the decriminalisation of the possession of small amounts of drugs for personal use. So

that is our position, as a church, that we have taken up after careful reflection and discernment.

DR PATERSON: Thank you very much for your submission. I really appreciate what you were saying, Simon, at the beginning about dignity and looking at the worth of every person and treating this holistically. I think that is really important. How do we reduce the stigma in relation to drug use?

Ms Maiden: Taking away the criminal consequences of being caught with a small amount of drugs for personal use is actually a really big part of reducing the stigma. When you talk to people who have been drug users, the criminal consequence is one of the barriers for them in terms of reaching out for help and assistance when they have needed it. I do feel that very act of not having that criminal consequence is very important.

We also advocate that what we want in our society is for there to be open and honest conversation around people with drug and alcohol use. All the evidence shows that having those open and honest conversations means that we do not drive this kind of behaviour into the shadows. That is what we would like to see and why we support a decriminalised system.

Yes, you could have education programs and other things, but I think we have had those for many decades now and I do not really feel that, with the current legal structure, they are working to fix the stigma. What we need to do is encourage those open and honest conversations and not have those criminal consequences, so that people can reach out for help if they feel they need it.

Rev Hansford: I want to add, too, something about the nature of the help. As long as the help is an encouraging, contextual community-based support as well and is not just some kind of function—and I know you were not asking this question—but if it is some kind of function actually valuing the whole person, that will certainly also help to reduce both stigma and engage the person more.

Ms Maiden: Can I just also mention the injecting centre that we run in Kings Cross? When we talk to people who have used that injecting centre—and 11,000 people have been saved from overdosing over the 20 years it has operated—they talk about it being the first time they have walked in somewhere where people know their name and they are not judged. They build relationships with the staff—supportive, healthy, community relationships.

You cannot really force someone who is dependent on a drug to get treatment. There are various stages. There is that pre-contemplation stage, the contemplation stage, the preparation stage and the action stage. And when they get to that point when they are ready, having that respectful relationship with a trusted health and welfare professional allows them to know where to go when they are ready.

I think building those connections in the community, whether that is through injecting centres or other health and welfare services, is really, really powerful so that then people do not feel judged and they know they have a trusted relationship with someone that can help them when they get to that point of being ready to take action.

DR PATERSON: We have had some submissions where, I think, for people who have not engaged much with the alcohol and drug sector or with people who use drugs, there is a bit of fear in the community around being open and honest and having these conversations. What would you say to those parts of the community that are scared that if you do not have massive public health fear campaigns on TV then you are going to end up with addiction rife throughout our community?

Ms Maiden: The evidence does not, of course, support that. You do not see an increase in drug use when you decriminalise. I suppose, just reflecting on it as a mother—I have a 19-year-old son and a 16-year-old daughter—the conversation that I will have with my children about drugs, about alcohol, about sex, about everything, none of that is going to change under the decriminalised system. I am still going to be telling my kids, "Don't do drugs, don't drink under age, and don't get in a car with someone when they have been drinking. Trust your gut about whether you feel safe and act." Those conversations in the lounge rooms of Australia, the ACT, are not going to change with a different law.

What we do know is that right now we have a system that does have that criminal threat that we might think gives us comfort as parents. But that is not the real world, because 43 per cent of over 14-year-olds have used an illegal drug in their lifetime. We need to live in the world as it is, rather in the world as we would like it to be, which is that having it illegal is not dissuading our young people from trying these substances. As parents, we can continue to talk to our children about the decisions we would like them to make because we want to keep them safe and protect them from harm. That is not going to change.

Rev Hansford: And working with the church, which is hardly what you would call a radical left-wing group, necessarily, all the time, what we found was that having the regular conversations, dealing with information, allowing people to ask how to question, helping people who are traditionally conservative to explore what is going on and understand things like their children and grandchildren being involved in these kinds of challenges and allowing the conversation to continue and to keep going helps our young ones move from being highly sceptical and highly concerned to being able to move this proposal to support this direction.

MR DAVIS: My question is around methamphetamines in particular. Some who have submitted and appeared before the committee advocate for removing from the bill methamphetamines as a drug. You quite specifically state in your submission that you would encourage including methamphetamines. Can you explain why you want to make sure that that is specifically referenced and what you see as some of the challenges there with dealing with that particular drug, particularly in the public consciousness.

Ms Maiden: I agree that it is a challenge in the public consciousness. The reason we really strongly want ice included is that we do not agree that the simple act of possessing ice should attract a criminal penalty. We actually think that, given the harm that the drug causes, having a health and welfare response is even more warranted than for the so-called softer drugs, if you want a stronger health and welfare response in relation to the drugs that do more harm. The other thing with ice is that

the earlier you get treatment the fewer the long-term consequences. It is another reason to be connecting ice users with health and welfare approach earlier.

Also, we want our legal system to help everybody, particularly those that are most vulnerable and disadvantaged. People that have an ice dependency, their families, their children, are the parts of society where we want our focus to be. We do not think that we should keep locking those individuals up. We think we should be helping them as a priority, as a community and as a society. It might present a PR issue perhaps.

Of course, in the legislation, any other crimes, be they drug taking or not, on the statute books of the ACT would be liable for criminal penalties. All this legislation is about is removing the criminal penalties for the simple acts of possessing that one substance. And why would we treat ice any differently to the other substances?

MR DAVIS: You argue that civil sanctions such as the fine that is proposed in this legislation do not follow the principles of equity, nor do they reflect concern for the most disadvantaged. I think those were your words. Would you mind just reflecting on that in a bit more detail, about what you would perhaps propose as an alternative or how you have come to that view about the fine sanctions in particular?

Ms Maiden: Obviously, people that are more vulnerable and disadvantaged are going to have less capacity to pay a fine. So it concerns us to have fines embedded in the system. Given that the vast majority of people who use drugs do not experience any kind of dependency, we do think that at the lower end of the spectrum doing nothing should actually be one of the options.

Then you could consider confiscation, perhaps. Of course confiscation does require an interaction with the criminal justice system in relation to police. We have certainly seen in other states and territories that diversion schemes can actually increase their interactions with police. And we know that sometimes these interactions can be inconsistent. Trying to reduce those interactions at all is a positive, we think.

Referral for assessment, a tailored response depending on that particular individual, is what we think is most appropriate. That is a bit like the Portugal model. It is a bit like what happens in South Australia, as I understand it. A tailored intervention allows you to not be wasting health and welfare resources on people who are using drugs recreationally and perhaps need some education information about that, about contraindications and the long-term health effects and then focusing some more intensive health response on that small proportion of people who are experiencing drug dependency. That is our approach.

We are concerned about the link in the bill with the referral for a health assessment. We do think that could be one of the areas that could be improved, as well as this issue of discretion. If it truly is a decriminalisation system, the diversion processes should not have a criminal consequence at the end if there is not compliance or other things. Otherwise, it really is not the decriminalisation approach. I think it is a bit unclear how the current diversion schemes would apply in relation to noncompliance. I assume there is more work to be done to nuance that. Our view would be that, even with noncompliance and other things, we would not want a criminal sanction further

down the line.

THE CHAIR: Thank you so much, both of you, for giving us your time. 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. If you have taken any questions on notice, please liaise with the committee secretary about that. Thank you for your submission and your time.

Rev Hansford: Thank you.

Ms Maiden: Thank you very much.

VUMBACA, MR GINO, President, Harm Reduction Australia

Evidence was taken via telephone.

THE CHAIR: Welcome. 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 confirm that you have read and understood the privilege statement that the secretariat has sent to you.

Mr Vumbaca: I can confirm that.

THE CHAIR: It is our practice to offer up to five minutes for an opening statement. Do you wish to make one?

Mr Vumbaca: Yes, I have a short statement, if I could?

THE CHAIR: Please proceed.

Mr Vumbaca: In my capacity as President of Harm Reduction Australia, I want to advise that we are the convenor of Pill Testing Australia, which provides pill-testing services and has done so at the last two Groovin the Moo festivals in Canberra. They are currently in discussions with the ACT government about a fixed-site pill-testing trial as well, in Canberra.

I have a long history, dating back to the establishment of the first needle and syringe exchange program in Australia, and I have worked overseas and worked in a prison context as well as in rehabilitation treatment services and obviously a lot in harm reduction. I currently hold a number of positions, honorary positions or voluntary positions, with the Aboriginal Legal Service and our Just Reinvest Program in New South Wales. In Macau I was president of a service that runs a rehab and needle exchange program and a youth drop-in centre.

I have a wide range of experience in and knowledge of what has gone into policies which have been developed and have since been implemented or removed. My most recent job was with the Australian National Council on Drugs which was the advisory body of the Prime Minister for over 10 years, before it was disbanded. I provided advice to John Howard and his ministry and then three or four subsequent prime ministers after that.

I am happy to answer any questions as well. If I do have one comment to make, it is about one of the other campaigns we are working on at the moment: medicinal cannabis and driving laws. Hopefully, I will get an opportunity to expand on that or provide further information for you later, if you have not got that.

THE CHAIR: What will happen now is that each committee member will have a turn to ask a question, which may prompt follow-up questions from any other committee member. We will just move down the line in that manner. My question is: noting that you are a volunteer organisation and you have alerted us to some broad considerations,

does Harm Reduction Australia have a view on the merits of the actual bill?

Mr Vumbaca: Yes. We are supportive and we think that when you look at the harms—we obviously talk a lot about this and we provide a lot of commentary and information to the decision-makers around this—the harm that is often caused far outweighs what the crime, for want of a better term, allows. By that I mean that young people are getting arrested and charged for a whole range of drug possession offences that cause interminable damage and harm to their lifelong aspirations and opportunities.

Really, when you look at some of the harm that causes, it is particularly focused on people who are already marginalised or disadvantaged in some way. They tend to be from poor socio-economic status and that is simply a factor. If you have resources at your disposal, if you are younger and you have parents with resources, you are able to often get around some of the harms that these laws cause, but that is inherently unfair for people who do not have resources to navigate their way through the system.

The benefits of the current prohibition approach are extremely limited and the harm they cause is not getting due acknowledgement. That is why I think this bill is very important. It also sets the standard, we would hope, for other jurisdictions. It is important that the ACT is often a leader in this field, as we saw with pill testing. I think it is important to continue that trajectory and actually demonstrate to other jurisdictions that the sky does not fall in when you reform policies that do not work.

DR PATERSON: In terms of your long experience in working with all sides of politics, by the sounds of it, in terms of your experience in bringing people to a position of decriminalisation, what would you say to someone who may be opposed to the idea?

Mr Vumbaca: That is a good question. If you look at some of the polling, not necessarily public polling but for the national household survey and other specific health surveys that have been done, there is quite a level of support for decriminalisation. I think that is reasonable and correct, in a way, because a lot of people, when you explain to them what the harms are from the current system and the number of people that it impacts upon, understand that there has got to be a better way to do this.

We have been doing this for 50 years, the war on drugs approach and prohibition approach. It has not got better. At no point could you point to a period where you could say, "During that period things were going really well because of that approach." They were not. They have got progressively worse, and drug access, availability, purity and price are all going in the wrong direction. If something is not working you just cannot keep throwing more and more money at it and think, "Maybe that will make it work." You actually have to look at whether your settings are right or wrong. I think most people get that.

What I find when I speak about this sometimes when I go to talks in Canberra—and I was with the National Council on Drugs—is that I get calls from people in prominent positions who had children of their own in difficulty with drug use. They would want to get access to treatment fairly quickly. They would want help and they

would want all the resources, trying to help their kids. I understood that. We would facilitate that where we could. I have lots of networks to make that happen. I always raised with them that not everybody has access like that and what you are experiencing is what every parent and every family member or close friend experiences when they have someone close to them with a drug use problem. You cannot publicly talk about punishing people and supporting punishing people over a drug use problem when it is someone that you know and the circumstances should be different and we should be helping that person.

No parent I have ever talked to—I have talked to thousands and unfortunately some of them have lost their kids to drug overdoses as well—ever thought that what their child needed was a more punitive approach or more law enforcement thrown at them, because that was not going to be the approach that would resolve the problem.

As I said earlier, I have worked in a number of prisons here and overseas, and I say to people that that is not the place for any therapeutic intervention. Nor is it really a place to rehab. You try. I had staff working across all New South Wales prisons for a while there and managed services there. We tried our best, but it is just the wrong environment. It would be much better to have people in a health environment than a penal or a law enforcement environment.

The other issue I have raised is that I do not think you can underestimate the impact that the criminal justice system has on young people. People do not have to end up in prison for it to have a negative impact. The arrest, the charging, being in the police cell, being picked up by your parents or a friend or some family member later, even if that does not proceed to any prison sentence, causes some real harm in terms of their attitudes towards law enforcement, their attitudes towards how they are treated by their society and the community they live in. I do not think we quite understand the impact that that can have on young people, that sort of interaction.

You weigh all that up and think, "If you are supporting the current regime or the current policy settings, do you really think that that is giving you the outcomes you want?" Point to somewhere where it is working or show how it is working in getting positive outcomes for anybody in the community. They are extremely limited.

MR DAVIS: I would not mind giving you an opportunity to reflect a little on the proposed $100 fine, the infringement notice. What are your thoughts about an infringement notice at all and the value of having a $100 infringement notice? I am interested in your opinion on that.

Mr Vumbaca: Firstly, I do not like monetary infringement notices because, as I said earlier, often the people who get caught up in the law at the moment are people who have limited resources, and that can often mean not much money or cash available. It is something that I worry about. I understand the rationale behind it. There has to be some penalty associated with it—if not a penalty, there has to be some quid pro quo. You are given an infringement and how do you then not simply pay that off but recompense for that?

But my point here would be: if you are providing $100 fines to people with no money, how does that serve anybody's interests? Then what would worry me is that you often

hear of and see people in prison who are there because they are paying off fines. They have racked up an extraordinary number of fines that they have never been able to pay and then they end up doing time in prison to pay them off. I never quite understood the theory behind that. Because you owe the state money, the state then puts you in prison, at an additional cost of $300, a day to pay off your fine.

But that would be my concern, that it would actually be what we would probably call net widening, just sort of catching people who do not have many resources and putting them into the system.

THE CHAIR: Something that came up with one of the other witnesses was that there are some in the community that feel that having possession of these drugs as a criminal offence is an actual beneficial disincentive. Some do think that. What do you think of the approach, say under current law, where police would give a person in possession of a drug the option of being referred to a health support service or entering the justice system?

Mr Vumbaca: To me, that is a reasonable approach. I was involved, when I was in the ACT, with the establishment of what was called the illicit drug diversion initiative, under John Howard, when he was Prime Minister, and one of the key principles of that was that you still had to provide choice to people. Often people want to put it in the system and say, "You have to do this," or "You have to do that." You still have to allow the people choice. And that is for two reasons.

One is in terms of how health services are provided, particularly treatment, if it goes down that path. It needs to be on a voluntary basis. The evidence is quite clear that compulsory treatment does not work and the impact is very short lived, in any case, if it does have any influence.

The other aspect is: just from a legal point of view, people should have the right to contest as well. They might not actually be guilty as charged and so there needs to be a provision there for people to say that it was not theirs or they were not in possession and contest the charge.

Going back to what I was saying before about the monetary aspect of it, my preference is that there would be that option for people to have a non-monetary option as well, to clear themselves of the infringement notice. It does not have to rely on having money only to clear it. Does that answer your question?

THE CHAIR: You are a witness. You are telling us what you think and giving the evidence to support it.

DR PATERSON: I am interested in the evidence from the health consumers' association, I think it was. We talked about drug driving and levels of cannabis. From their evidence and submission it seems like the research on this is pretty new. I am interested in what you alluded to about your campaign and what your thoughts are about it all.

Mr Vumbaca: We have a campaign called "Drive change". We are working with a number of key people, including David Heilpern, a retired magistrate from the North

Coast of New South Wales, who oversaw multiple cases every day of drug driving charges and saw firsthand the impact they were having.

Our issue is that the drug driving laws everywhere in this country, in every jurisdiction, are based on presence, not impairment. With alcohol and all other road safety measures, they are factored around the level of impairment, the increased crash risk and decreased safety that occurs if people are impaired. The drug driving test does not; it just tests for presence.

The evidence is becoming quite clear; the research is becoming, let's say, more robust and more clinical around the impact of cannabis, for instance, on someone's ability to drive or how it impairs their driving ability. It looks at around a six to seven-hour window, maximum, that it would impact on somebody. Yet we know that some of the tests being conducted can pick up days later that people have consumed cannabis. Clearly, that is a problem because of the heavy fines that are available, particularly for people who are not close to public transport routes and do not have many other options. A loss of licence can often mean a loss of employment and a whole range of other problems.

With medicinal cannabis, the particular issue we have is that it is a prescribed substance. For all of the prescribed pharmaceuticals, or prescribed medicines, there was a legal defence. Because it was prescribed and they used it as prescribed, therefore that allowed them to defend the charge of drug driving, provided they could prove they were not impaired. The onus was on the police or law enforcement to prove that there was dangerous driving or what amounted to impaired driving.

That is fine; we do not want people driving on the road who are impaired. But people who are taking a legally prescribed medicine should be able to have a defence base around that. That is denied for medicinal cannabis. If you are going to have legal medicinal cannabis prescriptions then the drug driving laws need to accommodate that development, and they have not. It actually deters people who may be recommended by their doctor to try medicinal cannabis for pain, or for whatever condition it is, when other medications have not worked. They are reluctant to do it because if they get caught driving, even a day later or two days later, having consumed their medicine, they could lose their licence. That is a huge deterrent for a lot of people. That is our particular issue with the roadside drug testing.

DR PATERSON: Just in comparison, for people who are on prescription pain medication, for example, is it like, "Do not drive; this medication will make you drowsy"?

Mr Vumbaca: Yes. They are not really tested. There is testing for opiates, but that does not occur in every jurisdiction. I think they do it in New South Wales and Queensland. If you are taking benzoxazepines or a whole range of other classes of drugs or something else—valium, for instance—there is no test for those. If you have a legal prescription, the police are unable to do anything about it, unless they can prove you are impaired. If you are obviously swerving all over the road, in an incoherent state or give rise to their concerns that it is not safe to have you in command of a motor vehicle then they can charge you, even if you have a legal prescription. But for medicinal cannabis it does not really matter how you are driving.

It does not matter whether or not you show any signs of impairment, or even if you are impaired or not. The fact that you test positive to THC on their roadside swab means that you are done.

THE CHAIR: Given your broad experience in both the implementation and policy development, a couple of things come to mind—firstly, the inconsistency with commonwealth legislation. The Police Association have raised this as a concern in that they are obligated to enforce both commonwealth and ACT criminal law; so it creates a dilemma, at least for some of them, it would seem. Do you have any comment on that?

Mr Vumbaca: I am not a lawyer, but I would assume that there are lots of inconsistencies between various jurisdictions around the country and commonwealth law. They are not always in sync and they are not always compatible or consistent. I think the primary duty of the ACT AFP would be to the residents of the ACT and to enforce the laws of the ACT. I appreciate what you say about the commonwealth. I do not know whether it would be a matter for constitutional experts or whoever about what would take precedence, but I think most people now—

THE CHAIR: I can tell you with great confidence that the commonwealth law would take precedence.

Mr Vumbaca: That may be the case, but is there an obligation, obviously, to the people of the ACT that have their own Assembly, and have voted for their own Assembly, to make the laws for the ACT?

THE CHAIR: Yes, but if there is a commonwealth law that we are inconsistent with, the commonwealth law prevails.

Mr Vumbaca: I am not sure I can say any more than I have said. As someone who has lived in Canberra for quite a while, I would have thought that you vote within your jurisdiction and you have a right for that jurisdiction to have its laws enforced.

MR DAVIS: You have tripped over a very real and live debate right now, as we speak.

Mr Vumbaca: I am not going to profess any constitutional experience, knowledge or expertise to contest that. If the commonwealth law has precedence, that is fine, but the commonwealth law is wrong then.

THE CHAIR: Right.

Mr Vumbaca: I am sure they will take my advice.

THE CHAIR: Regarding your experience with the pill testing, you have obviously been involved with the practical implementation of a regime such as that. Something that, again, the Police Association have brought up concerns some of the quantities that they have to be sure of before someone is committing a criminal offence, as opposed to a non-criminal drug enforcement notice offence, so to speak. For example, the police would apparently be in a tricky position to say whether a person possesses

two grams of cocaine, or less or more, because that decision on the spot means that, under the bill, they are either subject to criminal charges or not. It is a bit of a challenge implementation-wise.

Mr Vumbaca: If there is a bag of cocaine there, they do not actually know what the weight is. If they have pulled someone up and they have a little bag of cocaine, they do not know whether that is two grams, because of the purity and everything else.

THE CHAIR: Correct.

Mr Vumbaca: There is no immediate answer to that. Obviously, you can do testing; you can still make a determination that can be confirmed with testing. That happens now, as we know, with roadside testing for blood alcohol and the like. You have the breathalyser, but it has to be confirmed that it is over. That is not unusual, I would have thought. I would not see that as a huge barrier to introducing a system. We do it now if someone is charged with possession, supply or trafficking. There are limits in there. I am sure they do not know necessarily every time which category it would fall into in the charts now, which one is supply, possession or trafficking.

THE CHAIR: Thank you.

Mr Vumbaca: Can I add one more thing about pill testing?

THE CHAIR: Sure.

Mr Vumbaca: I just want to put it on the record that we have been engaged in negotiations and discussions with the ACT government for a long time about this. We are committed to providing that service and remain hopeful that we can get some announcement or some confirmation of the program going ahead. I think it is important to provide a service that engages with young people who are using drugs, which is predominantly what the pill testing service will do. It can have a huge health dividend for the ACT to actually be in contact with the people who are using drugs.

Generally, people who use what we would call party drugs, ecstasy, are occasional users and do not have a great depth of knowledge about what they are doing or the drugs they are consuming. Engaging with the health professionals on our team would be very beneficial for them and, I am sure, their family and friends. I think it is important to have it on the record that it is a service that can provide an extraordinary health dividend for the ACT.

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. I do not believe you took any questions on notice. Thank you again for your submission and for giving us your time today.

Mr Vumbaca: Thank you for the opportunity.

LALOR, DR ERIN, Chief Executive Officer, Alcohol and Drug Foundation
BAJURNY, MS LAURA, Knowledge Manager, Policy and Advocacy, Alcohol and Drug Foundation

Evidence was taken via telephone.

THE CHAIR: I call representatives of the Alcohol and Drug Foundation. 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 secretary has sent to you.

Dr Lalor: Yes, I have.

Ms Bajurny: Yes, I have.

THE CHAIR: Thank you. It is the practice to offer witnesses an opportunity for a five-minute opening statement. Is that something you would like to do, either one of you or together?

Dr Lalor: I would like to take that opportunity; thank you. I would like to start by acknowledging that I am attending this hearing from the lands of the Noongar people in the Whadjuk region and pay my respects to elders past and present. I thank the committee for the opportunity to provide feedback to the inquiry.

We applaud this bill as a really important step in treating drug use as a health issue, because we know that a health response to drug use improves health outcomes, it reduces drug-associated harms and it provides the best support possible to individuals, their family and friends and to the broader community. Adopting this approach means that we are going to be able to increase our focus on prevention and education initiatives on treatment, reducing stigma and enabling an open and honest conversation about drugs.

We also know that Australian public opinion is in favour of this approach. The National Drug Strategy household survey in 2019 asked Australians what action they believed should be taken against people found in possession of selected drugs for personal use. For each drug type, over two-thirds of Australians aged 18 years and older endorsed one of the following responses, which was either a caution, a warning or no action, referral to treatment or education, or a fine.

We think this bill can help address the fact that interactions with the justice system often exceed the harms that could be associated with drug use itself. It can also help us address the stigma and discrimination that is experienced by many people who use drugs. We know that stigma delays and prevents help-seeking and it contributes to health inequality and adverse health outcomes. It negatively impacts on social, employment, housing and travel opportunities. Reducing stigma, which will be done through this bill, and the associated fear of social and legal repercussions, can make it easier for people to reach out for help and support.

We have also identified in our submission that there are several opportunities to strengthen the bill—namely, expanding the list of included drugs and inserting a catch-all clause, providing a health response instead of a fine and providing an alternative to paying the fine. We have also identified increasing the personal possession limits to align with the reality of people's drug use and purchasing behaviours and, if the police response is to remain discretionary, providing very clear and consistent guidance for the police force.

In summary, this bill represents a critical step in reducing harms in the ACT, but it needs to be introduced alongside expanded access to prevention programs, treatment services and harm reduction initiatives. Access to treatment and harm reduction initiatives is needed to help people address harm in the short term. The prevention programs will also help reduce harm in the long term by strengthening protective factors, reducing risk factors and making it less likely that a person will experience harms from alcohol and other drugs.

In our submission we have talked about a number of our initiatives that we run in the community, such as the Local Drug Action Team program and the Good Sports program. We are happy to talk about those programs in more detail. I will stop there and leave time for the committee to ask us some questions.

THE CHAIR: Thank you. On your point that there needs to be an expansion of support and health services, is it your view that until that happens the bill should be put on hold?

Dr Lalor: No. In the submission that we provided we noted that not all people who use illicit substances will need or want treatment, but there will be some people who may benefit from some advice around how to reduce harms, the risks associated with drug use, how to recognise if it is becoming problematic, and to be connected to information and support services that can help them in those early stages.

It is certainly not expected that everyone who is stopped in possession of drugs needs treatment, nor would we want to see everyone who is stopped in possession of drugs referred to treatment, simply because it would overwhelm the treatment system. It is certainly something that can be done in parallel, but we would recommend that recognising that you will be referring some people to treatment needs to happen.

DR PATERSON: Especially at the beginning of this inquiry, there were a lot of submissions around the intersection between alcohol and drug services and mental health services and how the crossover is not there; they are too siloed, I guess. I am interested in your perspective as the Alcohol and Drug Foundation.

Dr Lalor: Our perspective on the interaction between mental health and alcohol and drug use?

DR PATERSON: Yes.

Dr Lalor: We are acutely aware, as anyone in the sector is, of the interrelationship between alcohol and drug use and mental health problems. That is not to say that everyone with a mental health problem is using alcohol and drugs, or vice versa, that

everyone who is using alcohol and drugs has a mental health problem. We are not saying that at all. What we are saying is that the relationship is bi-directional. Some people who experience mental health problems may use alcohol and drugs to support their response to that and some people who use alcohol and drugs may experience mental health issues as a result of their alcohol and drug use.

We do know that what we call this dual diagnosis, the coexistence of mental health and AOD problems, makes it really tricky for people to get the support that they need. It is certainly something that we encourage governments to understand—the need to have better integration between mental health services and alcohol and drug treatment services—and to be ensuring that the health of the workforce in those two sectors is able to respond to and support people who may be at risk of harm from either of those conditions.

Ms Bajurny: We have specifically advocated for the adoption of what is often referred to as a "no wrong door" approach, which means that if you are experiencing mental health and alcohol and drug issues, no matter which sector you go into you are linked in appropriately with the other and, ideally, you are having both of those issues treated simultaneously, instead of a more siloed approach.

DR PATERSON: Excellent.

MR DAVIS: I just want to dig a little deeper into providing alternatives to a fine. Obviously, as you know, as the bill is prepared at the moment there would be a $100 infringement notice issued. You have proposed a range of alternatives. Are you able to cite any sources of where alternatives like that have worked under any other decriminalisation model anywhere else? They are all very appealing. We are just a little bit challenged by our relationship with the commonwealth on that matter.

Ms Bajurny: I am sure that you are sick to death of hearing about Portugal at this stage, but I am going to bring them up again. They have the drug dissuasion committees to which people are sent. There are three people sitting on a tribunal, essentially, that speak to the person about their patterns of use, how risky they are and then what the path forward for that person would be.

Our suggestion around screening, brief intervention and referral to treatment is not dissimilar in that it looks at each individual case. It assesses how risky their drug use may or may not be and whether something like a brief intervention or a referral to a more intensive treatment might be appropriate. As Erin mentioned earlier, a number of people are not going to want or benefit from any kind of intervention; so it really does look at that on a case-by-case basis and provides the right option for that person, based on their needs.

On the point of fines, they will disproportionately impact the people who are least able to pay them. Our greatest concern is that if we are not offering an alternative to a fine, people who are already in lower socio-economic situations are really going to struggle to pay those off. That can result in what is often referred to as net-deepening, where someone gets pulled further into the system because of the non-payment of fines.

MR DAVIS: Just as a supplementary, I am not too sure if you are familiar with the ACT context specifically, but we currently have a drug court which exists, essentially, to take drug-related matters away from the Magistrates Court and silo them, if you will. What you are proposing sounds like something similar, but with a health approach. Would that be an unfair editorialisation of what you are describing?

Ms Bajurny: No, I do not think that is unfair at all. It really is recognising that drug use is best treated as a health issue, that the justice system does not specialise in health care and that the people who are best placed to support people around their drug use are in the health system.

Dr Lalor: Taking a health response to the possession of illicit substances can be done in a number of ways. There are cautioning schemes, which we have seen, for example, in New South Wales with cannabis, where people in possession of cannabis are given cautions and referred to an information service. There might be referrals to drug courts, but that still takes a justice lens to it. The Portuguese model refers people to a committee of dissuasion, where they are given an opportunity to understand what sort of support they need, recognising that it may not be treatment.

It is a model that could be replicated in Australia, using some of the health services that are available to support people who are using drugs to understand whether they need referral to a specialised service, whether they need support from a general practitioner or whether they need information and support in other ways. I think there are different models that you can take. We have done a bit of thinking around what are the pros and cons of those various models and how you might implement them in the Australian context.

MR DAVIS: Just to clarify, in the Portuguese model that you reference, what is the name of that committee or reference group that you described?

Dr Lalor: It is the committee of dissuasion.

MR DAVIS: The committee of dissuasion.

Dr Lalor: Yes. It is three people. It is a magistrate, a health worker and a social worker.

Ms Bajurny: Those are the three, yes.

MR DAVIS: In your understanding of the Portuguese model, is the drug user obligated to attend that committee of dissuasion or are they referred? That would obviously be a key difference to the drug court.

Ms Bajurny: My understanding is that they are obligated. I am happy to fact check myself and follow up on that.

THE CHAIR: Can we take that as a question on notice and you will get back to us?

Ms Bajurny: Absolutely.

MR DAVIS: I appreciate that; thank you.

THE CHAIR: I have a couple of specific implementation-type questions that, particularly, the policing submissions have raised. Firstly, if the bill is passed, it would be in conflict with the commonwealth Criminal Code. From a policing point of view, we would have a dilemma for them on the ground as to whether they should enforce commonwealth law or ACT law, given that the commonwealth law will prevail. Do you have a comment on that?

Ms Bajurny: I do. My understanding is that, when the cannabis bill was passed, the same issue was raised.

THE CHAIR: Yes, correct.

Ms Bajurny: My recommendation would be that the ACT police respond in the same way to this bill as they did to the cannabis bill.

THE CHAIR: Some submissions have said that cannabis is a different category of drug to the ones that are in the bill and that it might be more problematic for ACT Policing to perhaps even accept that it should not act with respect to these drugs as it did with respect to cannabis, given that—

Ms Bajurny: I cannot speak for the opinions that the police might hold, but I can say that people who are using substances with higher risk profiles are in greater need of support. It would be a real tragedy to see people discriminated against, based on the drugs that they are using, particularly if they are using a drug with a higher risk profile.

I would recommend that, as this bill is implemented, there be training done for the ACT police around how to respond to it, around stigma towards people who use drugs, and maybe some expanded training on what different drugs are and what their effects are, to try to combat some of that stigma that is often faced by people who use drugs other than cannabis.

Ms Lalor: My understanding is that the bill is not suggesting no response from police, so there is still a response. There are examples. If you look at the New South Wales criminal infringement notice legislation, it does have alternatives to a criminal response in relation to drugs other than cannabis.

THE CHAIR: I am not sure that we have heard of that New South Wales bill. Secondly, to do with practical implementation, for an officer dealing with someone who possesses an amount of cocaine, knowing whether or not it is two grams or pure cocaine is obviously a very on-the-ground challenge for them, in order to come up with a decision on whether they should issue a criminal sanction. Do you have any comment on that?

Ms Bajurny: Yes, it is certainly a challenge, but I do not see how that is particularly different. There is not an easy solution to that one. When you are testing for things like purity, often it is a best guess, anyway, when people are arrested right now. I do not think that it should have to be up to the officer to make a snap decision on how pure that person's cocaine is or is not. If we are talking in terms of weight, I do not

want to say that it is simple, but in a sense it is as simple as saying, "Is the weight of the substance that that person believes to be cocaine under the personal threshold limit or not?"

DR PATERSON: In your submission you talk about building the evidence base and expanding that through administration of grants. What would you say are one or two of the places we need to go to with research and what is at the cutting edge regarding what needs to be done in this field?

Ms Bajurny: In terms of information, if this bill were to be passed, I would love to see, as a practitioner, rates of drug use and rates of arrest in the ACT being monitored, so that we have a baseline prior to the passing of the bill, and we can monitor those outcomes. That would obviously be of great interest not only to other Australian states and territories but, frankly, to the rest of the world.

MR DAVIS: It is here in your submission, but I think it bears repeating, and I want to get it on the record—your suggestion that we increase the personal possession limits. We have heard varying degrees of evidence from people around the personal possession limits. The analogy used is that you do not do your grocery shopping every day; you do your grocery shopping once a week. Would you mind reflecting on that with a little bit more specificity, and letting us know how you have concluded that we need to increase the personal possession limits?

Ms Bajurny: I agree that it is a really important point that is worth expanding on, specifically from my point of view because one of the hallmarks of experiencing drug dependence tends to be requiring to use more of that drug to get the same effect. That means it is more likely that people who are dependent on drugs and who might be in the greatest need of support are likely also to be those who may be carrying over the personal possession limit because of that dependence. The reason that somebody might buy a greater amount of drugs varies. It could be their individual tolerance, how easily and frequently they are visiting a dealer, and whether or not they are purchasing in bulk. Even something like COVID-19 restrictions could change somebody's purchasing habits.

The real fear is that we are going to be punishing people as if they are drug traffickers when they are just people who are using drugs. We are basing our assumptions simply on the volume of drugs that someone has; then, in Australia, flipping the onus of proof onto them to demonstrate that they were not trafficking drugs. I am deeply concerned about the potential impact on individuals in our community of setting these personal possession limits too low.

I think that the best people to inform what realistic possession limits would look like are people who use drugs themselves. I would highly suggest that there be some collaboration with people who are using drugs on what that might look like, especially what that might look like at the high end, for people who are also experiencing dependence.

THE CHAIR: Is there anything that either of you would like to say in closing?

Ms Bajurny: I would like to make one more point. I want to expand a little bit on

why I think it is so important that there be not just an expanded list of substances but a catch-all included in that. I am not sure how much that has come up so far in these discussions. Looking at the list of included drugs, I do commend it, absolutely, for including some quite highly stigmatised substances. I am thinking of methamphetamine and heroin. I was thrilled to see those included there. Notably missing are things like GHB, ketamine and mephedrone. I want to point out that we are still seeing the emergence of new psychoactive substances. In order to futureproof this bill and make sure that people are not being discriminated against, depending on the type of drug they are using, there really needs to be that catch-all clause in there.

THE CHAIR: Erin, do you have anything to say, in closing?

Ms Lalor: No, nothing to add, beyond Laura's submission.

THE CHAIR: 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 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? Thank you again for your submission and for your time today.

Ms Lalor: Thank you.

Ms Bajurny: Thank you very much for having us.

The committee adjourned at 4.09 pm.