LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

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

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

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 30 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 9.28 am.

BUSH, MR BILL, President, Families and Friends for Drug Law Reform
LEE, MS JAN, Member, Families and Friends for Drug Law Reform

THE CHAIR: Welcome to this final public hearing of the Select Committee on the Drugs of Dependence (Personal Use) Amendment Bill 2021. The committee acknowledges the traditional custodians of the land we are meeting on, the Ngunnawal people. The committee acknowledges and respects their continuing culture and the contribution they make to the life of the city and this region. We also acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event or even online. Today we will hear evidence from a range of experts and treatment providers, as well as ACT Policing and the ACT government.

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 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.

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. Mr Bush, please confirm that you have read and understood the pink privilege statement.

Mr Bush: I have. I have done that.

THE CHAIR: It is our practice to offer witnesses an opportunity to make up to a five-minute opening statement. Would you like to do so?

Mr Bush: I would. If I may, however, could I begin by seeking an indulgence initially? My opening statement turned out to be far too long for that time, but I ask your indulgence to hand over a copy of the original one, because it has references to the submission that we have made. I also seek your indulgence to hand over copies of our submission, because it is bound in a way that I think is probably easier for you to access the references to it.

THE CHAIR: We will certainly happily take those. The secretary will take those documents from you. We have got some bound versions of the submission, as well as other documents. Thank you so much. Ms Lee, could you please confirm that you have read and understood the pink privilege statement?

Ms Lee: Yes, I have. I am accompanying Bill today to give my views and some of my personal history.

THE CHAIR: A five-minute opening statement, I believe.

Mr Bush: Families and Friends strongly endorses decriminalisation. As Jan can

testify, the parents, siblings and friends who have spoken at each of the annual remembrance ceremonies since 1996 are only too keenly aware of the fatal consequences that can flow from drug use. Our conviction, summarised in our submission before you, is that those deaths and other harms are avoidable by a drug policy that applies public health principles and not the coercive processes of the criminal law.

Consider Marion McConnell's son, frightened away from family and support in Canberra after being confronted by police in his hospital bed while recovering from a heroin overdose. Think of 16-year-old Bindi, whose mates were too scared of the legal consequences to seek help at the nearby Canberra Hospital and left her to die in the drain where they had been shooting up. Ask Jan about her beautiful Mary.

No, we are not advocates of drug use, but we and you need to recognise the reality that drug use itself does not necessarily produce this toll of death and suffering. 8.1 million Australians have used an illicit drug at some point in their life. Of these, just nine per cent are estimated to be seeking treatment. The ACT will not be flooded by illicit drugs. Recent drug use around the country is steadily increasing across states that have not decriminalised drugs, and the reference is in the longer part of this. Without prohibition, alcohol and tobacco use has declined. Existing drug laws are a form, in fact, of retail price maintenance for the benefit of organised crime. Harm is maximised when drug use is prohibited, just as much as harm flows from the open slather of commercialised gambling.

Your task as legislators is to aim for the sweet spot that minimises the harm that can arise from an addictive activity. An avalanche of harm descends on drug users when drug law enforcement intervenes. The 1998 comparison between South Australia, which had just decriminalised cannabis, and Western Australia, which had not, is at the heart of your decision on whether to endorse the decriminalisation here, the bill. Those prosecuted in Western Australia were more likely to report consequences for their employment, personal relations and accommodation.

Decriminalisation in Portugal tells a similar story. Bloodborne diseases and deaths have declined. It is the preservation of life that counts most. May I pass to you, if I could only find it—

THE CHAIR: Bill, just be mindful, we will be running a tight schedule. We are finishing at 10 and we need to give the committee an opportunity to ask questions.

Mr Bush: Okay. As we see it, the choice before you is a no-brainer. Our submission goes further. There are still too many overdose deaths in Portugal and still too many drug users disengaged from health and support services there.

Our submission calls on you to resurrect the case so strongly put by Liberal Chief Minister Kate Carnell for heroin-assisted treatment here in the ACT. Heroin was administered to our mothers or grandmothers for intractable pain in childbirth before epidurals. A 1994 handbook for medical practitioners stated that heroin is safe, effective and has a wide safety margin. Had not the Howard government blocked the heroin trial that Kate Carnell argued for so passionately, the ACT would probably not have needed to build its disaster of a prison. As a former Swiss criminologist put it,

heroin-assisted treatment constitutes, without doubt, one of the most effective measures ever tried in the area of crime prevention.

Low-threshold and low-intervention services are capable of drawing the small minority of drug users leading a chaotic life into the health system and to engage with services that meet their psychosocial needs. What must end is the disempowerment that, out of fear or having their child taken from them, deters young women from accessing accessible antenatal and postnatal care for the child and themselves.

The lived experience of drug users is of stigma and marginalisation. These lurk behind most, if not all, of Australia's intractable, chronic social problems and drive intergenerational disadvantage in the Indigenous community and create a parallel underclass in the non-Indigenous community.

THE CHAIR: Bill, you have got a written opening statement; is that right?

Mr Bush: That is the one that I hope you have before you.

THE CHAIR: And we are happy to have that presented to us.

Mr Bush: Okay.

THE CHAIR: But we might just go into some questioning, if that is okay?

Mr Bush: Okay. If I just might, could I, say, truncate the last bit?

THE CHAIR: Sure.

Mr Bush: The psychosocial support is identified by the Productivity Commission. If you want to implement the Productivity Commission recommendations on mental health, you cannot do so without addressing drug policy. They are interlinked.

The last point is that the medically supervised consumption room in Sydney—and there is data on that that I can give you—is as much a mental health service as a drug treatment service.

THE CHAIR: We will basically just take a turn to ask a substantive question. Committee members might come in with supplementaries. What is your view on the thought that until we have adequate drug support agencies operating in the ACT we should not make any amendments at this stage?

Mr Bush: I think the comparison that I mentioned between decriminalisation in South Australia and non-decriminalisation in Western Australia, when that was checked, tells you that there are immediate effects that flow from decriminalisation. To wait until all the services are in place will put more demand on services and lead to adverse harms. Again, rapid benefits were seen in Portugal, following their commissions of dissuasion. I provided to the secretary earlier this morning a handout that Dr Cardoso provided in Sydney in 2018 that really shows how quickly those benefits accrued.

I think the answer is: they have to be done at the same time; there are not enough

support services for parents and they are just so distraught, particularly where ice is concerned.

THE CHAIR: Just a follow-up from my question: you say they have to be done at the same time. What if there is not really any increase at the moment or policy to increase drug support services? You would still support the decriminalisation bill?

Mr Bush: I think there will be benefits. The example I gave you was the disempowerment of young women who happen to use drugs. Those benefits, the suppression of the fear of engagement with social welfare services and health services, come immediately that that is brought about.

DR PATERSON: Thank you very much for your submission. Jan, do you mind sharing some of your story?

Ms Lee: No; that is fine. In regard to the previous question, I was just thinking that if it had not been a criminal offence to use drugs, my daughter would have come out and sought help and, yes, it would have changed things immensely. Mary suicided almost 22 years ago now. Things were a little different then, but not that much.

There is a stigma associated with taking drugs, and her perception was that her parents would not approve of it. I certainly did not approve of it, but I certainly would have helped. I think the fact that it was a criminal offence made it even harder to help, because you are thinking, "This kid could end up in jail." She thought of that and she turned to prostitution to support her habit.

Had it been decriminalised, I think it would have changed things just that much. If it is not a criminal offence we can go and get help; we can investigate avenues for sorting this out. But the fact that it is a criminal offence makes everything much harder and there is the stigma of having to tell your parents that you are doing something that is criminal, even though she would have known that I would be supportive. I knew she was taking drugs because she had mental issues, anxiety.

We had great expectations for her; she felt she could not live up to them. It was a whole sort of melee of different things. But she was a very bright person and had a lot of ability. She kept a diary, and one of the remarks in the diary was that "everybody expects too much of Mary and Mary just does not deliver". If she had been able to seek mental help and reassurance and had been put on a path that gave her some future and she had been supported, it could have changed everything. But the fact that it was a criminal thing that she was doing makes all that so much harder.

DR PATERSON: Thank you for sharing.

THE CHAIR: The fact that it was a criminal thing was not a disincentive?

Ms Lee: No, because once you are hooked, you are hooked. If you are there sweating and trembling and you cannot eat and you cannot do anything and what you need is the next dose of heroin, you will come and lie to your mother and say, "You wouldn't believe it. I just took $200 out of my account and somebody snatched it from my hands." If you are that desperate, you are just desperate. You need medical help to get

you out of that situation. She tried it on her own from time to time.

At one stage she went to Brisbane and tried to get off drugs, but again I think it is just the desperation that you are not getting anywhere and that drug offers immediate relief for a short period, even though you know that the consequences are dreadful. She rang me up from Brisbane and said, "I need to come. I'm getting sick again and I don't want to be sick again." This was a sort of euphemism for, "I am trying to get off heroin and I need your help."

She came back. We had a farm at that stage, and she stayed out at the farm for a week. I did seek help from what help was available back in those days. The lady I spoke to said, "If she's been off it for a week she is probably over the worst part now. She will be all right." It is that sort of thing: "She has got to stay away from the friends that she has in Canberra," but that is the only group of people that she knows. There is the depression from being on your own and thinking, "Here I am, on my own. I flunked out of college. I had a bright future. I have nowhere to turn, I don't know what I am doing." So you go back to your group of friends and you start taking drugs again. You really need serious help to get yourself out of that ditch.

THE CHAIR: Thank you for telling your story.

Mr Bush: Sorry, may I just add something to that? The predicament that Jan has painted in relation to her daughter, in terms of prostituting herself, shows the extents that drug users will go to in order to raise money. Or they scam their parents. The honourable thing for many drug users is dealing, and that is why they get into dealing.

You simply have to look at the results of the Swiss trial of heroin-assisted treatment. That showed that the engagement of drug users in that illicit activity of selling was the most honourable thing. You sell it to your peers. You are not hurting anyone. That is the mindset and indicates how getting the criminal law out of this system actually reduces the supply of illicit drugs. You do not have as many low-level drug dealers.

MR DAVIS: On the first day of hearing of this inquiry we heard from a lot of parents who have been so impacted by their adult child's addiction that they have called for, and advocated for, the powers to put people into rehabilitation involuntarily. First of all, what is your organisation's stance on the merits of involuntary rehabilitation? Then, more broadly, as very invested parents, what opportunities do you see to better include parents in the healthcare provision for their adult children?

Mr Bush: Thank you for the question. We do not support involuntary treatment. The reason for this—and this comes from my years of experience of over 1,000 calls I have taken on as a volunteer on the family drug support line—is that the core of success is engagement with your drug-using child or other family member. If you can establish communication and maintain it, the chances are infinitely better for an ultimately good outcome. If you suppress it by nagging and telling people that they have got to stop drug use here and now, with the power of addiction it just does not work that way. Engagement is the thing.

I think you have had evidence put before you of brief interventions. Some of these brief interventions actually show the psychological capacity of skilled councillors to

engage with—how will I call it—chaotic ice users. This is one of the key examples of the success of the Kings Cross injecting room. If you look at the profile of people who go there—there are a large number of ice users who are allowed to inject there—what they have shown is that, in spite of the rise in injection of ice, the level of the injection has remained low and they have been able to engage with these people. A low threshold of short intervention methods works.

The other thing to support parents is services. I can tell you, you feel so absolutely lonely. You are alone against the rest of the world if you invest all your hopes and dreams in your child and you find that they have got in thrall to a drug and you just cannot get any help.

The answer is: we do not support involuntary treatment. But under the Mental Health Act we recognise, of course, that where suicide, like self-harm or harm to others, is likely then there is the capacity for people to be committed under the Mental Health Act. I have talked to parents who have sent their child and found that they provide no help whatsoever, and the child has been discharged into their care basically without any support at all. It is outrageous.

Family drug support needs to get some money from the government to run this service. They already get a call a day from ACT agencies like Directions, which run excellent programs. I think you have heard from Bronwyn Hendry, the head of that, about some of their family programs. They are relatively low-cost ones to run, but it is a family affair. The family needs to be brought in and needs to be supported in interactions and to establish, re-establish often, communications with their child.

THE CHAIR: If the bill does pass, instead of being an offence to possess one of these substances, it would result in the issue of a simple drug offence notice, with an accompanying fine. Do you think there are other avenues available to persuade people from being in possession of these things?

Mr Bush: That is directly addressed in the material that I emailed to the secretary this morning and he did not have any time to get copies of those to you.

THE CHAIR: We will certainly turn our minds to that.

Mr Bush: Yes, just to say that they are from what Dr Cardoso from Lisbon provided when he was in Sydney in June 2018. That lists some of the various measures they use there and the results, basically, of the short interventions. What is being taken to the commissions of dissuasion is there. They apparently work. It is hard for people to understand that people respond to engagement rather than harshness.

Ms Lee: I was actually thinking this morning about the correlation between taking illicit drugs and becoming anorexic or bulimic or other sorts of things that people do when they suffer mental issues. We do not regard being anorexic as a criminal offence. It is a response to a similar sort of thing that is happening in your life. I think we should be as empathetic towards people who turn to drugs as a solution as we are towards people who turn to other solutions to try and solve their problems.

DR PATERSON: One of the things that has struck me, speaking with you today and

with some of the other families who have been impacted, is that what we are seeing is the impacts of heroin in the ACT in the 1990s and your experiences. It is really clear that it had a significant impact on the community at that time. Your stories represent that. Methamphetamine is a different drug to heroin, and you could probably live with the addiction, without the overdose, for longer. You can overdose on heroin quite easily. Do parents come to your organisation if they are living and breathing the experience? What is your experience of parents coming to you today, basically?

Mr Bush: I think you are right. We grew out of the 1990s; we grew out of the flood of heroin that was coming into the country then and the overdose deaths that arose. The big factor with heroin is of course that it is a depressant, as opposed to a stimulant, as ice is. The first point to make is that you heard evidence today about how ice usage is going down, particularly in younger people. If you look at figure 23 of our submission you can see that. That is one thing.

Cocaine is going up but the harms are not really manifesting. That is a factor of the wealth the people have got. I happen to have been a lawyer and I can tell you that people who have got a lot of money can afford those expensive drugs. For those who can't, if you are at the bottom of the pile you will use the cheap and nasty stuff, which is what ice was. It came in after heroin.

The other big difference is the pharmacotherapies that are available for opiates, not just the illicit opiates like heroin but the Endones and the OxyContins. In America there is a real epidemic of those, and this is why the increase in age of drug users is taking place.

With ice, there are trials of two drugs that have been done. One trial was to have ended in June; so I do not know the results. One is of lisdexamfetamine and the other is N-acetylcysteine. I refer you to section 6.6.4 of our submission, on page 75. I think the committee really needs to find the outcome of those trials. It is vital because, if that can be done, it can stabilise, because they are linked.

THE CHAIR: We have got a couple of minutes. Would you like two minutes to wrap up?

Mr Bush: Perhaps you would have gathered from what I am saying—just for two minutes—that I think there is an intimate link between what you are on about and the mental health system. This was brought up by the Australian Drug Foundation yesterday. I am a member of a mental health group and I hear these horrific stories from that quarter. I will give to the secretariat, with your permission, some material that draws out these links between the core recommendations of the Productivity Commission and the crisis in the mental health system in the ACT and across Australia. It relates in large measure to stigma and to the absence of integrated psychosocial support.

The drug sector has experts providing psychosocial support. The mental health one is more clinical, medical and medically focused. The Productivity Commission says these things have to be integrated. They are not at the moment. So you can't, I don't think, come to a conclusion without fully taking into account the mental health dimensions of what you are on about.

THE CHAIR: Thank you both so much. On behalf of the committee, I thank you for giving us your evidence today. The secretary will provide you with a copy of the proof transcript of today's hearing for you to check for accuracy. I do not believe there were any questions on notice. We do appreciate your submission and your time.

Mr Bush: Thank you so much. And thank you for your indulgence.

CAMPBELL, DR EMMA, Chief Executive Officer, ACT Council of Social Service
KILLEN, DR GEMMA, Senior Policy Officer, ACT Council of Social Service

THE CHAIR: Good morning. I welcome representatives of ACTCOSS. 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 are reminded of this. Please confirm that you have each read and understood the pink privilege statement.

Dr Campbell: I confirm that I have read it.

Dr Killen: Yes.

THE CHAIR: It is our practice to offer witnesses an opportunity to make a five-minute opening statement. Would you like to do so?

Dr Campbell: Yes, I will give a brief opening statement. We always like to begin by acknowledging that we are meeting on the lands of the Ngunnawal people and pay respects to elders past, present and emerging.

The ACT Council of Social Service would like to thank the committee for the opportunity to appear before this inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021. I think you are familiar with what ACTCOSS does in the ACT, so I will highlight a few key points that we want to emphasise for the committee. The first is that we strongly support the passing of this bill and believe that moving towards the decriminalising of a range of drugs for personal use will have an enormously positive impact, especially for some of the most disadvantaged and marginalised people in the ACT and the broader community.

We want to highlight that people who experience social disadvantage are much more likely to have their drug use criminalised than treated as a matter of public health, and that many users of drugs suffer greater harm because of criminalisation and discriminatory engagement with the justice and healthcare systems ban than from the drug use itself.

We endorse our members' submissions to the inquiry, many of which speak to these issues, including the Alcohol Tobacco & Other Drug Association, ATODA; the Canberra Alliance for Harm Minimisation and Advocacy, CAHMA, and Families and Friends for Drug Law Reform.

Another really important point to emphasise is that we need increased funding and investment for alcohol and other drug treatment services and provisions in the ACT. That will be essential to the success of the passing of this legislation. That increased funding must occur alongside decriminalisation but also with significant investments in housing and in services for mental health.

ACTCOSS has long joined with Aboriginal community-controlled organisations in calling for the development of a community-controlled Aboriginal residential rehabilitation facility in the ACT. Australian Institute for Health and Welfare data

shows that 13 per cent of AOD clients in the ACT are from Aboriginal and Torres Strait Islander backgrounds, despite making up only two per cent of the population.

ACTCOSS supports the use of the simple drug offence notice, which issues a fine rather than a criminal charge or criminal record. However, we believe that there should be robust strategies in place for those who cannot afford to pay a fine, whatever the amount. Without these strategies, some of the most disadvantaged drug users will be further criminalised and deterred from seeking treatment.

The last couple of points include issues around mandatory treatment as an alternative to a fine. Evidence shows that successful outcomes are driven by informed choice and personal motivation for change. Given our current service gaps, we believe that funding and resourcing voluntary services should be the priority. We also urge the committee to consider raising the limits of the drugs listed in the bill. We need to make sure that the limits realistically reflect the amounts that people are buying for personal use, so that we do not risk further criminalising as traffickers people who use drugs. We are now happy to take questions.

THE CHAIR: What about the view that until the support services are adequate to meet even the current situation of need, we should just leave the law as it is, and then focus on the support services?

Dr Killen: We think that the priority should be passing the bill and moving towards decriminalisation. As other people have mentioned in their submissions and in this hearing, that will do some of the work of reducing harm from drug use. But it should be coupled with a commitment to increase funding for AOD treatment services in the ACT. Definitely, we support passing the bill as it stands.

THE CHAIR: To some it would seem counterintuitive to say that decriminalising will lead to lower usage. How would you address that? It is something that is out there in the world of opinion, so to speak.

Dr Campbell: I think the evidence from the decriminalisation of cannabis use has highlighted that it certainly does not lead to a rise in use. What it does is to lower the levels of people engaged with the justice system. But the question is not only about use; it is about harm, and harmful use. What is really important is that we reduce harm—harm to the users, harm to their families and harm to the broader community. Decriminalisation is the way that you remove stigma and allow people to access treatment so that their use creates less harm.

Going back to your earlier question, political realities show, in the experience of ACTCOSS and other advocacy organisations, that the best way to ensure that there are investments in services is to have the legislation that forces the incumbent government to invest in the services to make sure that the legislation they have introduced is successful. That might be a rather cynical view, but it is a view that has been proven by history. We think that is the best way to ensure that there is adequate investment in some of these services, as well as the positive outcomes that will come from the legislation and the decriminalisation itself.

THE CHAIR: The carrot and stick does work in the political arena as well, so

to speak.

Dr Campbell: We have been calling for more investment in AOD services. All the evidence is there. We would love that. We think that should be happening anyway. But if we wait, we do not get the benefits of the legal change, in terms of reducing stigma, and I think that it may be a way to force the hand of the government to do what it should be doing; that is, investing in these really important services.

THE CHAIR: That is a very interesting insight. I do not think we have heard that one before.

DR PATERSON: Thank you very much for your submission. In your submission you mention a government oversight committee, if the bill is introduced. Can you talk more about what your thoughts are around that and what that would look like?

Dr Killen: That is something that we support ATODA in calling for. That oversight committee would comprise community members impacted by drug use, and people who use drugs, as well as members of the AOD service provision sector. That would be about guiding the government on how to implement the legislation in the best way and it would also be involved in evaluation of how the legislation is working, so that we can have some evidence. I know that, in terms of the cannabis legislation, we do not have as much evidence as we would like to have. We want to ensure that, if we do this, we have an oversight committee that tells us if it is working and the best way to make it work into the future as well.

Dr Campbell: It is also really important because there are many agencies involved in the success of this. You have the police; you have health services in government, as well as those on the ground. They are often agencies that may have, particularly with difficult issues like this, some conflicts, and historical levels of distrust. This is a way to ensure that there are meaningful interactions and shared information as well.

MR DAVIS: They were very comprehensive opening remarks, Dr Campbell; you actually answered a lot of the questions that I was going to ask you. I want to explore more deeply the current funding arrangement for AOD services—those on-the-ground people, as you suggest. I might be asking questions that seem redundant, but I think it is very important to get them on the public record. At the moment, would you argue that the current investment in AOD services does not meet the demand for those who want voluntary rehabilitation in AOD services?

Dr Campbell: I would refer you to ATODA's submission, but my understanding from them is that there would be at least a doubling of the funding required to meet current levels of demand.

More broadly, to understand the kinds of challenges that we are experiencing with funding in our sector at the moment, the AOD sector has had to fight with the federal government to receive the equal remuneration order funding, to ensure that their funding keeps up with the additional cost of salaries. For ACT government funded services, we are having to pay a 2.5 per cent increase in salaries as a result of the Fair Work Commission increase to the minimum wage, plus increases to superannuation, plus increases to the long service leave contribution; yet our indexation increase so far

announced by the ACT government is only 1.75 per cent. We are not even treading water with the demand that we are seeing at the moment, plus we know that there is almost a doubling of demand out there.

MR DAVIS: In summary, the obligations on your member organisations to pay staff are greater than the funding increases you are receiving from both the commonwealth and ACT governments, and that is seeing a reduction in services?

Dr Campbell: Yes. The obligations that have come as a result of Fair Work Commission salary increases and the equal remuneration order are greater than the funding that we are receiving from both the federal and territory governments, and the increases.

THE CHAIR: Submissions from, broadly speaking, the legal aspect and the policing aspect highlight that the bill, if passed, is in conflict with commonwealth law, which creates, from some points of view, a real challenge for policing. I am a lawyer; the rule of law is very important to me, and having inconsistent legislation affecting the same community is a little bit not to be desired. Do you have any thoughts on the legal aspect of this bill being passed and the challenges to policing?

Dr Killen: To begin with, we are not lawyers, so we cannot speak in depth on legal issues. It is our understanding that currently the cannabis legislation sits in contrast with the commonwealth law, and that there are not significant problems with that in the territory. It is also my understanding—and I think 360Edge spoke about this a little bit yesterday—that the current limits for personal use in the ACT do not match the commonwealth personal use limits, which is part of why the limits that are proposed for the new legislation are significantly lower, so that they will match the commonwealth limits. There is already an inconsistency there. I think that the police in the territory have been adept at managing those inconsistencies so far. I think that if they were brought along with the legislative changes, they would manage these inconsistencies as well.

Dr Campbell: ACTCOSS is not really in a position to have an in-depth discussion about territory rights and so on, but these are important issues to the community in the ACT. They are bringing significant levels of injustice to marginalised communities. Cannabis laws have demonstrated that we can act in ways that we think are in the best interests of our community. I do not see that this legislation should be any different. I have strong faith in ACT Policing, who I think you are speaking to this afternoon, to work really constructively with the government and the community to make this legislation work, as they have done with the cannabis legislation.

THE CHAIR: We have already heard from the AFP Association. There was a view expressed that the adaption to the cannabis change has worked, so to speak, but we are talking about a whole different category of harmful substances which may cause some policing approaches to say, "These are so bad that we shouldn't even have them walking around in Canberra." Obviously, that is something that you can look up in *Hansard* as well.

Dr Campbell: Sure. It will be very interesting for you to speak to ACT Policing this afternoon. They are the people actually on the ground dealing with this.

THE CHAIR: Their submission is available on the website as well.

Dr Campbell: Yes. That argument is not a constitutional argument. It is just an argument about the law itself. We disagree with that, because the evidence shows that the decriminalisation of drugs, at the levels that we are talking about, actually leads to better outcomes for the community. It directs people into care and support, which in turn lowers rates of criminal activity and so on.

I do not think that that is a constitutional argument. They are using the constitutional argument as a way to try and show that they are against this legislation, whereas we think the evidence shows very strongly that it will actually help policing to achieve the goal that policing have, which is to lower the levels of criminal activity in the community.

THE CHAIR: Actually, the point made was that, under commonwealth law, they have obligations to enforce the commonwealth Criminal Code.

Dr Campbell: The cannabis legislation has demonstrated that you can balance that very successfully. We do not think there will be any difference just because the nature of the substance is different, alongside the fact that this is broadly supported by the ACT community, and we have an obligation to act in the best interests of the community that we represent.

MR DAVIS: The chair referenced that, in the AFPA's evidence, there were varying degrees of discomfort around the different substances. One narrative that seems to be appearing is particularly around methamphetamine and ice—around the concerns regarding decriminalising that particular substance. What would you say to those in our community who are either philosophically agnostic or are open to the prospect of drug decriminalisation but have reservations around the decriminalisation of that particular substance?

Dr Killen: We support what ATODA said about needing to decriminalise. If methamphetamine or ice is the most harmful drug then that is the one that we need to decriminalise in order to channel people into treatment services. Methamphetamine is the second highest drug for which people seek treatment in the ACT. About 22 per cent of AOD clients are methamphetamine users. The other two highest are alcohol and cannabis. We can see that legalisation or decriminalisation helps people to be in treatment. We can make that kind of reference, I think. The number of people in AOD treatment for methamphetamine will go up if it is decriminalised and people are directed into treatment services.

Dr Campbell: We know that a third of clients who are seeking treatment for methamphetamine use in Canberra are Indigenous. We know that Aboriginal and Torres Strait Islander people are already over-represented in the criminal justice system in the ACT. It does not make sense to deter treatment and to further criminalise people who are already so disadvantaged in our community by leaving out one type of drug.

DR PATERSON: We heard from Julie Tongs about the need for residential

rehabilitation specifically for Aboriginal and Torres Strait Islander people in our community and about the need for cultural safety in service delivery. I note that your submission recognises homelessness and mental health conditions as part of this whole conversation. Are there any other specific groups, targeted interventions, facilities or programs that are needed that are currently non-existent in the ACT?

Dr Killen: That Aboriginal and Torres Strait Islander community-controlled residential rehab is probably the biggest one.

Dr Campbell: We also know that, among people who use drugs, people with disability are over-represented. We know that people with mental health challenges are over-represented. Bill spoke to the importance of the mental health system and investment in that, in terms of supporting the treatment of people who use drugs. Also, of course, there are people who face other types of disadvantage, such as those experiencing homelessness. That goes to the issue that we were talking about earlier, where we also need significant investment in things like housing and mental health. One of the great challenges we have in the ACT is our lack of decent social housing.

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

Dr Campbell: We convene the Justice Reform Group. The Justice Reform Group will be giving separate evidence, with a different focus. One other point that I would like to make, which I think may be covered by the JRG, is the importance of reviewing drug and alcohol treatment in the AMC, a needle and syringe program in the AMC, and ensuring that we have adequate support for people who are exiting the AMC who also have drug and alcohol problems, so that they can be supported in their recovery and their treatment both inside and when they return to the broader community. That will perhaps be addressed in more detail in the JRG evidence later.

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. I do not believe there were any questions taken on notice. We will have a short break.

Hearing suspended from 10.24 to 10.45 am.

KEANE, PROFESSOR HELEN, Professor of Sociology, Drug Research Network, Australian National University
MANDERSON, PROFESSOR DESMOND, Professor, College of Law and College of Arts and Social Sciences, Australian National University
CALDICOTT, DR DAVID, Emergency Consultant, Drug Research Network, Australian National University
OLSEN, ASSOCIATE PROFESSOR ANNA, Associate Professor of Social Foundations of Medicine, Medical School, Australian National University

THE CHAIR: I reopen the public hearing of this committee and welcome representatives of the ANU Drug Research Network. Could you each state the capacity in which you appear?

Prof Keane: I am here as a sociologist who has done research into drugs and alcohol, and concepts of addiction.

Prof Manderson: I am jointly appointed to the College of Law and the College of Arts and Social Sciences at the ANU. I am appearing here as someone who has been writing about law, policy and history for close on 40 years, particularly a book called *From Mr Sin to Mr Big*.

Dr Caldicott: I am an emergency consultant, based in Canberra. I hold conjoint academic positions with the University of Canberra and the ANU. I am here as part of the ANU's expert group, with a special interest in music festivals and particularly harm reduction and harm minimisation.

Prof Olsen: I am based at the Medical School at the ANU. My career has focused on drug and alcohol use, and research around harm minimisation and health interventions in this space.

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 are reminded of this. Could you each confirm that you have read and understood the pink privilege statement?

Prof Keane: Yes, I have.

Prof Manderson: Yes, I have.

Dr Caldicott: Yes, I have.

Prof Olsen: Yes, I have.

THE CHAIR: It is our practice to offer witnesses the chance to make a five-minute opening statement—in total, not from each of you, otherwise we will not have time for questions. Would one of you like to do so?

Prof Olsen: We were very quickly going to introduce ourselves, to create a bit of context for who we are, and open it up to questions from you. As you know, we are

representing a larger group of researchers from the Australian National University. As a group, we would like to acknowledge the Aboriginal and Torres Strait Islander people of the Canberra region and acknowledge that we are meeting here today on Ngunnawal-Ngambri land. In particular, we also acknowledge that the laws and the systems that we will be talking about today unduly and unfairly discriminate against Aboriginal and Torres Strait Islander people.

As a group, we are a very mixed disciplinary group. We come from a large range of disciplines. However, we come together in support of this proposal. We have done quite a bit of work on the proposal and are interested in taking questions from you.

We understand there has been some particular interest in the potential conflict between the commonwealth and the territory, as well as some potential interest in the outcomes of the Portuguese decriminalisation change. If there are any particular questions that you would like to ask us, we would be very happy to discuss those with you today.

THE CHAIR: Would anyone else like to make a very brief statement?

Dr Caldicott: I would just commend the committee on this process. I think it is tremendous, not only for the ACT but for Australia, to at least be having a discussion on it. It is commendable.

THE CHAIR: I will start with a very specific question, because you have touched on it briefly, Anna. If the bill does pass, it would conflict with the commonwealth Criminal Code. We have had submissions from the Australian Federal Police Association that, given the nature of the substances, that would create more of a challenge for them in terms of discharging their commonwealth and ACT duties compared with, say, administering the cannabis legislation that was passed in the last term. Do you have any comment on that?

Prof Manderson: I am happy to speak to that. We do talk about it in our submission. I have checked over that submission and I am happy with what we say in that submission. Clearly, the proposed penalty regime here is quite different from the Criminal Code of the commonwealth. That is not unsurprising. That happens across Australia. Tasmania has a very different penalty regime. Queensland and the ACT have different ways of measuring drugs. There are different regimes in relation to cannabis cautioning, heroin cautioning in Victoria, and decriminalisation in states.

It is not a bug of federalism; it is a feature. It comes down to a constitutional principle, which is to do with the idea that the commonwealth have no specific powers to legislate in relation to drugs. Until the 1990s, they focused on laws relating to customs and excise, where they do have specific powers in relation to the importation of drugs, for example. It was only in the 1990s that this was expanded to a more broad coverage of drug laws, not under the customs and excise power but under the external affairs power. You will remember the Franklin Dam case and the idea that the commonwealth can give effect to conventions.

I can say a little bit about the interpretation of that convention at some point, if you would like me to. The proposal here is entirely in line with current thinking about

what our international obligations require. I think that is very clear. There would be no reason to suggest that this was somehow in contradiction to our obligations under the treaty, either the 1961 treaty, the single convention, or the 1988 treaty.

Going back to the Criminal Code, the High Court says very clearly that the drug laws are not intended to cover the field of drugs. In other words, concurrent operation is envisaged. If you look at the Criminal Code, section 300, under "Concurrent operation intended", specifically says that this part is not intended to exclude or limit the concurrent operation of a law of a state or territory, even if the penalties or defences are different under commonwealth and state law.

They specifically note, in relation to possession offences, that the commonwealth Criminal Code envisages legislation by the states or territories that allows for drug users to be diverted from the criminal justice system—this is written into the commonwealth Criminal Code itself, at section 308.1(3)—and that penalties can be less punitive than commonwealth law but must not be more punitive than commonwealth law, which is exactly what we see here. Leaving aside the constitutional question, the commonwealth Criminal Code itself clearly envisages exactly the kind of difference between state and territory laws that is expressed here. Section 308.1 says much the same thing.

There is then simply a question about enforcement practices. What do you do if there are different enforcement regimes, which are envisaged precisely by the commonwealth law itself? The answer is that in this area, as in many areas of the law, the DPP provides charging guidelines which say what you should do and when you should exercise that discretion to enforce state law or commonwealth law where they apply it differently.

The general practice in the DPP charging guidance—2014 is the latest version that I have seen reference to—is to prefer the state or territory law, where possible. The mere fact—and this is in the charging guidance—that a commonwealth offence may have a higher penalty is not a sufficient reason for preferring commonwealth offences to state offences. As practice, in the law, on a constitutional principle and in line with international obligations, there is not a problem.

THE CHAIR: Thank you for your submission on that.

DR PATERSON: Thank you very much for your submission. I am really interested to talk about the policy impacts on women. This has not come up at all. I think this is a really important point, particularly when women often have primary caregiver responsibilities, and the impact on seeking help and support when you may have custody issues, and that type of thing. It is such a gap in what we have talked about, so I would be really keen to hear from the panel about this issue.

Prof Olsen: Helen and I both have research areas in this space. We will probably both say something about this. One of the many reasons why I support this proposal is that it is shifting the lens from criminalisation, which not only punishes people but also stigmatises people, to helping people. When someone has an issue with drugs, there is more capacity for them to then seek help.

What we see in the ACT, in Australia and across the world is that women who use drugs, whether it is harmful or not, can sometimes be criminalised. Women who have problems with their drug use sometimes do not seek help because they know what that means for their family. We have systems in place that routinely remove children from families who try to seek help for their drug use.

In discussing these changes, where we are shifting criminalisation of drug use to helping people who have issues, there is a capacity to open up a discussion around drug use in families that is less about punishing families and more about assisting people and assisting families to continue as a unit.

Prof Keane: I endorse what Anna says. The effects of criminalisation on women can be very profound, especially in relation to mothering and childcare practices. What I would add to what Anna is saying is that stigmatisation is really profound in this space. Women get judged generally more harshly for drug use than men do. Of course, the relationship between the law and stigmatisation is not a direct one. I think that decriminalisation acts to support destigmatisation, which is something that I see as really significant.

In particular, there is research that shows that women will avoid going into treatment—for example, methadone-based treatment or opiate-based treatment—because that can actually increase their vulnerability to things like child removal. We want to make sure that treatment does not increase these risks; that it actually decreases it. You sometimes see women being punished for disclosing their drug use, which, of course, is counterproductive.

MR DAVIS: I want to talk about schools and education programs in schools. You have suggested a review of school and youth-based drug education programs. What kind of broad drug harm reduction interventions are useful in schools, and what are some of the risks of engaging with drug education in schools?

Dr Caldicott: I am involved in providing drug education in schools in the ACT. There is clearly a concern that if you flag sex education or drug education, you are going to turn your school population into fornicating drug abusers. There is not a lot of evidence that that is supported in outcomes. What you need to do, really, is to mitigate against that onslaught, the tsunami of information that is uncurated and available to them online. When you have reliable information that appears to be sensible and based on fact, neither exaggerating nor underestimating the impact of drug consumption, you find that younger people, or the generation that we are talking about, tend to pay attention.

You see that most clearly in, for example, people who go to music festivals. Maybe there is an overlap at the end of school and going into the university environment, where organisations like DanceWize provide non-judgemental, factual information about potential harms and about choices. I think that is very useful. The evidence suggests that it does alter behaviour significantly. I think that within the Australian context we need to see a lot more of this sort of service being provided, hedging down towards younger age groups but, obviously, not necessarily in the primary school environment.

We need to be talking about drugs in the same context and at the same time as we talk about sex education, when this becomes a matter of interest to people, to provide an alternative line of information that comes with some sort of authority. I think the idea that this will contribute to people knowing about drugs when they did not know about drugs previously is to completely misunderstand the nature of the internet at the moment.

Prof Olsen: One of the reasons we called for a review in the submission is that, from an academic or research point of view, there is not a lot in the Australian space that is actually evaluating education programs in schools. We do not know a lot about what is being provided, let alone how well it is working. So there is an opportunity for us there to review what is happening in Canberra schools and also consider its effectiveness.

MR DAVIS: As a supplementary, there has been a high degree of public commentary recently about academic outcomes in our schools. That has put a lot of pressure on teachers, who essentially feel like they must be the authority on all things. Dr Caldicott, you touched on sex education as one of those things. Do you see drug education in schools as being best delivered by classroom teachers, who are supported and provided with the appropriate resources, or do you see it as being better provided by outsiders coming into the school environment as authorities in the space?

Dr Caldicott: I would return to Anna's comment, in that we probably do not really know the answer to that. There are clearly people who are gifted educators and they can teach anything and will influence children on everything. A lot of this is probably interpersonal. We do not genuinely know. I think we live in a society where a devolved service is very much the way services are provided. There are many services providing drug education around Australia. As Anna says, none of these have been evaluated. We do not know.

I think some teachers who have particularly lived experience might be excellent educators in this space. But, then again, we get to Helen's point that that probably involves a degree of stigma to be able to stand up and say, "I can tell you something about drugs from this perspective." It might actually be easier to have a system in place where that could be devolved to somebody who has expertise.

Prof Manderson: However we think about designing this kind of information, we need to have children involved in the process.

Dr Caldicott: Yes.

Prof Manderson: I am not saying they know all about drugs, but they have access to a lot of information. In terms of thinking about what is true and what is not true, that is a question that relates to drugs, but more broadly it relates to many things. That is an important task in which children themselves need to be involved with their schools and the people they have interpersonal relationships with that are so important in the decisions that they make.

MR DAVIS: For the parents watching this, who might be challenged by the idea of how much information about drugs is available to their young people, who are not

inclined to trust my perspective on the situation because I am a politician, what would you say to those parents who are concerned about actively involving their children in the development of curriculum and programs to talk about drugs? I imagine there would be some more conservative people in our community who might be a bit challenged by that suggestion.

Dr Caldicott: I have no doubt you are right. You would see the same with sex education. There is a spectrum of opinion in this space. The pedagogical research suggests that children, when provided with information in a safe environment, make sensible decisions. That is probably difficult to contest. I think there is clearly a group in society who wish to contest that across an entire range of issues, including LGBTQI stuff and the whole lot.

Children of this generation are considerably more capable of processing information purely because of the slew of information that is available to them. It is absolutely critical, as Des says, that it is formatted in such a way that they feel that they are self-directing and that they understand it. With guidance, I think children almost unanimously will arrive at the appropriate decisions.

There is an excellent piece, which I can submit to you later, on safer partying, from the Drug Policy Alliance, which is a way of talking to children about drugs. There is a lot of material out there that is discussing how to do it, and it all suggests that children can process this information sensibly.

THE CHAIR: Please send through anything that you think supports your submission to the secretary. We will add that to the bulk of material.

Prof Keane: It is really important, I think, that the most harmful drug in our society, which is alcohol, is included in these education programs and not separated as if there are two problems—one is alcohol and then one is everything else which is illegal. I am a parent of teenagers. It is alcohol, I think, that is really concerning, or should be the most concerning, in terms of harms, availability et cetera.

The other thing I would say is that I think it can work really well to have external speakers come into schools, because they are not in the same strict authority position as teachers. I think there has to be careful judgement about the value of specific speakers. In this field of drug and alcohol education a lot of people are offering themselves as experts who may or may not have the best information. I do not think you can open up and say just anyone who wants to come to talk to a school can do so.

My view is that often people who have had terrible problems with their drug use are seen as authorities on drug use, to my mind, in a slightly strange way. To talk to children about drug use, you pick someone who has become addicted, who has had terrible life consequences from their drug use and they become the experts—whereas I think it is equally important to talk to people who have used drugs and have not had those kinds of problems.

Prof Olsen: I just want to add a short point, following on from David and Helen. In terms of saying that these parents are worried about presenting information about drugs, the evidence that we have in this space is that slightly older cohorts, for

example, who go to festivals, are all talking about drugs anyway. Where they are getting information from is each other and the internet. We would also argue that that is not necessarily the best way to disseminate information about illicit drug use. Being able to counter some of that misinformation—and there is some misinformation in this space—and provide more evidence-based information from more reputable sources than one's peers or random internet sites can only be beneficial.

Dr Caldicott: For anybody who might be watching this, the best way to consider providing your children with sensible information is as an inoculation in the current climate. Knowledge is always inoculating against harm.

DR PATERSON: I am interested in your recommendation:

> We urge a comprehensive review of the ACT Drug Action Plan in order to develop a Territory specific Drug Strategy …

In terms of the current drug action plan, what do we need to be putting in the next drug action plan or a territory-specific strategy?

Prof Olsen: I have a bit of a conflict of interest in that I am on the committee reviewing that action plan as well. What we have in the ACT at the moment is not an action plan. The limitations are that it is fairly broad and there is not a lot in there that can keep us accountable to measure and perhaps design new interventions in this space, new services in this space, or even perhaps new legislation in this space as well.

In designing a new plan, there are some positives around thinking about it as a strategy, as opposed to an action plan. There are also some positives in using this opportunity right now in the ACT to design a new strategy that has evaluation built into it so that we have some baseline data to follow what is happening currently in the ACT around drug services, drug education and particular services for in-need populations, and that we can actually track and evaluate what is happening. That will be particularly important if we put new legislation in place.

THE CHAIR: There has probably been a general consensus that the support services in the ACT are inadequate for the current situation. What is your response to the view: why change the law until we have got those support services at an adequate level?

Dr Caldicott: I think the ACT has demonstrated that it is capable of both walking and chewing gum. We can improve the supports that are available and ensure that the necessity for those supports is diminished because we are addressing the health care side of things; we are addressing the harm of the systems in place. At the same time, there is a need to address whichever harms are left residually.

MR DAVIS: Given that you have strong support for decriminalisation, in the broad, what do you identify when you read the bill? What are some of the key risks? What are some of the obvious things in the bill where you think, "That's a good idea," or a couple that may be cumbersome parts of execution that we should be looking at?

Prof Manderson: I want to jump in on that. One thing I did want to talk about was the question of thresholds, which probably does need a bit more thought. However,

I notice some remarks that the thresholds may be too high. I think the real risk is that the thresholds are too low. There is as much danger involved in having the thresholds too low as too high. If the thresholds are too low then we are not really dealing with the problem properly and we are, in fact, re-criminalising users and possibly in a more serious way than they are being criminalised now.

Some excellent work was done in the ACT some years ago by Hughes and Ritter, who were commissioned by the ACT government, I believe, to do a comprehensive report on how to approach the question of thresholds and what those thresholds ought to be. I am not sure whether anything has happened to that report since then. Hughes and Ritter's report identifies ways that you can think about that problem—how to work out what really represents an appropriate level for personal use for particular drugs—and it is obviously not a one-size-fits-all question. I notice, for example, in relation to cocaine, that they think an average session may involve three grams of cocaine and a heavy session could be up to seven grams of cocaine. Those figures are not out of line with what has been proposed in this bill. It certainly does not suggest that the thresholds identified for cocaine in this bill are too high, as I noted, for example, with all due to respect to the Law Society, they said in their comments to this committee just the other day.

More work needs to be done on that. The difference between what Hughes and Ritter are saying and what the Law Society is saying may be to do with the difference between pure and mixed drug amounts. That may be the issue, or it may be just to do with how we understand the kinds of practices. If we do not reflect what personal use of a particular drug is and we get that wrong then we risk undermining the whole idea in the bill. We need to get better evidence—and I think the Hughes and Ritter report is an excellent place to start—and perhaps some consultations with users in this drug community about what is an appropriate level.

I do not think anyone thinks that the levels in relation to cannabis, for example, are too low, but that is a different question. I do not think anybody thinks that the levels in relation to ecstasy are too high. Those levels are comically low and do need rethinking if we are to seriously address this problem. The point is that thresholds are not about what counts as safe levels of use. No-one thinks that drugs are entirely safe. It is about the counterproductivity of criminalisation. That is really the point.

Alcohol and tobacco are clearly not safe at any speed, but we do not prohibit them because we recognise that criminalising those drugs will be counterproductive in many ways. So what we are trying to capture here is not levels of use that are safe but levels of use in which it is appropriate to be finding non-criminal solutions to the issues that users may be confronting.

THE CHAIR: One of the drivers of the threshold is to distinguish between users and dealers.

Prof Manderson: Yes.

THE CHAIR: One category will be criminalised and one will not under the bill.

Prof Manderson: Right.

THE CHAIR: Obviously, just being tipped over the scale will make you a criminal, a dealer, policy-wise, and under will not. I do not know if you have any thoughts on that.

Prof Manderson: You are right. That is why it is important to get that number right, as best we can, so that we capture the people we genuinely believe are using it for personal use and we do not capture the people we genuinely assess as being dealers or involved in sale or supply. That raises the question of the deeming provisions, which we also refer to in the submission. Deeming means that you are just looking at a number rather than the actual conduct. We are opposed to deeming provisions. They do not have deeming provisions in Queensland and their legal system seems to work fine. I realise that may be more than you want to bite off in this particular law.

DR PATERSON: We had one submission yesterday that said we should have an and/or other drugs clause in it, because a lot of drugs are not captured in the legislation. Would you agree with that?

Prof Manderson: Yes. Again, as I think we say in the submission, what normally happens with drug laws is that you have a schedule. The schedule includes the drugs that are covered by the law and the schedule is open to review. That gives you a much more flexible way of responding to changes to new drugs and to changes in behaviour. That is the way the system has worked since we have had a system like this. We think that we need a system like that and we need to have a regular consultative process where we can keep under review the drugs that are included in the scheme.

Dr Caldicott: It is an incredibly dynamic thing to try to regulate and legislate for and, therefore, it needs consistent and constant review.

THE CHAIR: Anna, I think you were appointed by your colleagues; is there anything you would like to say in closing?

Prof Keane: Is there anything else that we would like to add?

Dr Caldicott: Just one issue on what we were talking about—the difference between dealership and personal consumption. In the modern era that is actually fairly blurred. Maybe part of the problem of legislating in this space is that, for example, somebody goes to a party and one individual might be responsible for ensuring and keeping safe that which people are going to consume for the evening. That does not make them a dealer; they are just a holder of product. Therefore, that differentiation becomes more difficult. It is important to consider the society in which drug consumption occurs before you attribute some sort of Hollywood demarcation that is black and white into dealer and consumer.

Prof Keane: I think there is a category called social supply in the research which identifies this practice. David is exactly right. I do not think trafficking and personal use are the only two categories. Just because someone possesses a certain amount of drugs does not mean either that they are going to sell it or that they are going to use it all, all at once. People stockpile, just like we do with alcohol. You go to Dan Murphy's and you buy a certain amount. You are not intending to drink it all at once. That goes to the safety question. I think there is complexity in this space that has to be

taken into account.

DR PATERSON: What did you call that?

Prof Keane: Social supply.

Prof Manderson: I think our discussion about the sale and supply laws goes to that question too.

Prof Keane: Exactly. Supply does not necessarily mean for profit.

THE CHAIR: Thank you so much. We could possibly have had a lot longer with you folk. 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 there were any questions on notice for you to respond to, but you are welcome—

Prof Manderson: Can I say one more thing, or are you out of time?

THE CHAIR: Very briefly.

Prof Manderson: I have seen a lot of discussion here about ice in particular that, again, I think seems to misunderstand the fact that this is not about whether it might be safe but what the consequences of criminalisation are. The one thing I would do in relation to that, apart from saying that hyperbolic references and hyperbolic rhetoric are not helpful in understanding the kind of problem that ice is for the vast majority of users—is to point you to the fact that there has been outstanding work done in New South Wales recently.

The Howard report on ice and methamphetamines did an enormous amount of work looking at the various aspects of this problem. Recommendation 11 of that committee was to remove criminal offences of use and possession for personal use. They looked specifically at ice. It is one of the most outstandingly well-done pieces of drug commissions and government reports that I have seen in this country. It was specifically about ice. Their recommendations are very much in line with our own and with the bill.

MR DAVIS: You referenced a Hughes and Ritter report. So that the committee can best reflect that in whatever recommendations it chooses to make, would you mind submitting that as an exhibit, on notice?

Prof Manderson: Yes.

THE CHAIR: Thank you. Thank you so much for your time, for your submissions and obviously your commitment.

WRIGHT, MS KATHRYN, National General Manager, Alcohol and Other Drugs Services, Social Mission Department, The Salvation Army 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 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.

Ms Wright: I have.

THE CHAIR: Thank you. It is our practice to offer witnesses an opportunity to make a five-minute opening statement. Would you like to do so?

Ms Wright: I would; thank you.

THE CHAIR: Please proceed.

Ms Wright: First of all, I would like to acknowledge the traditional custodians of the Ngunnawal land on which I appear virtually today and also the Wurundjeri people in the Kulin nation on whose land and waters I live and work. I pay my respects to their elders past, present and emerging. Both personally and on behalf of the Salvation Army, I commit us to reconciliation. I thank the committee, on behalf of the Salvation Army, for the opportunity to present our evidence and to share our experience with you.

The Salvation Army is an international Christian business, with over 130 years of service delivery experience in Australia. Our vision is that wherever there is hardship or injustice, Salvos will live, love and fight, alongside others, to transform Australia one life at a time with the love of Jesus.

Today we are one of the largest providers of social services and programs for people experiencing hardship, injustice and social exclusion. We are also a major provider of AOD services in the ACT, and more broadly in Australia, with our national AOD budget amounting to approximately $7 million annually.

The services that we offer in AOD range across the country to include residential and home-based withdrawal services, residential rehabilitation, counselling, consultancy and continuing care, AOD supported accommodation, outreach services, drug diversion and forensic drug programs, after-care of post withdrawal linkages, support groups, and programs that are specifically designed to meet the needs of special populations, including correctional clients, injecting drug users, women, homeless people and particular cultural groups within the community.

It is due to our significant service delivery experience, together with the outline of relevant evidence, that the Salvation Army provided its submission to the inquiry and encourages the ACT government to consider the provision of a stepped-care approach for AOD treatment in the redesign of its AOD service system.

As is evident and clear from our written submission, the Salvation Army's response does not address the issue of decriminalisation of drug use in the ACT. This is because the specific expertise of the Salvation Army resides in our deep and longstanding experience in providing treatments and support services. The Salvation Army has not at this time formed a view on the issue of decriminalisation. As such, it would be inappropriate for me to speculate on that particular issue.

Rather, we focus on the terms of reference section (e), which seeks input on issues specific to drug treatment in the intervention sector, including models known to best suit people's needs. In doing so, we assert the features of an effective stepped-care treatment system in the hope that the opportunity for sector reform is seized by the ACT.

In summary, we believe that the service system could be redesigned into an approach which would make better use of resources already available in the community and eradicate or significantly reduce waitlists. Hopefully, you read in our submission an example of where we have done that over many years in our Tasmanian services. Interestingly, since we wrote the submission, we have also started piloting a program in the ACT, just one month ago, which has effectively eradicated our waitlist now. I hope to have the opportunity to speak a little bit more about that this morning.

THE CHAIR: Thank you. Is there anything else you would like to say in opening before we get to questions?

Ms Wright: No; let us go to questions.

THE CHAIR: Firstly, I note that you are not expressing a view on the decriminalisation bill that is the subject of this inquiry, and we will proceed on that basis. You mentioned a few things that you think are deficient or could be improved in current ACT drug support services. Obviously, apart from more money to do more of what is happening now, what other things do you have in mind that would improve community access and support with respect to drug addiction?

Ms Wright: The current system is very much a one-size-fits-all approach. There is an over-reliance on residential rehab—it seems to be that for many people it is the first port of call—and there is a lack of options for other service types. It is not that there are no options, but there are very limited options both in terms of quantity and variety of services. So we end up with people who are in ill-fitting services, if you like, that are very often resource intensive, when they could be assisted by less intensive services, being treated in the community more readily in a more tailored way, depending on their individual needs.

DR PATERSON: Thank you very much for your submission. The Canberra Recovery Centre is one of only a couple of residential rehab facilities in the ACT. What you are saying about too many people attending that service who perhaps do not need that level of intensive service—are they overwhelmed with people wanting to attend that service?

Ms Wright: We have no problems filling that service with people who need that level

of intensity. What we have had is a lack of opportunity to send people to different intensities or different settings for service delivery.

What we have been able to do in the last month because of a little bit of resourcing that we got in opportunistically is that we have opened a day program, a medium-intensity day program, which is operating out of our Braddon Salvation Army site, a set of church and community buildings. That has effectively eliminated our waitlist. On a shoestring budget we would like to offer more associated services, which would cost more, but on an absolute shoestring. As of this coming Monday we will have 21 people in treatment in the community that have come off our waitlist for residential rehabilitation or deserted from residential rehabilitation.

There has been great anecdotal feedback. It is a little bit early to see the outcome, but our experience in other parts of Australia, and supported by international experience, is that most people—certainly not all; we still do need the intensity of residential rehab for some people—have very similar outcomes in community-based treatment, which can be tailored. It can be tailored around men and women, for example, and childcaring responsibilities. It can be tailored around part-time work, and a number of participants in Canberra at the moment are continuing to work while they are in treatment, something that is usually not able to be done in residential rehab. So you end up with people leaving residential rehab who feel disconnected from the connections that they had prior to going in.

We think there is a really exciting opportunity to offer the level of service that people need, when they need it, in a very responsive way if we diversify the treatment system. The other thing I could say about community-based services is that they have a lower threshold for access. For example, somebody does not need to be 100 per cent clean and abstinent before they start in our day program. They need to turn up not overtly under the influence on the day.

A very common story I have heard around the country and also internationally—I have heard it again this week in speaking to our manager in Canberra—is about people accessing day programs because they do not want to make that commitment to abstinence first up. But in the course of treatment they will go, "Actually, I think I don't want these drugs in my life at all now." So it is not unusual to land at the same places you are aiming for at residential rehab. If people do choose to continue some level of use of drugs, we can still do an awful lot of good work with them and they can still have great outcomes very often as well.

MR DAVIS: Many of the submissions to this inquiry so far have cited the federal government's review of the alcohol and other drugs services sector. They have made the recommendation to double the existing funding that the ACT allocates to AOD services. If the government were to do this, what opportunities do you believe this would offer the sector to reorganise and evaluate their own work?

Ms Wright: It would be such an exciting opportunity. One of our recommendations was that evaluation be included in the new sector service system design. Opportunities would include, like I said, various levels of intensity and context for treatment, and a huge emphasis on partnerships because treatment cannot be all about drugs and alcohol; it has to be situated in the broader health and community sector. It would

offer the opportunity to eliminate waitlists. It would offer the opportunity to be more accessible to people. Yes, it is a very, very exciting prospect.

THE CHAIR: I know you have not got a comment on the bill, but let's say you were in the position of changing the law in the ACT. Is there something you think should be given strong consideration?

Ms Wright: Regardless of what the law is around drugs that are currently illicit, the design of the service sector will make the bigger impact. Undoubtedly, more people would access treatment if it was more accessible, obviously, and that in itself could impact probably more than any impact of the legislation itself.

THE CHAIR: What if there was something within the legislation, for example? Let's say that, under current law, a police officer found someone in possession but there was an amendment to the law to allow them to give the individual an option to go to a support service versus enter the criminal justice system.

Ms Wright: Diversionary programs are big all around Australia. We have a number of beds in the ACT at the moment which are diversion beds. The international and national evidence from that is that they are a very, very successful way of working with people with good outcomes generally.

DR PATERSON: We have heard from other groups about the need for a residential rehabilitation facility for Aboriginal and Torres Strait Islander people in the ACT, as well as potential barriers to women seeking help, particularly long-term help, for drug issues because of its impacts potentially on childcare responsibilities and custody. Do you have any comments around services targeted at specific groups and how we may improve that?

Ms Wright: Yes, I do. We either provide or partner with a number of specific population treatment services around the state. Where they are services for Aboriginal and Torres Strait Islander people we tend to partner with them because we genuinely are of the belief that they are obviously better run by people themselves. We also run particular population group services—for example, a women-only residential rehabilitation centre.

Those services are, again, easier to tailor in the community than residential services because you have to have a whole separate facility, whereas if you are, for example, running women-specific groups in the community you just make it on a certain day or at a certain time. Or if it is for a particular religious group or cultural group you can, again, just make it at a different time or have staff who are from that cultural cohort. There is definitely a place for specific groups, but, again, that needs to be done in a way that is cost effective.

THE CHAIR: Thank you, Kathryn. Is there anything you would like to say in closing?

Ms Wright: Just to thank you for your time. I was fascinated by your previous witnesses, so I understand why you went over. But thank you for your time and for considering our submission; we really appreciate it.

THE CHAIR: On behalf of the committee, I thank you for giving us your evidence today. The secretary will provide you with a copy of the proof transcript of today's hearing, when it is available, for you to check for accuracy.

GOUGH, MR CHRISTOPHER, Executive Director, Canberra Alliance for Harm Minimisation and Advocacy, CAHMA

THE CHAIR: I call the representative from the Canberra Alliance for Harm Minimisation and Advocacy. 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 pink privilege statement?

Mr Gough: Yes, I have read and fully understand the privilege statement.

THE CHAIR: Thank you so much. It is our practice to offer witnesses a five-minute opening statement. Would you like to do so?

Mr Gough: Yes, I will give a brief preamble. CAHMA is a peer-based organisation, which means that everybody within the organisation has lived experience of drug use and of using drug treatment services. The majority of us have that experience from the ACT drug treatment sector. This allows us to run a drop-in centre in Belconnen. It is a low-threshold drop-in centre, so we do not expect people to change their behaviour. We do not expect them to be seeking abstinence when they come and engage with CAHMA. Because of this, we cater to some of the most marginalised people who use drugs and are looking to engage with drug treatment services in the ACT.

We run a number of different programs out of our drop-in centre. But at the very basis it, people can come, they can feel safe, they can know that we understand fundamentally on a human level what they are going through in terms of being marginalised, socially isolated and stigmatised. They know that they can, at the very least, come and have a coffee, sit on our couch, use our computers, use our phones and use our office as their office. The idea is to empower them to take control of their health and wellbeing, and that is the first step.

From there we build rapport with them. Community members will then start to talk to us about what is going on their lives and what they need help with. We offer case management, but we call it peer treatment support because we think that people are not cases to be managed but rather people who require support. Navigating healthcare services and the referral system in the ACT is sometimes very complicated, so we provide that support.

Our peer treatment support service means we can transport people to any service they want to go to. We can advocate for them. We can sit in their appointments or doctors' appointments. We can translate between what the doctor, for example, is saying about the treatment and what it is going to look like in their real life and also what the person needs from the treatment and in that way get better treatment outcomes for people.

The other thing we find by doing this program is that, instead of just referring people to services, we can actually track them and make sure they get support to attend the service and then help in following up to provide wraparound support and integrated care. We have people who have been with us for a number of years, providing support

to them as they need throughout their journey.

On top of this we run the naloxone program in the ACT, giving out approximately 150 to 200 naloxone kits and training everybody in terms of opioid overdose reversal within the community to make people lifesaving citizens. We also provide crisis services where we help to hook people up with housing. We fix the crisis and then flick them to the peer treatment support for longer support as they go through the system and their journey.

We work closely with the drug and alcohol treatment sector in particular, all of the residential rehabilitation services, and across the board, including the needle and syringe programs, the harm reduction services and all the way through to abstinence-based services.

After people come out from abstinence-based services they often re-engage with us. If they are not seeking abstinence when they have become in control of their health and wellbeing, we provide a volunteer program, a community development program, where we skill people up and we try and introduce them back into the workforce. We have a five-module training program where we train people in what drug and alcohol treatment is, what harm reduction is, what our partner organisations are and how to act professionally.

From there, once they have received their training certificate, they are allowed to take part in our volunteer work. But also we then transfer them into our workforce. We currently have eight casual workers and three contracted part-time workers who have come directly from that program. So we are starting to provide the drug and alcohol treatment sector of the ACT with workers who actually have a lived experience basis in what clients are looking for in their programs and what the different services in the ACT look like.

THE CHAIR: With respect to your submission, you have a very thorough overview of the bill, with some very specific recommendations as well. One thing I am interested in is, firstly, is it your opinion that decriminalisation would decrease or keep at level or increase drug use? And, if it is the third one, should such a change await better support services?

Mr Gough: My take on it is that it is something that needs to be done in tandem, at the same time. The reason for that is that after the cannabis reforms—these are quite small numbers, as we usually see quite small numbers of people where cannabis is the primary drug of concern—over the next year our numbers increased fourfold. From talking to people, the reason is that they now feel comfortable at coming out into society and saying, "I actually have a problem." The first step is almost always talking to friends and family, and the stigma and discrimination that comes with criminalisation causes silence.

We have had an increase in family members ringing us and asking, "What services can the ACT provide for my family or my friend? How do we have these discussions?" as well as people coming in and saying, "It's time for me to talk about my cannabis use."

We ask what support they have, and we have found that people are now talking about it more. They are not hiding in their bedrooms and puffing their smoke out their window. You are changing the platform on which people can have these conversations. So that is the first step, the integral part of this bill for us—that it is about decreasing stigma and discrimination and allowing people to feel like they can come forward and hold their heads up.

One of the things that came out of the cannabis inquiry, for us, was that people who use cannabis could hold their heads up and say, "I no longer have to hide the fact from my family. I can come forward and I can say, 'Listen, I've got an issue with this and I need you guys to help me to get on top of it.'"

DR PATERSON: Your drop-in centre in Belconnen, do you feel there is a need for that in Woden or Tuggeranong? I imagine vulnerable people on the south side of town would find it difficult to get to Belconnen. It is not easy to drop in if you are on the other side of town. Is there a need for this service on the south side of town?

Mr Gough: Absolutely, and that is what we would be looking for in the future—to have one of these on the south side. The south side and the far north side are actually quite underserviced. There is Directions in Woden and there is a needle and syringe program in Woden, but there is nothing else down there.

We moved to Belconnen because we identified through a strategic process that, just like the south side, the north side was actually in the same position—it had no drug and alcohol services. We pride ourselves on being a drug and alcohol treatment service, so we moved to Belconnen because that was where the majority of our clients were. Having said that, there were a lot of our clients in Tuggeranong and in Woden and further south than Woden.

I am sure you have heard it many times that we need to double the investment in treatment services across Australia. One of the major problems we have here is that, even if someone can get to Belconnen, for example, and they want to go into residential rehabilitation, it is quite a complex process and it takes a considerable amount of time—from our experience, between three weeks and two months, depending on the service and the time and the amount of advocacy we apply.

One of the big things with this is that we need services to be available not when they are ready but when the person who needs the help is ready. As you said, it is incredibly difficult to ask for help around these things, which is one reason that we need to decrease the stigma and discrimination, to let people have that forum. But once that is done we also need for somebody to be able to walk in the door and get that treatment place when they are ready.

So, yes, in a perfect world we would be setting up another CAHMA in the south. We would be providing more transport options for people across the entire ACT. Currently, we only have one vehicle to transport people. Transport is a major difficulty in terms of people engaging with healthcare services, because the majority of people are on Centrelink and it is very difficult just to provide the basics for yourself, let alone a car and mobile phone credit and all the stuff that you need to engage with services.

MR DAVIS: If you were provided with the appropriate resourcing by the ACT government to establish CAHMA on the south side, in Woden or Tuggeranong, do you believe yours is the kind of program that could be co-located with other AOD organisations and services, or do you believe the types of program that you offer, particularly being peer support layered with the low access drop-in, really requires, for lack of a better word, separation or isolation? I am perhaps thinking a bit like a bureaucrat, for efficiency's sake. Would you need to be alone, or could you co-locate with someone else?

Mr Gough: We would absolutely be looking to co-locate because, as I said, every month CAHMA sits down with all of the executives of all the drug and alcohol treatment services and we talk about referral pathways; we talk about how to get people from our service to other services. The lady who just spoke talked about another service that has come up in Braddon. We trained those workers this Tuesday for a full day in harm reduction and harm minimisation. We work hand in glove with all of these services.

Our remit is not about providing one size fits all; our remit is about using a toolkit that we have, which involves all of the different services within the ACT. Part of the peer treatment support program is identifying what a person's goals are, what their priorities are and then helping to tick those off. And they look different for every single person.

So the more we are co-located and the less transport we need and the more we can walk next door and the more we can meet with and have champions within other services who understand CAHMA's referral pathways, the more partnerships that we have, the better.

MR DAVIS: I want to talk about fines. The bill has a $100 infringement notice for those people found in possession of drugs. What kind of impact would that have on the people that you support and what alternatives would you propose to a punitive, fine-based system?

Mr Gough: We have outlined this in a fair amount of detail. For us, fines are a problem. The problem is that the theory that sits behind decriminalisation is support—do not punish. We have gone through punishing people for using drugs for the best part of a century now and we know that does not work. The literature is in; the researchers have let us know. Certainly, from a community perspective and as someone who has gone through it personally, it does not work. So our problem with the fine model is that it is simply another way of punishing people.

Further to that, once again we are talking about people who are on a low fixed income that is below the poverty line. They are going to have difficulties in paying that fine, and there have been cases where the inability to pay a fine has pushed people back into the criminal justice system.

So we would like to see an untied referral system. We know that this is actually happening in some instances already within the AFP, and we applaud them for it. Police officers are making discretionary decisions where, instead of fining somebody

who has been caught with a personal amount of heroin, they have actually confiscated the heroin and referred them to a drug treatment service. That is what we would like to see, instead of a fine or instead of penalty units or community service. That is simply because we are trying here to get down the road of support, and by imposing a fine we are back onto the railroad track of punishment, which we know does not work.

THE CHAIR: Is it your understanding that the current practice is that police have the discretion to seize the drug and refer them to a support agency?

Mr Gough: We have heard from several people who that has happened to. I have had no information from within the police force. But on the ground I have had, from one person in particular who I know very well and who I trust implicitly, and certainly that was the case with him. In fact, in that instance, there was a sergeant and a constable and the sergeant looked like he was training the constable and was watching the constable and how he went through searching this car and finding cannabis and heroin. Subsequently, the cannabis was left, obviously because of the law that has been in place, and the heroin was confiscated. The constable had a talk with the person and then referred the person to a drug treatment service, which I will not name.

THE CHAIR: But they were not compelled to go?

Mr Gough: No; my understanding is that they were not compelled to go. I think it is important that there is not a compelling process. The drug and alcohol system in the ACT works very well because it is voluntary—people come forward when they are ready and when they know they need help. Drug use, once it gets on top of you and you start to be controlled by it, your finance dwindles, your relationships dwindle and you become extremely depressed. It is at that point that you will say, "That's it. I'm going to seek a service out."

That is a very well-known cycle within the drug and alcohol theory, and it is at that point when you need to hit people and get them into treatment. For drug treatment, or any form of mandatory treatment, there is a lot of literature saying that in terms of human rights it is not a good approach; it is not a human rights approach. But also, if you force somebody into treatment when they are not ready for that treatment, that treatment will not be successful.

DR PATERSON: I was struck by your description of your service and how it works, how it sounds like such an empowering process, and what you just said about how addiction can be so crippling and disempowering. We have had a submission from Drug Free Australia, and they very much see criminalising the person taking the drugs as the way to go to stop this. Can you speak to how detrimental that view may or may not be and why it is important that we empower people?

Mr Gough: Absolutely. I will use my own experience. In my 20s I found myself well and truly dependent on heroin. This was nothing to do with my upbringing; I had a beautiful upbringing. I lost my father when I was quite young, and he was very important to my life. He was an entomologist. I completed my university course, but through a process of not having any strong male role model I took the wrong path. This got so serious that my family did not want to have anything to do with me because I just could not stop. I physically could not stop. Eventually it got so bad that

I ended up getting a criminal record and that that took me on a path of homelessness for the next 10 to 15 years. It was incredibly debilitating.

I clawed my way back up into the workforce and I was very lucky to reach back out to my family. But the process was incredibly long and incredibly destructive for me, in terms of my health as well. I was exposed to blood-borne viruses on multiple occasions and it was just through sheer luck and not good management that I did not end up with hepatitis C or hepatitis B.

When I look back, the pivotal part of that journey was when I was finally pulled over by the police and I had drugs on me and I was entered into the criminal justice system. If I had had a different pathway there, where the police approached me and they had some training and they had some referral pathways—that was the period when I needed the support to change my life. Unfortunately, that did not happen, and I was criminalised and everything then disintegrated. It was bad, and then it got appallingly bad. It destroyed any relationship that I had with my family. It destroyed any work that I had. I actually had to end up leaving the state. On an individual level we know that criminalisation does not work, and that is just an example from my perspective.

The other thing about criminalisation is that I am sitting here, giving evidence to you, but I had a privileged upbringing. I can tell you that people who are more highly marginalised than I was, who perhaps did not have my supportive mother and father—I had a trauma-free upbringing except for my father's death—they do not have the tools to make it back from being criminalised. That causes a tax burden on society that is phenomenal. It causes those people to relive that trauma, over and over and over again, and it causes the majority of them to live in and out of jail for the rest of their lives.

We do not criminalise people that have a health problem. We know this. We know it does not work to criminalise people with a health problem. We know that we need to support them in every way we can, even if it is just for the simple reason that we are saving taxpayers' money. But I suggest that a society is judged by the way it treats its most marginalised community members.

MR DAVIS: I just want to pick up on that point because I think that you have hit the nail on the head. This is for a challenge for us. There have been some in our community that have been critical of the proponent of this legislation and this committee process more broadly because there are bigger issues to focus on in Canberra. They point to the issues of homelessness, which you have raised in your presentation, and the issue of pressures on our healthcare system. What, in your professional and personal experience, do you think the benefit would be on issues of homelessness and pressures on our healthcare system if we were to decriminalise drug use?

Mr Gough: They are absolutely right. It is not just that drug and alcohol issues do not happen in isolation. Homelessness comes into it, social isolation comes into it and lack of employment comes into it. But, really, I think the crux of the issue is that you need to appreciate how deeply marginalised people who use drugs are. We have started to address this by having some fairly robust discussions with our homelessness service providers, who do wonderful work.

The way the system is set up at the moment means that there are not many places for people who identify as having a drug and alcohol issue. Even if they have the support of residential rehabilitation units, even if they have come out of residential rehabilitation units and are abstinent, there are very few places available for people who have identified as having drug and alcohol issues. You can see how marginalised they are. That is what we are talking about.

There is homelessness and then there is having homelessness and drug and alcohol issues and social isolation. All these things go together. Absolutely, homelessness is a massive issue and it is the thing that we try and fix first when someone comes in.

At CAHMA we do not think that health is just about drug and alcohol issues. It is the social determinants of health. It is the fact that you need to have a roof over your head. It is the fact that you need to have friends and family. It is the fact that you need to have education. I would say that this is part of one and the same issue and, really, it all needs to be addressed.

We do know that this criminalisation has been going on for many, many years. There is a reason that we are all sitting here today, discussing this issue: the good work that the ACT has put into this. By doing this and stopping criminalising people who use drugs we will be able to find, much more easily, housing for people who are homeless and have drug and alcohol issues.

DR PATERSON: On your peer support work, does it make a difference in terms of having support from peers who use the same drug? Is it heroin with people who are struggling with heroin, or methamphetamine? Does that make a difference at all?

Mr Gough: No. Our humble opinion is that actually it does not. There was a school of thought a while back that said you have got to have the same: if you are talking to someone that uses heroin you have to have had that same experience. What we have found actually is that people who have problematic drug use, whether it is alcohol or heroin or methamphetamine, are all looking for the same things. They are all looking for a supportive ear. They all have quite similar issues.

In fact, unless it becomes really necessary, we may not even ask a person what their primary drug of concern is, because we have found that the system that we use, with peer treatment support, is about empowering the person, not necessarily about finding out what the drug is. If the person is saying, "Listen, I need help with my alcohol dependence," then of course we will make sure that we work in partnership with other services who will be able to make sure that that person goes through a detox, having the right medical regime to make sure that they do not go into seizures and stuff like that.

But in terms of the process of empowering someone through peer treatment support or case management, it actually does not make a lot of difference. It is just about providing that support, believing in the person, letting the person know that you understand the stigma that they are feeling and the internal stigma that they are feeling, and working with them towards positive steps in their life and what is important for them.

THE CHAIR: Thank you for sharing your own personal story. It humanises this whole inquiry.

Mr Gough: Thank you very much for having me along. I really commend the Legislative Assembly for looking at this issue. It will cause such amazing reforms in the healthcare system and really provide some empowerment to some of the most marginalised people in the ACT if it does happen.

THE CHAIR: On behalf of the committee, I thank you for giving us your evidence today. The secretary will provide you with a copy of the proof transcript of today's hearing, when it is available, for you to check for accuracy.

KILLEN, DR GEMMA, Representative, Justice Reform Group
GOUGH, MR CHRISTOPHER, Manager, Justice Reform Group

THE CHAIR: I need to do this for the record. You heard this before. 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. All participants today are reminded of this. Please confirm that each of you has read and understood the pink privilege statement.

Dr Killen: Yes, I have.

Mr Gough: Yes, I have read the privilege statement and agree to it.

THE CHAIR: On behalf of the Justice Reform Group, would you like the opportunity for a five-minute opening statement?

Dr Killen: Yes. I will just make a short statement, if that is all right. Thanks for having us and for having us both back again. Many members of the Justice Reform Group have been represented throughout this process. It is nice that we get to present our evidence separately as well. Just so that you know, we are a cross-sectoral community agencies forum that works on policy issues related to the criminal justice system here in the ACT, including justice reform, human rights and social determinants and contact with the justice system in the ACT.

I just note that, because we have a broad membership, not everything that we say will necessarily be shared by all members of the group. But, as a whole, the JRG is supportive of the passing of the bill and treating problematic drug use as a health issue rather than a criminal issue. We have limited data at the moment on the number of people arrested and incarcerated in the ACT for personal drug use. JACS has stopped publishing its arrest data publicly; so we do not have access to that anymore.

However, in 2014-15, which is the last year that we have data for, there were 268 offenders detected for personal use and possession of illicit drugs. For 79 per cent of those people, that was their first offence. The same research tells us that, on average, there were six people every year, from 2010 to 2015, sent to the AMC for drug possession charges. That is for personal use, rather than supply or trafficking.

We might say that that is a relatively small number of incarcerations, given that there are currently more than 400 people in the AMC. But the impact on each of those people's lives is quite significant. I would say the impact on engagement with the criminal justice system in general, which Chris just spoke to, is quite significant. I think lots of people have spoken about the effect of stigma and shame that comes from engagement with the criminal justice system. There are also very intense material impacts from being in prison, such as the impact upon people's ability to seek treatment and help for potential drug problems. Criminalising responses, rather than harm reduction measures, do not divert people from drug use but they compound and entrench harms that they might encounter.

Entering the prison system does not stop drug use. The evidence tells us that people in

the AMC use drugs and tobacco and, in the case of tobacco, at much higher rates often than they would in the community. We know that approximately 10 per cent of people who enter the AMC as non-smokers come out as smokers. We know that drug and tobacco and alcohol use does occur within the prison. According to the most recent healthy prison review, more than half the prisoners in the AMC say that it is easy to obtain illicit drugs inside the prison. A third say that it is easy to obtain needles and syringes. Once inside the prison there are extremely limited AOD treatment options available. As far as we know, there is no peer support available within the prison.

A third of detainees think that the programs that are available are not helpful for addressing problematic drug use. Given the high levels of satisfaction that people report for AOD services in the community, there is a clear discrepancy in terms of equivalence of care that is happening inside the prison.

As a matter of priority in terms of these issues, we would like to see a needle and syringe program within the AMC. There is an existing policy framework that supports this but it has not been put into practice yet. We would also like to see, amongst other AOD treatment services, smoking cessation support. A quarter of detainees say that they would like to quit if they were given adequate and free support to do so within the prison. We also need a range of pharmacotherapy options for those with dependence on opioids so that people can make informed and participatory choices about treatment pathways towards better health outcomes.

In short, what I am trying to say is that the prison should not be seen as a solution to drug use because drug use continues there and often in more harmful ways—for example, dirty needles and syringes—and with less access to treatment pathways than there is in the community. Is there anything that you want to add?

Mr Gough: The only thing that I would like to add is that there is incarceration of people but it is not the be-all and end-all of criminalisation. Even just having a criminal record causes incredible destruction in terms of somebody's job prospects and things like that.

THE CHAIR: I have a very open statement/question. You have both been here before us this morning as witnesses for your home organisation, for want of a better term. As a witness for the Justice Reform Group, what do you feel you have not said yet, that is not yet on the record?

Dr Killen: One of the reasons that I wanted the JRG to have their own evidence space and to make their own submission was to talk specifically about the impacts of criminalisation. We have talked a lot about the benefits of decriminalisation in our other evidence, but there are serious material harms that happen from engagement with the criminal justice system. And engagement with the criminal justice system is much higher for people who are from marginalised backgrounds. I think that is really concerning. I think the lack of treatment services in the AMC contributes to our high rates of recidivism in the ACT as well.

THE CHAIR: Of course my comment was not to say you could not say what you like, because you can.

Dr Killen: Yes.

Mr Gough: The big point for me—and Gemma has already touched on it—is that we tend to have an out-of-sight, out-of-mind approach to people who use drugs once they enter prison. As a human-rights based prison there should be the same interventions for drug and alcohol treatment in the AMC as outside. I think that is a crucial part of what I would like to say.

At the moment there is Solaris and there are a few pieces of in-reach but there are no low-threshold services that get access to the prison. Absolutely there are no needle and syringe programs. I would also like to comment that I think we need, probably, to be a little smarter in terms of the way that we approach needle and syringe programs in prison and ensure that everybody is brought along on the journey of this particular health intervention.

The last time that we broached this subject in any meaningful way in the ACT, I do not believe that we engaged enough with the corrections officers and the union. Therefore, it failed. I think everybody needs to come along and understand the benefits, because there are substantial benefits to the workers at the AMC in terms of an intervention such as this. Really, it is all about how we are expecting somebody to improve their health and wellbeing if they are in jail and they actually cannot get access to those services which they need to empower themselves in their lives.

DR PATERSON: I think it is important to talk about the disproportionate impact of both incarceration and drug use on the Aboriginal and Torres Strait Islander population. I am keen to talk about that—to understand your perspective from the Justice Reform Group—and how we could improve services in there for Aboriginal and Torres Strait Islander people.

Mr Gough: We have one of the two highest rates of incarceration per capita, along with Western Australia, for Aboriginal and/or Torres Strait Islander people. It is a bit of an abomination when you consider that we are a small jurisdiction. There really is no excuse. If you look at Western Australia, it is an enormous tract of land. When you look at the ACT, we have a fairly good set of services and we have a good police force that is probably the pinnacle of police in Australia, yet we still manage to incarcerate the most Aboriginal and Torres Strait Islander people per capita in Australia.

One thing that I would like to say is that, obviously, community control in Aboriginal health is very important and we need to have those community members involved, just like CAHMA, which is peer based, so that we understand what that person is going through. Exactly the same thing needs to happen with Aboriginal and Torres Strait Islander services. They need in-reach in the AMC and the services need to be done by the Aboriginal community. As people get released, there needs to be a planned service available to provide that linkage back to community. But we need to, even more critically, look at the discrimination that causes Aboriginals and Torres Strait Islanders to be locked up in such a huge proportion in the first place.

DR PATERSON: Can you speak to police discretion around personal drug use—I

think it was in your submission, Chris—and this issue of potentially targeting specific groups of people?

Mr Gough: I understand, as a citizen, that police need discretion on the front line—and every single time they stop somebody in the streets it is different—and they need to weigh up a myriad of different factors. Regardless, what happens, without having a lot of knowledge about how from the police perspective but having some from a community perspective—and we also run CNECT which is an Aboriginal and Torres Strait Islander-specific program within CAHMA—is that we do get some feedback on this, and that is that Aboriginal and Torres Strait Islander people are targeted more by police.

If you look at, for example, the drug driving laws, which we have covered in our submission but we have not covered today, once identified as somebody who has been caught drug driving, the police have a system where that will come up whenever the person drives past. They become targeted again and again and again, not because the police are targeting the person but simply through the system of how the police mechanics work.

A similar kind of thing happens to Aboriginal and Torres Strait Islander people. They are targeted through a bunch of different means, including that type of thing, and they tend to come to the forefront of police attention. That is because of their marginalisation. You can imagine having not only marginalisation because you belong to an Aboriginal or Torres Strait Islander community but also because you use drugs. You are talking about people who come to the police's attention absolutely all the time.

Once that happens, that is where discretion and how the police act becomes problematic from the community perspective. We are essentially asking police to be experts in just about everything here. I really do not want you guys to think that we are in any way anti police. We believe that more training needs to happen, where police need to come and sit down with the Aboriginal and Torres Strait Islander community, come and sit down with the Aboriginal and Torres Strait Islander community of people who use drugs, and talk through what is happening in their lives. We need more identified positions within the police so that Aboriginal people are policing Aboriginal people. It is all about community control and making sure that there is that equity of power.

I would say that is our concern about just saying that police discretion is good enough without significant training. As people on the first line, they need to be experts in mental health, they need to be experts in drugs and alcohol, they need to be experts in culturally secured training practices and they need a lot of identified positions, Aboriginal identified positions, in there.

The last thing I will say is that I hope the Aboriginal and Torres Strait Islander people will forgive me for speaking on their behalf. I really should not be. But I do think that in this case it is important since, neither of us belongs to the community.

MR DAVIS: I want to talk a bit more about the NSEP. You presented a really compelling body of evidence on why the NSEP is necessary not only for inmates but

for corrections officials and other people coming in and out of the prison. Simply, to put you on the spot, who and what are getting in the way?

Dr Killen: As Chris mentioned, the last time this came up the correctional officers were not necessarily brought along. I think there is significant concern from correctional officers about health risks. The evidence tells us that it is much safer for correctional officers to have a needle and syringe program. They are less likely to encounter dirty needles. They are also less likely to have stick injuries when they are doing searches, because the inmates do not feel the need to hide their needles in places where they might be found by correctional officers accidently.

I think that one of the key ways to get around that—and this is something that I spoke to ADLR about recently, when they were doing some planning on this before COVID happened—is to do some seminars where they bring correctional officers from other parts of the world that have done successful needle and syringe programs to speak to the ACT and try to bring people along in that way.

MR DAVIS: Have you and your organisation spoken to any individual correctional officers or have conversations been had primarily with leaders of the union of the corrections officers?

Dr Killen: We have not.

Mr Gough: No. It was before my time that this happened. This was not actually CAHMA. I am not sure who spearheaded this, to be completely honest with you. But what I do know, from talking to the people who were involved, was that there was little engagement. At that point it came down to a vote, and the vote was very clearly: "No, we do not want this," hence the need to bring people along—everybody, all stakeholders, along. It is a big piece of work and we need to re-engage.

Something like this would require resourcing. It is not something that we would just decide to go to the union and start having talks about because of what happened last time. We got right to the very end and then, because of the process, it fell over. This time we really need to work very closely with the staff at the AMC and make sure that they are absolutely included from day dot. But it is a big piece of work and would require resourcing before we would want to jump in and try and have another crack at it.

MR DAVIS: Just to be clear, is that resourcing that you would expect to be provided by the ACT government? Would you expect them to, if not lead, at least facilitate that dialogue?

Mr Gough: Yes. We are not talking about giving an organisation $100,000 or anything like that. We are talking about leading the dialogue here, bringing everybody together to have those really difficult discussions. That has to be done by government. We really do not want to have this fail again. I think it needs to be done in a very structured manner and we need the government front and centre, pushing to have these dialogues slowly and considerately, going forward.

DR PATERSON: Naloxone kits in the AMC, is that what you are advocating for?

Can you speak about that?

Mr Gough: Over the last five to eight years, CAHMA has been advocating for us to go and train prisoners within the AMC, naloxone training, so that when they come out they get a kit in their discharge pack. We know that the first 72 or so hours after release are crucial in terms of overdose. People may have used in prison. They may not have used in prison. The strength, the purity of the drugs is different. That is a real period of risk.

One of the things that stopped that from happening was that naloxone was, until recently, in a vial that you had to empty into a syringe and inject intramuscularly. Of course, that brings up a whole myriad of issues. But it is now a nasal spray. In the ACT, unless someone says, "I specifically want the intramuscular preparation," we give just a nasal spray, and it is a squirt up the nose. There is that part. And I must say, it has been great.

Over the last four or five years the AMC has been identifying people who, for example, are on pharmacotherapy, opioid maintenance treatment, and has been providing them with naloxone on discharge. But it has not been locked into the policy settings of the AMC; that is my understanding. Sometimes it might happen for a period. It is very dependent on staff. That is my understanding of what is happening from outside, talking to the community who go through the AMC. Take that with a grain of salt. That is just what I have heard.

But regardless of what we would like to see, now that we have a very safe preparation which is very easy to use, we would like to see staff, not just medical staff but corrections officers, trained in naloxone use so that when medical staff are not there during the night, for example, an overdose can be reversed on site while the ambulance is coming and is in attendance, just to provide that safety factor and minimise that risk both for the inmates but also for the AMC itself, as an organisation. We feel that naloxone is an integral part of a risk mitigation strategy at the AMC.

THE CHAIR: We are coming to a close. Would each of you like to make a short closing statement?

Dr Killen: I do not have anything to add. Do you want to anything?

Mr Gough: The Justice Reform Group tries to look at it this way: it is a fairly big picture we are looking at. Probably everybody who has come up here has said, "We need a billion dollars for this and a billion dollars for that, and a million dollars for this," and you guys obviously have to make those difficult determinations. I think the main part of this is that, across the drug and alcohol sector, we are willing to start working more closely with the AMC to provide In Reach. Yes, that In Reach would have to be resourced, but I do not think we are talking about an enormous amount of money.

To go back to the core of this committee, decriminalisation is not suddenly going to make a jail that is free of drug use and people who use drugs. This is a generational problem. What I do think we will see—especially with the provision of more low-threshold services within the community and the ability for police officers to

refer to those low-threshold services so that people with expertise in building trust and drawing people in can empower them and put them in the driver's seat of their health and wellbeing—is a reduction in people going to jail for those specific offences.

We have a good diversionary system in the ACT. We have a drug court for those higher range issues. What we really need is that equity of service provision within the jail so that people are not coming out and likely to offend again because they have not received the help that they should be expecting in a human rights prison.

THE CHAIR: On behalf of the committee, I thank you for giving us your evidence today, both of you. 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 there were any questions on notice. I thank you again and I suspend this hearing until 1.20 pm.

Hearing suspended from 12.41 to 1.20 pm.

DIETZE, PROFESSOR PAUL, Program Director, Behaviours and Health Risks, Burnet Institute

STEWART, MISS ASHLEIGH, Research Assistant and PhD Candidate, Burnet Institute

Evidence was taken via telephone.

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

Prof Dietze: I am the head of the Behaviours and Health Risks program at the Burnet Institute, which is a medical research institute here in Victoria.

Miss Stewart: I also work at the Burnet Institute, within the Behaviours and Health Risks scheme, as a research assistant, and I am also a PhD candidate.

THE CHAIR: Thank you. Please be aware that today's proceedings are covered by parliamentary privilege, which provides protection to witnesses but also obliges them to tell the truth. The provision of false 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 Dietze: Yes, I have.

Miss Stewart: Yes, I have.

THE CHAIR: Thank you. It is our practice to offer witnesses a chance to provide an opening statement of up to five minutes in length. Would you like to do that?

Prof Dietze: That would be good.

THE CHAIR: Please proceed.

Prof Dietze: We are very thankful for this opportunity to present to the inquiry. We have a long history of working within alcohol and other drug policy and practice in Australia, but also in the ACT specifically. I will talk a little about some of that work in a minute. Fundamentally, the idea of removing sanctions for possession and use of small quantities of illicit, or what are currently classed as illicit, drugs has significant merit.

The evidence from overseas, which we summarised in our submission very briefly, highlights how removing those sanctions has real potential benefits for both the individuals who might be exposed to receiving such sanctions and also the wider community. It reduces drug costs to the community in terms of courts and so on, but it also improves the opportunities that people might experience. It removes any barriers to employment that might come with a conviction, for example, and so on. It also limits the potential for incarceration, which is a major contributor to drug-related harm for individuals and society. We will talk a little bit more specifically about those in a minute.

One thing that I did want to make reference to was the potential to establish a medically supervised injecting room in the ACT. Essentially, we were involved in a feasibility study that highlighted that not only is it feasible to establish a facility in the ACT but also it is something that would be well utilised. All indications from the participants we interviewed as part of that work were that it would be well utilised. It is widely supported within the policy and practice community. In the ACT in particular it is widely supported in the available evidence from general population surveys as well. That is something that, we would argue, should clearly be pursued and should be pursued as part of an overall strategy within the ACT.

I might throw quickly to Ashleigh to cover off some of the issues connected with incarceration that we are very familiar with. I want to highlight that we did work previously around the potential for extra harm reduction services in the Alexander Maconochie Centre.

THE CHAIR: We could cover that during our question and answer period, if that is okay, but I am happy to defer to Ashleigh on that. I am sure it will come up.

Miss Stewart: Yes, absolutely.

THE CHAIR: Given the general consensus that support services are currently not adequate, what is your view on waiting until that is in place, given your support for the bill, and then doing the decriminalisation?

Prof Dietze: Realistically, I think that there is no reason why both cannot occur at the same time. Depending on the exact framing of how it ends up working, I think the enhancement of support services is something that the sector would be able to do. There is excellent work by organisations like ATODA to ensure wide upskilling of the workforce in the ACT, so there would be no reason why those service improvements could not happen at the same time as a decriminalised version of the bill is enacted.

DR PATERSON: As a medical research institute, are there studies around different treatment programs, particularly for methamphetamine? We have touched briefly on a couple of programs that are running trials of drugs in Australia. Do you know anything around that that might be able to assist the inquiry?

Prof Dietze: You mentioned that you have spoken to people about some of the pharmacotherapy trials. Is that what you mean?

DR PATERSON: Yes.

Prof Dietze: We were involved in some of those pharmacotherapy trials. One in particular was connected to N-acetylcysteine, which Rebecca McKetin from the National Drug and Alcohol Research Centre was leading. Ultimately, the early promise that ran with some of the findings in N-acetylcysteine we did not find in our randomised trial, with a decent sample size and proper binding and so forth. Realistically, there is little evidence of the benefit of N-acetylcysteine.

There are other pharmacotherapy trials, but I am not familiar with the results yet. You would need to speak to the people involved in those trials. Basically, at the moment

the gold standard is psychosocial counselling and, realistically, we should be actively pursuing other pharmacotherapies. I know that there is a recent trial, funded under the MRFF, that Rebecca McKetin will be leading again as well.

MR DAVIS: My question is about an injecting drug consumption room. Can you talk me through, as a layperson, how an injecting drug consumption room here in the ACT would reduce harm?

Prof Dietze: One of the things that came through our work was that, despite the general perception that public drug use and drug-related activity in the ACT is not what it was in the late 1990s, the evidence from all of the interviews that we conducted with people who inject drugs themselves suggests that they do still engage in a significant amount of public drug use.

The key things that an injecting room is designed to address are the issues connected with public drug use, the amenity issues that go with it, and so on. A facility in somewhere like Civic would act to essentially take people off the street, because we know that public drug use is occurring in and around Civic. Basically, it creates an environment in which the risks for drug use are managed completely differently. If they were, for example, to experience an opioid overdose, because most people who inject drugs in the ACT are still using heroin with frequency, the facility could step in to manage that overdose.

That reduces harms connected to the costs associated with an ambulance attendance and so forth. It means that the intervention can happen really quickly, which means that some of the other things that we do not talk about very much in relation to overdose, things like hypoxic brain injury and other things that go with being unconscious for a significant period of time, can be addressed really quickly. By getting people oxygenated and then using the overdose reversal drug naloxone, you can reverse overdoses effectively in the room. They can be managed there, which obviously reduces the requirement for ambulance attendances and so forth. Ultimately, it is very clear that no-one has ever died from an overdose in an injecting room. They do work to preserve lives.

Further to that, the injecting rooms also act as hubs for referral to other services, like the drug treatments that we know are effective. For opioids we know that there are opioid agonist therapies, like methadone, buprenorphine and so forth. In relation to methamphetamine, we did speak about some of the counselling that is available at some of the services in the ACT. That kind of referral is really important.

There are other harms that can be reduced in an injecting room as well. We demonstrated in Melbourne recently how the treatment of hepatitis C can be effectively managed in the injecting facility down there. There is a demonstration project underway there. There are a whole range of opportunities that go with engaging people in the service itself that will then ameliorate harm for them. Obviously, taking the drug use off the street and into an environment that is controlled is a mechanism of ensuring that the public gets some protection from some of the things they do not want to see around injecting drug use.

MR DAVIS: As a supplementary, while we are talking about safe injecting rooms, we

had some evidence earlier today about the complexities of a needle and syringe program at the Alexander Maconochie Centre, the jail here in the ACT. Do you believe that a safe injecting room at the prison might be an effective way of delivering such a needle and syringe program?

Prof Dietze: That was one of the models we canvassed in our report that we compiled for the ACT government a number of years ago. I think there would be a lot of merit in managing it in such a way. Most of the needle and syringe programs in prison do not operate in that kind of way around the world. The ones that do exist generally just provide equipment, but there is no reason why it could not be a potential model. The only concerns that go with it are that you would really need to be thinking through how the service operates and the context of the wider environment of the prison, the structures that are in place, how prisoners relate to one another and so forth. Certainly, that kind of model could be explored.

THE CHAIR: As a supplementary on that, Ashleigh, you might want to come in with a bit more on the AMC that you were going to talk about as well.

Miss Stewart: In relation to criminal justice costs and associated harm?

THE CHAIR: You were going to speak to the AMC issue, yes.

Miss Stewart: One of the things that we highlighted a lot in our submission was around the decriminalisation of drug use, particularly some of the costs and associated effects of imprisonment for people. I can talk a little bit about that. Obviously, we know that people who end up in prison have a really high risk of being re-imprisoned. We know that there are a lot of flow-on effects for people when they are transitioning from prison back into the community setting and cycling through prison. Being within that transition period frequently for people is quite challenging.

We know that when people leave prison they have a higher risk of opioid overdose because they return to substance use. We know that there is a higher risk of poor mental health. There were some studies in Queensland previously that have shown that there is a higher risk of suicide and self-harm. A lot of these things are really exacerbated with this period of transition back to the community setting. Reducing some of that would be really beneficial for people.

Paul mentioned in our presentation at the start that we know that there are a lot of problems as well for people in trying to find sustainable employment when they have a criminal record, which is quite difficult. Obviously, the decriminalisation of drug use prevents that from happening and keeps people out of the prison system for these minor, non-violent drug-related crimes. That is one of the big things.

We know that other countries have done this previously. Portugal is a good demonstration of how this has been really effective. After a number of years of implementing decriminalisation across the board for these drugs, they have reduced significantly the costs in their law enforcement, particularly with imprisonment. They have actually reinvested some of those costs into some of the harm reduction approaches that Paul has been covering off as well. It has freed up some money and really reduced the cost to the individual and to society.

MR DAVIS: I have a substantive question. Your submission suggested to the committee that we make recommendations to government that previous convictions for drug possession that would have been covered by these laws be expunged.

Miss Stewart: Yes.

MR DAVIS: Of all the submissions we have received, that one raised an eyebrow as it was one that no-one else has spoken about. Do you want to reflect on that in a bit more detail and perhaps let us know how you think it might affect some of those people?

Prof Dietze: This is, again, reflecting the things that go with having an offence listed on someone's record. It means that they have their opportunities limited. We are talking of minor drug possession offences, for example. That can limit one's employment prospects and it can limit one's capacity to get a liquor licence, for example, and so on. If the standard now is that a criminal penalty should no longer apply then it seems entirely appropriate that that be removed from a person's record.

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

Prof Dietze: I would just like to reiterate something from our submission. We believe that the ACT went through a really important exercise in working through what a personal possession limit should look like. That was informed by work by the Drugs Policy Modelling Program. We note in the draft amendment bill that those quantities that were worked up were not applied. We would really urge the ACT to look at applying those threshold quantities, because they have been developed on the basis of appropriate consideration of the evidence.

THE CHAIR: I would like to thank you both, on behalf of the committee, for giving us your evidence today and also for your submission. The secretariat 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 there were any questions on notice.

WODAK, DR ALEXANDER AM, Chair, Australia21

Evidence was taken via telephone.

THE CHAIR: Good afternoon. 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.

Dr Wodak: Yes, I have read the statement that the secretary sent me.

THE CHAIR: And understood it?

Dr Wodak: Yes, I understood it.

THE CHAIR: Thank you. It is our practice to offer a witness up to five minutes for an opening statement. Would you like to do so?

Dr Wodak: Yes, and I will be brief. I thank the committee for the opportunity to give this evidence. Firstly, we need to acknowledge that relying heavily on drug law enforcement, as Australia and other countries have for over half a century, has failed abjectly. Drug markets have grown and become more dangerous. More importantly, death, disease, crime, corruption and violence have all increased. Drug prohibition has turned out to be an expensive way to make a bad problem worse. But bad policy has been good politics, which is why this policy has been maintained for so long, despite these results.

Secondly, in contrast, drug harm reduction has a very impressive track record. It is almost always effective, safe and cost-effective. The problem is that it is often an uphill battle explaining and advocating for drug harm reduction. So good policy becomes bad politics and drug harm reduction is not implemented as often as it should be and it is not implemented as vigorously as it should be.

Thirdly, the threshold step needed is to switch from a reliance on drug law enforcement to a primary focus on harm reduction and then systematically switch policies over from those that have been ineffective in reducing harm to those that really are effective at reducing harm.

A good place to start is with trying to reduce deaths due to drugs or drug policy. Smoking-related deaths, 21,000 a year in Australia, exceed deaths from alcohol, plus prescription drugs, plus illicit drugs, plus HIV, plus road crashes, plus suicide. Up to two out of every three smokers will die from a smoking-related condition. Fortunately, we now have a dramatically effective new weapon we could use to reduce smoking-related deaths, such as those due to cancer, heart and lung disease. Tobacco harm reduction in the form of vaping and other reduced risk options is this dramatically effective new weapon. Australia is the Western democracy most hostile to vaping. We are the only Western democracy that still requires a prescription for nicotine used for vaping.

The ACT will not be able to argue for drug harm reduction while opposing tobacco harm reduction. What the ACT could do is exempt nicotine from its poisons standard and ask the ACCC to regulate it as a consumer good. Evolution is much more common in politics than revolution. Shifting nicotine from schedule 4 to schedule 2 in the poisons standard would be an incremental step, but it would be a very good start in the process I have outlined. If it were shifted from schedule 4 to schedule 2, nicotine for vaping could then be sold in vaping shops.

Fifthly, smoking rates in the ACT are much lower than in any other Australian jurisdiction, but they are much higher in low-income and disadvantaged populations. Also, smoking rates in Australia have been declining only slowly since 2013, whereas the decline has accelerated in countries where vaping rates are much more popular, such as the US and the UK.

Sixthly, shifting nicotine for vaping from schedule 4 to schedule 2 in the ACT's poisons standard may be overruled by the commonwealth, but it would, in my view, be well worth trying and a clear signal that harm reduction is now front and centre of the ACT's approach to alcohol and drugs.

THE CHAIR: Thank you for that. Just confirming, to lead into my first question, you would support the bill in its current form?

Dr Wodak: Yes, I would.

THE CHAIR: What is your response to the view that until we have drug support services at an elevated level then we should just leave the legislative change until the support is there?

Dr Wodak: I think it is very important to improve the health and social services available for all people struggling with illicit drug problems, or any drug problems. I retired nine years ago, but it was very common, while I was working, for me to get calls from family and friends of people with serious drug problems, or people with those problems themselves, begging me for help in finding effective support. That effective support is rationed in Australia. It is rationed—and I use that word deliberately—basically for political reasons, because there is not enough political support in the community for improving services. Somebody has to take a lead on this and start the process of raising support for people with alcohol and drug problems. There is no better place to do that than in politics, in my view.

We did this some years ago, when Morris Iemma was the Premier of New South Wales. He worked together with John Howard, the then Prime Minister of Australia. The two of them made a huge difference to the funding support for people struggling with mental health problems. That level of support is now much greater than it was 20 years ago. It probably still is not enough. That process needs to start also in the alcohol and drug field.

DR PATERSON: You have sparked my interest around the vaping issue. I find your perspective interesting, because I would have viewed it as a harm minimisation approach that people can now get prescription nicotine. There have been multiple articles recently about children vaping and what a massive issue this is becoming.

With the normalisation of smoking behaviour, if you are able to get nicotine at your local cigarette or vaping shop, are we not just going to end up with a whole other generation of children and adults smoking?

Dr Wodak: That is the contention of some people. Unfortunately, when you ask them to support that with evidence, they are unable to do that. It is important to always compare vaping. There are a range of other harm reduction options available, apart from vaping, but let's just keep to vaping for the time being. With vaping, we are restricting what is undoubtedly a lower risk option and leaving a deadly option readily available.

Cigarettes can be bought from 20,000 outlets across Australia, and some of those outlets are open 24 hours a day, seven days a week; whereas people will have to jump through hoops to get something with a much lower risk—not zero risk, but a much lower risk. There are estimates that the risk is reduced by more than 95 per cent in people who switch from smoking only to vaping only. What we are doing by restricting the safer option is in fact protecting the deadly option. In relation to teen or youth vaping, there is no convincing data or good data available anywhere in the world, including Australia, showing people who have never smoked commencing vaping in large numbers and doing so frequently for a long period of time. There is no data to support that.

A recent study published in the *Lancet* within the last month, funded by the World Health Organisation and the Bill and Melinda Gates Foundation, studied 26 countries, including Australia. It found that the pooled average for those 26 countries of daily vaping in teens was 0.8 per cent. What people are talking about, when they are talking about teen vaping, is very often experimentation which lasts weeks or months, not longer, and which often does not even involve nicotine. It is typical teenage adolescent experimentation risk behaviour. I wish they would not do it. They have much higher rates of much more dangerous activities, including binge drinking and unprotected sex. I do not say that we do not need to worry at all about teen vaping—we need to keep an eye on it, by all means—but those other concerns are much more serious.

MR DAVIS: I was just hoping for some specific initiatives that you would encourage the ACT government to invest in to reduce the harm of smoking in the ACT.

Dr Wodak: The biggest single step would be reducing the scheduling from schedule 4 to schedule 2. The way the system works is that—and I know this seems very arcane to most of us, including me—the commonwealth has a poisons standard, and most states and territories simply follow what the commonwealth does in its own poisons standard. The system allows for states and territories to differ from the commonwealth, so the ACT would be able to do that—that is, shift nicotine and vaping from schedule 4 to schedule 2. Ultimately, the ACT would be able to exempt nicotine for vaping altogether from the poisons standard.

Currently, tobacco for cigarettes is exempt from the commonwealth poisons standard. That is where vaping ought to end up—exempt from the poisons standard. Vaping could then be regulated, and should be regulated, in my opinion, by the ACCC. The regulations should be proportionate to the risk. It is not laissez-faire; it is regulating it

according to how risky it is.

THE CHAIR: Obviously, it seems like smoking is one of your primary concerns here with this submission. What about the bill itself, which is targeting current illicit drugs like cocaine, heroin and ice? Does your tobacco perspective, I guess, just flow straight over to the current drug schedule in the bill?

Dr Wodak: Everything is linked, in my view—that is, if we have a harm reduction approach to heroin, cocaine, amphetamines and other illicit drugs, we should adopt the same framework for tobacco. The logic applies equally to all of them. It is illogical and irrational, in my view, to have a harm reduction approach to just a group of drugs and have basically a supply reduction approach to another group of drugs. I think we are now recognising that the war on drugs has been a costly failure. It is not a good time then to start a war on vaping, which follows the same kind of approach that we are just now starting to abandon in relation to illicit drugs.

In relation to illicit drugs, where I would like to see the ACT heading is to do what Portugal did on 1 July 2001. We just missed out on celebrating the 20th anniversary of that. I have been to Portugal a few times to have a look at what they have done and it is very impressive. It is not perfect, but it is certainly better than what they had before. In the 1990s, Portugal was really struggling with serious illicit drug use problems—deaths, HIV, crime and, significantly, a lot of children of leading politicians in Portugal had very well-publicised problems with illicit drugs, a bit like Australia had in 1984.

There was a furious debate in the Portuguese parliament and the community. That ended up with the parliament commissioning a report from a committee. The committee was chaired by their leading drug treatment expert, Dr Joao Goulao. He and his committee came back with a report which recommended that the parliament adopt all of the recommendations or none of the recommendations; they should not just cherry-pick the politically easy options. The cabinet—I guess it was the cabinet rather than the parliament—accepted that recommendation and adopted all of the recommendations.

Principally, there were two major themes in the recommendations: firstly, to abandon all sanctions for people found in possession of personal quantities of all illicit drugs—the actual threshold level was set at different weights for different kinds of drugs—and, secondly, that treatment and support services be dramatically improved.

The way this works in practice in Portugal is that if somebody is apprehended for some reason, say a drug or licence check, and found to be in possession of quantities of illicit drugs, the drugs are identified and weighed and a determination is made as to whether they are above or below the threshold level of any of those drugs. If they are below the threshold level for all of the drugs they have in their possession then they are treated as a civil matter. If they are above that threshold level, they are treated as a criminal matter, similar to the way we treat those matters in Australia. They are treated as a drug trafficker.

If they are treated in a civil matter, they are referred to a network of 10 assessment centres across the country. You go before a panel of three people and they check on

whether you are carrying out your responsibilities as a citizen—whether you have got a job, whether you are looking after your children, whether you are looking after your ageing parents, whether you are keeping up with your rent and whether you are keeping up with your car repayments and that sort of thing. They check on what you tell them.

If you are using drugs and you are functioning as a Portuguese citizen, they simply leave you alone. They may make a tokenistic appointment for you at a drug assessment centre just to get you into the system, in case you might need it later, but basically you are left alone. If, on the other hand, you are struggling as a citizen to keep up with your responsibilities, they make an urgent appointment and make sure that you get the help that you need. That is the way the system has operated since 1 July 2001. There was a dramatic fall in drug overdose deaths, in HIV infection among and from people who inject drugs, in crime and also in what they call problematic drug use in their prison system. It has been a huge success. It has also been very popular in community opinion polls. When the government has changed from socialist to conservatist a few times in elections since then, the incoming governments have barely tinkered with the system. They are both pretty happy with it.

When Portugal was threatened by a very serious financial situation in the global financial crisis—and Portugal has a weak economy—this area of government activity was pretty well left alone; whereas I understand that many other areas of government activity were severely cut back. So it has been a huge success. It is surprising, astonishing, that more governments have not shown greater interest in it. Several Australian politicians have gone to Portugal, some on my recommendation, and seen for themselves; they have all come back with similar views. These are people from a range of different Australian political parties.

It is something we really should be familiar with, and it is a model. Norway was about to appoint a similar system, based on the Portuguese model, and then the political agreement across the different political parties fell apart. For the time being, Norway is not proceeding, but I would not be surprised if Norway comes back and adopts its version of the Portuguese system. It is not perfect. The drug trafficking system still exists, regulated by criminals and not regulated at all by the government.

The most common criticism you hear in Portugal of the new system is in relation to outdoor dining. Outdoor eating is very common in Portugal and it is quite common when you are eating in an outdoor restaurant in Portugal to be approached by someone who wants to sell you heroin, cocaine, cannabis or whatever. Those people are usually told to run along. That is the most common criticism that is made of the system in Portugal. It works very well and we in Australia should follow that up very closely and carefully, in my view.

THE CHAIR: We have finished with our questioning so, on behalf of the committee, I would like to thank you for giving us your evidence today, and also for your submission. The secretary will provide you with a copy of the proof transcript of today's hearing, when it is available, to check for accuracy.

Hearing suspended from 2.13 to 2.36 pm.

CHEW, COMMANDER MICHAEL, Deputy Chief Police Officer, Response, ACT Policing

THE CHAIR: I reopen this public hearing of the committee. I welcome the representative of ACT Policing. We have one witness appearing 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 pink privilege statement.

Cmdr Chew: Yes, I have.

THE CHAIR: It is our practice to offer witnesses an opportunity to make a five-minute opening statement. Is that something that you would like to do?

Cmdr Chew: Yes, I would like to make an opening statement, Chair. Thank you for the opportunity to appear before you today. ACT Policing's utmost priority is community safety. We are committed to supporting the ACT government initiatives to protect the community, promoting harm minimisation and health-led approaches to the treatment of substance abuse. It is my intention today to raise operational issues that we believe require consideration prior to the implementation of the proposed bill. These issues are also outlined in our submission.

ACT Policing already adopts a harm minimisation approach to illicit drugs, and the personal use of substances is very rarely criminalised in isolation. I can assure the committee that ACT Policing resources are firmly directed at the detection, disruption and prosecution of those that profit from the importation, production and distribution of drugs in our community.

As we have seen recently through the efforts of our broader AFP colleagues, organised crime is where we must focus our efforts, and these organised crime groups have a very real presence here in Canberra. Diversion is already a key component of our efforts to promote harm minimisation. Last financial year we completed 158 referrals to the Illicit Drug Diversion Program.

The bill proposes that officers issue a simple drug offence notice if they seize drugs under the limits identified in the bill. This step by itself does not connect individuals with the health support services they need. It is also the case that individuals sometimes choose to participate in diversion programs to avoid harsher criminal consequences. Without a trigger or incentive, we are concerned that there is no guarantee that individuals will engage with the support offered.

We know well that drug use is a driver of crime, and timely engagement with the right support services can decrease the chances of reoffending. Ensuring that these support services are accessible at times of crisis, not solely by appointment, is an issue we see across all of our work with vulnerable members of our community.

The Australian Institute of Criminology found that methylamphetamine users reported deriving a higher proportion of their income from crime when compared to non-users.

Those using methylamphetamine also cited that their drug use was the reason for their offending, either because they were intoxicated or needed money to fuel their addiction.

To truly address illicit drug abuse and its connection to criminality, those offending need to be connected to the appropriate services in such a way that ensures their engagement and commitment. Further consideration should also be given to any other unintentional flow-on impacts of the bill, such as our ability to support individuals with untreated substance abuse issues, consuming drugs in public places or any increase in road-related trauma.

The personal use amounts included appear inconsistent across the drug types and also require further consideration. Two grams of heroin could be approximately eight doses, two grams of ice could be approximately 20 doses, and half a gram of MDMA could be more or less than one dose, depending on its purity. We hold serious concerns that, if enacted in its current form, the bill will inadvertently be enabling drug trafficking.

We are already aware of drug traffickers using their knowledge of the new cannabis framework to their own advantage. Criminals actively seek out loopholes within legislation to undertake their activities and make it their business to understand the challenges and limitations that police face. It is for this reason that we are highly concerned that some amounts are far above the regular personal use limits and need to be revised down appropriately. Confirming an accurate average dose or usage amount based on current ACT-specific research would assist the bill to achieve its harm minimisation intent, rather than potentially enabling drug trafficking and supply.

Our submission proposes alternative and staged approaches to illicit drug decriminalisation. For example, if implemented in stages, we would propose that stage 1 include cannabis, as per the current laws, and MDMA or ecstasy. Police are able to identify MDMA or ecstasy with enough reasonable suspicion to refer for further testing. We are also able to conduct roadside tests for these substances, which may discourage driving under the influence.

We strongly believe that the decriminalisation of harder drugs such as methylamphetamine requires a staged approach so that the needs of each demographic of drug user can be accurately addressed and support services tailored and enhanced where appropriate. The decriminalisation of illicit substances that are stronger in purity or more addictive could establish a gateway for users to engage in a harder or more harmful drug type. Decriminalisation needs to be accompanied by other prevention mechanisms, with a focus on education, so that the general public understand the health-related harm that they can expect, should they choose to use illicit drugs.

We would also be supportive of a scheme that adopts an acknowledgement and acceptance approach with the identified offender, removing the need for further testing. Alternatively, I refer to a notice scheme that mirrors the existing traffic enforcement regime, which sees officers able to issue a criminal caution and clear the offence through a traffic infringement notice. These proposals are further outlined in our submission.

I would again like to reiterate our ongoing support for the ACT government's effort to minimise harm within the community. Combating illicit drug use is a difficult task, but we do know that police cannot do it alone. It requires a holistic approach, including strong, health-led policy and support services. We look forward to continuing to work with our partners in relation to this bill and thank the committee for their consideration of the practical challenges we have raised. I would be happy to take any questions.

THE CHAIR: Obviously, we are coming to the tail end of hearings, having received many written submissions and having many people appear before us as witnesses. There seems to be a general consensus that the decriminalising of cannabis in the last Assembly has worked without much issue. I am interested in what you see and your evaluation of that decriminalisation—lessons, continuing risks et cetera—and how much of that would translate if this bill became law.

Cmdr Chew: Certainly, with the introduction of the legislation last year, we have not seen any significant change in our approach to that, because we did have that diversion activity in place anyway, with cannabis, prior to the new bill with the personal limits being introduced.

The point is that there is various research out there about whether one drug leads to further drugs. I cannot comment on that, because we have not seen that in relation to the personal limits for cannabis. It still creates, and has created, some challenges for policing, because of the nexus between the ACT legislation and the commonwealth legislation, which we highlighted at the time of the discussions around that bill being put forward.

THE CHAIR: Has that been realised and caused any problems?

Cmdr Chew: It has not created any problems, but it does create challenges for the constable on the road. As a police constable, they can enact the commonwealth legislation as well as the ACT legislation. ACT Policing have taken a proactive approach to their members in that space, to say, "Where possible, given the entirety of the circumstances of what you're looking at at the time, err towards the side of the ACT legislation."

THE CHAIR: Has anyone been charged under commonwealth law?

Cmdr Chew: I do not have that particular breakdown of the charges.

THE CHAIR: Is that possible—

Cmdr Chew: But there has not been any significant increase in charges relating to cannabis.

THE CHAIR: Under ACT law?

Cmdr Chew: Under ACT law, yes.

THE CHAIR: I would be interested to know if there have been any charges under commonwealth law with respect to cannabis.

Cmdr Chew: I will take that on notice and we will find out for you.

THE CHAIR: Thank you. I am sorry; I was interrupting.

Cmdr Chew: The other thing is that it creates a challenge for the members on the road. There is also the testing regime and the evidentiary standards that we need to get to in relation to any of the drugs that are in our society at the moment. Establishing that evidentiary standard on the side of the road at 2 o'clock in the morning is quite challenging. For cannabis, it is reasonably easy to readily identify what cannabis is. When we talk about powder drugs and tablets, it is not as easy for the officer on the road to say, "That's MDMA," or "That's cocaine," or "That's ice." The evidentiary standard, going forward, is that it would then be sent away for testing and a formal certificate from ACTGAL would come back.

If we went down the personal use road with the powders, we would need to factor in some form of acknowledgement of what the thing is that they have been caught with. That is where the simple drug offence notice would come into account. The person we are dealing with could say, for instance, "I purchased a tab off the bloke around the corner who said it was MDMA. The police have now found me with that tablet; yeah, I think it's MDMA." If they acknowledge that fact, we could issue a simple drug offence notice without having to follow through on further testing, potentially, in an evidentiary situation. So there is an acceptance by the user at the time that that is the drug they have been caught with, because of the circumstances. That would give us a chance to divert them into those programs. As I said, we have a very strong diversion already with our illicit drug use.

THE CHAIR: What if they did not choose to acknowledge anything?

Cmdr Chew: It would be a matter of the circumstances at the time. It could lead to an arrest and going into the criminal justice system. It could lead to a seizure of the particular thing, given the circumstances, testing and coming back for a summons or an arrest at a later time, provided we can guarantee the identity of that person for further summons service or further inquiries down the track. That would create an extra level of difficulty for the constables on the road.

THE CHAIR: If the bill became law in, say, three or six months, would you feel confident that your officers could apply the new legislation?

Cmdr Chew: I think it would be very challenging. It would be very difficult in its current form, with the quantities involved. The quantities are really concerning. As I said, an X quantity of drug can be cut in a number of ways. That then creates a trafficking environment. Someone could have a bag of cocaine, for instance, cut it into lines and sell the lines individually, but the total amount of that could be under the current limits. Therefore, that is not a person with a drug habit or a drug user that we are trying to divert into a program; that is someone who is trafficking in drugs.

We have seen that a bit with the new cannabis law, where people have had a personal

use quantity, but divvied up into separate bags for selling. They are called "tenners", so it is $10 a bag. They actually had under the new amounts for personal use. In fact, given the circumstances at the time, they were actually trafficking, but we did not have any witnesses that were prepared to help us in that regard, and we had to let that person go because they were under the prescribed personal limits.

We then had to mount a significant police operation in the background, because that person was constantly outside a school at the time, but they were constantly back there, allegedly dealing to the students at the school. We had to mount a significant operation to capture the evidence to support the charge of trafficking, because they were, at any one time, under the personal limits, as per the—

THE CHAIR: This was with respect to cannabis?

Cmdr Chew: Cannabis, yes. The same can be applied to the powder drugs as well, with the current quantities in the proposed bill.

MR DAVIS: I am a little bit challenged by the evidence you have presented today around the quantities, not because I dispute your knowledge in the area but because it is contrary to the overwhelming bulk of evidence we have received from those who work in the alcohol and drug support sector and those who presented to the committee with lived experience of drug dependency, many of whom have advocated that the bill is too soft and we should have substantially higher limits.

I think an analogy was put this morning by a representative of the ANU Drug Research Network that it was a bit like going to Dan Murphy's once a week to get your wine for the week; you do not go and score every day. They said that the unintended consequence of the bill as it is drafted might make small users drug traffickers. I am interested in your reflections on that, given that, to my recollection, you are the first person to present to the committee advocating lower quantities.

Cmdr Chew: I think it comes down to the circumstances at the time, as I said earlier. Powder drugs in their current form can be cut with other substances. Therefore, whilst it may be two grams at, say, 100 per cent purity, if you can get that purity out of the drugs, you can step on that or cut that 10 times and still have a reasonably high level of purity, which will allow the drug user to get the high they need while, in fact, you are making 10 times the amount of what it cost you.

That is the risk in the details of the quantities; it is the fact that, with cannabis, you cannot cut it. You cannot add stuff to it. You cannot add parsley to it, and that sort of thing, to make it look different. With powder drugs, you can; you can add glucodin and a variety of things to bulk up the quantities. Therefore, you can distribute and traffic a larger quantity, but if you are caught with the two grams or whatever the limit is, you are under the personal use but you have been trafficking. I am not saying that is the case with everyone who has issues with drug use, but it is a real possibility with the powder drugs.

MR DAVIS: That probably leads to something further that the same representative of the ANU Drug Research Network described. They introduced the committee to the concept of social carrying, where somebody might, under the current law, be deemed

as a trafficker, but they are neither selling the large amount they might have on their person, nor are they consuming the large amount they have on their person. They are going to that party or that event and aiding the supply to their friends, but not for profit or a sinister criminal motive; that was the position that was put. How do ACT Policing separate situations like that from situations of more sinister criminality and drug trafficking?

Cmdr Chew: It is based on the circumstances at the time. Taking your example—that person going to the party who has a bag of coke or whatever it may be—supply is supply, regardless of whatever the limits are, anyway. But if they have that in one bag and the quantity is under the proposed bill quantities, that would be a different circumstance from someone who has 10 Clipsal bags in their pocket and is going to that same party.

The evidence presented would be: why is that drug cut 10 ways or in 10 separate bags? Is there a reasonable inference or a suspicion that that person is actually dealing, as against going to a party? It comes back to my point about the supply. Even if it is in the quantity under the personal limit, the person is still committing an offence of supply under the current legislation, even though they are going to a private party where they might allow their friends to participate in drug use. I think it is the circumstances at the time that dictate the direction that the police officer would go in.

MR DAVIS: Those circumstances are, in large part, dictated by the discretion of the officers at the time, rather than—

Cmdr Chew: As with any of our powers in any of the legislation, the office of constable has discretion to apply the law within the circumstances and the situation that they are presented with. That is the cornerstone of policing.

DR PATERSON: Thank you very much for all of the work that you and the other officers already do in the community in addressing this issue. This ties in with the discussion that we have been having. The figure in your submission, that 5½ thousand people would have been diverted from the system, is pretty striking.

Also, tables 2 and 3 are really interesting in terms of the breakdown between being over the proposed limit and under. Looking at those statistics for 2020, it looks like it is pretty spot on. With respect to methamphetamines, 273 of last year's seizures would fall under personal possession and would have been at the limit or under, and 59 were over. Looking at those numbers, it looks like what is already coming through is quite reasonable, in terms of that two gram limit, in picking up personal use versus not.

Cmdr Chew: Yes, it is. Again, I think a missing part to it that we have not touched on yet is the second and third consequence. In relation to personal use and a person going to that party with an amount of drugs on them, they are probably not going to come to police notice. It is the drug use, the behaviour that goes with that and the circumstances at the time that bring police notice to them. For example, they might be at a nightclub, they drop a pill, they come outside the nightclub, have an argument with someone and commence a fight. That is what will attract police attention. The seizure of drugs for personal use under the limits proposed in the bill is a consequence

of the actions that led them to come to police notice.

As I said it leads to crime, it drives people to crime in certain circumstances, and it is the criminal activity that they undertake, or the attention they bring to themselves as a consequence of having possession of and/or using the drug, that attracts the police attention to then apply what is proposed in the bill. There would be additional charges and the limits would then come into it, and saying, "Would that fall under the proposed bill?"

DR PATERSON: There is an idea around that if you did not have to worry so much about these people who are using drugs, you could focus on the supply issue and the bigger amounts. Is that an accurate statement?

Cmdr Chew: I think it is about supply and demand. If we get the harm minimisation piece right, the diversion into programs, and people make different choices about whether they will or will not take drugs, that creates a demand void for the traffickers and the organised crime groups who want to exploit that market. It is well documented that drug prices in Australia are very lucrative for the dealers, the traffickers and the organised crime people because Australians do pay a lot more than other countries in the world for their powder drugs.

I think it is about the circumstances and the fact that the demand is still there. If we can reduce the demand through diversion programs and people not making those choices, that will stop organised crime from making profits from those people. If people have a bad habit or a drug abuse issue, they are more susceptible to influence by those organised crime groups to maybe flaunt the personal limit things as well.

It is a really complex issue. Harm minimisation is something that we need to focus on—get the right programs, and get the programs in place at the right times of the day. It will be very challenging for us, under the proposed bill, to divert someone at 2 o'clock in the morning and get them the help they need at that time to have that early intervention.

We saw that a little bit with the pill testing at the festivals over the last couple of years. Some people in that pill-testing regime have chosen to put the pills in the bin and have gone about their business. That harm minimisation, that education piece and that reduction in demand are all going to affect the ability for organised crime and organised crime groups to develop a market within Canberra.

MR DAVIS: You mentioned the challenge at 2 am to redirect somebody into alcohol and other drug services. Could I deduce from that that you would support a lot of the comments other submitters have made about needing to have a substantial increase in investment by government into those alcohol and other drug services, so that they can be accessible at those times?

Cmdr Chew: I think it is critical to the bill that all of the emergency services, all of the services, have the ability to intervene at the earliest opportunity. At the moment, we do not have that ability at 2 o'clock in the morning, in the nightclub precinct or wherever we may engage people, to have that early intervention. We take a course of action, whatever action that may be, and a follow-up is conducted with the referral

agencies, SupportLink or something like that, 12 hours, 18 hours or 24 hours down the track. If it happens on a Friday night or Saturday morning, that follow-up may not occur until Monday morning. It is important that those support services are available at the time that the person needs them, for that early intervention.

MR DAVIS: You would be aware of the significant over-representation of Aboriginal and Torres Strait Islander people in the criminal justice system, some of whom are involved in the system due to their behaviours or experiences related to drug use. This morning we heard from the Justice Reform Group. They expressed interest in collaborating between First Nations communities and ACT Policing to ensure that racial and cultural bias is not a factor in the over-representation of these communities. What work is ACT Policing doing to ensure that the discretionary work of the police force is not unintentionally discriminatory?

Cmdr Chew: The Chief Police Officer has an Aboriginal and Torres Strait Islander advisory board where he and elders within the First Nations community talk about these particular types of issues. Yes, they are over-represented, as are other ethnic groups as well. With the engagement with the advisory board that the CPO has set up, we talk about these types of issues and how we can best work together.

We have introduced training for our frontline members around not only First Nations people but also Islam, Muslims and other core groups. We have just rolled out a significant training program for dealing with people with autism. That brings with it a different type of interaction from what police have probably traditionally interacted with people around.

We do work closely with those other groups around working out what is best. The incarceration and the over-representation, again, is a vexed, complex issue that has a number of different inputs to it outside the criminality of the behaviour. We need to work together to get the best result to try and reduce that recidivism and the incarceration rates across all of our ethnic communities, not just First Nations people.

THE CHAIR: I would like to touch on something that we have not explored. We have heard a lot about the assumption that, for want of a better phrase, the war on drugs has failed, so we need to try something else—whether you call it the war on drugs or tackling supply issues in the territory. Do you think that, with increased resources, that could make a significant dent in drug supply in the territory?

Cmdr Chew: I think the Chief Police Officer would welcome additional resources. I do not know of any commissioner or chief police officer who would not welcome more resources. Again it is a challenging space to work through. We have had discussions with government recently around the police services model funding that we got nearly two years ago, regarding looking at a different way to do things. That is essentially what the police services model is about. It is about early intervention, prevention and disruption before it gets to the criminal prosecution, the judicial system, and the corrections system on top of that.

With more resources, yes, we could do more. That would allow us to focus on the organised crime side of things and potentially attack that as something that is probably a more efficient use of resources because we would be attacking the supply chain. The

demand would still be there but potentially we would have the ability to cut off a portion of the supply. We would never be able to cut off the entire supply. That is part of your war on drugs commentary, Chair, around it not working well. I do not think anywhere in the world has cut off total supply. Yes, they have reduced the supply in cases. I refer to AFP Operation Ironside, recently. The volume of drugs and assets is another thing that I will talk about in a minute.

The volume of drugs that that operation across all of the states and territories intercepted was phenomenal. Has that affected supply in the short term? We are yet to see that. Has that affected supply in the long term? I think the commentary around the war on drugs not working is multifaceted in attacking the supply, reducing the demand and looking at what the drivers are of the organised crime groups. Essentially, it comes down to money. You must have a strong asset confiscation regime in place, legislatively. If you take their flashy cars, their flashy motorbikes, their houses and their businesses off them, you are going to disrupt them for a while, but for how long that lasts is the question. It is a bit of a cliche, that war on drugs, because it is working in its various different guises, and I do not think we will ever get to that euphoric state where there is no problem.

DR PATERSON: Going to your suggestion about the staged approach, we have had a lot of submissions and we have put this to a lot of people. The argument that comes back is that if the government is going to take a health approach to personal use, rather than a criminal justice approach, taking the two drugs—for example, methamphetamine and heroin—that cause the most harm, and saying that we will keep them as criminal, and for everything else there will be a health approach, you are conflicting your own messaging and health approach, really. It is completely at odds with that. I am wondering what your thoughts are. Maybe we could intensively manage this as a health approach and that might actually reduce that.

Cmdr Chew: It is probably a demographic, societal issue. I have been around policing for quite a number of years. Back in the 80s and 90s it was very much a heroin problem. We all know the devastating effect that heroin has on people, and heroin addiction. The so-called party drugs were not a big thing back in the 80s, 90s and even the early 2000s. But as societies change and the demographics have changed, the powder drugs are becoming more prevalent.

I think the harm minimisation side of what are perceived as the harder drugs—heroin, ice and those sorts of things—creates a circumstance where long-term addiction is probably attached to it, whereas we see social use with the party sorts of drugs, for want of a better term. I think that is the differentiation. The ability to intervene early with someone using cocaine, ecstasy or whatever, with the right programs, would probably have a better outcome because of the nature of the addiction that sits with the harder drugs. I think that is the differentiation. With the harder drugs, the addictions are generally longer and more severe, whereas people would now go out on a Friday night and drop a pill, and the next morning nothing has changed. Nothing has changed in their lifestyle because it does not grab them as hard as the harder drugs do.

MR DAVIS: A lot of the people that have written submissions or presented before the committee who support the proposed legislation have spoken about ending the stigma and discrimination that stops them coming out to their family and friends, and stops

them accessing AOD services. Many have spoken about personal experiences around what they felt to be stigma or discrimination based on their relationship with police and the criminal justice system more broadly. I appreciate that my question might sound spicy, but it goes to that very point. When your police officers meet somebody in the field who is under the influence of drugs, or has drugs in their possession, do they see a sick person that needs to be helped or a bad person that needs to be punished?

Cmdr Chew: I could not talk to what is in the mind of every police officer in that circumstance. Certainly, the ACT Policing approach is to deal with each situation as it presents and the circumstances of that situation. As I said, we did over 150 diversions last year in relation to those particular types of circumstances.

I challenge the issue that it is broad across ACT Policing, because our officers are very professional and have the right training, education and understanding to work out where that differentiation lies. I would have great confidence that every interaction is dealt with appropriately. As to whether that progresses to another thing because of the circumstances, I could not make a comment on that. I think that the professionalism of the police officers, the men and women in ACT Policing, is beyond reproach in that case. We do a lot of training in that space as well, to allow them to understand that there are health issues and harm minimisation issues that can create a better outcome for that person.

Going a little bit off topic, I think that is where we have been so supportive and have driven the early intervention PACER program in relation to mental health. That has created a really positive outcome for the consumer in the mental health space because they are not being whisked out to ED to be scheduled or assessed and then taken out of that environment. The PACER environment is a very good example of where ACT Policing, ESA, the Ambulance Service and Health have all come together and said, "What is a better outcome for that person?" That is where we get to with that commentary around the policemen and women reacting to what they are presented with, and that is their training. That could be anything from X to Y. I do not think there are any underlying issues there. I have full confidence that the people out on the road doing the business treat everyone as equals.

MR DAVIS: It is a bit left field, but you brought up the PACER program. I am just having an out-loud mental conversation with you at this point. Do you see an opportunity for exploring something not dissimilar to the PACER program for people that are under the influence of a substance—perhaps partnering with AOD services, for example?

Cmdr Chew: That would be something worth exploring. We have seen a significant reduction in workload for the police and for the emergency department around PACER. Ultimately, we are getting a better result for that consumer. With anything in that space, you could take that across a number of other interactions. You could apply that in the family violence space as well. That sort of multi-agency, early intervention ability to get a result for that consumer, whatever the situation is at the time, is really good. But it comes back to the original point I made about having those services available outside business hours.

DR PATERSON: I have a quick question about the fines. A lot of community stakeholders have said that the fine might be too much or make it too difficult for some people, particularly those with active addiction and who are on Centrelink, to pay. What are your thoughts about not having a fine associated with this?

Cmdr Chew: There has to be some carrot and stick, I think. I understand the socio-economic environment at the moment with COVID, people losing their jobs and people that were relatively affluent beforehand now potentially being out of work. I think it is a challenging space. Potentially, there has to be an outcome that will satisfy the community that an amount of intervention has been done. Is that going into the criminal justice system? Probably not in every case. Is that a monetary fine? Probably not in every case. There has to be some consequence for the action taken at the time.

As I said, a lot of the interactions with drug users, to use the term broadly, are a consequence of some other action that has brought them to police attention. I understand the financial difficulties that a lot of people are facing at the moment, but there has to be some consequence for that action. That consequence could be, "You have to go and participate in this alcohol and drug rehabilitation program for the next six months," or three months, depending on the circumstances.

THE CHAIR: On behalf of the committee, I would like to thank you for giving evidence today and for the ACT Policing submission. The secretary will provide you with a copy of the proof transcript of today's hearing, when it is available, for you to check for accuracy. I believe you have taken one question on notice.

Cmdr Chew: Yes.

THE CHAIR: Thank you so much.

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health
CROSS, MS REBECCA, Director-General, ACT Health Directorate
BRIGHTON, MS MEG, Deputy Director-General, Health System, Policy and Research, ACT Health Directorate
PEFFER, MR DAVE, Interim Chief Executive, Canberra Health Service
LAGIOS, DR KATERINA, Acting Clinical Director, Alcohol and Drug Service, Canberra Health Service
HARLAND, MS JENNIFER, Acting Operational Director, Alcohol and Drug Service, Canberra Health Service

THE CHAIR: I welcome representatives of the ACT government

Ms Stephen-Smith: Thank you, and we all acknowledge and understand the privilege statement.

THE CHAIR: 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. I note that everyone has acknowledged and understood the privilege statement. It is our practice to give an opportunity for an opening statement. Minister, would you like to do so?

Ms Stephen-Smith: I will do that. Thank you very much for the opportunity. The government obviously welcomes the committee's ongoing thorough consideration of the Drugs of Dependence (Personal Use) Amendment Bill and broader alcohol and drug policy approach within the ACT as part of the committee's terms of reference. I am pleased to see the depth of information and careful consideration that has been presented to the committee so far, and I can assure you that it will be used to inform the ACT government's alcohol and other drug policy and program work as well as our response to the private member's bill.

The government's comprehensive submission to the committee's inquiry underlines the seriousness of our commitment to harm minimisation but also the importance of getting this work right as well as the many social, economic, and operational considerations this bill requires.

The ACT government is committed to investing an evidenced-based and practice-informed harm minimisation responses to alcohol, tobacco and other drugs. The bill being considered by the committee aligns with the broad approach the ACT government has consistently taken in pursuing harm minimisation as a guiding principle for alcohol and other drug policy.

As the committee would be aware, a harm minimisation approach is made up of three pillars as agreed by all Australian governments: demand reduction, supply reduction and harm reduction. We know prohibition does not work in preventing people from taking drugs that may be considered illegal or illicit. We know criminalisation does not work. Indeed, no-one sensible is suggesting that the war on drugs was anything other than a failure, and continuation of it is not something that this government

would support.

I am proud the ACT government has an extensive track record in drug decriminalisation and recognising illicit drug use as a matter for health services instead of criminal proceedings, in particular, in 2001 the illicit drug diversion initiative, a police diversion program that results in people found in possession of small amounts of illicit drugs being referred to drug diversion services as part of a national initiative funded by the Australian government.

I reiterate the point made in the government submission on pages 16 and 17 that the ACT has the lowest rate in Australia at 68.9 per 100,000 of offenders whose main offence is personal possession and the second highest proportion of diversions at 78 per cent.

In the ACT we have sought to treat alcohol and drug use not as a criminal issue but, rightly, as a health issue, and we have made real progress. The ACT drug strategy action plan 2018-21 has guided our progressive approach to addressing the harms associated with the use of illicit drugs. Most recently, the passing of the Drugs of Dependence (Personal Cannabis Use) Amendment Act 2019 continued this work. I note that there has been no evidence subsequently of increased use or presentations to hospital as a result of cannabis use.

We have also successfully trialled pill testing at festivals and partnered with the Canberra Alliance for Harm Minimisation and Advocacy, whom you spoke with earlier today, to provide increased levels of overdose response training and greater community access to take home doses of the opioid reversal medication naloxone.

To support a health-focused approach, the ACT government invests more than $22 million each year in specialist alcohol, tobacco and other drug treatment and support services in the territory, and we are ably supported by a highly collaborative and engaged alcohol and other drugs treatment sector, as demonstrated by the whole-of-sector response to COVID-19 to maintain access to treatment, which was well coordinated by the ACT Health Directorate.

I recognise that in this space there is always more that can be done and we continue to work closely with the peak body, ATODA, and its members to prioritise investments and new initiatives to reduce the harm associated with illicit drug use in this context. Some of these most recent initiatives representing key achievements made in our drug strategy action plan across 2019 and 2020 include the first clients being referred to treatment by the new ACT drug and alcohol court—or drug and alcohol list—a key harm minimisation and diversion initiative.

The new Canberra Health Services opioid treatment clinic opened in Belconnen on 1 December 2020, increasing access to treatment in the north side of Canberra. The ACT festivals pill testing policy was released, although I note there have not been any festivals since that time. I recognise that many of these elements are referenced throughout our submission, but I appreciate the opportunity to highlight them for the committee.

Returning to the bill being considered by the committee, the three main conceptual

elements proposed by the bill are: removal of prison as a sentencing option for primary offences involving possession of a below threshold amount of certain illicit drugs, otherwise known as depenalisation, although a person can still be sentenced to prison for other offences committed at the same time under the influence of those drugs; a substantial reduction in maximum penalty for possession of small amounts of illicit drugs from 50 penalty units to one penalty unit, currently equivalent to reducing a maximum $8,000 fine to a maximum $160 fine; and the introduction of a simple drugs offence notice for nine illicit drugs in addiction to cannabis.

As the government's submission outlines, conceptually these approaches align with our strong policy posture of harm minimisation, but we also recognise that there may need to be sensible adjustments to ensure that it can be implemented to achieve all of the goals it seeks to achieve—supporting people who have health needs to access the care that they need and reducing the stigma associated with illicit drug use so people are more able to access health care.

I look forward to the findings of the committee when considering both the implications of the bill and the opportunity to further entrench a health focus and harm minimisation approach to illicit drug use in the ACT. Thank you for the opportunity, Chair. We are very happy to take questions.

THE CHAIR: Thank you, Minister. I have a question about the decriminalisation of the cannabis by the last Assembly—what lessons have been learnt from that, what risks have been highlighted and how much of that would translate if this bill became law?

Ms Stephen-Smith: That is a really good question. From my perspective one of the key lessons that has been learnt is that not much changed except that people were no longer subject to a fine. In terms of increased use, we do not have evidence of that. We do not have evidence of increased hospitalisation. But the stigma associated with cannabis use is arguably significantly less as a result of taking that approach to fully decriminalising cannabis use.

Ms Brighton: Out of the key learnings seen in the international research, what has been very evident to us through what has happened with cannabis is it is not the criminal action or the justice action that is important, it is about the health dimensions. That has been reinforced through the cannabis trial. As the minister said, we have not seen an increase in usage either through our evidence or, I believe, presentations to the hospital system.

Ms Stephen-Smith: I should clarify—I think we have seen in our wastewater testing an increase in cannabis, but that has been during the COVID lockdown and that was seen right across the country. That was not an outlier for the ACT and our results were consistent with the rest of the country.

THE CHAIR: How much do you feel that would be paralleled if this bill became law? What evidence do you have for that?

Ms Stephen-Smith: Maybe just to flip the question a bit, illicit drug use and possession of small amounts being a criminal offence is not stopping people using

illicit drugs. The flipside is what we have seen internationally—that there is no strong evidence that decriminalising possession of small amounts of and use of illicit drugs significantly increases the likelihood that people are going to take drugs. It destigmatises the use of drugs and enables people to get better access to health services. That is clearly our expectation around the impacts of decriminalisation.

Ms Brighton: In the 2019 household surveys the ACT had one of the lowest rate of illicit drug use in the country at 14.6 per cent. We have seen across a whole range of drugs a change over time, so that is an important feature overall.

DR PATERSON: Part of the police submission was that there should be a trigger for people to be referred to a service and ensuring there is some point of service contact and they just do not walk away. We have had mixed responses from others about that. Someone talked about Portugal, where they have a panel that people present to and have a discussion about their health pathway. What is the government's view on it being legislated that people go to a health service to ensure they do not just walk away and that is the end of the matter?

Ms Stephen-Smith: We certainly want to see that people have a very clear pathway to diversion and treatment services. I think it is a really useful thing for the committee to consider the broad range of views in relation to how mandated that should be and associated with a simple offence notice. Sorry, I have forgotten the next part of your question.

One of the key things about decriminalisation is the destigmatisation element and the fact that people will feel safer going to services voluntarily. While there is an important element of diversion and having very clear pathways for people to be actively diverted to service responses, there is also the element of people feeling more confident and comfortable voluntarily accessing drug treatment services when they understand there is not then a potential for them to come into contact with the criminal law as a result of coming forward for treatment.

You mentioned a panel approach to supporting people, and from my perspective it would be really interesting to explore those options. In relation to the discussion paper on raising the minimum age of criminal responsibility, that is something we have explicitly called out as a potential response to people under the age of 14 whose behaviour is problematic in the community then who would not be subject to criminal sanction with the raising of the minimum age. So there would be a restorative pathway to support those young people to be accountable for their actions but also to be supported.

There is some level of parallel in terms of one of the things we know about illicit drug use—it is not everybody—is the trauma background and the health issues that people might have that lead to them self-medicating with illicit drugs. Some kind of restorative approach that enables people to get the help and support they need but holds them to account for any behaviour is something I think is worth considering right across our criminal justice system. Now I am talking way outside of my brief, but thank you for the opportunity.

MR DAVIS: The virtue of having you here as the Minister for Health and as the

Minister for Indigenous Affairs means I can ask you the next question. Julie Tongs from Winnunga Nimmityjah was with us yesterday and she spoke about the work being done with the government on the Aboriginal and Torres Strait Islander community-led residential rehab facility. Are you able to update the committee on where that work is up to, what commitments have been made so far and when the community can expect that service to come online?

Ms Stephen-Smith: We have committed to the delivery of that service, and I think Julie talked about the fact that a site has been identified. We have been funding Winnunga to develop the model of care, but I will hand over to Meg to say more.

Ms Brighton: A site has been identified. We have been working with Winnunga for some time on the development of the model of care. That model looks at the totality of services that would need to be offered in a residential-based facility. We have received that and the next steps will be looking for in the first instance mechanisms to fund that service and then for the service provider to be able to get that up and running.

In order to have the facility we need to go through the construction and design phase, so we are talking about a couple of years before that service is up and running in the community. In the meantime, all the existing services will continue to operate and this will be an augmentation of all the existing residential services.

We require all our existing residential services and all alcohol and drug services to actually participate in cultural awareness training and offer a culturally sensitive program. If we get feedback from participants about further work required, we certainly give that feedback to those providers.

THE CHAIR: You referred to the war on drugs and there is an assumption that it has failed. I do not think anyone has not said that in all the hearings. But I wonder about tackling supply. We are keeping the actual supplying and trafficking criminalised and I wonder whether tackling that might also be an important part of your harm reduction program, which obviously touches on resources. I do not know if that is within scope along with this legislative change.

Ms Stephen-Smith: As you say, it is not something the bill is directly relevant to but tackling supply is absolutely one of the pillars of harm minimisation. That is agreed as part of the national strategy. In terms of resources it is not really something I can speak to because it is not a matter for any of my portfolios. If there is a specific question you would like us to take on notice we can come back to you.

THE CHAIR: It certainly fits within the terms of reference of this inquiry, so I would be interested if you would like to reflect on that and get back to the committee.

Ms Stephen-Smith: Can I clarify the specific question? There is a broad question of resourcing for supply disruption. So is the question what is the current resourcing and do we think this bill would require any further resourcing?

THE CHAIR: In company with the bill. Again, the terms of reference talk broadly about dealing with reducing harm, and this is obviously related to that—if you do not have the substance you cannot harm yourself with it. It is not part of the legislative

approach but is it part of the intention of government to do so through policing or other resources? We have a very broad scope of things we are looking at.

Ms Stephen-Smith: I think the best thing is to take the question on notice in relation to supply reduction and come back to you on resourcing.

DR PATERSON: One of the things that has come through from some of the families we have spoken to is the struggle they have when their child's addiction may have started when they were still involved in their child's health care and how they are very much kicked out of the system when their child becomes an adult. That has been very distressing for some families. Are there ways we might be able to help families better support their adult children?

Ms Harland: We take that very seriously and we want to involve the families. You are right; up until the age of 18 the family is involved and is part of the situation. After turning 18, it is then up to the person whether their family is involved. From our perspective we would really like the family to be involved. We are not blocking them in any way, and it is unfortunate to hear that that is how people feel, because we like to encourage families to be involved as much as the person wants. But we are a bit limited by the person in treatment about how much family involvement they want, but we are very open to it.

MR DAVIS: I have got a question about smoking. You have noted the lower rate of smoking in the ACT and the success of prevention. We have got a stubborn eight per cent and I am curious about what work we are doing to try and bring that stubborn eight per cent down.

Ms Stephen-Smith: I will start to answer and then I will hand over to Meg. I think one of the things that we are doing to address that stubborn eight per cent is really looking at those groups where the rate is actually much higher. There are a number of groups in the community, including Aboriginal and Torres Strait Islander people and other marginalised groups in the community, for whom the smoking rates are much higher. They are a specific part of our Healthy Canberra grants program, and our work with the community sector is actually looking at specific work with those groups. We provide funding to Winnunga, as does the commonwealth, to tackle smoking in the Aboriginal and Torres Strait Islander community.

MR DAVIS: I am interested in exploring it in more detail, but I flag that we had some evidence presented by somebody earlier today that there is a high rate of people who leave the AMC with an addiction to tobacco but who did not go in with the addiction to tobacco. I would be interested in exploring your point about what we are specifically doing in some of those key target areas as well.

Ms Brighton: Thank you for the question. I think that part of what we are trying to convey here is that there is a really complex intersection between drug use, be it tobacco or illicit drugs, and the other social determinants. You mentioned that last hard 10 per cent, and that is exactly what it is.

MR DAVIS: Is it 10 per cent? I got it a bit wrong there.

Ms Brighton: It was 10 per cent. That is where we are at. I think we have made significant progress in this jurisdiction over a number of years and we are, as the minister has indicated, down at that point of dealing with those more complex matters where we do have the intersection of the other determinants, social determinants, that are influencing one's tobacco use.

As the minister indicated, we have a range of different entities we fund. We also work closely with the Education Directorate on the health curriculum that they implement at school, as well as with Winnunga and Gugan and a range of different service providers who are working with vulnerable communities. What we are seeing is that that is where the smoking is still very prevalent.

It is a longitudinal approach and it is deeply seated in those other components of social determinants. When we are funding entities, it is not just an education program about quitting smoking; it is much broader than that, and a wraparound service through those different organisations. We are working hard, but I think it will be some time before we can get that down to the very lower end of the single digits.

MR DAVIS: Would anyone like to explore the question of the AMC? It was a bit confronting to hear the evidence this morning that we have a government facility where people are leaving with a higher rate of smoking than when they came in.

Mr Peffer: I might invite Dr Lagios to come up and say a few words about that.

THE CHAIR: Could you state that you understand the parliamentary privilege that you are under?

Dr Lagios: Yes, I understand the privilege statement. Just to comment on smoking at the AMC, there is definitely a significant problem. That is probably the biggest choice of drug use in the AMC. There may well be people that do take it up when they come into the AMC, when they were not smoking prior, because there is such a high rate of smoking. Smoking is permitted in the AMC and, as you well know, it is one of the very few places in Australia where people in custody are permitted to smoke.

We actually have been running a very intensive program, a 12-week program, with a group from the therapeutic community and a group of women. We have our smoking cessation clinician and both the nurse and doctor coming in. We have provided all the NRT requirements to help people through very intensive counselling. It has been very difficult for our patients. They say the presence of so much smoking elsewhere, and the lack of activities, is a dilemma. Corrective Services are well aware of this and are looking at improving the day-to-day activities for people. But it is difficult and it is a significant problem.

DR PATERSON: Just on the AMC, we have heard submissions that the rate of drug use within the AMC is about 50 per cent and that people are sustaining their drug addiction through their incarceration and when they come out.

Dr Lagios: It is probably similar across all prisons that 50 per cent of prisoners would indicate when they first come in that they have a rate of drug use. Certainly, like in all prisons, there is an ability for prisoners somewhat to continue. We see a lot of people

when they first come in and we do the initial assessments and monitoring, identifying that there are risks of withdrawals and we actually manage a lot of people.

We do detoxification withdrawal when they first come in, but if they present to us later on, saying that they do use—and we do have people coming along and saying, "I have started to do this. I am injecting. I am using this."—we will review the options of what we can do for treatment. In terms of longer term treatment, we have the opioid maintenance therapy, which is really what all alcohol and drug services have, for ongoing ability to help with that, and there are various counselling groups at the AMC, through Corrective Services, that help patients as well.

Ms Stephen-Smith: I do not want to filibuster, but it might just be worth touching on the increasing capacity for people to go onto Buvidal at the AMC and the potential impact that that is having.

Dr Lagios: Buvidal is a new treatment. We were quite revolutionary, one of the first custodial settings to get it going, and one of the first groups in the ACT to get it going. It is a long-acting opioid treatment. Eventually, you have one injection a month. It is buprenorphine, which is actually, in terms of opioid therapy, a much better medication than methadone, which zonks you out, basically.

What this means is that you do not have to turn up every day to get medication. It provides people with true rehabilitation. They are able to get jobs, to go on holidays, and it really makes a significant difference. Most of our patients are now on Buvidal, seeing the benefits of this, and they continue with groups in the community.

THE CHAIR: I have a more specific question now. Minister, has Health costed this bill and, if so, what is the cost of implementing this bill?

Ms Stephen-Smith: There is probably no explicit cost of implementing the bill. Probably the question is: is there a cost associated with any additional demand for health services that might be associated with a reduction in stigma and people therefore wanting to go, and being happier to go, and access health services voluntarily and/or potential increased diversion? Given the high diversion rates that we already have, I think it is unlikely that there would be a significant cost associated with that.

Ms Brighton: I will answer that. Once the committee provided their advice and the bill was considered in the Assembly, at that point we would need to look at, depending on what the bill was proposing, what additional costs there might be to the service and then provide advice back to government about what those costs might be.

THE CHAIR: You are saying that you have not actually done a formal costing of the implementation of this legislation?

Ms Stephen-Smith: There is probably not a health cost specific to the implementation of this legislation, the way it is drafted at the moment, but there is also the whole committee process, to go through any amendments that might be made by the opposition, by the government, that would end up shaping what the bill is going to look like in its final form. That would be the point at which we would then be

able to appropriately assess whether that is likely to lead to any increased demand on health services and, if so, how we would then meet that increased demand, whether that is through the community sector or through Canberra Health Services.

Ms Cross: You could also look at whether there was any reduction in costs in other parts of the system: reductions in the justice system, court costs and so on. You would need to weigh up any reductions as well as any increased demand.

THE CHAIR: On the assumption that the bill as put to the Assembly goes through the cabinet process, are you saying that you have not done an assessment of the costs of doing that?

Ms Cross: I think it would be normal to do that when the policy parameters were far clearer. There are too many unknowns in terms of how it would be implemented, whether people would have a choice of paying a fine or a diversion. Until we have got more certainty, we would not normally cost this sort of bill.

THE CHAIR: But don't you have certainty now, if the bill in its current form becomes law?

Ms Cross: I think, with it going to a committee to consider all the expert advice, we are really waiting for the advice on the detail that would sit underneath.

THE CHAIR: You have not assessed the cost of the bill, if the committee says we support the bill?

Ms Stephen-Smith: No, because that is not the standard process that we would go through in considering private members' bills.

MR DAVIS: I can appreciate why you might not have costed the bill, because the bill itself does not appropriate money or assume any greater investment. But you have noted in your opening statement that you and members of the directorate have been watching the proceedings and you have been hearing from the same submitters that we have heard from, particularly those from the alcohol and other drugs sector, who have made the case that, irrespective of whether or not this bill is passed, there are still, in their minds, funding shortfalls across the alcohol and other drugs services. Has any work commenced, in the health department in particular, on reflecting on some of those learnings from the committee process thus far and preparing to perhaps fill some funding gaps in the future?

Ms Stephen-Smith: Not necessarily specific to what has come out of the hearing so far, but I think there has been a recognition, certainly in ACT Labor's election commitments, and I know also in those of the ACT Greens, that there is more investment required in the alcohol and other drugs sector. One very important element of that, of course, is the establishment of the Aboriginal and Torres Strait Islander residential rehabilitation service. We also have work underway with other services, including Karralika and Ted Noffs, around their infrastructure. We did put some additional investment into Karralika's infrastructure as part of the COVID-19 response.

We are in an ongoing conversation with the alcohol, tobacco and other drugs sector around service needs and demand. We have obviously had that conversation as part of the implementation of the Drug and Alcohol Court, where additional funding has been put in to purchase services specifically for people who are going through the drug and alcohol sentencing list and are specifically required to access services. We need to make sure that those services are available for them, so they are purchased specifically and in addition to the other services that were already available in the community. This is an ongoing conversation with the sector about what they are seeing in terms of demand. We certainly recognise that they are seeing demand for their services that exceeds their current capacity.

MR DAVIS: Minister, the government has an ambitious and supported policy platform in terms of the nurse-led walk-in centres that will continue to be rolled out. We heard some pretty exciting evidence from Chris from CAHMA, who spoke about the power of co-locating facilities and their enthusiasm to be co-located with other alcohol and drugs services, and, I imagine, other health provisions more broadly. Is the government open to considering some options there, particularly on the south side of Canberra, where Chris from CAHMA identified a gap in the access to services?

Ms Stephen-Smith: We are open to all kinds of conversations with the sector. We certainly recognise that CAHMA's model of peer support services, sitting alongside the other health services, is really valuable. One specific example of that is the work that they have been doing with Directions. We have provided some additional funding for the Directions mobile service, for an additional three days a week, in partnership with Capital Health Network funding two days a week for that mobile service.

One of the locations—I think it is the Civic one—is a partnership with CAHMA to build trust with that community of very vulnerable people so that they will then have trust in the Directions health team and they can get access to GP services, mental health services, the alcohol and drug nurses, and peer support as well. Absolutely, co-locating services is part of a model that we would really support.

DR PATERSON: Further to Mr Davis's question, with mental health, and co-working and co-locating, a lot of people have said that they have really struggled with falling into the gaps between mental health services and AOD services, and that there is crossover happening in individual aspects but sometimes they have struggled to access the correct points.

When we spoke to the police, they talked about the PACER model, how fantastic that is, and how there could potentially be an opportunity to do something like that in this space. I want to hear about this sort of no-wrong-door approach that the government is taking.

Ms Stephen-Smith: It is a constant challenge in addressing the comorbidity of mental health and drug and alcohol use, and accessing the right services. I hear that a lot as well. That is part of the reason that, specifically in relation to young people, one of our election commitments was around a specific service response for young people with comorbid, alcohol and drug, mental health and disability trauma—that holistic service that will support the young person where they are, rather than requiring them to get one thing fixed before they go and do something else. We know that is an issue

in the adult space as well.

Part of the reason that mental health and alcohol and drug services are co-located within Canberra Health Services, as part of the same division, is to try to break down those silos as well.

Ms Harland: A key point there is about having a holistic approach. That is what we are doing from the alcohol and drug perspective. We see it as a two-pronged approach. First of all, for our health professionals, it is about training—competencies and confidence. Wherever that person presents, with the no-wrong-door approach they can walk into a service—be it mental health—and the staff are trained up and feel confident and competent to be able to ask that person about their drug use and know what to do, to a certain level. That keeps that person with that counsellor, and there is that holistic approach.

They also know that if they are at high risk—they might be dependent and have complex and chronic issues—they can put up their hand and ask the alcohol and drug service to come in for that expert advice. That is what we do. We have the alcohol and drugs liaison service that works specifically with the mental health units, both inpatient and community. We also have alcohol and drugs clinicians sitting on things like the multidisciplinary team meetings, so that they have that in-reach as well. It is about having that ongoing training, education and expert support.

THE CHAIR: I think we have pretty much come to a close, unless there is something really specific. Minister, we did start a fraction late. Do you want to make a closing statement?

Ms Stephen-Smith: No, thank you very much, Chair.

THE CHAIR: On behalf of the committee, I would like to thank you and your colleagues for giving evidence today, and for the very comprehensive submission. The secretary will provide you with a copy of the proof transcript of today's hearing, when it is available, for you to check for accuracy. I believe there were some questions taken on notice—at least one.

Ms Stephen-Smith: I think there was one, yes.

THE CHAIR: Please liaise with the secretariat with respect to that. I would like to thank all of today's witnesses. This hearing is now closed.

The committee adjourned at 4.01 pm.