T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 8 May 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
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Witness

Professor Paul Dietze, director, behaviours and health risks program, Burnet Institute.

Necessary corrections to be notified to executive officer of committee

The CHAIR — Welcome to Paul Dietze from the Burnet Institute. It was good to get your submission, and I see that you have got more material that you are presenting to us now. Just to clarify, Hansard is recording everything we say. In a couple of weeks you will get a transcript of what has been recorded. You can correct any typographic errors et cetera, and then it will go on the public record. It is a public hearing; there is no need for confidentiality, okay?

Prof. DIETZE — Sure.

The CHAIR — If there was, we can facilitate that if we see the need. I think they are the key things I need to cover, so if you would like to initiate your presentation, giving us an overview for perhaps 15 minutes, then we will have some questions which we can follow up with.

Visual presentation.

Prof. DIETZE — Thanks very much for the invitation to come and speak to you today. I would like to acknowledge the traditional owners of the land, the Wurundjeri people and their elders past and present, for their custodianship of the land upon which we meet.

Basically we have provided a submission which focuses on drug law reform. There are lots of other elements of drugs policy that we could have covered off in consideration, but we were really focused on the terms of reference. Before I begin, I draw your attention to the disclosure up there. I have received funding from Gilead Sciences related to hepatitis C treatment drugs, and a very long time ago some money from Reckitt Benckiser to do with suboxone. Really they are unrelated to this presentation, but I feel it is appropriate to disclose that.

The summary that is up on the screen at the moment just highlights the sort of eight main features of our submission. Basically when we look at drug law reform, we would argue that the evidence — and we are an evidenced-based organisation; that is what we focus on — suggests that we should be moving towards decriminalisation of the use and possession of illicit drugs.

The CHAIR — Just stopping you there, Khalil and Martin and I are having trouble seeing the screen, but you have given us a written presentation that is the same as this presentation.

Prof. DIETZE — It is exactly the same as what the slides are, but it is probably easier just to read off the screen.

The CHAIR — If members want to move around the table for this part of the presentation, please do.

Prof. DIETZE — Sorry, I should have made that point.

We really need to improve our incarceration policies. There are some real anomalies in the system that really need to be addressed. There does need to be some legislative support for supervised injecting facilities — obviously there is a bill around supervised injecting facilities that is before the Parliament at the moment as well — but in terms of what we understood this committee would be thinking about it would be about legislative support for that kind of facility. I really do want to focus on supporting take-home naloxone and overdose response. Our submission has some elements which I actually want to revise a little and talk a bit about some specifics in a minute. We also argue that there should be a real-time drug monitoring and surveillance system to improve people's awareness of the sorts of drugs that are out there, and so that we can actually inform them so they can make informed choices about using those substances. We also would strongly argue that we should — and this is a very simple thing — decriminalise peer-to-peer provision of needles and syringes. It is a very straightforward thing that could easily be done — it is done in other jurisdictions — and we really should be looking at that.

We would argue that we should be improving roadside drug-testing procedures to bring them in line with community standards around alcohol, for example, and other work that is going on overseas. There are various elements of improving pharmacotherapy programs. But I think the previous speakers from Turning Point would have been more kind of abreast of the sorts of things that need to be done, but there are some issues that we might raise in relation to that.

I am going to, given the time constraints, just hone in on a couple of points that I have listed there, but I am happy to speak to any of them as we go through. I just want to make the point that we have a whole series of

studies that are out in the field. We conduct cohort studies of people who inject drugs, for example. We are doing cohort studies of people who smoke methamphetamine. All of the studies that we do, some of which are listed up there, actually involve us getting in contact with people in the places where they are actually using substances. This is a fieldwork site that we have in Footscray, for example, and we have been there since the mid-2000s following people up, looking at how they are actually going, trying to work out the best ways to meet their needs in relation to, say, hepatitis C and so forth, but also just tracking how they are going in their lives. We actually get our hands dirty so we are not just sitting in some kind of academic ivory tower or anything like that.

I just draw your attention to one of our studies. This is a cohort study of people that we have been following since 2008, and we have been following up how they have been going. We interview them every year. We link their information to various databases provided by the Department of Health and Human Services, for example, and we can look at a whole range of outcomes for them. But the main things that we know are that these people are dying at an incredibly high rate, much higher than their age-matched people in the population. They are using a lot of services and those services are not adequately meeting their needs, so more than half of them have an emergency department presentation. When you think about how many times you have been to an emergency department in your life, it is probably pretty rare — or I hope it is rare — and so on.

A lot of them have hepatitis C, but we are working to try and eliminate hepatitis C from this group of people and we really should be thankful for all of the mechanisms that are now in place to try and do that. But the other point is that this is a relapsing condition, so lots of people actually cease their drug use within the times that we have been investigating them, but then they do go on and relapse. We find that about 17 per cent had ceased by the first follow-up that we did of them, but by the time we went to the second follow-up of these people, so this is one year later, about 50 per cent of those 17 per cent had relapsed. So there is this cycle of people going through drug use and some of them are already in treatment but we need to be enhancing that.

One thing I would like to draw your attention to in relation to drug law is the statement you will have heard a lot of recently with people saying in relation to, say, methamphetamine, that we cannot arrest our way out of this. I presume people have heard that. If you have a look at this slide you will see that in spite of what we have been saying about that, that is exactly what we have been doing. These are federal figures but the Victorian figures basically show the same trend. You can see that the number of methamphetamine-related or amphetamine-type stimulant-related arrests has gone through the roof from 2010 onwards. By far the majority of them are targeting consumers, so people for use and possession offences. A lot of these are fairly minor use and possession offences, not connected to any other kind of offending like property crime or violent crime and so forth, although obviously some of them are so we should not lose sight of that. But this notion that we should not arrest our way out of this is not actually how we are practising it.

If we have a look at our spending, we suspect that illicit drugs, for example, probably cost something like $15 billion to the Australian community a year. We spend about $1.7 billion per year. Most of that is done at a state or territory level and that is because states and territories have most of the jurisdiction here. But the vast bulk of it is going towards law enforcement. To see that again, in this pie chart taken from work by Alison Ritter's group you can see that around two-thirds of all that spending in relation to illicit drugs is on law enforcement, a much smaller proportion on treatment, a little bit on prevention, very little in relation to harm reduction. But we are not unique in that regard. This is another slide from Alison's group and it shows that basically the law enforcement emphasis in Australia is very similar to what has been going on overseas in other countries. So it is not unique, but it is still something that we could work to address.

I will skip this slide and go on to talk specifically about decriminalisation. I understand that the committee will be visiting Portugal, and I want to talk briefly about the Portuguese decriminalisation of illicit drugs. It is talked about a lot. These are just media mentions you can see there in the right-hand corner, and you can see that they went through the roof in terms of the Portuguese decriminalisation. There are lots of errors. Lots of people equate decriminalisation with legalisation. It is not anything of the sort. Legalisation is something that you will experience in relation to cannabis in Colorado, but it is not what is happening in Portugal.

In Portugal what they did is they decriminalised all use, possession and acquisition of all types of illicit drugs in 2001. The main thing that they were trying to do is shift from a law enforcement punitive approach to a health and social approach that recognised it as a humanistic kind of issue and they set up that kind of response. The main thing is that they took away these criminal penalties and set up an administrative system to respond to

people who got into trouble with the law. It was introduced as a part of a whole suite of changes — this was not the only thing that occurred — and the main thing was that they did a lot of reinvestment from law enforcement activities into health and human services.

What were the effects of that? Not surprisingly, the number of arrests for possession and use went down dramatically, so it is the red for the left-hand figures on the screen there. Given that it is no longer an offence you would expect the numbers to go down. You can see that they did actually see a slight up ticking in the numbers of charges related to the trafficking of illicit drugs, and that possibly reflects their ability to actually properly target trafficking rather than focusing on consumers.

You can see from the middle slide that in terms of trends in recent drug use there certainly was not any increase in illicit drug use across the population in Portugal, but there was a little bit of evidence of some shifts in specific sub-populations. So if you have a look, in 2007 there was a slight increase in the 25 to 34-year-old age group reporting use of illicit drugs but then that had dissipated again by the time we got to 2012, which is in the yellow there.

In kind of a key group that we are probably most interested in in relation to this, in the 15 to 24-year-old age groups there has just been a steady decline in reports of illicit drug use in that age group in Portugal, and that is fundamental. It suggests very clearly that this change in Portugal did not lead to an explosion in illicit drug use amongst youth. Importantly there was also a dramatic change in the number of HIV-related deaths that were due to drug use and the number of cases of HIV related to drug use. You can see in the red bars there is a big decline through to 2012. Similarly the number of people dying as a result of drug use basically declined through to 2006 and then has bounced around ever since at fairly low numbers, lower than what we have here in Melbourne.

So these are pretty positive outcomes, and there is no evidence of any increase in any of the other harms that you might associate with illicit drug use like property crime or public order or amenity, and that is because we have not seen any kind of concomitant increase in the use of drugs. What this has effectively done is target mostly very vulnerable people. They are such a small group in the population but they take up a lot of prison time; they take up a lot of other service time that we really should be trying to avoid. So this is a pretty clear statement that decriminalisation is effective. So we have this reduced burden on the criminal justice system, reductions in problematic drug use, reductions in drug-related harms, better access to employment assistance and so forth, and reductions in the social cost of drug use. This is all happening, do not forget, in the time when across that period Portugal experienced some pretty massive other social effects.

The other thing that is really important is to note that there is this bipartisan approach to the drug issue in Portugal. Drugs are much less stigmatised. Basically we cannot only say that this is driven by decriminalisation. Undoubtedly these benefits have been observed, but we cannot say that that is entirely due to decriminalisation. We expect that it is the case, but basically, as I said, there is this suite of reforms introduced as part of the package.

Here is just a brief comparison of our current situation. The main thing that we find at the moment and the takeaway from this slide — and again I pay tribute to Caitlin Hughes and Alison Ritter for this — is the big thing that we have really lost is our bipartisan approach to illicit drugs that was really evident from the mid-1980s onwards. When we come to think about, say, supervised injecting facilities, I do want to note that back in 1999 both of the major political parties went to that election with supervised injecting facilities as part of their platforms. But our debate has since been polarised, whereas in Portugal they have a much more pragmatic and bipartisan approach to illicit drugs.

I now want to turn specifically to overdose response and some support for take-home naloxone. I am assuming that people will be familiar with what take-home naloxone is, and I suspect that some of the other people who have presented this morning will have already canvassed some of the issues around this. But basically it was first mooted at a harm reduction conference here in Melbourne in 1992 by Professor John Strang from the UK, who suggested we should be getting this life-saving drug out to people who use heroin and other opioids. We have a long history of waiting and not really doing anything about it, even though we had a heroin overdose emergency in the mid to late 1990s, but it has been recommended in strategy ever since. The National Drug Strategy recommends take-home naloxone as an evidenced-based intervention. It took us through to 2012 to actually establish a program in Australia, and that was in Canberra, which was the first program, and shortly

followed by a program established in New South Wales as well. We called for a trial of it in 2000, but really it was not until 2011 that we finally got some action there.

Basically this program consists of a 60 to 90 minute group-based training program where groups of people who are at risk are sat down and they go through basically training people how to use it. We have subsequently realised that that is way too long and not needed, but it is kind of a bit peripheral to legal issues and things like that that I want to come to. The main thing is that we have found that when we trained people in this way and we provided them with naloxone, they could effectively respond to overdoses. We trained 200 people, including 18 inmates at the prison up there, the Alexander Maconochie Centre, and we have documented 57 overdose reversals that those people subsequently made in the community, which is really impressive. All of them were successful. There were no serious adverse events at all, and the program actually had positive emotional impacts on participants. Some people sort of saw themselves as naloxone heroes, and looking after their friends and saving people's lives is something they really got into.

The program was recommended to continue, and it does in the ACT, but we are at a bit of a crossroads in relation to take-home naloxone. The programs are all relatively small scale with limited reach and very little funding allocated towards them, although I note the Victorian government is looking at ways in which funding can be distributed to some of these programs. We have got inconsistent practices across different states and no federal coordination whatsoever, which is very odd considering this is a health program. Also there is no formal legislation for good Samaritan protection. So as it currently stands people are protected under the Victorian Wrongs Act 1958, for example, but I will go into why I think we need to actually change our approach to this in a minute.

The main thing we need to start doing is actually scaling this up and getting it into part of normal practice, and in New South Wales they have basically rolled out over 1000 people who have now been trained, but most of them are being delivered in one very small part of Sydney. It has not been taken up right across the state, even though people outside of south-east Sydney are actually at risk. Most drug and alcohol services are not providing it and so forth, and so what we have actually done in New South Wales — and I pay tribute to Dr Nicholas Lintzeris and his team up there — is the New South Wales government has funded a translational research grant that will allow us to accredit and credential people other than prescribers to actually give naloxone to people. So as it currently stands someone can go and purchase naloxone over the counter because of the changes that took place in 2016, largely due to a local pharmacist here in Melbourne, or people can be prescribed naloxone by a GP, but the best way to get it to people is to actually get it into the hands of the people who are going to come into contact with people who use these substances, and those are people like needle and syringe program workers, drug and alcohol counsellors and so forth; and if we were actually able to accredit them to be able to dispense naloxone themselves, to hand it out themselves rather than going through a convoluted process of getting a prescription or getting it through a pharmacy and so forth, we could actually get it out there more effectively, and that is what we are aiming to do in this New South Wales program.

Take-home naloxone is not a silver bullet for opioid overdose. Not everyone is going to take it up, and we have not had the reach that we need. It is an additional intervention to those that are already there. We know from work overseas that it does actually work, and in Victoria we really need to continue with wider implementation. I should have mentioned that in 2013 a number of organisations moved to start distributing take-home naloxone, but they were really doing it on the smell of an oily rag when you have a look at how much funding was allocated to them. In our submission we actually make mention of needing to provide specific good Samaritan support around take-home naloxone, but I think we actually need to go further than that. I have brought in a copy of the equivalent New Mexico legislation, which I think has been distributed.

If you look through it, what it actually does is it makes specific mention of the need for take-home naloxone and the dispensing of naloxone, and it provides for what are called standing orders. What that means is there is almost a general prescription for the substance that then covers people who are credentialled or accredited under that standing order to actually give it out. So the standing order will rest with the senior medical practitioner, but anyone who is properly accredited and credentialled will be able to hand it out. Naloxone really has no side-effects apart from reversing the effects of opioids like heroin and so forth, so it is really not a dangerous drug to be giving out to the community.

We also need really clear protections for program participants, whether that be prescribers or whether it be the actual people who are using the substances and so forth. But I think we actually need some specific act like this.

When we have spoken about making changes to good Samaritan legislation in the past, there has often been a reluctance articulated about doing any kind of legislative change around take-home naloxone, and so we have relatively ambiguous coverage through good Samaritan legislation. What we need is a specific act that covers people in these instances — that properly articulates the regulations needed to make sure that we can get naloxone into the hands of the people who are going to be able to respond. Here is the kind of model. Lots of US jurisdictions have this kind of act in place already, and I think it is time that we actually moved towards a specific mention of this in legislation.

They are the two main points I wanted to cover-off for my presentation. I have probably already gone way over my 10 minutes, but I am happy to hand over now for further questions about our submission.

The CHAIR — Good. Thanks, Paul. Can I just follow up: I do not think I saw anything in your submission about opioid substitution therapy and what work Burnet has done in that area, and whether you have any recommendations for us.

Prof. DIETZE — We do make mention of pharmacotherapy, which is opioid substitution therapy. Our main recommendation in relation to that is to really streamline systems so that people can access it easily and can access things like takeaway doses easily and safely. One of the concerns that has been raised with recent changes is that the restrictions on takeaway doses really do limit people's capacity to stay on the program effectively.

The CHAIR — We certainly heard from the coroner that they are concerned about the number of take-home doses that can be — —

Prof. DIETZE — And there certainly should be concern about that, but the way in which we could respond to that is to properly equip people with ways of maintaining their doses securely to prevent people getting unauthorised access. We would strongly support that kind of measure. We would also recommend other initiatives that have been specified by other groups in the past around the cost of the program be closely examined. The cost of the program to participants because of the dispensing fees is relatively prohibitive, given that a lot of the people who are on the program are of meagre means. If you think about it, some people will be paying up to a third of their income in dispensing fees, which is really counterproductive.

The CHAIR — Just in terms of what you said about streamlining the pharmacological or the opioid replacement services, are they easily available right across the state or have you looked and seen whether there are pockets where there are not enough people trained, whether it is pharmacists or GPs or whatever?

Prof. DIETZE — I think others will have raised this concern, but there is a major concern about a small number of prescribers having a large caseload. We have a small number of relatively vulnerable prescribers because some of them are becoming quite aged nowadays and they may well retire. If they retire, then how their clients are managed and so forth needs to be really carefully thought through. I guess that does mean that we have quasi, almost like public, clinics in some respects for some of these large caseload prescribers and we really should be trying to distribute the cases much more evenly across primary care. I know that there have been some moves towards doing that, but I am just not sure how successful they are. But the Department of Health and Human Services should have those data.

Mr DIXON — You mentioned earlier roadside drug testing and that you had some concerns with that. Could you just elaborate on that a little, please?

Prof. DIETZE — I guess the key thing there is at the moment it is simply a detection threshold, so unlike alcohol, where there is an established impairment threshold that is used that is related to research studies about that impairment, the detection threshold for illicit drugs is simply yes or no. Work going on in Europe and in the UK — and I would encourage you to explore some of these things while in the UK — basically is arguing for impairment to be the key threshold, so determining what sort of threshold of illicit drug on board would correlate to a specific amount of impairment. Because what that then allows, if you focus on impairment, is that you can also pick up other substances that are out there that do cause impairment as well but that we do not actually test for.

Ms PATTEN — So benzodiazepines, for example?

Prof. DIETZE — Things like benzodiazepines. We know that they do impact on driving performance, yet we do not test for them at the moment, and that is partly because there is no established threshold. There are excellent groups in Victoria who are world leaders on driving safety who could easily do the kinds of work that would need to be done to underpin any kind of impairment regime.

Mr DIXON — There would be different thresholds for different drugs is what you are saying, and you would need to establish all of those?

Prof. DIETZE — Yes. It is tricky work, but I think it needs to be done because at the moment the detection is flawed in various ways.

Ms PATTEN — I notice that you talked about incarceration and looking at alternatives. Quite rightly you are saying that incarceration possibly should be the last way to try and deal with it, but you were talking about people, and particularly people on community orders. When they relapse — and certainly abstinence and drug testing is part of a community order very regularly — that relapse into drug use is what quite often sends them back into the prison system. You talked about how there should be alternatives to returning to incarceration. Could you just expand on what kinds of alternatives we could offer there?

Prof. DIETZE — I think it is really about drug treatment and enhancing access to effective drug treatment, and that comes back to even credentialing the drug treatment sector more effectively. At the moment there are all sorts of things — and I know the Turning Point people were talking about this as well — that constitute drug treatment. There is no special credentialing or anything like that, and you can get completely different care when you go into a different service. So we absolutely need effective treatments to be put on offer in those instances and we really should be trying to keep people out of prison.

The other issue that that immediately raises is the issue in one of our points there about outstanding warrants. I actually draw your attention — and it is way down the back — to this case, for example. This is one of our study participants who came out of prison after an eight-month sentence. As soon as he came out he was presented with an outstanding warrant that then led to him being fined. He had come out of prison and did not have a job and all of those kinds of things and now he had a fine debt. He is still caught up in the courts. He probably would not go back to prison for this, but he just was not in a position to pay it. It just defies logic that we do not have this person see out all of the warrants that are outstanding at the time of his incarceration. I am not saying that they all should be wiped or something like that, but the reality is that they really should be dealt with in one hit.

Ms PATTEN — Why are they not being dealt with in one hit?

Prof. DIETZE — I would love to know. I do not actually know. I think you would need to speak to someone like — —

Mr TILLEY — But that would be the exception, not the norm.

Prof. DIETZE — No. Many of the participants in our studies have outstanding warrants, and they sit over them for a long, long time. They do not get expunged after time. There is no limitation on them or anything like that. Again, we really should be looking at expunging outstanding warrants after 10 years or something like that at a minimum. But further I think we really should make sure that our systems are sufficiently streamlined that they actually pick up on all of the outstanding warrants that someone might be facing when they do front a court.

Mr TILLEY — Well, make sure you make that a point please, because I find that extraordinary. That would be an exception — an absolute exception.

The CHAIR — Any other questions?

Mr TILLEY — Yes. I just want to finish off on the impairment. What jurisdictions are you aware of around the world that might be testing for qualifying impairment?

Prof. DIETZE — So there is the European DRUID project. They are looking at all sorts of elements around impairment. It is a big connected project across all of the European Union. If you look into the Wolff et al reference that I have cited there, it actually lists the various jurisdictions that have different detection thresholds

for impairment. One of the things is that they are not standardised across even Europe, which is surprising. So in the Wolff et al reference that is in our submission, on the last page — —

Mr TILLEY — So for example, with cannabis are you looking at the level cannabinoids, or — —

Prof. DIETZE — Yes.

Mr TILLEY — So you having a cut-off point for the level of cannabinoids present at the time of the test.

Prof. DIETZE — And ultimately there are cut-offs in there at the moment. I mean, there has to be a detection threshold.

Mr TILLEY — Yes.

Prof. DIETZE — But those jurisdictions already do have those impairment thresholds in place.

Mr TILLEY — I am just very interested in determining where the legislation might look at what the level of impairment is.

Prof. DIETZE — Again, the UK has got limits suggested in this document. It is worth having a look.

The CHAIR — Can you just go into a little more detail on needle and syringe program improvements to be made?

Prof. DIETZE — Sure. It is clearly something I have missed. The reality is that at the moment we criminalise peer-to-peer distribution, and we really just need to decriminalise this. It is a very straightforward thing to do. It is already happening in the Northern Territory, the ACT and Tasmania. With the ACT change I think I have actually got the link in there for it.

It is simply so that if someone picks up a box of needles and syringes and they come across someone else who needs one at the time, to prevent blood borne virus transmission these are the people who can easily distribute it to them so they do not have to go and get needles and syringes from a fixed site or exchange somewhere or something like that. It prevents blood borne virus transmission, and that is ultimately the aim of the program. We have got documented cases of some of the people in our studies who have them. They will give them out to some of their friends and they will at the same time be imparting safe injecting advice and all of those sorts of things. They are at least as skilled as the people we have staffing the needle and syringe programs.

The CHAIR — So they are being charged for those things? There are examples of people being charged for a syringe, or is it — —

Prof. DIETZE — There is in other jurisdictions; I am not aware of them in Victoria. But it is not something that gets prosecuted. So already people are using discretion around that. It would be rare that you would see it. But the reality is we should decriminalise it just to make sure that people are fully protected and they are not at risk of this kind of thing biting them.

Mr TILLEY — I have one important question on public health. Can you remind us — there was something — whether the federal government last year in relation to hepatitis C put some form of specific pharmaceutical on the PBS?

Prof. DIETZE — Yes. So there has been a massive change in the way in which we treat hepatitis C. There are new what they call direct-acting antivirals that we are in the process of rolling out. The federal government has essentially committed $1 billion. It is an incredible time; we are in the process of what we call eliminating hepatitis C.

Mr TILLEY — There are no studies and that data at this stage is coming and rolling off the back of it.

Prof. DIETZE — There are a lot of studies going on. We work in partnership with various organisations in Victoria to at the moment establish what we call the Eliminate C partnership. In that we are working to upskill all of the sector in how to best get the direct-acting antivirals into the hands of the people who are most at risk, and that is people who are currently injecting drugs. In Australia we are really fortunate that the federal government has not made any exclusions around that so that they can actually receive those hepatitis C

treatment drugs, and they are incredibly effective. You saw the picture of the van before. We are actually running some studies in those vans. As people are coming in they are being given these drugs by nurses, so we are really pushing — pushing is the wrong word; we are really working to establish a nurse-led model of care here because again these are not particularly dangerous drugs or anything like that. The previous hepatitis C treatments were terrible. These new ones are amazing, and they are very well tolerated. If anything, the side effects are just positive. People seem to feel quite good as soon as they start taking them. It is pretty amazing.

Mr EIDEH — Paul, your submission — the Burnet Institute's submission — welcomed the Victorian government's support of take-home naloxone and suggested that further work is needed. Can you provide details on what the Victorian government should do?

Prof. DIETZE — I think so. You should have an example of the act in New Mexico for protecting people with really strong good Samaritan provisions allowing standing orders so that people who are working in, let us say, needle and syringe programs and drug and alcohol treatment services are actually able to give the people at risk naloxone straightaway, and really just reframing it. So I think we need a legislative support as well as the financial support that the government is providing.

Ms PATTEN — Referring to novel psychoactives, I note that you touch on the bill that is before us at the moment, which is yet another prohibition approach. I wondered if the Burnet Institute had looked at the New Zealand approach which, while it is not necessarily active at the moment, was taking an approach of testing for the harm.

Prof. DIETZE — I guess our approach is to always take an evidence-based approach, and we would be really interested to see what happens in New Zealand, but, as you said, New Zealand is not actually progressing at the moment. I think anywhere where you can regulate and control the environment, the substance and all of those things is fundamental; it will reduce harm. At the moment we have this relatively out-of-control, unregulated, uncontrolled market that is causing a lot of harm. I think we really should be exploring alternatives. If we do explore alternatives, we absolutely need to make sure we evaluate them well.

Ms PATTEN — This legislation is mirrored on a UK piece of legislation. It was Wales, I believe, where again they took on this notion of prohibition. although on a positive note they have not prohibited the possession and use of it. So it is probably the first illicit substance that we have taken a Portuguese approach to. But from what I understood, yes, we may have taken it off the high street, but all we did was hand it over to — —

Prof. DIETZE — To the internet.

Ms PATTEN — To the internet and to the street dealers. From what I understood there was no reduction in use and supply.

Prof. DIETZE — And that does appear to be the case. The reality is, I think, that most people would probably try and avoid using a lot of the substances that end up being these novel psychoactives if they could.

Ms PATTEN — If they knew.

Prof. DIETZE — Yes, if they knew. That is why we have recommended a testing service that we actually think could minimise a lot of the harms that go with these unknown chemicals that are potentially highly dangerous.

Mr THOMPSON — In relation to arenas where there has been decriminalisation which can help people who currently have addiction issues, is there much practical evidence of that decriminalisation expanding the incidence of drug use?

Prof. DIETZE — I think the slide I showed you before from Portugal really does suggest that there has not been any expansion of drug use at all in Portugal as a result of implementing their new program. If anything, drug use is just on the decline in Portugal and so in actual fact it seems to be going the other way. I do not think there is anything particularly sophisticated anywhere else. I think it is a different question when it comes to something like legalisation. Legalisation is a completely different kettle of fish. There is emerging evidence in the US that legalising cannabis there does seem to have been having some impacts, and it is not surprising because the way they have gone about legalising it is to create a relatively unfettered, very commercial market where I do not think that is an appropriate public health kind of recommendation.

Mr THOMPSON — And the ability of a place like Portugal to capture and measure the incidence of drug use, would the collection methods of data be sophisticated enough to understand the patterns of usage?

Prof. DIETZE — They are comparable to what we have here. They are not perfect. None of the data sources that we have access to are perfect and that is because these are largely hidden behaviours. People do not necessarily want to disclose that they use substances and things, but what they have in Portugal is comparable to here and so it is probably as good as you can get.

Mr TILLEY — What is Portugal's population? Is it growing? What is their population? Are they going backwards?

Ms PATTEN — Portugal?

Prof. DIETZE — I do not know off the top of my head; I am not sure.

Ms PATTEN — No, I think they are still breeding. They are good Catholics!

Mr TILLEY — There is the problem, isn't it?

The CHAIR — On that note, thank you, Paul. Without making any further comment on the population of Portugal, thank you for your time. It has been very useful.

Prof. DIETZE — No problem. Thank you.

Witness withdrew.