T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 19 June 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witnesses

Dr Caitlin Hughes, Senior Research Fellow, and

Professor Alison Ritter, Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre *(via teleconference)*.

Necessary corrections to be notified to executive officer of committee

The DEPUTY CHAIR — Good afternoon, Doctor. Thank you for your time, and welcome to the public hearings for the Law Reform, Road and Community Safety Committee's inquiry into drug law reform. Firstly, you do not mind me addressing you by your first name?

Dr HUGHES — No. I should note that I have also got my boss, Professor Alison Ritter, with me here as well. You have managed to get two of us. We are missing our third colleague, but at least you have got the two of us here.

The DEPUTY CHAIR — Thank you for that. Do either of you mind if we address you by your first names?

Dr HUGHES — No, that is completely fine.

The DEPUTY CHAIR — The committee has received over 220 submissions since releasing the terms of reference and calling for submissions. The purpose of these hearings is to obtain further evidence from selected witnesses. Thank you so much for making yourselves available and giving your time to the committee today. Hansard will be recording today's proceedings, and within a fortnight of the public hearing a proof version of the transcript will be sent to you for corrections of any typographical and factual errors. The corrected transcript will then become a matter of public record and published on the committee's website. The committee hearings are usually held in public. However, in special circumstances the committee can decide to hear evidence in private. Please advise us if you wish to present all or part of your evidence confidentially. If the committee approves the request, the public gallery will be declared closed, and none of the confidential evidence will be published on the committee's website or quoted in the committee's report. We will hand it over to you now.

Dr HUGHES — My name is Caitlin Hughes. I am perfectly happy for this to be on the public record.

The DEPUTY CHAIR — Terrific. Thank you.

Prof. RITTER — I am happy to for it to be on the public record as well.

Dr HUGHES — I would like to begin by thanking all of the members for the opportunity to speak today. Before taking questions, I will just briefly outline who we are and some of our expertise and the core recommendation from our written submission. As I said, my name is Caitlin Hughes, and with me here today is Professor Alison Ritter. We are researchers at the National Drug and Alcohol Research Centre, which is the largest drug and alcohol research centre in Australia. More specifically, we work within a unit called the drug policy modelling program, which is dedicated to improving the capacity for evidence-informed drug policy. In particular we provide decision-making tools for government and policymakers and build the evidence base around policy domains, including drug laws, of note today, as well as law enforcement, harm reduction and other areas. Between us we have got over 40 years of research experience in the illicit drugs arena, much of it collaborating with international drug policy scholars.

In relation to our written submission, we made a number of key recommendations. I will just flag three before opening up for questions. The first is that we know laws and regulations are a vital part of the government response to the use and control of drugs, but in spite of the best intentions prohibition and criminalisation of drug use and supply, has often increased health, social and economic harms associated with illicit drugs.

The second key point is that in recent times particularly there has been increasing domestic as well as international recognition of the need and benefit for a more health and social response to drugs.

The third point is that we have outlined seven specific options that Victoria could adopt in efforts to reduce harms associated with illicit drugs. Of note we particularly recommend that Victoria remove criminal penalties for the use and possession for personal use of all illicit drugs. This is something that is also termed de jure decriminalisation. We recommend the removal of laws preventing peer distribution of sterile injecting equipment. We recommend passing laws to enable pilot studies of pill-testing or drug-checking services. We recommend revising roadside drug-testing laws and rethinking the blanket ban on all new psychoactive substances.

We are happy to speak to each of these, but the recommendation that we particularly want to emphasise is that of decriminalisation of use and possession. This is important because while Victoria, as with many other states, has had a de facto decriminalisation approach for many years, particularly via police providing diversionary options for a first or a second-time offence involving use or possession, there remain very strict eligibility

requirements around such programs, which means that large numbers of people continue to be policed and sanctioned for the use of drugs alone. This wastes scarce resources of the criminal justice system, reduces employment prospects of many people who use drugs and increases stigmatisation and discrimination of such people. It also, importantly, reduces access to drug treatment and harm reduction services. We welcome your questions about any of this, as well as our broader written submission.

Mr DIXON — I have a question in an area that you have not mentioned at the moment — I may have missed it, but it has certainly been an issue for us — and that is the issue of prescription drugs and the increased incidence of them. I was just wondering what some of the contributing factors are to this trend and your views on that.

Prof. RITTER — I assume you are referring to pharmaceutical opioid drugs in particular when you are talking about prescription drugs.

Mr DIXON — Yes.

Prof. RITTER — There is no question that Australia is experiencing an increasing trend and an increasing, for example, rate of mortality. It is certainly nothing like what is being experienced in the United States, and we are definitely not at epidemic proportions at this stage. You are probably aware that the federal government is rescheduling codeine to make it available via prescription only, I think as of February next year. This is a signal, I think, of a desire, certainly at the federal level and I presume at the state level as well, to tighten up the controls on drugs that are potentially liable for abuse. Certainly the rescheduling of codeine is an important policy initiative in tightening up the availability of those kinds of prescription drugs.

The other comment that I would make is that drug markets are very dynamic and people who are experiencing dependence on opioids will seek those drugs from the most suitable and most available source, whether that be someone's grandmother's medicinal cabinet or someone who they know is dealing in illicit drugs. That is the nature of dependence — that people will continue to seek these things out. I think the tighter and better regulations on prescription drugs should reduce that as a potential source of supply into the black market.

Mr DIXON — Why is it a greater issue in the US? What is the difference between the two markets, or is it just that we are going to follow them inevitably?

Prof. RITTER — The US market has not had a focus particularly on opiates, on heroin; they have always had a much more significant problem with cocaine. And there is literature that describes the recession and the economic downturn in the US as creating an enormous environment of both personal stress and also structural inequality and that that has forced people to seek alternative medications to manage that psychological distress and unemployment and boredom and that they have turned to opioids, which are more readily available in the US than they are in Australia, which has actually produced an upsurge in heroin. The heroin market is now taking off. It is a lagged heroin market which is taking off from the pharmaceutical opioid market in the US, whereas in Australia we have always had a relatively strong heroin market and tighter controls on pharmaceutical opioids. That is not to say that we should not be very alert to what is happening with pharmaceutical opioids in Australia.

Ms PATTEN — Going back to the notion of decriminalising the use and possession of all drugs, or depenalisation as you have recommended, there is a body of thought that says that this will make them more popular and that the unintended consequence of this will be that it will lead to greater drug use. In your research have you found that to be the case, or can you counter that argument?

Dr HUGHES — Thank you, Fiona, for the question. This is a really important question because it is one of the most commonly raised fears, that if you decriminalise use and possession of one drug or multiple drugs, you will have increased drug use. What we are able to say is that there is an ample research body showing that this is not actually the case in practice. So drug use rates do not dramatically differ in nations that have decriminalised use versus those that have retained a criminalised response.

Also, when we look at nations that have undertaken change and we look at levels pre and post, you do not see a dramatic upswing. One particular example I will draw your attention to is that of Portugal. It is probably one of the most talked about examples of drug law reform and it is an area that I have been able to research now for close to 15 years. What we saw after the Portuguese decriminalisation, which was an approach that removed

criminal penalties for use and possession of all illicit drugs, was that lifetime rates of use increased from the time of reform to after but the prevalence of recent use remained stable. It is recent use rates that are particularly important for understanding the impacts, because lifetime rates could have increased because you were removing the stigma around illicit drugs, so we expect there might be many more people who are willing to say, 'Well, 10, 20 years ago I did use an illicit drug', because it is no longer a stigmatised market.

The really important data is around what happened to recent drug use. There we see that, as I said, rates have either been stable or they have actually decreased, particularly amongst the youth population. Added to that, what we found in Portugal is that the prevalence of problematic drug use as well as rates of harm, such as overdoses and prevalence of drug-related HIV, actually decreased. This is very consistent with the broader notion that if you shift from a purely criminalised approach to more of a health and social response, then you can better address some of the harms that are associated with the use of drugs.

Ms PATTEN — Thanks, Caitlin. Just following on a little bit from there, you have talked about deemed supply legislation. Could you just expand a little bit on this? I gather what you are saying is that just because you have 3 grams of a certain product does not mean that you are supplying, and to kind of have a condition of being considered guilty and you having to prove your innocence — that is judicially unfair.

Dr HUGHES — Yes. The research around deemed supply is something I have done with Alison Ritter as well as Nicholas Cowdery; I would like to acknowledge them both. Our basic premise has been to see to what extent Australian deemed supply laws are fit for purpose. These laws were introduced many years ago, back in the 1970s, under the premise that it is very hard to catch a trafficker in the act and so thresholds were set over which carrying a particular amount of drugs became grounds for charging someone with trafficking.

Some research that we did now a few years back that was funded by the Australian Institute of Criminology enabled us to take the threshold limits that had been established in Victoria and other states and territories and see to what extent these threshold limits actually take into account the practices of users. What we found is that often people who use drugs will carry or purchase or consume in a single session a quantity that exceed the existing threshold limits. By definition, these people are committing an offence that could make them liable to be charged as a drug trafficker when their intent is purely to use the drugs for their own personal use.

What we have been suggesting is that the threshold limits should be revised to take into account the best practice knowledge about user practices so that the threshold limits do actually reflect what we know about drug traffickers and can actually be used to target drug trafficking rather than people who are using drugs for their personal use alone.

Ms PATTEN — Thanks, Caitlin. That was really good.

Ms SULEYMAN — I have just got a quick question. The committee has heard evidence about the significant increase in dependence on prescription medication. What are the contributing factors to this trend, and what would be, I suppose, your view on addressing this concern?

Prof. RITTER — I think I addressed that.

Ms SULEYMAN — Did you? Sorry, my mistake. That has been addressed already.

Prof. RITTER — Unless there is any other specific information, I think that was the first question from Martin Dixon.

Ms SULEYMAN — Yes. My apologies; it is my mistake. Can I just go back? We have heard submissions today in relation to pill testing in particular. What is the view of yourselves in relation to pill testing?

Prof. RITTER — Sure. The international research evidence that has been developed over many years in relation to pill testing suggests that it is a very plausible harm reduction strategy. We know that people who have their pills tested reduce their consumption of those substances when the pills or drugs contain substances that they do not expect. We know that it can shift the black market over time. We know that it provides an opportunity for excellent education and information in situ.

What we do not know is whether pill testing will work the same ways in Australia. The drug policy modelling program is very keen to support a trial of pill testing that has a rigorous evaluation component to be able to

assess whether the benefits that have been shown overseas would still apply in Australia. We also know that one of the risks with pill testing that has been mooted is that it increases the perception that the drugs are safe to use and therefore may inadvertently increase the likelihood of people consuming drugs. The international evidence on this has shown that that is not the case. Pill testing, in association with festivals and entertainment venues, has not been associated with an increase in drug use.

Again, we want to know whether that evidence applies in the Australian context, so any study or trial of pill testing would involve also assessing what the risks or the perceived risks might be and evaluating the extent to which it did or did not increase drug use amongst patrons.

Ms SULEYMAN — Thank you. I just had one more question. You can come back to me, if that is possible. I have to find the correct term.

Mr THOMPSON — I note the comment in relation to the decriminalisation of all drugs. You are of the view that heroin ought be decriminalised.

Prof. RITTER — Yes. Can I just clarify — and you have probably heard this from everybody — the important distinction between the decriminalisation of just use and possess and retaining the criminalisation of all supply provisions. The research evidence supports only the decriminalisation of use and possess. It does not support the decriminalisation of supply offences. So our position, based on the evidence, is that the supply of any illicit drug is illegal and a criminal offence, but the use or possession of a small quantity for personal use would be a civil offence or an administrative offence rather than a criminal offence. That is the position on decriminalisation. It is not legalisation and it is not decriminalisation of supply.

Dr HUGHES — Just to add to that, the reason that we say it is important to do this for all illicit drugs gets back to the fact that many people who use drugs are polydrug users, and if you have a response that only decriminalises, say, the use and possession of cannabis, then often you are excluding many of the more marginalised people who use drugs and continuing to criminalise those people and reduce their access to drug treatment and harm reduction services as well as employment services. The evidence base is increasingly strong that by providing a decriminalised response to the use and possession — just for personal use — of all illicit drugs, then you are really maximising the potential for a health and social response.

One thing we have also flagged in our submission is that how you go about decriminalising is a different question to whether you decriminalise or not. There are a whole range of ways by which you could decriminalise use and possession, and you could have quite different responses to some drugs as opposed to others. There is capacity, for example, to provide referral through to treatment systems, if you like, for particular drugs. That is something that they have very much used, for example, in Portugal. They have decriminalised use and possession of all illicit drugs but then set up special committees in order to identify people who are dependent on drugs and people who may have more need for treatment but also for assistance in getting employment, and getting assistance in welfare areas. That is a model that, as I said, there is now a very large evidence base to support.

Mr THOMPSON — Thank you. In the event of there being a pill testing service where they deduce or analyse 140 ingredients and give a substance the all clear, how does the state then deal with the trafficker who has provided the all-clear substance? Does he get a big blue tick to say, 'Keep distributing. Your product has been given a pass'?

Prof. RITTER — Let us hope that the trafficker is detained by the police and arrested for her or his trafficking in an illegal substance. That is categorically clear. It is unlikely that the trafficker would actually be at the venue or in the entertainment precinct. The person who is submitting the drug to be tested is the person who is consuming the drug, not the person who is trafficking in the drug, one would assume. Thirdly, no pill testing service — and they operate around the globe — ever says that a drug is safe. The message is always, 'This drug contains X or Y. Let's talk about the potential impacts that this drug might have on a person consuming it'.

Unfortunately Dr Monica Barratt could not join us due to technical difficulties, but she has been spending the last month visiting a number of the pill testing facilities around Europe and has personally confirmed to us that there is no verbal or written message that because a drug comes back with X substance in it, it is then advised that it is safe to consume, because everybody knows that no drug is safe to consume.

Mr THOMPSON — Let us say that Marmaduke is celebrating his 21st birthday at a rave concert. He has his pill that he bought from supplier X tested and it comes back all clear. Might he not send out a tweet or a social media message to advise that Dealer or Trafficker Cruise has a good product they can all try?

Prof. RITTER — Marmaduke might well do that, but I would suggest that that is a fairly foolish thing to do, to be identifying someone who is trafficking drugs on social media. I assume that the police are well alert to monitoring social media for precisely this kind of communication. That is the job of the police, isn't it, to arrest people who traffic in drugs?

Mr THOMPSON — But it is a safe product.

Prof. RITTER — Okay. I think I have made my position clear.

Mr THOMPSON — I trust I have made mine clear too. Thank you.

Prof. RITTER — Indeed.

Mr EIDEH — The committee have heard evidence about Victoria's current roadside drug testing law, where having any detectable level of a drug is an offence. Stakeholders have highlighted international research suggesting that a threshold for impairment is more appropriate than the current approach. What is your view on that?

Dr HUGHES — Thank you for the question. Yes, our submission agrees with that evidence and that position. As we wrote in our submission, we have been conducting a review of the roadside drug testing laws across the Australian states and territories, and all currently have this zero tolerance approach. But when you do look at the international approaches, particularly in Europe, you see many more countries that are starting to move towards an impairment approach. Two such examples are the Netherlands and — —

Ms PATTEN — Norway.

Dr HUGHES — Norway, yes. Thank you very much, Fiona. So the reason for this is that, firstly, if you have a zero tolerance approach, that reduces or impedes general or specific deterrence of illicit drug-related road accidents, because the current law, the zero tolerance, is not connected to impairment. If you have got a law — —

Prof. RITTER — Can I just come in? This is about road safety. This is about protecting the community from people who are at heightened risk of having an accident and potentially injuring or killing someone. The laws should be about road safety. The most dangerous drug to be consuming is benzodiazepines in combination with alcohol. We need to introduce drug-driving laws that include pharmaceutical medications, particularly benzodiazepines and the opioids, if this is about road safety, and we need to assess impairment or the likelihood of a risk of causing an accident or having an accident, and the presence of drugs in a bodily fluid, whether that is saliva or blood, is not associated inevitably with having an accident.

So it is a mismatch between the goal of the legislation, which is road safety, and the mechanism of the legislation, which are per se laws detecting the presence of any drug which does not have an evidence base that it causes an increased risk of a car accident. It makes a mockery of road safety laws.

Dr HUGHES — Just to add to that, this argument underpins much of our submission, that if you want the drug laws to be reducing harm associated with health or social or economic harms, then the laws need to be fit for purpose, and the unfortunate reality is that many of the current laws are not actually fit for purpose. But if we do make them fit for purpose, then you are much more likely to have laws that will have better perceived legitimacy but that also can actually achieve the goal of reducing harm and increasing the capacity to target our current law enforcement approaches on drug traffickers and those that cause the most harm, rather than the current approach where it is the drug consumers who bear the lion's share of the attention.

Ms PATTEN — I was hoping that Monica could be on the line to talk a little bit more about NPS or the new psychoactive substances. We are going through a process in Victoria, as you are aware, where we want to introduce a blanket ban, as you raised in your submission. Is anyone doing it better? We looked at New Zealand try and take on a regulated approach to psychoactive substances, but are there any other international examples where they are dealing with these new psychoactive substances in a different way?

Prof. RITTER — It is probably worth inviting Monica to comment on that, but she has said to me that one of the features of the system in the UK is that there is clarity about which substances are covered under which act. That is an important area of confusion here in Australia; it is extremely unclear. She may be able to provide further advice about what is happening in the UK.

I think the other thing that is important about new psychoactive substances is to distinguish between intentional use versus unintentional use. There is a lot of unintentional use of these, where they are being sold as other substances, whether it is supposed to be ecstasy or MDMA and it is not and so on, and the policy levers for dealing with intentional use should be quite different, obviously, from the policy levers that are dealing with unintentional use.

Ms PATTEN — Interestingly in the bill before us they are not going to criminalise the possession and use of new psychoactive substances, only the sale and distribution of them.

Prof. RITTER — Right.

Ms PATTEN — So oddly enough if you are caught with a new psychoactive substance that you thought was ecstasy, you are in luck.

Prof RITTER — That is a good example, Fiona, of an unintentional use issue.

Ms PATTEN — 'I thought it was a new psychoactive substance, not ecstasy'. Thank you. Hopefully we will follow up with Monica when she gets back.

Prof. RITTER — Yes. Thanks, Fiona.

Mr THOMPSON — A different question. In relation to psychoactive substances, what is the impact upon the mind of a psychoactive substance, and what might the effect be on productivity if someone has a psychoactive substance on a Saturday night? What is the delayed impact? Is it something where they will be on the 6 o'clock train on Monday morning going to work and they might feel a bit queasy?

Prof. RITTER — It depends entirely on the substance and on the individual. We know there are people who can tolerate large quantities of psychoactive drug and be at work on time and be highly productive, potentially more productive than others, because they have developed a tolerance to those substances and it does not have any impact on their productivity, if that is the kind of metric.

For other people, they can certainly have a negative impact, and that depends on the quantity that is taken, the time of day that it is taken, what the metabolism is of that individual and the co-consumption of food or other substances like alcohol. So just think about the different impacts that two glasses of wine will have and how wildly different they will be between people. It is the same for any psychoactive substance, of which alcohol is of course one.

Mr THOMPSON — A follow-up question. My colleagues are aware of a constituent of mine who has been on psychoactive substances for five years and, according to his parents, his mind has been fried. He has had multiple hospital admissions and he is in his second program of intensive treatment. Do you have any thoughts on treatment programs for people like that, where there are deficiencies in the system? They are taken to hospital, measures are taken of key indicators, and if they are breathing and they can stand up, then they are discharged. They then move back into the cycle again of ingesting a psychoactive substance and ending up in the back of an ambulance.

Prof. RITTER — Thanks, Murray. I am sorry to hear about this story. One of the key challenges, I think, in terms of providing effective treatments for people is that it is all about right place and right time, and our systems are not set up to provide people with the help and support — and their family members — in the right place and at the right time. Everything is set up around booking systems and 9 to 5 and all of that sort of stuff. Emergency departments are not the place. They can respond to a medical emergency but they cannot respond necessarily with an effective treatment. So we need to rethink drug treatment in terms of right place, right time, for each person.

The second thing I would say is that when it comes to circumstances like this, one must then consider the potential options for involuntary treatment. I know this is controversial and difficult. I am currently involved in

evaluating the involuntary treatment program here in New South Wales, and I know that you also have an involuntary treatment program in Victoria. Clearly the loss of liberty is a substantial step to take, but where someone is at serious risk of harming themselves or harming another person — an immediate, serious risk — then there are grounds for the potential for involuntary detention with appropriate health care, medical support, medication and so on. It is not a step that one would take lightly, but the availability of a small number of these treatment places, I think, forms an important part of the overall response.

Dr HUGHES — Just to add to that, I think a more general issue and challenge is that we have much poorer knowledge about many of these new psychoactive substances, because we have not had the capacity to look at the impacts of them like we have for many of the more traditional substances, like how does heroin affect the brain, or how does cannabis affect the brain? This makes it much harder to develop effective responses, and it is one of the concerns with the cat and mouse response where constantly these new substances are emerging.

But there is a more general concern about the potential for displacement, that people will use these new psychoactive substances and choose to use them because they see them as not having been banned in the same way as the traditional substances. Then we do not know what risks they are placing themselves in, and that is where it does raise this vexed issue of: would it be preferable that people are using the more traditional substances or these new unknown NPS?

The DEPUTY CHAIR — Caitlin and Alison, thank you. Is there anything else that you would like to add?

Dr HUGHES — No. I would just like to say again thank you very much for the opportunity to be able to speak to you today, and if you have got any further questions, please do not hesitate to ask.

Ms PATTEN — Thank you.

The DEPUTY CHAIR — Terrific. Thank you so much for your time. We appreciate it. We will no doubt be chasing up with Monica anyway at some stage.

Dr HUGHES — We wish you well in your deliberations.

Ms PATTEN — Thanks very much, and thanks for a great submission.

Committee adjourned.