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

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Professor Margaret Hamilton, Melbourne School of Population and Global Health, University of Melbourne.

Necessary corrections to be notified to executive officer of committee

The CHAIR — We are continuing on with Professor Margaret Hamilton, who is going to speak to us in a moment. We are pleased to have you here this afternoon to add to the group that we have been listening to today in our first day of formal hearings on this inquiry. You are aware that Hansard is recording what is being said, so you will get a transcript of that to look at before it goes on the public record. I think that is all I need to say. I see we have got some notes in regard to your presentation to us, but if you would like to give us an overview of who you are and your expertise, we will ask you some questions from there.

Prof. HAMILTON — Thanks very much for that. Firstly, I think I should just say that since I retired I made a decision to not try and do all the homework of written submissions, but then I was pestered by various people: 'Please, would you come and give evidence?'. In doing that, of course, I have ended up writing a piece. If it is appropriate, I would like to, in a sense, table that and then speak to it and go through it somewhat briefly.

I do not know how much you know of my background, but I have spent 48 years working in this area as a non-medical clinician — I am not a doctor — in both psychology and social work and subsequently public health. I have also worked as an educator, a researcher and a drug policy person — a supposed expert — and it is from that experience that I come today rather than any particular role that I currently carry. I have got a few of those, so I am still involved in a number of things.

One of those, and a most recent one, is that I was appointed as one of two people from this United Nations region, Oceania, to represent non-government organisations' and civil society's voice in the international drug policy forums. So I am a member of the civil society task force, though I am also trying to hand that on to others.

I do have a view about a lot of current debates and issues, and it is not the view that I would have had 48 years ago, nor even probably eight years ago. I have tried to stay in touch with change, new ideas and experience from elsewhere, so that is what I am going to try to bring to you today.

The first point I make is the importance of evidence, and in making that point, the importance of being willing to change one's mind. Over that long period — and I did some study prior to that, so I should say it is 50 years — I have changed my mind on some of the controversial proposals and issues. I suppose I bring that to you because I am not someone who easily changes their mind. I require evidence. I require a chance to talk with people. I require a chance to see things for myself and to mix that with things that are happening on the ground. In light of a lot of that, I have had things I have changed my mind on. It is not easy for most of us to change our minds, and I think it is probably hardest for politicians, where you have already got statements that are in the public domain and you are somewhat constrained from time to time by history, by party allegiance and by a whole range of other things.

What I would say in the drug policy space is that one of the hardest things that I might ask you to do is to try and put aside what you think and try and listen and learn and be willing to defend what you think but also willing to change your mind if you decide maybe that is not the answer or maybe that is not the way to go.

The second thing is that I think that regulation and forms of laws and various regulations do have an absolutely vital part to play in our response to psychoactive drugs. These are very potent substances. Because they are potent, we love them. Many, if not most of us, use them, and that is why we love them — because of what they can do to us. Pretty quickly they can make us feel relaxed, less concerned or more focused, if we think that they will, or whatever it is that we might desire.

My use of alcohol at the end of a day over dinner is a very important part of my cultural ritual, and I am very aware that I am using a psychoactive drug. I grew up on a tobacco farm, so I learned early about tobacco, including the trade side of it and a whole range of other aspects of it. It was only when our father made the comment to our mother that he thought maybe the dogs had taken up smoking, since there was smoke coming from the dog kennel, which was rather large and was our preferred location for making our own rollies, that we realised he was onto us.

But I think we have learned through our experience in Australia in particular that regulation has a very important part to play when it comes to the exposure of people to these substances. And I have no doubt that it is important to have regulations about who can manufacture, who can produce, who can sell, circumstances of use and a whole range of things. So I am not a total libertarian when it comes to drugs, and I do think there are some drugs that are inherently more risky and potentially more harmful than others.

I think we have learned over time that in relation to illicit drugs we have tried and tried to use a particular kind of fixed position — that we should try and get rid of them; we should try and not have them available; we should do all that we can to have certain classes and named drugs out of action, not available. What we have learned is that that is pretty hard to achieve; in fact, no-one has yet achieved it. Having done some consultancy work in far more complex or unusual, for me, situations in Doha and in Saudi Arabia and had contact with people in Iran, what I saw there were countries where alcohol is a prohibited substance but cannabis or marijuana are not. So these choices are as much cultural and historical and political as anything to do with the inherent nature of the substances themselves. And you see the same thing is happening around illegal alcohol in Doha as we see happening around illegal drugs here in Melbourne and Victoria.

I do understand the complexity of adopting any change in the drug policy arena, and as a result I think we tend to try incremental — add a bit, add a bit, change this, look at different sizes of packages that will do different things or whatever. But I think overall I have historically been someone who has always said that we need patience and persistence to achieve the kind of change we need to have. I think there are times, though, when we absolutely need leadership to make a bit of leap of faith or a leap based on evidence into some new ways of responding. We have spent a long, long time. I was a member of what has become known as the Penington inquiry. I was then in the Premier's drug prevention expert group. I was in the very first evaluation group that evaluated the first national drug campaign, or our national drug strategy. I have seen many different strategies in various forms over time. I think from time to time we do see, instead of what I used to think of as little creepy steps, reasonable strides taken. That is what I think we are in need of.

Many people will say, 'Well, surely we should just do prevention, and if we do prevention, both attacking supply' and 'Let's not have the drugs' and trying to socially inoculate young people from any desire to have drugs, that that is what we need. I think prevention, including education, does have an important part to play in preparing young people for decision-making about risky behaviours and a range of situations and products and opportunities that come their way. But we know that while it is necessary, it is not sufficient. I am not going to spend a lot of time here and in this submission on the prevention arena; I have other things I could say about prevention.

I think that the current structure of our response to drugs is disproportionate. It is optimistic at best, and it is pretty naive. It costs us a huge amount and it contributes probably to increased damage to people in the community who use drugs, but also probably costs us a lot more than it needs to.

I have listed a number of things in that first lot of dot points, things that we do in our community that I think we ought to stop and reflect on. We do not have to do all, or we could do better than the things that we currently do. We spend a lot of money on policing the products that are in high demand that I would suggest we will never be able to rid ourselves of. Just as we pass laws and we train our law enforcement and customs people to detect these things, the chemists internationally invent a new formula and so it is no longer covered by our laws. The training has not included that.

So then we have to put all those customs officers and all the police and the sniffer dogs and everything else through a whole new training program. By the time we do that and we are starting to use those skills and knowledge, there is another lot of new products. Some of the old products are very resilient. We know that we have got heroin back around now. We see that people are using heroin. We had a heroin glut late last century, if you like. We have got heroin back with us, and we can see that in heroin overdose or opiate overdose deaths. These drugs are resilient, and they are resilient because people will always look for the things that make them feel good. That is why I have my drink when I have dinner at night. It happens to be a legal drug, probably more dangerous than some of those that are currently illegal, or potentially dangerous — actually dangerous.

We do not provide enough treatment. We do not provide accurate information to drug users about the products they are about to use. We spend a lot of time in schools and elsewhere telling people to look at labels and to think about what they are consuming in our food environment. We work very hard to try and have a lot of detail on labels so people can make choices. When it comes to these drugs we leave them completely without information. So when a young person buys something, they do not know what it is. They are told by the seller that this is what it is, but they have got no quality assurance, no potency information, no standard dose — this is 10 standard doses, half a standard dose or no standard dose at all. So we do not provide them with information.

We expect emergency response teams to go out and revive people who have overdosed, say on opiates, and we could do some other things that would mean we might not need to have always the emergency response teams

go out to them by the provision of Narcan — or naloxone — to drug users themselves. They are nearly always with another drug user when they overdose; it is rare that they are actually on their own. So if we had a system where drug users themselves knew that they had something and they could reverse the immediacy of that impact to save that person's life, we could do that.

I will not go through all of this list, but there are quite a few things I think that we do that we could do differently. At one moment our history of drug policy in Australia was really good, and in the 1980s we had a bold and far-reaching drug policy. Originally known as the National Campaign against Drug Abuse, released in 1985, it was evaluated in 1989. I was a member of team that evaluated it, and I was very proud of that scheme and what Australia had achieved. We put licit and illicit drugs under the same umbrella and we looked at them all together. We looked at supply reduction measures, we looked at demand reduction measures and even then we looked at harm reduction measures. And we were seen as leaders internationally in international forums.

But I think, while we espouse the principle still of social justice with a primary focus on the big bad traffickers and suppliers rather than drug users and we talk about harm minimisation and harm reduction, we do not do some of the key things that evidence tells us we could be doing, and we have really fallen behind. I no longer can stand in international forums proud of us being on the front foot. There are many countries that are well ahead of us when it comes to really respecting the rights of individuals, responding appropriately to keep them alive and doing all that can be done to reduce the harm, not just to the drug users but to their families, and to reduce the costs to the overall community, because many of the costs we currently incur are there because of the way we have our laws.

Increasingly internationally the attention is shifting to human rights, and over all the United Nations instruments the statement that it requires greater cohesion in responding to various issues, including drug use, especially when it interferes with someone's freedom, can be often heard in those corridors. In this regard, I think we do need some fresh framing and some fresh thinking about how we approach our principles — which I would still uphold — of focus on those who are gaining huge amounts of money and trafficking in some of these very potent products. Mind you, I would include tobacco and alcohol in there as well as the illicit markets. That is on the one hand, and then protecting and recognising the rights of individuals to information, to health and to justice, and that is where I think we could do a lot more.

Hopefully other submissions have provided and will provide you with much more specific detail about research, about other places experience. That is part of retirement. I just think, 'No, I'm not going to do all that homework. There are others now, many of whom I have trained, who can do that'. But I think we could do some things, like improving the capacity, both the facilities and the training of our personnel, to deliver a menu of treatment options, because at the moment people do not necessarily know where to go, what they are going to get. There is no quality assurance in that system. We desperately need a system of accreditation for services claiming to be drug treatment services. Anyone at the moment can put up a shingle and say, 'I do drug treatment'. Some of them in my experience, which includes having been a health complaints investigator on drug treatment complaints for another jurisdiction, will charge $50 000, $100 000, to desperate families and provide mush — an absolutely appalling response that is not evidence-based, that has no support. Yes, they will have one, two, they might have 100 anecdotal 'We have cured them'. But if you follow those people long enough, not all of that 100 will remain clean, and anyway many of them could have achieved what was achieved with much more directed, specific and professional care.

We do need enhanced provision of safe injecting equipment, and there are some intricacies about regulations around injecting equipment and its distribution and provision, including the user-to-user distribution, that sort of are impediments to probably being sensible. I too would call for us to have injecting equipment programs within prisons. I know it is controversial, I know that prison officers and correctional people do not like it, but it has been shown to significantly reduce the spread of viral infection and also other problems. It has been done now in many, many other countries and we still resist it here, and yet that is probably a main source of ongoing infections of a range of things — HIV, AIDS, hep B, hep C et cetera et cetera.

Mr TILLEY — What jurisdictions are doing this practice exactly?

Prof. HAMILTON — I am probably not up to date with exactly which ones: Scotland, I know a number in Switzerland, in Germany; I think now in Sweden and some of the UK prisons. I am sure there are others, and I can dig them out and send stuff to you if you want to pursue that with perhaps your research officers and others.

I have already mentioned the distribution of naloxone, the reversal opportunity that could be done. It is being done in the ACT. They have had a very careful distribution program. They have trained drug users, drug users' families; sometimes drug users' employers. They provide them with the drug that is needed, they teach them how to use it — and that has all been done without any huge drama to my knowledge at this point. I caught up with that a couple of months ago, so it is fairly up-to-date.

I think we need a pilot program. I have said here at the bottom dot point on this page, to explore means of providing information about the presence or otherwise of expected substances in pills. This is the pill-testing issue. I think doing a full assay and working out exactly what is in something is a very expensive exercise, but we might be able to do something to say, 'It does or it doesn't have MDMA, or it does or doesn't have in it what you thought you'd purchased'. I think there is pretty good and emerging evidence in a range of places — Austria is one that I am familiar with — that drug users at those sorts of partying and music events will make different decisions about using it based on that knowledge. If they are given information — if people say, 'Well, it hasn't got any of what you think you've purchased in it', users say, 'Well, I'm not going to use it'. Or if they are told, 'It's got a tiny little bit, but hardly any of that. It's got a lot of other stuff, and we can't afford and we're not going to be able to tell you what else is in it', they tend not to use it. So I think there is some emerging evidence there that we really should tune into and give some thought to.

Families — families are part of this scene, but they are not part of our treatment. Families are affected, families are often at their wit's end, families are desperate, families do all that they can. When it comes to formal treatment programs, our targets and funding are so tight that there is not much money to engage families in a systematic manner with the treatment process for each person who comes into treatment, and there are not many in our community, notwithstanding the couple of services across Australia, including here in Victoria, that work to support families. There is not much to help families know what to do. So families, not surprisingly, go from support to 'We'll be tough' to 'No, you can't come home' and 'We're not going to do that'. Then some catastrophe or some crisis arises, and then they say, 'Well, we've got to keep them alive, so we'll let them come back home again', and then all their stuff is pinched or their favourite whatever. Families are in this terrible bind, having no clue about how they can most appropriately respond when they know they have a member of their family who is using something that is causing them grief. I think we just have not sorted out how to respond appropriately to families, and how to incorporate them, including funding for that, into our treatment provisions.

I think we need to retain, as much as possible, some flexibility in legal responses and dispositions in courts, because I think each of these young people, in particular, are different. They are coming from different contexts and different situations, and magistrates and judges need to be able to take some of that into consideration if we are to have humane as well as programmatic responses.

I am not someone arguing that we should let all big-time traffickers go. I am talking about people who have got themselves hooked up in drugs. I think I came in before the last pair finished, and they were talking about the young African man from the Sunshine area. I think that shows an example of extreme wisdom on the part of that magistrate or judge to think, 'Okay'. I think it was a suspended sentence that was given. I think that that kind of nudge is absolutely essential, and we have got to retain that capacity for our legally qualified professionals to use that level at least of discretion when it comes to those kinds of judgements.

I thought I would just say a couple of things about what is happening internationally. The language is really changing. I have probably been about 14 times over the last 15 or 16 years to the international meeting where drug policy is considered — the Commission on Narcotic Drugs — and last year I went to a special session of the General Assembly of the United Nations which was on drugs and drug concerns. Historically the dominant language was clearly one of prohibition, punishment and, 'We will have a drug-free world by the year 2020'. I do not think so, which is why I said before: naive.

Mr TILLEY — Booze free.

Prof. HAMILTON — All of those things. But at this year's opening session a number of very high-ranking officials spoke in a manner that was really quite different. So the newly appointed UN Secretary-General called for reinforcement of the links between drug policies, health and human rights. There was quite a sit up and take notice, because most of the country delegations attending the Commission on Narcotic Drugs are headed up by their law enforcement personnel — justice departments, police and so on — and Australia, Canada, the UK and some of the European countries tend to head them up with their health department personnel, but they have the

AFP, customs et cetera all on the delegation. I was a member of the government delegation as an expert adviser for 12 years. More recently I am going there as a civil society representative in my newer role.

After that, the director-general of the World Health Organization, Margaret Chan, addressed the meeting by invitation, the first time ever that health at that level had been invited to address the meeting. She reminded everyone — and the quote is at the end of that paragraph:

> We must not forget that the ultimate objective of drug control policies is to save lives.

I think it was a kind of reminder, because there is a huge industry in just policing drugs for policing drugs sake and finding drugs and getting rid of drugs and then dealing with drugs, so I think it was just a reminder. The reason we have rules and regulations around these products is that we do not want people to die.

Then the president, the most unlikely, of the enforcement arm of the international drug apparatus, the International Narcotics Control Board — and the name is what it is; it is the policing arm at the international level that all countries report to and they prepare an annual report and so on — said:

> The fundamental goal of an international drug control system remains the protection of the health and welfare of humanity.

I think it is just worth being reminded of this. And so on. It is all there for you to read. But I think it is just an important time for us to start to reconnect with human rights, health, justice, people, rather than still chasing the big industry — that is, the illicit drug industry.

I have got some selected issues. One is around the disproportionate amount of resources that goes into the policing of all of this apparatus — the drugs at our local level and national level — in the context of far less going into treatment and harm reduction. I am particularly troubled by the increasing population in prisons, including many who are using drugs. I think that what we find is that those environments are pretty brutal. They are intended to be to some extent, and they tend not to heal, prevent harm and encourage positive contributions and citizenship in our people.

The tougher on drugs we get, it seems to me the more likely we are to have increased potency of small packages, because out on the streets people will try to have the smallest possible thing so that they can try and avoid detection. This tends to push people into trading in more and more potent forms of drugs, because if you are going to be caught and you are going to get pinged for carrying a bag of, say, cannabis, and you are going to get pinged for carrying paraphernalia with some phials of something or other, then it is very tempting to say, 'Well, I'll just carry something that is so small that you won't detect it, and it will be much easier to sell and much harder to detect'. Historically research has shown the harder we go on drugs, the more likely we are often to increase the potency that people try to deal with at a street level.

Most recently, at the same meeting in March of the Commission on Narcotic Drugs, the director of the UN Office on Drugs and Crime, a former Russian diplomat and a former policing person, in an informal conversation and then commenting in a recorded meeting, noted that one of the increasing concerns for member states — meaning all of the countries in the world — was that prisons can be and are becoming, he said informally, the vector for radicalisation of youth. A lot of the European countries are recognising that the people they are trying to now follow and keep an eye on, who they are classifying as high risk in terms of radicalised and, potentially, terrorist activities, have touched base with that through time in prisons — often short time for not very serious crimes. Rotating them through prisons gives them opportunities for identity, for connectedness, for group affiliation that they did not have before. And they go out and they can readily connect and have support in that sort of environment. So not only do I think prison for drug users is not good for the drug user, it may ultimately be actually contributing to increased harm for all of us.

I make mention of the youth justice system, and I think that is especially where we need to be really sensible about how we respond, for obvious reasons.

Let me go briefly then to the treatment arena. Treatment does work, it can work, but hardly ever first time, so for anyone to think that going into treatment is, 'We've got that person into treatment, great'. If any of you have ever been tobacco smokers, it is rare for a tobacco smoker to have given up the very first time they decide that they will. But each time they try, they tend to learn, 'Oh, that was a bit silly last time. I thought I could be a social smoker, so when I was offered a really nice cigar at that function, I thought, oh, that will be fine. So I have learned I mustn't have a cigar next time'. But next time it is something else. But over each trial they learn

what triggers them to the risks to be smoking again, and eventually most people can stop their cigarette smoking. It is the same with all of these drugs, but we have to be willing to try, try and try again, and to accept and accept, and to make sure our treatment facilities and services are positive, supportive and tough but likeable so that people will come back. There is not much point making it so rugged, so tough, so nasty that somebody who might achieve for a bit and then relapses says, 'I'm not going back there'. So we have got to be able to have that balance between attracting people into treatment but knowing that they may need to come back, so be careful how we treat them, and make sure we do it well.

I would just pick up on a couple of these other points. I have mentioned accreditation. I think the substitute pharmacotherapy service in Victoria probably needs some refreshing. I think Victoria has been lagging behind a number of other states in what we do here and how we do it. We struggle to get prescribers and dispensers, and the costs of this for users is significant. So there is a conundrum in there, and I think there are others who you might be seeing who will be better at giving you more detail on that. The real-time prescribing monitoring program is I think a sensible thing, but it needs to be properly thought through, considered, reflected on and maybe tweaked.

I do think it is also time for us to initiate a drug overdose prevention trial, a drug consumption place, in those locations that have very high risks of overdose deaths in particular. I will not spend a lot of time on that because I know there is a parallel inquiry on that. But I will just say that that same head of the narcotics control board internationally did say that drug consumption rooms could be justified provided that they aim at effectively reducing the negative consequences of drug abuse and must ultimately lead to treatment, rehabilitation and reintegration measures. And I think that Victoria could operate such a facility within these internationally suggested parameters without difficulty.

I think we should pilot test some form of pill testing. And if you want to be really controversial, I still think that we should consider a trial of an opiate prescription service for people who, for whatever reason, are unable to and are not stopping their use, to actually bring them into some kind of program that allows regularity, systematic contact and opportunities for dealing with other physical and mental illness issues et cetera. On processes I would just say three things: the collaboration of health and law enforcement is vital at every level; there is a greater need I think for a wide engagement of the community in all these discussions, because the community has had nearly 100 years of strong messaging about 'drugs are bad', 'get rid of the drugs', and to shift that is not easy; and I think that issue about looking at what is happening elsewhere, in other states, in other jurisdictions and in other countries is important. I have always thought it was important to look beyond our own situation.

That is why I initiated and then got the first tranche of money for the drug policy modelling program and started it here in Victoria, and it is now in Sydney at the National Drug and Alcohol Research Centre, but Alison Ritter, who worked with me at Turning Point at that time, took that up to Sydney to that centre and continues. I think they have made a submission to you and are likely to be available for evidence.

I have just made a note about tobacco, but I will not bother speaking to it. It is really around the issue around illicit tobacco. I know a bit about that because tobacco funded my own education, and my summer holidays were spent tying up tobacco for curing and climbing up the racks to get the tobacco down.

Mr TILLEY — Don't tell me you are a Myrtleford girl, are you?

Prof. HAMILTON — Up that way — Ovens River, between Myrtleford and Wang.

So in summary drug use is something most of us engage in, including me, but I happen to use products that are not illegal. The only harm to me is the harm that I am very aware of and I know about and the risks. I have got all the information I need. I choose to still use alcohol, though it probably would be better for me not to. I have a mother who had breast cancer and bowel cancer, and alcohol consumption is a risk for both of those, but I still drink.

So even the most apparently rational of us do irrational things. I would just hope that here in Victoria we can be humane and pragmatic and make sure that my grandchildren if and when they make decisions that might be risky or not sensible, either survive them or, if they are in trouble, that we are good enough to provide a safety net that ensures they will grow to maturity and be citizens we can all be proud of.

I do wish you well. This is a tough arena. I have been in it for a very long time, and I am here because my credo is patience and persistence.

The CHAIR — We do not have a lot of time for questions because your presentation took us through a broad range of issues. One of the themes that has come through regularly today is about a lack of training out there either for GPs or people to then direct people onto programs, and of course you talked about a number of programs there that are not accredited and how we do that. Who is responsible for training overall, do you think, or where are the key points? It is not just a state issue, is it? It is more broad than that.

Prof. HAMILTON — No, it is not. In some ways I would start at the pointy end, and I would start with the specific drug treatment services. If we do not have funding sufficient to have properly qualified people staff those, we have already made mistakes. So if the funding for X beds for this amount of time for this many people for however many target episodes is not sufficient, what we will see is services going from employing people with degrees and postgraduate qualifications in drug-specific interventions to maybe people who have got a generic degree to maybe people who have got a diploma to maybe people who have got certificates. In this arena we have historically not had well-qualified staff.

I can recall when I was the director of Turning Point insisting to the government that they bring in a policy that everybody had to at least have a certificate-level qualification as a bare minimum — so cert IIs and cert IVs. There was no way anyone should be working in a treatment service that did not have some training. I also argued that then those same people should be trained up, so they should get further qualifications, not only so they could do things better but that they had some kind of capacity to move between jobs and not always just drug treatment.

So to answer your question I think a lot of it comes out of the requirements and the expectations in the contracts for service and what that means in terms of ultimately who is employed. Most other states have done better with their medical specialists than we have in Victoria because they have decentralised and they have funded special units through hospitals. That has attracted and given a career path for doctors to be attracted to this as a medical specialty, and there would be some of them who are here but most of those that I supported and had trained at Turning Point are now working interstate because that is where their careers took them. So the best ones at that time were not here. There were some who were beginning as I was leaving who are still here, but that was quite a revealing finding for me.

Medical schools try, but they have got crowded curricula and this is not a popular area to work in — not paid well, it is not acknowledged, it is not recognised, and if there are no jobs or career path, why would you do it? I am not a medico, but I have always supported trying to have our medicos very well qualified and specialists in this area, providing scholarships if necessary — whatever it takes — because they are a lead profession in the environment and if we have got enough of them, they can come and speak at things like this and be leaders and provide support for other staff.

That is why I say I would start at the pointy end rather than at the GPs. It is hard to train all the GPs. I have tried to do that with alcohol, and even that is hard.

Mr TILLEY — I just had a quick look at the terms of reference, but I am interested in that you said you were not going to comment on tobacco. Could you just give us a quick 30 seconds on that?

Prof. HAMILTON — The only reason is that I think there is quite a lot of information which is contrary to the information that I have access to about illegal tobacco. I understand that there is a KPMG report which was commissioned by the tobacco industry to do an estimate, and that is quoted everywhere and it says something like — I think it says — 14 per cent of all of the tobacco in circulation in Australia is illicit tobacco.

Well, other sources who have used a range of evidence say, 'No, that's ridiculous. It's more like 3 to 4 per cent'. So I think one just has to be cautious. The tobacco industry is voracious and very experienced at lobbying and very experienced at providing opportunities for a better deal, and in an environment where excise tax is going up and there is a commitment to increasing it each year — and I know this is not a state matter, but that is why I just put it as a coda — they will argue that that is causing more illicit tobacco, so the illicit tobacco is a reason why we should not have the excise because the more expensive it is the more, you know. I do not buy that.

Mr EIDEH — Just a quick one in regard to your involvement in the recent United Nations General Assembly special session on substance abuse. What were the significant achievements or outcomes and how will this resolution have a beneficial outcome for drug policy reform? Would you agree with the views of some progressive reformers that the United Nations General Assembly special session was ultimately a disappointment or a failure?

Prof. HAMILTON — I will go to the special session because there was a lot of discussion at the most recent meeting on whether internationally we should go back to the 2009 declaration or use the outcome document from the special session at the General Assembly in New York last year. As I understand it, the agreement is to go with the outcome document from last year. I do not think it was a failure. Yes, there were some disappointments. If people went there expecting a revolution, they were very distressed. I have been around long enough not to expect revolutions and I think even those people, if they read through the outcome document now, they would say, 'Okay, it did actually talk about harm reduction. It did talk about it being unacceptable to have capital punishment for drug-related crimes. It did say it is important to make opiates available in the countries where they are not currently available and that people die in pain because they are too scared of what they hear about drug abuse'. So there are a lot of elements in that outcome document that I think are important.

Overall I think the general thrust was to, as I suggested, bring a higher profile for human rights, respecting human rights, respecting health and the importance of health driving these agendas as we become more and more knowing. Rigorous, very rigorous, endless law enforcement to try and stop production and distribution and availability of these substances — yes, it can modify the market from time to time in certain locations, but it will bubble out somewhere else or with another product. So I think there is recognition that some of that is necessary, as it is with tobacco and alcohol, but that is not where we should be putting such a high proportion of our funding.

Mr THOMPSON — Thank you for your wideranging commentary on potential law reforms. Have you ever contemplated whether there might be any unintended consequences from wideranging reforms so that while the objective is to minimise harm and to improve wellbeing there might be other areas that involve increased levels of harm?

Prof. HAMILTON — I think that is a very important question, and it is one I always ask whenever I am suggesting something. I say, 'Okay, that would be great for them. What might be the downside or what else might happen?', because in this arena we are very experienced with perverse outcomes of policies. I think you have always got to ask that.

It is a bit like when I have chaired Melbourne uni's research ethics committee. I had some members who would say, 'Oh, there is just a possibility and a risk that something could happen if we do that', and I would say, 'Our task is to balance the risk with the benefits and really have a look at how likely is that risk versus what are the benefits'. I think that is the drug policy space. There are not silver bullets. There are not things that will treat and fix, nor are there policies and laws that will be perfect. There will be some adverse outcomes, I would suggest, of any shifts and changes that we make because there are a lot now.

There are a lot of perverse consequences of some of what we do now. I have mentioned some of them: people trading in more potent products because they can be handled in smaller quantities; people going to prison who are not already infected with bloodborne viruses as a result of drug use, and then they go in there, they cannot get access to safe injecting equipment and they become infected. There are a lot of things that we contribute to through our current policies. So yes, I have, and I think it is an important reflection to always bear in mind.

The CHAIR — Any other questions?

Ms PATTEN — I have got one quick one and it is a hard one. It has been reflected quite of few times today that Australia was a leader. Going back to Murray's idea of the risk-and-benefit analysis, we were there to try things, whether that was the needle program, whether that was peer education networks — all of what we did. Have you got any thoughts as to what happened? Why did we stop being brave or why did we stop being leaders?

Prof. HAMILTON — One answer to that is a very simple one. We thought we were so good that we could rest on our laurels. Things change in this environment. The drugs change, the people who use them change, the

way they are used change, the context of use changes — and we did not change with them. So I think it was like we were so proud and cocky and we thought, 'Well, we've got this sorted'. That is one reason.

I think the other reason is that after a while when things are not drama, they drop from attention. So what we saw at a national level was high-level meetings of ministers — health and justice ministers — meeting every year, initially, two or three or four times. Then it became — —

Ms PATTEN — Was this solely because of HIV?

Prof. HAMILTON — No. I think it was also because we had a Prime Minister who had a daughter who was heroin-dependent. He himself had been a big alcohol user. So I think what we saw over time was that they went to once-a-year meetings and then half-a-day meetings and then senior officials and then government officers, who were very senior initially, and then I used to sometimes go to those meetings and I would see more and more junior officers and they did not know anything of the history. They had been in the job for three months, they were heading off to agriculture or trade and so they did not know what they were talking about. So you could not have a meaningful discussion. I think that lack of cohesion from high level right down to grassroots between law enforcement and health also became dissipated. Justice people and law enforcement started meeting on their own; health started meeting on their own. They stopped talking to one another in a way that — —

When I started Turning Point I remember one of the first people I went to see was the policeman on duty at Fitzroy police station. I said, 'You and I have to work really closely together because this is our mutual patch', and I did the same thing nationally and I now do it internationally, and I think you have got to do it at all those levels. If you are not working together, you cannot satisfactorily engage the communities of interest and of location so you end up with a dissipated group and people going back to things that they have learned or been taught because of the messaging that has been out there: 'This is what we need to do'. We know that most of the popular calls are the least successful interventions and most of the successful and effective interventions are the least popular, because they are the scary things. It is ever thus in this field.

Ms PATTEN — Yes; that is interesting. Thank you.

The CHAIR — We have gone over time, as we keep tending to do with all of our witnesses today. Any other questions?

Ms SULEYMAN — I just have one quick one. Thanks for your presentation. At the beginning you made a statement that over the years you have changed your mind on things that perhaps 48 or eight years ago would be different. What is one of the changing points in relation to this particular — —

Prof. HAMILTON — The most obvious one is drug consumption spaces. When I first started Turning Point a policeman in Heidelberg or somewhere — it was not actually in the Fitzroy patch — made a statement in the newspaper that we should provide a place for people to inject their drugs, and I was asked about it on the hop without ever really thinking about it, and it was actually before there was much information about this overseas. I said, 'Oh, I don't think that's a very good idea'. So my first reaction was just a layperson's reaction, as all the community would say. So I took it upon myself when I had opportunities to go and visit these in other countries, to talk with people, to be involved with communities and then during the Penington inquiry I went to Tallangatta and to Frankston and to Portland, all sorts of places, to talk to communities about drug policy and what works and what does not work. I know it is hard work, but in the local hall the good news is that the CWA suppers are great in the country. That is something I have definitely changed my mind on. I think we need that.

Probably the other reason is that I did walk out from work late one night at Turning Point, down the little alley opposite Turning Point, to go to my car and one of our clients had dropped and was in the lane. I had that moment of thinking — yes, I did ring 000 — 'I've got to do something because this is critical', and having to make a decision because I thought, 'I don't know if he's hep C positive and he could be well be HIV. I've just got to do it'. I used the only filter I had, which was my shirt, and I started resuscitation. At that time I also thought, 'People shouldn't have to deal with this in the street, in this locality where we know it's going on, if there was a place that they could go and use'. So it was also that personal experience. He lived; I will just say that he lived.

The CHAIR — All right, Margaret. Thank you very much for your contribution.

Prof. HAMILTON — Thank you. Thanks for the opportunity. I guess I should thank you for pestering me, in retirement, to sit and actually write it down. Thank you. I wish you well. It is not an easy one.

Witness withdrew.