T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 21 August 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

Mr Trevor King, director programs, and
Mr Paul Aiken, evaluation and advocacy team leader, UnitingCare ReGen.

Necessary corrections to be notified to executive officer of committee

Mr DIXON — Welcome to this subcommittee of our full committee. We have got a few members absent, including the Chair, due to some transport issues with planes and cars. We have so far received about 220 submissions since releasing the terms of reference and calling for submissions. The purpose of these hearings is to hear a little bit more from some of those selected witnesses.

Hansard will be recording today's proceedings, and within a fortnight, roughly, you will receive a transcript. We will ask you to check for any typographical or factual errors, and the corrected transcript then becomes part of the public record. You are covered by parliamentary privilege here. If you want to go in camera and give confidential evidence at any stage, please indicate that to us; otherwise it is all out there to discuss. We are running a little bit late. We would like to finish this about half past 10, so we would appreciate some input from you — 10 minutes or so — which will give us lots of time for questions. Once again I apologise for the lateness, but these things cannot be helped, especially when you are the first witness on a wet Monday morning. As I said, members will probably appear over the next 20 minutes or so. So, over to you. Who is speaking first?

Mr KING — I will lead off. Thanks very much for the opportunity to appear before the committee. We think this is really important work. I thought I would just give a very brief overview of the work that we do just to give you a sense of context and where we are coming from.

Uniting ReGen is a specialist alcohol and drug service of the Uniting Church Victoria and Tasmania. We have been operating for 47 years now, previously as Moreland Hall — and a lot of people know us as Moreland Hall. We are operating over around 15 locations now, from Richmond to Epping to Broadmeadows down to Werribee, providing a range of services. The sorts of services that we provide are intake and assessment. We provide residential and non-residential withdrawal services, including recently for mums with babies; counselling services; therapeutic day programs. We have got six-week therapeutic programs for people, including some forensic clients who come into a program that we are running. And we run a range of psychoeducational courses for people often diverted by police or magistrates. We have got probably about five or six programs that we operate. We also offer a needle and syringe program, and we provide naloxone to our clients and training around naloxone.

We work with a very broad range of people, but they are often marginalised and stigmatised and experiencing a whole range of co-occurring mental health, physical health and social disadvantage. We are of the view that one of the reasons why our clients experience serious drug-related harms is current illicit drug laws. We see that as a major contributing factor.

I think our key message in our submission and what we want to reinforce today is that we would like to see much more acknowledgement that drug use is a health issue rather than an illegal issue to avoid some of the serious, adverse and unintended consequences. We believe this is going to take a lot of change in terms of policy, including changes to laws. I think there are some well-documented limitations of the prohibition approaches that we have had to date. I think there is now considerable expert and community support for those changes.

Whilst retaining tough sanctions on the manufacture and importation of dangerous drugs, we think there is considerable room to at least decriminalise possession of small quantities of drugs for personal use. Of course there are other law reform options as well.

We think that could free up police resources. You would have heard many times before that something like 20 per cent of arrests at the moment are for traffickers, the more serious offenders, and about 80 per cent remain people who are detected with drugs, essentially for their own personal use.

We also think this would allow a shift from the least to the most harmful drugs. We know again — and you will have heard before, many times I am sure — that the emphasis on cannabis is prominent. I think something like 47 per cent of the arrests are for people who are using cannabis.

We think this could also assist in rebalancing Australia's harm minimisation policy and the resource allocation. We do know that the vast majority of funds — something like 60 per cent of funds — go into law enforcement, into supply reduction strategies. One of the issues with that is that harm reduction, prevention and treatment programs we believe are chronically underfunded. If change were to occur, what would be the potential impacts on clients of our services? Most importantly we believe it would reduce stigmatisation, which currently prevents people and their families from seeking help. There would be a much greater opportunity to access harm

reduction services to keep drug users alive and disease-free, particularly given that we do know that for many people there is a drug-using career and people can come out successfully at the other end. We want them to be as healthy as possible. We want to ensure that they have not got criminal charges if they can be avoided, because these are things that can certainly impact on the remainder of their lives.

We think this could also provide greater opportunity for early intervention, including voluntary diversion into evidence-based psychoeducational programs, like some that we run, or treatment interventions. We also know that the earlier you intervene, the more successful the outcome is going to be. There is less likelihood that criminal charges will have a detrimental effect on people over the remainder of their lives. The sorts of things we typically see with our client group is that they have real difficulty gaining employment, and this is critical in terms of recovery from alcohol or other drug use. They would also not have the same opportunity to travel to some places as others would.

In summary, we see drug law reform as the potential to make a significant contribution to reducing the impacts of alcohol and drug use on individuals and families and communities. But it is only going to be effective if it is combined with a range of other things. Those things, we believe, are that there needs to be much more focus on the social determinants of health and disadvantage. We need to invest in what we believe are chronically underfunded harm-reduction, prevention and treatment services. We really struggle. We have got waiting lists constantly and people who want our help. There are delays in getting into our service.

We also think there is a real argument for improving the quality of public debate around some of these issues. There is a whole range of stereotypes about our client group, and some of those are simply not helpful. We believe in evidence-informed public debate, which is something we really try and do — and Paul is the person who takes the lead on that on our behalf — challenging some of the myths, adding evidence when people are making some fairly outrageous claims about our client group and whether or not treatment works. We know that some people who use drugs experience a wide range of harms and we know that changes to drug laws could reduce that harm. Others will respond very well to the various interventions that we provide, whether it is psychoeducation or whether it is harm reduction in focus or whether it is treatment focused.

The CHAIR — Thank you, Trevor. My apologies for not being here at the start, but in coming down from Ballarat this morning I got a little bit caught up in the traffic. Did Paul want to make any contribution at the moment? Okay, so we can go to questions. If I could just understand first from you, Trevor — I do not know whether you covered this — in relation to the service provision you provide at the moment, physically where are those services provided from?

Mr KING — Our main base is in Coburg, so behind the John Fawkner hospital is where we are located. But as a result of some of the reformed alcohol and drug services, we are now operating in a whole range of locations. I did not mention Narre Warren. We are running a therapeutic program down at Narre Warren — a six-week program. We have got staff located in Richmond, with Odyssey House. Some of our services are provided in partnership with Odyssey House and some are not. That is the inner-north catchment. The north catchment is Whittlesea, Epping, Preston. The north-west catchment is Broadmeadows into Footscray. The south-west catchment is — I might be geographically embarrassed here — Werribee certainly and Melton is another. But there might be only one or two or three staff located there. We are 170 staff all up, and the vast majority are based in Coburg.

Ms PATTEN — Thank you very much for your submission and for coming in. I was interested in looking at diversion, because you mentioned in your submission that it is inconsistent, and you are not the first to say that. I was wondering if you could speak a little bit more about that inconsistency and how we might be able to make it more consistent, and that might be law reform, but also whether you have evaluated the diversion programs and which ones have been successful or what we could learn from that?

Mr AIKEN — Sure. Heterogeneity is probably the word that gets used to describe both the implementation and the research that has been done on diversion programs to date. Certainly what has been well established in the past is that both within jurisdictions and across jurisdictions the nature of diversion programs and how they are implemented, what the eligibility criteria is, has been quite diverse. Some of the work has been done at NDARC at the University of New South Wales by Alison Ritter and Caitlin Hughes. They have really helped map the evolution of Australia's diversion programs, and we seem to be getting more consistency now across the board, but there are still a range of programs around and different approaches. Certainly what we have seen at a local level is that with police cautioning schemes and diversion programs they often rely on a local

commander at a local station and what their attitude is. They shape the culture within their station and their officers follow their lead. So you can get a wide range in approaches across different stations and different areas within the state and the same system.

Ms PATTEN — Is it regional versus urban? Are there differences there? Also is it due to the fact that there might not be programs like your own in some areas?

Mr KING — I think that is certainly true. If the diversion is for an assessment and possibly counselling and other programs, I think they are available right across metro and country regions. Access varies considerably. Some of the psychoeducational programs we run are drink-drive, drug-drive education programs. Others that magistrates refer to — Cautious with Cannabis is an example. DDAL, people would have spoken about previously, where police caution someone, usually at a music festival. Turning Point is the organisation that then refers people on to services like ours that people are required to attend for an assessment and a brief intervention. There is a lot of variability.

Now those sorts of programs are typically metro-based, and that is a shame, I think. But that is a resourcing issue. I would probably also say — and part of your question was about evaluations — that the alcohol and drug services have never really committed to any substantial evaluation of services. We do what we can, and what we know. For example, with a psychoeducational program we can measure whether there is a change in knowledge, whether there is a change in attitude and whether there is a change in intention. They are easy enough to measure. But what does that actually mean? We do not know. Paul and I were talking about this earlier. What we do know is that a diversion option will certainly be less costly and will have a less harmful impact, even though there might be some question about the extent of benefit you might get from them.

Mr AIKEN — There was a 2016 review done by NDARC — Marian Shanahan, Caitlin Hughes and Tim McSweeney — looking at cannabis diversion programs in Australia. What they found was that compared to a traditional criminal justice response — criminal charges, potential imprisonment — and in terms of impact on cannabis use, they are equivalent, but that diversion programs come without all the extra baggage and potential impacts of having a criminal record. They had singled out areas like social connectedness, family and partnerships, and future employment as being areas that the current criminal approach tends to have significant impacts on.

Ms PATTEN — Negatively impacts on —

Mr AIKEN — And ongoing impacts on things; a criminal record has a significant impact on people's ability to seek employment. Interestingly, they also found that participants in diversion programs had significantly better attitudes towards police and police authority than those caught up in the criminal system.

Mr DIXON — Private rehab residential sorts of programs: do you have much interaction with them; and what would your views on them and their industry be?

Mr KING — We do not have very much interaction. Our view, or my view — I have to be careful here — is that what comes with being a funded alcohol and drug service or rehab service is that there is a whole range of compliance issues. This is, you know, all of the complying with legislation, aligning your practices with the evidence, having minimum standards in terms of the qualifications of your staff, and all of the things that we do routinely now that is around reporting child safety concerns and responding to a whole range of issues. Because the private system is not regulated in any way, Paul and I could and possibly should start up a private rehab —

Mr AIKEN — That is a retirement plan.

Mr KING — on the coast somewhere. The problem with it is what we find is —

If you go to a website, the things that I immediately look for if I look on their website is, one, whether or not there is any warning from Consumer Affairs Victoria saying, 'Some of the claims made by this organisation are not supported by evidence', because that has happened in Victoria. The other thing I want to know is who is running it and what is the nature of the program they run. We have a very clear sense of what things work now. There is good research evidence around cognitive behaviour therapy approaches, motivational enhancement approaches, engaging with families, and if I do not see those things as part of the program then I think I am concerned already because there is not that alignment with the evidence. So one of the issues is there might be

private programs out there that are doing great work but we simply do not know, and we are hearing some things about some that might not be that are very concerning.

Mr AIKEN — There has certainly been a recent growth in the establishment of private services, particularly since the emergence of methamphetamine and the generation of the more widespread community fear about methamphetamine. I guess also what we are seeing is some of the marketing claims by these services are quite unrealistic and can prey on the vulnerabilities of desperate families who just want to have their child fixed, and those of us in a similar industry know that is not how it works.

Mr KING — And there are delays getting into public services.

Mr AIKEN — Yes.

Mr KING — You know, there are waiting lists, and again people want instant sort of access, and I understand that.

Mr AIKEN — And if people have to take out a second mortgage on their house to pay for a private rehab, if it means they get in this week as opposed to in three months time, that is what they will do.

Mr THOMPSON — How long is an effective private rehab program, measured in months?

Mr KING — I think most of the private ones now range from somewhere around four weeks, often four weeks, because I think any sort of private insurance cuts out at the end of four weeks, so that is one of the reasons why four weeks is probably the minimum period, and others can go up to 12 months or even longer. It varies considerably in duration.

Mr THOMPSON — I note you have quoted Professor David Penington in your submission, and I quote:

> … Professor David Penington, for example, advocates a system whereby Australians over 16 have access to a limited, regulated quantity of cannabis and ecstasy from a government approved supplied —

I assume source —

> once they registered on a confidential national register (Penington, 2012).

And you go on to recommend:

> Consider the future adoption of regulated supply and distribution of some drug types.

That would be a large game change in terms of availability and access. Do you have any other reservations in relation to it, or would you recommend that we as members of Parliament or you as people within the industry would take advantage of that service if we had a Saturday night function that we were looking to give a bit of a kick, in terms of it enlarging the social acceptability of drugs that are now currently not condoned?

Mr KING — Professor Penington, who has good experience in the area, has made those recommendations. One of our views is that most policy change tends to be incremental and difficult. I am sure as a committee you are absolutely aware that it is difficult to change particularly laws. So in our submission we have talked about decriminalisation, but there are other options and there are many advocates out there, including Professor Penington, talking about one step beyond that, where based on drugs that are seen as less harmful there are other options in terms of regulation. Legal availability is what he proposed. We are not charging hard down that track, but it is certainly one of the considerations that as a committee I am sure you would be debating vigorously, no doubt. I am not sure if you want to add to that.

Mr AIKEN — Yes, the consensus within our sector is really around decriminalisation at the moment, and I think even proponents of legalisation recognise that there is not the robust evidence base yet of research to support or to look at the sorts of issues that you are raising. While it may have the potential to have the most powerful impacts in terms of reducing harm within our community, there are a range of other factors that need to be considered as well, and because there are not many examples internationally of a legalised market or regulated market in place to be studied, we do not know fully what the full outcomes would be.

Mr KING — Some colleagues of mine, or ex-colleagues of mine, from the Drug Policy Modelling Program in the University of New South Wales, are also saying, 'We don't know what the best options are here'.

People — David McDonald is an example, and Caitlin Hughes is also very active in this area in terms of drug laws and did the review of the Portugal experience — are a little reserved. They are not sort of charging out there saying, 'Look, this is the panacea'. They are saying, 'We need to be thoughtful about how this might work and what the pros and cons would be. And if you do introduce regulated sorts of legal options for some drugs, which drugs?'. You know, how do you regulate? The complexity, as you know and would have heard, is enormous.

To be honest, from a drug treatment point of view, we are happy to leave that to others. We are really trying to just limit the harms that the people that we see are experiencing on a daily basis. That is what our motivation is.

The CHAIR — We are sorry you have not got the answers for us on that score!

Mr AIKEN — I am assuming in your recent tour you would have seen in the States that their approach has been a bit messy and it is difficult to draw any clear conclusions, but with the States where there has been legalisation there have been some mixed results. There is some increased cannabis use, some increase in drug-driving offences but also reduced demand for prescription opioids and related harms of those. That is obviously an area that is going to have some fairly close attention in the coming years.

The CHAIR — I wanted to ask a bit about methamphetamine — ice — use and treatment and ask about ReGen. Do you have some programs that are directed particularly at ice users?

Mr KING — We do.

The CHAIR — Can you tell us a little bit about those and what you think are the needs of a good program to deal with ice, and the delay times that you are experiencing?

Mr KING — We are proud of our efforts in terms of methamphetamine. When we saw this iteration of the methamphetamine issue, a lot of alcohol and drug services in Victoria had been dealing with alcohol, heroin and cannabis for many years, and the nature of the programs you need to offer are quite different to methamphetamine users. For example, we are pretty confident that for someone with an alcohol or heroin problem, we can bring them into a residential withdrawal facility, or indeed a non-residential program, and within about seven days they will be detoxed. We can withdraw them, and we can do that quite safely.

What we found with methamphetamine, though, was that we were getting people who were presenting much more agitated. We had people stay with us for detox, as I said, for around seven to 10 days. That was not enough for this group. We found that initially they were just crashing. So for the first three days all we were really able to do was just give good nursing care — you know, hydration and feeding them in a low-stimulus environment. We also found that then after that three-day period, for the first probably about seven days there is the more acute phase of the withdrawal, and then it can go on for a couple more weeks after that.

So we did a review of our practices. We had discussions with the Department of Health and Human Services and said, 'We actually need to extend out the detox period for this group'. We also found that aggression was an issue, although we think that we are pretty good at managing it. We have not experienced huge problems. We found that a lot of other services were saying, 'There is nothing we can really provide'. We felt that was an inappropriate response, so we have done a lot of work in this area. In terms of the post-withdrawal phase, which is critically important regarding —

The CHAIR — So what are you looking at as a withdrawal phase now? About three weeks?

Mr KING — For us it is around an average of seven to 10 days in withdrawal, but we also know that in terms of cognitive impairment people can experience problems for a much longer period than that.

Mr AIKEN — Often up to a month.

Mr KING — We offer quite specific non-residential rehabilitation six-week programs, where people will come in and they will, as I said before, undertake a program that is based on cognitive behavioural therapy. So this is giving people strategies to avoid relapse and giving people strategies to take care of a whole range of other issues in their lives. They might have an associated mental health issue. It could be anxiety, it could be depression, it could be some psychotic symptoms associated with methamphetamine use — all things that we will be treating during that period. But essentially this is getting people back on track and giving them strategies

to stay drug free. And then after that we would argue that if it is not family support, it needs to be mutual help or facilitated programs that we might run, which are just simply support groups that people can continue on for years if they need to. It is the extensity of the treatment that becomes important rather than the intensity. Initially it is intensive but then to stay with people.

We have got a program as well where we are offering people now the opportunity to come back into study. So we are running competency-based courses, where clients of our services can come in and do first aid, they can do alcohol and drug competencies, and they can prepare for work and studies. We are really trying to position them well to get their lives back on track.

The CHAIR — And the delays in terms of getting into these courses? I am wondering whether if they are longer programs, there are greater delays?

Mr KING — Yes, it can be. In terms of detox usually within around a week you could be into a detox program, and if you cannot get straight in, there are other staff that will assist you, possibly non-residential nurses who can visit you in your home prior to getting into detox. In terms of getting into the therapeutic programs, they are closed, six-week programs, so that does mean that there can be some delays. But during that period we can hook people into counselling and provide them with other supports prior to them getting into that program.

Mr DIXON — Where do your referrals come from?

Mr KING — Pretty much statewide. Certainly our withdrawal services are statewide. For young people and adults we have got two residential withdrawal services and people can come from all over, although our non-residential programs and counselling and so on, as you would imagine, is much more focused around the geography. Where we provide the program is where people are coming from.

Ms PATTEN — Just following on from talking about methamphetamine, has there been any evaluation or are you aware of any evaluation around pharmacological, so dexamphetamine treatments? There were some of those programs in Australia but there do not seem to be any now. Is that something ReGen has looked at or is aware of?

Mr KING — We monitor that research, but no, we are not directly involved. I worked at Turning Point, and there was a modafinil trial going on at Turning Point. I think we are still in a position where there is nothing that is absolutely standout as a treatment. I think various people that are doing research might say that dexamphetamine is looking promising, and I think there are a few of those, but I do not think we are quite there yet. But certainly we are not doing that.

Mr AIKEN — Nadine Ezard is leading that work in Sydney, but yes in terms of that, we are a way off in having an endorsed product to recommend and integrate into practice.

Ms PATTEN — Can I just follow up on that? You made that very good point, and we have heard so often that the earlier you get people into treatment, the better the outcome. I just wonder if you have got any suggestions as to how we might do that? Is it through school education. Have you got any thoughts?

Mr KING — It is probably fair to say that the alcohol and drug service system in Victoria has tended to go down to the sort of tougher end. With limited dollars —

Ms PATTEN — Yes, of course.

Mr KING — we have got to a point where some of the people we see are in dire need of our services. One of the problems is that with earlier interventions that previously might have been in place, they have never been really strong. We have worked really hard to get GP involvement in providing brief and earlier interventions. But we find that some GPs are fantastic; others are not. This is not a client group that they particularly want to work with.

I think there is a general raising of awareness, as we referred to earlier, that sort of community debate that is more informed about when is it that you need to go along to treatment, how do you recognise that you or a family member needs some assistance, and how do you do that early? A lot of people use a variety of drugs

without experiencing huge harms, but when people do, it needs to be identified early. It might be through prevention programs. That is certainly something, and that sort of community —

Ms PATTEN — Resilience.

Mr KING — Yes. But there is not a lot of early intervention that is offered at the moment from what I can see.

Mr AIKEN — I just think there is not a need for alcohol and other drug-specific interventions particularly in primary schools. That is not really the most effective thing. We hear this from seeing our non-residential rehab programs. People say, 'If I had learned this sort of content, the CBT and mood management content like managing emotions and that sort of thing, when I was in school, I would not be here now'.

The resilience work that is being done in schools now is teaching kids that work. But really in terms of early intervention and diversion programs they provide a great opportunity for teenagers and above who have not yet developed any pattern of dependence of using, and have not been coming into contact with the justice system. It is an opportunity to be brought into contact with a service like ours. They may not see themselves as requiring treatment or any support, but having a positive interaction with a service like ours then provides opportunities further down the track to increase the accessibility to treatment services. I was just thinking about your earlier question about regional access. I think it is an issue across our sector, whether it is treatment or diversion programs, that regional and rural access is a major issue. We support some regional providers to deliver diversion education programs, like Cautious with Cannabis, but it is typically one worker in a community health service, and when that worker moves on, things tend to fall over. There needs to be more capacity amongst regional services, otherwise people have to travel in to Melbourne.

Mr THOMPSON — Very succinct answers would be helpful in terms of our time context. Have you noted an increase in synthetic cannabis addiction in the last several years — yes or no?

Mr KING — It is not a yes/no question in terms of our service. I do not think there is any question that there has been an increase. But it is not coming through clearly in our service at the moment, mainly because there is such a long queue of people with opiate addiction and methamphetamine addiction and so on. It is not coming through. If we went through our figures, our stats in terms of people coming through our service, it is not coming through.

Mr AIKEN — We did notice an increase last year in presentations for synthetic cannabis withdrawal, and as we were preparing to do a clinical audit of those cases it dried up. So we have not seen any of it for a while.

Ms SULEYMAN — Just a couple of questions. Do you keep a record of how many clients would go through some of your services?

Mr KING — We do. I think off the top of my head we would see something like 5000 episodes of care over a one-month period or thereabouts.

Mr AIKEN — I am just getting our annual report.

Ms SULEYMAN — That is fine. Out of, let us say that number, do you keep track of how successful the program or the treatment has been?

Mr KING — It depends. As I say, the department at the moment is developing up what it is calling a performance management framework — this is the Department of Health and Human Services. As part of that, there will be a much more systematic way that we will be following up people and asking questions exactly, like, 'How are you going now?', and measuring the outcomes of treatment. That is not in place at the moment, so there is not an across-the-board outcome strategy. However, there are a lot of programs that we run, particularly if we get funding to run a pilot program. So the non-residential therapeutic programs we run have all been evaluated, and we just routinely put the evaluation results up on our website for anybody that is interested. In some of the work that we were doing around methamphetamines in terms of withdrawal, once again we had that evaluated. We had a program that was described as a step-up, step-down program, so people using methamphetamines would see a non-residential withdrawal nurse initially, then go into our residential facility and then step down and be followed up by a non-residential nurse. Once again, that was evaluated. All of these things are on our website. It should be routine.

Ms SULEYMAN — Yes, it should be. I am just trying to understand. Let us say there is someone that has issues with drugs and lives out in the western suburbs of Melbourne. I am just throwing in a suburb in my electorate: Sunshine. Is it easy to access your services? Because I have found that a lot of the concern and inquiries have been about the lack of ability to get quick, reliable treatment in getting people in.

Mr KING — There is an issue about how well we communicate with the community in terms of what is available out there, and I think that has been an ongoing issue. We have had discussions with the department on a regular basis about this. We have got a 1800 number. So if someone is living in Sunshine, they would ring that number. We offer services from Footscray, so there would be screening, usually over the phone. That can be instantaneous. Assessment can be probably within a week — that sort of time period. Someone would come in for a full assessment and then from that point would be referred on to counselling. There are not typically long delays getting into counselling. If it is a residential withdrawal or a non-residential withdrawal, then that could be referred over to our Ivanhoe-based adult withdrawal service. The delays in getting into that program can be one to two weeks, I would say off the top of my head.

Mr AIKEN — Our sector has been quite fragmented for a long period of time. The 2014 reforms addressed some of the issues there. Those reforms have not been well communicated to the wider community, so there is still a low level of awareness of just what services are available, particularly publicly funded services.

The CHAIR — Thank you very much for your time. We need to move on, but thank you both for your submission and for the time you have spent with us today.

Mr KING — Thank you very much.

Mr AIKEN — I look forward to seeing the report.

Witnesses withdrew.