My qualifications and expertise

I am a Senior Lecturer in Law at the Faculty of Law, Monash University. I am a practising solicitor and Academic Director of Springvale Monash Legal Service. I also hold a competitive research fellowship from the Australian Research Council in the form of a Discovery Early Career Researcher Award (DECRA) Fellowship. This fellowship was awarded in 2016 and runs until 2018. It funds me to undertake a major international comparative study on alcohol and other drug issues/‘addiction’ in Australian and Canadian law. This research has led me to meet with and interview for my research a range of key stakeholders, including lawyers, across Canada, to examine how alcohol and other drug issues are dealt with in law.

As well as my abovementioned affiliations, I am an Adjunct Research Fellow at the National Drug Research Institute, Curtin University. This is one of the three major alcohol and other drug research centres in Australia, and receives Commonwealth funding. I was previously employed as a postdoctoral research fellow. I am a member of the editorial board of the international specialist journal *Contemporary Drug Problems*, and regularly peer review papers, by invitation from other experts around the world, on alcohol and other drug law and policy, including for prestigious international journals such as the *International Journal of Drug Policy*.

I have honours degrees in arts and law, and a PhD. I am the author (together with Professor Suzanne Fraser) of the world’s first full-length social science book examining hepatitis C and injecting drug use (*Making disease, making citizens: The politics of hepatitis C*, published through Ashgate). I am also the author of multiple technical reports, including reports for government, a number of peer reviewed journal articles, and other popular publications (e.g. pieces for the academic website *The Conversation*). The vast majority of my work examines alcohol and other drug law and policy.

This Inquiry

My submission addresses the refined terms of reference of the *Inquiry into Drug Law Reform*. These terms of reference are to report on:

1. The effectiveness of laws, procedures and regulations relating to illicit and synthetic drugs and the misuse of prescription medication in minimising drug-related health, social and economic harm; and
2. The practice of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law.

Summary

My submission contains several recommendations for drug law reform. In summary, these recommendations are:

1. Commission research designed to map alcohol and other drug laws across Victoria. Then, assess the extent/potential for Victorian law to generate stigma among people who use alcohol or other drugs, including people living with or at risk of blood borne viruses that often associated with alcohol and other drug use (such as HIV and hepatitis C) and consider further reforms as appropriate;

2. Remove the prohibition on peer distribution (also known as the prohibition on ‘secondary supply’) of clean needles and syringes appearing in section 80(5) of the Drugs, Poisons and Controlled Substances Act 1981 (Vic);

3. Implement needle and syringe programs in Victorian prisons;

4. Establish a supervised injecting room (also known as a supervised injecting facility or drug consumption room) in the City of Yarra;

5. Establish an expert working party to explore options for the repeal or amendment of s49(1)(bb), (h) and (i) of the Road Safety Act 1986 (Vic) with a view to ensuring that any amendments are more properly aligned with the policy goal of minimising risk to public safety;

6. Amend s48 (2) of the Road Safety Act 1986 (Vic);

7. Amend s54 of the Victims of Crime Assistance Act 1996 (Vic) to limit the circumstances within which past evidence of illicit drug use may adversely impact a victim of crime application;

8. Revise the procedural requirements for revocation of fines under the ‘special circumstances’/‘serious addiction’ component of the Infringements Act 2006 (Vic); and

9. Introduce a formalised (de jure) system for the decriminalisation of cannabis and other drugs. In the alternative, introduce improvements to de facto decriminalisation through the removal of strict eligibility requirements in place in Victoria (e.g. those pertaining to diversion programs).

Overarching principles in support of reform

Drug law reform is justifiable on a number of grounds. There is, as I shall explain, a substantial body of academic research supporting specific reforms. In addition, reforms are justifiable (and according to some interpretations, necessary) by virtue of a set of
additional overarching principles. These principles should be given weight in any consideration regarding whether and in what ways Victorian drug laws might be reformed. The main overarching principles are threefold:

(a) Reform would be consistent with Australia’s existing policy framework of harm reduction: Australia’s National Drug Strategy has a ‘three pillar’ system of supply reduction, demand reduction and harm reduction. Through its focus on harm reduction, Australia has previously implemented a number of world-leading and highly effective measures designed to reduce the harms that can sometimes be associated with alcohol and other drug (AOD) use. Reforms to drug laws including those that focus on reducing the harms that can be associated with drugs and reducing the harms that can be associated with prohibitionist approaches are consistent with Australia’s overarching commitment to harm reduction.

(b) Reform would be consistent with human rights principles: In recent years a number of key stakeholders including international figures and organisations have expressed concern that existing drug laws and policies enable human rights breaches. For instance, Paul Hunt, the former United Nations Special Rapporteur on the Right to the Highest Attainable Standard of Health has said that in many societies,

[…] people who use drugs are invisible, stigmatized or demonized. And history teaches us that when this happens – when a group of people are invisible, stigmatized or demonized, widespread human rights abuse often follows.¹

According to UNAIDS:

Global efforts to control narcotic drugs and psychotropic substances are based on the premise that the misuse of these substances can lead to serious harm to the individual and society. As countries gather at the United Nations General Assembly Special Session (UNGASS) on the World Drug Problem on 19–21 April 2016, more than a half century after the Single Convention on Narcotic Drugs was agreed, the harms caused by international drug control to people who use drugs require much greater attention.²

Human rights considerations are particularly pertinent in Victoria. In 2006, Victoria became the second Australian jurisdiction (after the Australian Capital Territory) to introduce a human rights charter (formally known as the Charter of Human Rights and Responsibilities Act 2006; hereinafter ‘the Charter’). The Charter recognises a number of rights for Victorians, including the right to life (section 9). There is a substantial body of jurisprudence suggesting that some protected rights (including the right to life) place positive obligations on government, including the obligation to preserve life. The Charter therefore arguably enables and/or necessitates drug law reforms, including reforms that would likely reduce harms and/or improve health.

Importantly, as well, the Charter requires new Bills introduced into the Victorian parliament to be assessed for their compatibility with human rights. Many existing drug laws were introduced before the Charter came into operation and have thus never been assessed in this way. In this sense, the Inquiry offers an opportunity, at the very least, to consider whether and to what extent existing approaches comply with human rights obligations. Moreover, if any legislative reform were to be proposed as a result of this Inquiry, that legislation would need to be assessed for its human rights compatibility. This Inquiry thus provides an opportunity to proactively consider not only whether existing laws comply with human rights but how proposed or potential reforms could adequately account for and incorporate human rights obligations.

(c) Reforming AOD laws may help to reduce the stigma that is often experienced by people who use AOD and in so doing, generate important social, health and economic benefits: There is increasing recognition at both the international and national level that legislative frameworks sometimes play a role in contributing to or producing AOD-related stigma. For some, this is a human rights concern. There have been a number of calls for drug law reform based on the notion that existing approaches can be harmful and that reducing AOD-related stigma is a desirable and achievable goal.

Recommendations for reform

Recommendation 1: Map AOD laws across Victoria and conduct further research on law’s stigmatising and/or discriminatory potential

There is an extraordinarily wide range of provisions in Australian law (including Victorian law) that deal with AOD issues or that are in some way relevant to the lives of people who use AOD. As my previous research has found, ‘drug laws’ are not confined to the realm of the criminal law. In recent years, colleagues and I undertook a major piece of research exploring how ‘intoxication’ features in Australian criminal law. We found that over 500 provisions across the Australian criminal law attach significance to the fact of ‘intoxication’, alone. This gives a sense of just how prevalent AOD provisions are in Australia, especially as ‘intoxication’ is just one way in which AOD issues might figure in law, and also as these findings were confined to one area of law. In any discussion about drug law reform there is a need, as I have argued elsewhere, to first consider where in law drug issues feature, and to make some attempt to grapple with the breadth and complexity of those provisions, as well as how they overlap and interact.

Once new knowledge about these issues has been produced, laws can be examined more carefully. As noted earlier, problematic AOD use is one of the most stigmatised activities in the world. Recent research suggests that AOD-related stigma arises from a wide range of sources, that it can be long lasting (including across a person’s lifetime), and that it

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carries a range of adverse health, social and economic consequences. Stigma is a key cause of health inequalities. It has been said that stigma:

thwarts, undermines, or exacerbates several processes (i.e. availability of resources, social relationships, psychological and behavioural responses, stress) that ultimately lead to adverse health outcomes. Each of these stigma-induced processes mediates the relationship between stigma and population health outcomes.

Stigma can also delay or impede people’s willingness to seek help or health care.

A number of international organisations, key stakeholders and bodies are becoming increasingly cognisant of the prevalence of AOD-related stigma, the adverse dimensions of stigma, the need to understand its origins and to address them. The law has come into increasing focus as a result. For example, in the 2008 World Drug Report, the United Nations Office on Drugs and Crime (UNODC) described stigma as one of the ‘unintended consequences’ of the international drug control system and its application. Then, in the 2016 World Drug Report, it was noted that people who use drugs are frequently subject to stigmatisation and discrimination. Other international bodies have raised similar concerns, including in relation to the needs of people living with conditions that can sometimes be associated with drug use, including blood borne viruses (BBVs) like hepatitis and HIV/AIDS. In 2014, for example, the World Health Assembly passed an historic Resolution on Hepatitis, in which it urged member states to:

Review, as appropriate, policies, procedures and practices associated with stigmatisation and discrimination, including the denial of employment, training and education, as well as travel restrictions, against people living with and affected by viral hepatitis, or impairing their full enjoyment of the highest attainable standard of health.

The World Health Organisation’s (WHO) Global Health Sector Strategy on Viral Hepatitis 2016-2021 also urges consideration of the relationship between law, policy, stigma and discrimination. In that strategy, the WHO notes the importance of developing an ‘enabling environment’ for supporting people living with hepatitis:

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12 World Health Assembly, Resolution on viral hepatitis 2010, WHA 67.6. (emphasis added)
As with other public health programmes, the hepatitis response requires an enabling environment of policies, laws and regulations that support the implementation of evidence-based policies and programmes, and promote and protect human and health rights, reduce stigma and ensure health equity.\(^\text{13}\)

The strategy calls upon countries to prioritise putting an end to ‘policies and practices that condone or encourage stigma and discrimination against people at risk for hepatitis or living with hepatitis, especially in health care settings and places of employment’.\(^\text{14}\) These calls have been echoed at the domestic level in Australia. The *National Drug Strategy 2010-2015*\(^\text{15}\) stresses the importance of reducing the stigma associated with drug use.\(^\text{16}\) Likewise, one of the objectives of Australia’s *Fourth National Hepatitis C strategy 2014-2017* is to ‘eliminate the negative impact of stigma, discrimination, legal and human rights issues on people’s health’.\(^\text{17}\) The *Fourth National Hepatitis C strategy 2014-2017* also states that ‘an enabling policy and legal environment that addresses criminalisation, stigma, and discrimination and human rights issues will help to increase access to services and improve the health and lives of people with hepatitis C’. In all of these respects, then, there is increasing recognition that existing policy and legislative frameworks might require reform. These calls are based in part on the recognition that existing frameworks may generate stigma and/or foster discrimination.

Elsewhere, I have argued that there is little guidance, either domestically or internationally, about how law relates to stigma and what should be done about it.\(^\text{18}\)

Colleagues and I have argued that:

> Ambitious statements calling for the elimination of stigma and discrimination […] are rarely, if ever, accompanied by details on precisely how law produces stigma and discrimination. It is not clear, therefore, exactly how we might take steps to address it. Comprehensively understanding *how* law produces stigma (rather than merely assuming a relationship) would appear to be an essential step before determining how policy makers and legislators might address it.\(^\text{19}\)

In at least one Australian jurisdiction work is already underway to map how laws and policies might generate (or help sustain) AOD-related stigma and/or discrimination. This research is being undertaken by myself, Professor Alison Ritter (Director, Drug Policy Modelling Program, NDARC, UNSW) and Dr Kari Lancaster (Fellow, Drug Policy Modelling Program, NDARC, UNSW). We have developed a framework designed to map AOD laws and then assess the extent to which such laws might stigmatise and/or discriminate against people who use AOD.\(^\text{20}\) This framework is designed to illuminate

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\(^{16}\) At the time of writing, Australia’s next National Drug Strategy was still under development.


which laws have the potential to generate stigma and/or enable discrimination and to highlight the reasons why law is more (or less) stigmatising. These findings can then be used to inform future decision-making regarding reform.

As a first step, therefore, I recommend that a mapping exercise be undertaken in the state of Victoria, which is designed to ascertain all areas of law in which AOD issues feature and then to assess the extent to which those laws have the potential to generate stigma and/or discrimination. If followed, this recommendation would result in:

a) A comprehensive ‘map’ of all provisions in Victorian law that pertain to AOD use (including provisions pertaining to BBVs);

b) New knowledge on the stigmatising and/or discriminatory potential of each provision;

c) Insights into the specific reasons why certain provisions may be more (or less) likely to generate stigma as well as how Victorian law might generate, sustain or reduce the potential for AOD-related stigma and/or discrimination; and

d) Where targeted reforms might be worth considering.

**Recommendation 2: Remove the prohibition on peer distribution in s80(5) of the Drugs, Poisons and Controlled Substances Act 1981**

AOD use, including injecting drug use, can be associated with certain harms, including, in some instances, blood borne viruses (BBVs). Approximately 230,000 Australians live with the BBV hepatitis C, and approximately 10,000 new infections occur each year, 90% of these among people who inject drugs. Hepatitis C is highly infectious with research suggesting that it is much more readily transmitted than HIV. Hepatitis C can be associated with a range of very significant health problems, including chronic fatigue, depression, cirrhosis and liver cancer. Chronic hepatitis C infection is also the primary indicator for liver transplants in Australia; liver cancer is now the fastest-increasing cause of cancer death in Australians. Hepatitis C costs the Australian health care system around $250 million annually. Crucially, as I have argued elsewhere, people living with hepatitis C are also a highly stigmatised and marginalised population.

Through its [National Drug Strategy](http://www.nationaldrugstrategy.gov.au), Australia has a range of strategies designed to reduce the harms associated with AOD use. Many of these seek to minimise the risk of BBV transmission among people who inject drugs. Although injecting drug use and BBVs are sometimes inappropriately conflated, it is important to note that people who inject drugs do not automatically acquire BBVs such as hepatitis C by virtue of their drug use;

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instead, they might acquire it if they share needles or ancillary injecting equipment with others. Access to clean needles and ancillary equipment is thus crucial to minimising the risk of new infections. One way that people who inject drugs can acquire clean needles and syringes is through Australia’s national network of needle and syringe programs (NSPs). Efforts to distribute needles and syringes have been shown to effectively control rates of HIV transmission among people who inject drugs in Australia; crucially, however, coverage has been inadequate for controlling hepatitis C infections. It has been suggested that distribution of sterile injecting equipment is limited by supply rather than demand and that increased coverage is possible. Consideration should be given, therefore, to how distribution can be increased and coverage extended.

One of the key methods for distribution of sterile injecting equipment in Australia is through the method of peer distribution of injecting equipment (also called ‘secondary supply’, ‘extended distribution’, ‘satellite exchange’ or ‘secondary exchange’). Peer distribution is recognised as an ‘unofficial adjunct’ to NSPs and is common in Australia and other parts of the world. Peer distribution has been defined as: ‘the giving or receiving of new sterile needles and syringes to/from another individual that were originally obtained from formal or “safe” sources and may include ‘trading, purchasing or selling of needles and syringes for money, drugs or other commodities or services; or it can simply involve the giving or receiving outright of needles and syringes’. A national survey of NSP clients in Australia found that more than one third (37%) of participants admitted that they were engaged in the onward distribution of needles and syringes. Despite the frequency of peer distribution in Australia, it is in fact illegal in most Australian states and territories, including Victoria. These laws are often colloquially referred to as ‘laws that prohibit peer distribution’, or the prohibition on secondary supply. In Victoria, peer distribution is unlawful by virtue of section 80(5) of the Drugs, Poisons and Controlled Substances Act 1981. That section states that:

(5) A person who sells or supplies a hypodermic needle or a syringe is not guilty of an offence under this section or of being involved in the commission of an offence against any provision referred to in this section by reason only of that sale or supply—

(a) if the person is, or is engaged or employed by, a pharmacist and the sale or supply is made in the course of the lawful practice of a pharmacist; or

(b) if the sale or supply is by a specified person or organisation or specified class of persons or organisations in specified circumstances as authorised by Order in Council published in the Government Gazette.

Two Australian jurisdictions have recently lifted the prohibition on peer distribution. The first was Tasmania, through the Public Health (Miscellaneous Amendments) Act 2015, and the second was the Australian Capital Territory, through the Justice and Community Safety Legislation Amendment Bill 2016. The ACT reforms were based in part on my own research, undertaken with Dr Kari Lancaster (of the Drug Policy Modelling Program, NDARC, UNSW) and Professor Carla Treloar (Director of the Centre for Social Research in Health, also at UNSW). We had successfully argued that the prohibition on peer distribution was unnecessary and outdated, that it was out of step with current practice, that it was at odds with Australia’s National Drug Strategy and focus on harm reduction, and that should the prohibition be lifted, it may help to reduce the spread of BBVs such as hepatitis C and HIV. It would also likely have other ancillary effects such as reducing the stigma associated with injecting drug use. Reforms in both jurisdictions are significant developments that have likely long-term benefits for Australia: they will likely help to prevent the transmission of BBVs, and the associated social, economic and personal costs associated with these diseases.

Importantly, since our research into the prohibition on peer distribution was published, new drugs (direct acting anti-virals) for the treatment of hepatitis C have appeared on the horizon. These have been heralded as revolutionary, with the potential to cure hepatitis C. These medicines have now been added to Australia’s Pharmaceutical Benefits Scheme, leading to claims that Australia might eliminate hepatitis C altogether within the next decade. Although these medicines are promising, there is a risk that efforts to control new infections may be undermined if complementary harm reduction strategies are not available. In other words, treatment should not be the sole focus of government policy; instead, it should form part of a complementary suite of measures designed to tackle hepatitis C, including harm reduction strategies designed to increase coverage of clean needles and syringes across the state. There is a real risk, should these measures not be introduced, that work underway to eradicate hepatitis C through treatment will be compromised.

Given the many practical benefits associated with increasing the availability of clean needles and syringes, as well as recent developments in other jurisdictions designed to extend coverage, I recommend reform of section 80 of the Drugs, Poisons and ControlledSubstances Act 1981 to lift the prohibition on peer distribution. Parliament can choose between two models, being the Tasmanian model (which extends peer distribution) and the ACT model (which repeals the prohibition altogether). The latter is a more comprehensive approach that allows for extended coverage without the ongoing risk of prosecution. This model is, in my opinion, preferable.

Recommendation 3: Implement needle and syringe programs in Victorian prisons

The UNODC, WHO and UNAIDS argue that a package of supports should be made available to people who inject drugs. As I outlined in the previous section, Australia has a suite of harm reduction services available, including a national network of NSPs. Although national NSP coverage is less than optimal (as previously noted), one particular problem area involves prisons. Prisons have been described as an ‘incubator’ for BBV transmission\(^{36}\) and a ‘powerhouse’ for hepatitis C transmission.\(^{37}\) Prison NSPs are a harm reduction measure designed, like other NSPs, to minimise the risk of BBV transmission. Prison NSPs have been around for 25 years, with the first opened in Switzerland in 1992, and there are now more than 60 prison NSPs worldwide.\(^{38}\) There is a range of different prison NSP models, including: hand-to-hand provision of needles and syringes by prison personnel, and hand-to-hand provision by external personnel (which might include peers).\(^{39}\) There are no prison NSPs in Australia.

Like NSPs in the general community, prison NSPs offer a range of potential benefits including the prevention of BBVs. There are also other reasons to consider establishing prison NSPs. Recently, for instance, it was argued that the absence of prison NSPs represents a significant human rights violation,\(^{40}\) a proposition that appears to be supported that numerous international human rights principles and instruments. For instance, Principle 9 of the United Nations Basic Principles for the Treatment of Prisoners states that:

Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.\(^{41}\)

Some interpret this to mean that where countries offer NSPs outside prisons, there is a positive obligation to provide them within prisons. As well, principle 24 of the World Health Organisation Guidelines on HIV Infection and AIDS in Prisons states that in countries where NSPs operate within the community:


Consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this.

Human rights considerations might also support the development and establishment of prison NSPs. As noted earlier, the Victorian Charter protects the right to life (section 9). The UNHRC and the ECtHR have made clear that the right to life entails more than a negative duty to refrain from arbitrarily taking life, but also includes an obligation to take positive steps to safeguard life. In practice, the courts will generally allow a wide margin of appreciation to states as to how they regulate such matters, as well as a reasonably wide discretion to law enforcement authorities as to how they deploy resources. However, the Courts have emphasised that a particularly high duty applies to persons in state custody, due to their particular vulnerability. I have elsewhere argued that the right to life protection under the Victorian Charter thus supports the provision of prison NSPs, and that they should be considered as part of a suite of harm reduction services on offer across the state.

For these reasons, I recommend that NSPs be established in Victorian prisons. Should parliament wish to establish prison NSPs, they may choose from the range of available models, as noted above.

**Recommendation 4: Establish a supervised injecting facility in City of Yarra**

There were 172 heroin overdose deaths in Victoria in 2015. Of these, 20 occurred in the City of Yarra. The Victorian Coroners Prevention Unit Investigation in the case of Ms A noted that in an additional 15 fatal overdose deaths outside the City of Yarra in 2015 there was positive evidence that the heroin contributing to the death was purchased or sourced in the City of Yarra. This has led to growing calls for the establishment of a supervised injecting facility somewhere within the City of Yarra: perhaps in North Richmond.

Supervised injecting facilities (also known, variously, as supervised injecting rooms, drug consumption rooms and drug injecting facilities) are places where people who use or inject drugs can consume drugs in an environment designed to minimise the risk of

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42 For example, the UNHRC has stated that: ‘the right to life has been too often narrowly interpreted. The expression ‘inherent right to life’ cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures’: General Comment 6, *Article 6: The Right to Life* (1982), U.N. Doc. HRI/GEN/1/Rev.1 at 6 (1994), [5]. See further Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), Chapter 8, especially [8.01], [8.39]-[8.64]. The same interpretation has been applied to the equivalent right to life under the European Convention on Human Rights, see eg *LCB v UK* (1998) 4 BHRC 477, 456 [36]; *Osman v UK* (1998) 5 BHRC 293, 321 [11]; *Koen v UK* (2001) 10 BHRC 319, 348-9 [88]-[90].


44 Keynote address to the Australasian Viral hepatitis conference, Gold Coast, September, 2016 https://addictionconcepts.files.wordpress.com/2016/10/viral-hepatitis-2016-keynote1.pdf


harm. At the time of writing, there were about 90 such facilities around the world, with the majority of those based in Europe.47 Australia has just one such facility, being the Medically Supervised Injecting Centre (MSIC) based in Kings Cross, Sydney.48 There is a substantial body of evidence suggesting that supervised injecting facilities reduce fatal and non-fatal overdoses, facilitate connections with other services and have a range of associated benefits for the community.49 The National Drug Strategy also acknowledges that supervised injecting facilities are an important intervention.

Research undertaken by the Centre for Research Excellence into Injecting Drug Use (CREIDU) has shown that injecting in the City of Yarra is ‘widespread, frequent and highly visible’ and that a supervised injecting facility should be explored as part of a suite of harm reduction measures for the area.50 After an extensive coronial inquest into the death of Ms A, Coroner Jacqui Hawkins recently recommended a trial for a supervised injecting facility in the city of Yarra.51

I have previously argued that there is no legal barrier to the implementation of a supervised injecting facility in the state of Victoria.52 Legislative reform is needed to allow for the possession and use of otherwise (presently) illegal drugs. The MSIC is covered by Part 2A of the NSW Drug Misuse and Trafficking Act 1985. The MSIC framework allows for illicit drug possession and consumption, and offers police discretion in relation to charging people with drug offences if the person is travelling to or from the MSIC. I note that in February 2017, the Honorable Fiona Patten MP introduced a Bill into the Victorian Parliament that would allow for reforms of this nature and that essentially mirrors the MSIC model.53

In other parts of the world (including, most notably, Canada), human rights principles have also been deployed to support the operation of supervised injecting facilities. Human rights principles were central to the Canadian Supreme Court’s decision in Canada (Attorney General) v PHS Community Services Society (the ‘Insite’ case).54 The Insite case concerned the legality and status of a supervised drug injecting facility located in Vancouver (‘Insite’). That case did not involve the establishment of a new facility, but, rather, the question of whether an already-established facility could be closed down. The Court found that the Federal Government’s attempts to close down Insite engaged and

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54 [2011] 3 SCR 134.
limited the rights of people who use drugs under Section 7 of the Canadian Charter of Rights and Freedoms. Section 7 protects the right to life, liberty and security of the person. The Court found that in limiting peoples’ access to health care services provided at Insite, the law creates a risk to both the health and the lives of people who use drugs, and in so doing, deprives them of the protections afforded under Section 7. The facility was thus allowed to remain open and indeed plans to establish several more supervised injecting facilities across Canada are now well underway.

As noted earlier, international jurisprudence suggests that the right to life comprises more than a negative duty to refrain from arbitrarily taking life, but also includes an obligation to take positive steps to safeguard life. As with prison NSPs, it is my view that the establishment of a supervised injecting facility is supported by the ‘right to life’ principle that appears in section 9 of the Charter. Given the high likelihood that a supervised injecting facility would bring a range of community, health, social and economic benefits, and given that it is consistent with established human rights principles, I recommend that parliament establish a supervised injecting facility (also known as a supervised injecting facility or drug consumption room) in the City of Yarra.

Recommendation 5: Review s49(1)(bb), (h) and (i) of the Road Safety Act 1986

I have read the submission of Springvale Monash Legal Service to this Inquiry, including its recommendation to review the operation of the ‘drug driving’ provisions under the Road Safety Act 1986 (specifically s49(1)(bb), (h) and (i)). I agree that these provisions are problematic and potentially counterproductive. In particular, because these provisions criminalise individuals who have any concentration of (specific) drugs in their blood or oral fluid, they have the effect of ensnaring (and criminalising) people who are might be operating a vehicle some time after consuming a drug, whilst not actually impaired, and who pose no appreciable or immediate risk to public safety. These should be the immediate policy considerations which any drug driving legislation addresses. As my colleagues and I recently argued:

The widespread inclusion of drugs other than alcohol in statutory definitions of intoxication is [...] problematic, particularly where intoxication is defined as the mere presence of any quantity of a drug in a person’s body, without reference to when the drug was consumed, without reference to impairment or other adverse consequences of consumption, and without recognition that different drugs have different effects. The policy objective of deterring the use of certain drugs via criminalization needs to be disentangled from the separate question of the capacity of drugs (like cannabis, ‘ice’, cocaine, and ‘ecstasy’) to produce cognitive...
and/or behavioural effects and risks that are relevant to the administration of criminal justice.\textsuperscript{57}

In recent years, a number of others – including a NSW Magistrate – have raised similar concerns, suggesting that insufficiently targeted or nuanced drug driving laws risk creating a range of other problems and unintended consequences.\textsuperscript{58} I agree, and thus I recommend that a working party be established to explore options for the repeal or amendment of s49(1)(bb), (h) and (i) of the \textit{Road Safety Act 1986} (Vic) with a view to ensuring that any amendments are more properly aligned with the policy goal of minimising risk to public safety. Consideration should be given to whether a method of biological detection should be employed, and the relevant threshold for such.

\textbf{Recommendation 6: Amend s48(2) of the Road Safety Act 1986 (Vic)}

I have read the submission of the Springvale Monash Legal Service pertaining to amendments to s48(2) of the \textit{Road Safety Act 1986} (Vic) and endorse that recommendation.

\textbf{Recommendation 7: Amend s54 of the Victims of Crime Assistance Act 1996 (Vic) to limit the circumstances within which past evidence of illicit drug use may adversely impact a victim of crime application}

The state of Victoria offers a comprehensive system designed to support victims of crime, established under the \textit{Victims of Crime Assistance Act 1996} (VOCAA) and administered by the Victims of Crime Assistance Tribunal (VOCAT). As prominent professor of law Ian Freckelton explains:

\begin{quote}
The payment of financial compensation for the non-pecuniary effects of crime, such as the pain and suffering engendered by criminal acts of violence, is a phenomenon of comparatively recent experience. It accompanied the dawning of awareness of the impact of criminal offences of violence upon victims during the 1960s and into the 1970s.\textsuperscript{59}
\end{quote}

These schemes, including the VOCAT scheme, are generally known as ‘therapeutic’, ‘beneficial’ or ‘remedial’ schemes, in that they are intended to remedy wrongs, benefit

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victims and assist them in their recovery from crimes perpetrated against them. The stated purpose of VOCAA is to assist victims of crime (as per Section 1(1) of the Act), and there are three main objectives, as per Section 1(2) of the Act:

(a) to assist victims of crime to recover from the crime by paying them financial assistance for expenses incurred, or reasonably likely to be incurred, by them as a direct result of the crime; and

(b) to pay certain victims of crime financial assistance (including special financial assistance) as a symbolic expression by the State of the community’s sympathy and condolence and recognition of significant adverse effects experienced or suffered by them as victims of crime; and

(c) to allow victims of crime to have recourse to financial assistance under this Act where compensation for the injury cannot be obtained from the offender or other sources.

Importantly, and appropriately, VOCAA established a number of eligibility criteria and other hurdles that must be satisfied before a person might receive an award of compensation from VOCAT. Section 54 of VOCAA sets out a series of matters to which VOCAT must have regard when considering an application for an award of compensation. That section reads as follows:

In determining whether or not to make an award of assistance or the amount of assistance to award, the Tribunal must have regard to the following:

(a) the character, behaviour (including past criminal activity and the number and nature of any findings of guilt or convictions) or attitude of the applicant at any time, whether before, during or after the commission of the act of violence;

(b) in the case of an application by a related victim—

(i) the character or behaviour (including past criminal activity and the number and nature of any findings of guilt or convictions) of the deceased primary victim of the act of violence;
(ii) any obligations owed to the applicant and any other related victim applicants by the deceased primary victim of the act of violence;
(iii) the financial resources (including earning capacity) and financial needs of the applicant and any other related victim applicants;
(iv) if the related victim is a close family member of, or had an intimate personal relationship with, the deceased primary victim of the act of violence, the nature of the relationship between them;

(c) whether the applicant provoked the commission of the act of violence and, if so, the extent to which the act of violence was in proportion to that provocation;

(d) any condition or disposition of the applicant which directly or indirectly contributed to his or her injury or death;
(e) whether the person by whom the act of violence was committed or alleged to have been committed will benefit directly or indirectly from the award;

(f) any other circumstances that it considers relevant.

In 2013-14, Suzanne Fraser and I conducted research into the nature and operation of section 54, including how the ‘character’ and ‘behavioural’ elements of the section had been interpreted and applied.60 We found that a victim of crime’s past history of drug use, (including their ‘addiction’) was found to be relevant in a number of cases to the question of whether a victim should be compensated. We also noted that:

[…] section 54 offers no guidance as to what might be a relevant consideration, what weight should be given to relevant considerations in deciding whether or not to make an award, and how those considerations impact on decisions about the kind or size of award to make. The upshot of this is that judges have considerable scope for determining what is both ‘relevant’ and ‘problematic’, notions that have the potential to be taken up in subsequent case law as self-evidently relevant and problematic […] It is telling, therefore, that drug use and ‘addiction’ were understood to be of note, and a potential obstacle to the provision of compensation […], although the apparent relevance of drug use and addiction varied.61

Judicial approaches to these questions were highly variable. While in general there are sound public policy grounds for permitting Tribunal members to retain a broad discretion in regards to eligibility, the character test in section 54 is overly broad. In its present form, it is possible, for instance, that a victim of a very serious crime (such as attempted murder, rape or family violence) might be denied victims of crime compensation, including vital financial, social and medical supports, by virtue of having a history of illicit drug use. This may be the case, as I have previously argued,62 regardless of whether the crime was related in any way to past drug use (i.e. section 54 does not require a nexus between the act of violence and the victim’s drug use).

There is a range of problems with this approach, including that it:

1. Is at odds with the remedial nature of \textit{VOCAA}, including its focus on supporting and rehabilitating victims;
2. Risks punishing people twice, as where, for example, a person has been previously sentenced in relation to a drugs offence and is then sanctioned again (through denial of compensation) for having a past drug use history;
3. Offends on public policy grounds, including because it establishes two ‘classes’ of victims (‘deserving’ and ‘less deserving’ victims). The provision in this sense has the potential to stigmatise and/or discriminate against people with a past history of illicit drug use; and

4. Is at odds with other approaches to drug use and/or ‘addiction’ in law, including under Victorian law. In other areas of Victorian law, drug use and/or ‘addiction’ is treated as a health problem (e.g. Severe Substance Dependence Treatment Act 2010), or a mitigating factor as regards offending (e.g. ss3 and 65 of the Infringements Act 2006 (Vic), discussed in more detail below).

For these reasons, I recommend amendment of section 54 of the Victims of Crime Assistance Act 1996 (Vic) so as to limit the circumstances in which past evidence of illicit drug use may adversely impact a victim of crime application. Specifically, the ‘character’ test in section 54 should be significantly tightened and/or repealed.

Recommendation 8: Revise the procedural requirements for revocation of fines under the ‘special circumstances’/‘serious addiction’ component of the Infringements Act 2006 (Vic).

The primary piece of legislation in Victoria for the administration and enforcement of fines is the Infringements Act 2006 (Vic). This is a complex law, one part of which is particularly relevant to people who have experienced AOD problems. The Act establishes a process by which a person who has accrued infringement/s may assert ‘special circumstances’ and seek to have those fines revoked. For the purposes of the Act, special circumstances are defined (in section 3) as including:

a serious addiction to drugs, alcohol or a volatile substance within the meaning of section 57 of the Drugs, Poisons and Controlled Substances Act 1981 where the serious addiction results in the person being unable –

(i) to understand that conduct constitutes an offence; or
(ii) to control conduct which constitutes an offence.

In practice, evidence is required to establish that an individual was experiencing a ‘serious addiction’ and that there is a nexus between this ‘serious addiction’ and the accrual of infringements. This evidence might come in the form of a report from a treating practitioner, drug or alcohol counsellor, psychiatrist or psychologist.

Based upon my own experience as a solicitor representing clients claiming special circumstances, this evidence is often difficult to obtain. One of the main reasons for this is that many clients do not have a drug or alcohol counsellor, treating practitioner, psychologist or psychologist who can reliably attest to their past history of AOD use. This might be because the client was not engaged with support services at the time, or because – as described earlier – AOD issues are highly stigmatised and they felt ashamed or embarrassed to seek support. Moreover, many people never pursue or require treatment or counselling to deal with their AOD issues, and instead are able to resolve those issues themselves. For these people, there is no ‘evidence’ that a problem existed, even though those people might understand themselves to have been experiencing a ‘serious addiction’ in the past. In these cases, although the underlying intention of the legislation is to support people with AOD issues, practical barriers may have a counterproductive effect. Some individuals are denied relief. There is a real risk that the legislation also effectively punishes those individuals who did not have the means, wherewithal or motivation to seek AOD support at the time they were experiencing
AOD issues. In order to correct this balance, serious consideration should be given to allowing alternative forms of evidence to be introduced in support of special circumstances applications. This might include evidence in statutory declaration form from the clients themselves, or evidence from other individuals or support services.

For these reasons, **I recommend that parliament revise the procedural requirements associated with revocation of fines under the 'special circumstances'/ 'serious addiction' component of the Infringements Act 2006 (Vic).** In particular, other forms of supportive evidence (beyond existing categories) should be admissible, including evidence in the form of a statutory declaration from the clients themselves and/or evidence from other individuals or support services.

**Recommendation 9: Decriminalisation of drug use and possession for personal use**

Under Victorian law individuals may be prosecuted if they use or are in possession of a range of substances (illicit drugs). In the state of Victoria, a number of people are sentenced for drug use and/or possession each year. Questions have been raised, however, about the efficacy of laws that criminalise drug use and possession, including, in particular, drug possession for personal use. In 2016, the Global Commission on Drug Policy advocated for a model of decriminalisation that eradicates punishment of drug use. Decriminalisation is defined as 'the removal of criminal offences for specific penalties'. Decriminalisation is distinct from legalisation and may occur in a variety of ways. A distinction is sometimes drawn between ‘de facto’ and ‘de jure’

decriminalisation:

In a **de jure** reform criminal penalties for use/possession are removed in the law (with optional use of non-criminal sanctions). In a **de facto** reform criminal penalties remain in the law, but can be lessened in practice (eg via police guidelines to not enforce the law).

Research suggests a number of benefits associated with decriminalisation. These include financial savings from reduced law enforcement activities and improved social outcomes.

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Research from the Drug Policy Modelling Program based at the University of New South Wales suggests that Victoria already has a form of de facto decriminalisation in relation to cannabis and other illicit drugs. They note that there is a range of options for further reform of drug use and possession, including:

1. Adoption of de jure decriminalisation for cannabis in all jurisdictions;
2. Adoption of de jure decriminalisation for drugs other than cannabis;
3. Amendment of de jure decriminalisation to remove criminal sanctions for non-compliance;
4. Amendment of de facto decriminalisation by removing strict eligibility requirements;
5. Amendment of de facto decriminalisation to remove criminal sanctions for non-compliance.

Given the harms that can be associated with criminalisation of drug use and possession and the benefits that are associated with decriminalisation, I recommend parliament adopt a formalised (de jure) system for the decriminalisation of cannabis and other drug use and possession. In the alternative, I recommend improvements to de facto decriminalisation by removing strict eligibility requirements in place in Victoria (for example those pertaining to diversion programs).

### Conclusion

I thank the Committee for the opportunity to make this submission and for their time and consideration. I would be more than happy to appear before the Committee to answer any questions or to elaborate on my submission should this be of use.

Yours sincerely,

Dr. Kate Seeax  
BA (Hons), LLB (Hons), PhD  
Australian Research Council DECRA Fellow  
Senior Lecturer in Law, Monash University  
Academic Director, Springvale Monash Legal Service  
Faculty of Law, Monash University  
15 Ancora Imparo Way, Clayton, Victoria, 3800  
Email: [redacted]

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*Decriminalisation of drug use and possession in Australia – A briefing note.* Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia.  
*Decriminalisation of drug use and possession in Australia – A briefing note.* Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia at 5.