

TRANSCRIPT

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Sydney — 23 May 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

Mick Palmer AO APM, Vice President, Australia21.

Dr Alex Wodak AM, Director, Australia21; and President, Australian Drug Law Reform Foundation.

Paul Bodisco, Secretary, Australian Drug Law Reform Foundation.

**Necessary corrections to be notified to
executive officer of committee**

The CHAIR — So I'll welcome everyone to this hearing of the Law Reform Road and Community Safety Committee, which is looking at issues of drug law reform and I'm able to welcome - well, we'll start with Paul. I'll have to read your name, Paul, sorry. I haven't got your name there, have I? Paul Bodisco, Mick Palmer and Alex Wodak, all from Australia21. Have I got this right in front of me? Yes, Australia21 - I am on track. I'll start by introducing us to you - Geoff Howard - chair of the committee, Bill Tilley is deputy chair, Martin Dixon is the Member for Nepean, Fiona Patten, Member for Northern Metropolitan, Natalie Suleyman, Member for St Albans and Murray Thompson, Member for Sandringham.

You're probably aware we've had something like 220 written submissions come to our committee since we opened the inquiry. This is the second day of public hearings we're holding, the first outside Victoria and so we're particularly pleased that you have been able to come along and join us today. We do have Hansard recording all of our proceedings today, as you might be aware, and after a couple of weeks we'll send you a transcript of anything that's been said so that you can correct it if there are any typographic errors or any information that needs to be corrected factually. Then after that is approved, it will go on our public record.

You are aware when you speak with a parliamentary committee that you are covered by parliamentary privilege. I don't know whether that's relevant to you today, and you have opportunity to speak in confidence if you need to, but I think you're happy for this to be in the public domain today? That's very good. So all I ask is before you speak - since there's the three of you - that Hansard does know which one of you is speaking first, that you introduce yourself and go from there. Certainly, thank you for your very detailed submission, providing us with the information on the significant forum you held and we look forward to you making any overall comments in regard to your submission and some discussion beyond that.

So over to you - who is leading off?

Mr PALMER — Thank you, Chair. Thanks very much. Mick Palmer is my name. I'm a former commissioner of the Australian Federal Police - essentially a sort of whole-of-life career police officer with about 33 years' service. I had 25 years in the Northern Territory, including seven years there as their commissioner and then seven years as commissioner of the Australian Federal Police before retiring in 2001. Since then I've done a series of reviews and become more active in issues like this. Drug reform and post-traumatic stress and other issues that during my operational career were obviously issues about which there were lots of problems and lots of uncertainty and, which seemed to me, we needed to do better at. I am now a director emeritus of Australia21 but Australia21 was the body that I was then director of that commissioned the report that I understand you have in front of you. That was driven by - it was intended as a practitioners' forum. Obviously the more I saw, even as an operational police officer, the way in which our drug policy ran the more I realised that despite the best will in the world, the best intention of government, the best intentions by a police officer, no matter how effective we were, we really weren't doing much more than scratching the surface.

We weren't having an impact on the issues that we really wanted to have an impact on. We weren't achieving the outcomes that we really had set for ourselves and the main one, as you know - the predominant one - was to minimise or reduce harms that in many ways were aggravating the very same problems that we were trying to cure. But having said that, we realise that this is a very complex and difficult problem, both factually and certainly politically. So it really caused me to think very strenuously about that we shouldn't and couldn't possibly be happy with where we are, the outcomes we're achieving: the state of play that we're now involved in embracing can't possibly be one that we're satisfied with.

You know, we really haven't contributed much to reduction of harm in any aspect of the issue. We thought it might be useful to run a round table involving 15 to 20 practitioners: judges, magistrates, lawyers, police commissioners or senior police operational people and some coal-face practitioners and academics. That was run in September 2015 in Sydney at the University of Sydney. We had 17 participants, I think 11 of whom were practitioners in the field, police magistrates, judges serving and past. We just spent a day brainstorming the question - on the basis that we can't be happy with the outcomes we're now achieving in terms of our current drug policy, what we're getting for the investment, if you were to consider change what would you consider, what would it look like, how might you go about it?

So we really just simply - on a Chatham House Rule basis - brainstormed that for a day and it was that discussion that led to the report that you have in front of you, where there was overwhelming and in almost every instance unanimous agreement about the fact that we can't possibly be satisfied with where we are. There are lots of things

wrong with our current policy, most of those are unintended consequences but there have to be smarter ways to do business and here might be some of the ways by which we might achieve it. I can address some of the issues, if you wish, that we considered to be most important.

My position has changed fundamentally since my days as a young, operational police officer, as you would imagine. That has been a long, evolutionary journey for me - it's not one that I suddenly became aware of after I retired. I became aware of it while I was still an operational detective, when all of a sudden I found myself dealing with issues and seeing the result of my endeavours as a detective that were really counter-productive to the very aims that we were trying to achieve. This included victimising and if you like branding the wrong people and causing enormous harm to people who had simply committed very minor offences and had strong and overwhelming social or dysfunctional mental health issues which had caused them to conduct the behaviour that had drawn our attention to them.

So the more you think about it, the more you see it, the more you realise that the way we're going about business is really counter-productive. Most police officers actually come to the same conclusion privately that what we're doing in many ways is counter-productive to what we're trying to achieve. It became obvious to me that the predominant issue had to be and should be - that drives all of our illicit drug policy - the reduction of harm; that everything we should be about, achieving all the arrangements we have in place, the legislation, the practices, ought to be about reducing harm. Every time we find a practice or an arrangement that in fact aggravates the harm or doesn't lead to a reduction in harm or a potential reduction of harm we should re-evaluate it and say, "Hang on, what the hell are we doing that for?"

That is what led me on this journey to say there are many things, when you look at it, that are counter-productive to the very aims we have set for ourselves. Nobody else imposed these aims on us: we set these for ourselves and government set them for themselves. So what might we do that will make a difference? Perhaps I might leave it there for the moment.

The CHAIR — Okay, anybody else want to make any lead comments at the moment?

Dr WODAK — If I may -

The CHAIR — Alex? Yes, sure.

Dr WODAK — Thank you all for devoting yourselves to this topic and like Mick, I want to persuade you that what we're doing now is - in terms of illicit drugs - clearly isn't working and to urge you to consider the possibility of supporting reform as a process, which would be incremental, careful and rigorously evaluated before going onto the next reform. I started at St Vincent's Hospital in Sydney in July 1982 and soon after I arrived it was clear that there was a major HIV epidemic occurring in Australia and in the vicinity of St Vincent's Hospital, which is about 25 minutes' walk from where we're assembled. St Vincent's Hospital is in the middle of the largest concentration of men who have sex with men in Australia, the largest concentration of people who use drugs and also Australia's largest drug market, which is in King's Cross and the largest concentration of people dying from drug overdose, is all in walking distance of the hospital.

So that is where I started and soon after I arrived there was an estimate that some 3,000 to 4,000 men who have sex with men had acquired HIV infection in the early 1980s. When I heard that estimate I immediately thought that some of those gay men would also inject drugs, they would share their needles and syringes with men and women who did not engage in homosexual contact but injected drugs. HIV would follow in a cascade and it would follow from that second population of heterosexual men and women who use drugs to the broader community. Australia was at great risk of having a generalised HIV epidemic, which has occurred in about a dozen other countries, starting from people who inject drugs.

I was fearful that this would happen in Australia and that we would face severe health, social and economic consequences as a result. I wasn't the only one who had that view. I started working with a group of people - like-minded people - and we realised we had to do something effective very quickly and it was clear that what had to be done first off was start needle syringe programs. I ended up writing 13 submissions to the New South Wales Department of Health begging permission to be allowed to start a pilot project. Each of those 13 submissions was declined. My colleagues and I decided on 12 November 1986 that we had to resort to civil disobedience. I had four children, a wife, a new career. I happily put all that at risk in order to get needle syringe programs started.

Fortunately, the New South Wales government at the end of 1986 changed its view on needle syringe programs, allowed them to go ahead. The next year I was sitting in my office and I wondered what all that was about and I realised that what had stopped the needle syringe program being accepted was the war on drugs. That it was the entrenched commitment to drug prohibition that would not allow authorities to start the needle syringe program, which was clearly needed in order to protect the health and wellbeing of the Australian community. So that really got me thinking: What was Australia's drug policy? Why did we adopt it? Did it work? Were there better ways of handling this issue?

I basically spent the next 30 years travelling around the world, reading whatever I could get my hands on, speaking to experts and that is really why I'm here today. In 1987 I took three months' sabbatical leave to look at how countries in Western Europe and North America were handling that issue of protecting the community from HIV, starting among and from people who inject drugs. I want to tell you very briefly about two experiences I had. One was in the Bureau of International Narcotic Matters, as it was then called, in the US State Department. I happened to have a meeting with the deputy director of that department and in the US system the State Department is the lead government agency for drug policy. I asked the deputy director whether he thought what America and the world was doing in response to illicit drugs was working.

He told me that in the previous 12 months, the US dollar had depreciated against all foreign currencies and this made the work of the State Department more expensive, as most of the budget was spent outside of the United States. So they had to revise their budget and all sections of the US State Department had taken a cut, except for two: embassy security and drugs. I thought for a minute, "What is he trying to tell me?" I realised that what he was trying to tell me was that drug policy worked bureaucratically and whether it worked in any other way didn't really matter. The other experience I had which was in Williamsburg, Brooklyn - part of New York City - I spent an evening in a shooting gallery with people bringing their own drugs to the shooting gallery.

They hire the shooting gallery for the night and they inject drugs. The local police are paid-off so there is minimal risk that it is going to have law-enforcement consequences. That night there were four Hispanic people shooting speedballs of heroin and cocaine. For the first time in my life - only time in my life - I watched people actually injecting illicit drugs. I can't convey to you how horrific that experience was, to just sit there and watch it. They didn't speak English, I don't speak Spanish, but through an interpreter I found out that they all knew about AIDS. They all knew people who had died of AIDS - who had got AIDS from injecting drugs and yet their recklessness was something that just astonished me.

There they were, in the semi-darkness, getting whose needle and syringe it was mixed up, whose tourniquet it was mixed up, whose spoon it was mixed up and I watched all this realising that HIV was being spread in that room while I was watching it. My first thought, of course, was that their behaviour was totally irrational and then as the evening wore on I realised these people would live in squalid housing or be homeless. They would never have had a decent job. They wouldn't have had a decent education. The same fate would befall their children and their grandchildren. There was no hope for these people and so what they were doing was actually quite rational.

They were having four hours of an enjoyable, chemical vacation in a life of total wretchedness and misery. I'll come back to that issue in a little while. I want to say to you that I've been involved in what has been an intellectual, sort of academic debate about the war on drugs for 30 years and it's clear now that that debate is over and that the reform side has won. It's getting harder and harder to find people willing to defend the war on drugs. The media contact me asking me for the names of credible people who will defend the war on drugs because they want to have a balanced discussion. That's been going on for about 10 years and it's been harder and harder for me to find credible names for them to interview. But the political change has been glacial, especially in this country.

Australia in the 1980s was a world leader in pragmatic, effective responses to drugs. We're now one of the laggards. Many other countries in the world, especially in Western Europe, especially in the Americas, are now moving much more down the pragmatic road. We're still stuck in this ideological log jam and many politicians, I'm afraid to say, are still all-too-happy to kick the can down the road. We've got to stop kicking the can down the road and we've got to start looking at the realistic options. I want to put five propositions to you: the first is that we redefine this issue as primarily a health and social issue. Of course there is a law enforcement component; always will be. But by redefining the issue as a health and social issue there are ethical implications, there are research implications and most important of all there are major funding implications.

Secondly, we need to expand and improve drug treatment. Drug treatment is seen through the prism of law enforcement. It needs to be seen through the prism of health and social services. Services for people who use drugs should be no better but no worse than our services for people who have breast cancer or diabetes or high blood pressure. That is the standard we should aspire to. Thirdly, we should illuminate the sanctions for people found using or possessing drugs, as many other countries have now done. Fourthly, we need to make a start on regulating as much of the drug market as we can. We'll never regulate all of it but we need to start that process and we already do that with the needle syringe program. We do that with the medically-supervised injecting centre.

The next step should be taxing and regulating cannabis. We need to expand the other things we're doing. We will never sell and I don't think we ever should even contemplate selling kilogram blocks of 100 per cent pure heroin or cocaine in the supermarket checkout. That is never going to be on the table but we have to find realistic options that politicians can support and the community can accept. We did this before. Until 1906 in Australia edible opium was taxed and regulated and sold in grocery stores. Until 1903 Coca Cola in the United States contained cocaine so we can find those compromise options and we must do that and do that quickly.

Finally, I think we should shrink poverty. The more extensive poverty is in the country, the harder this problem is to make progress with and those four people - those four Hispanic people that I met in Williamsburg, Brooklyn - their problems were much worse because they were so impoverished. So reducing poverty is a very key part of this. I just want to make one additional comment before I close and that is a lot of what we do now is supported by fears, unrealistic fears, that the sky will fall in and in particular that liberalising drugs will increase drug use and by implication increase drug-related harm. If we actually look at the evidence for that proposition, it's very unimpressive.

There are many countries in the world who have reformed their drug laws, where drug use has not increased or it has increased minimally. For some of them, drug use decreased. There are many countries where drug laws have been intensified - made even more restricted - and those countries have not seen a decrease in drug use. There is very little relationship between drug policy and the extent of drug use but the more restrictive we make drug policy, the more we harm people. We also - as Mick pointed out to you - the focus should really not be on drug use, per se, but on harms from drugs and harms from drug policy. That should be the focus. Thank you very much.

The CHAIR — Thanks, Alex. Do you want to make a couple of comments before we go to questions, Paul?

Mr BODISCO — If I could, and I would like to actually tell a story about what happened to me last Thursday as I was on my way into work. I am a barrister by trade. I've lived in the King's Cross area for the past 30 years. Over that time I've got to know an Indigenous lady - I'm going to call her Suzie because I haven't - and I'll explain later why - I haven't been able to track her down to get her permission to use her name. But I was walking into work via the King's Cross Station. At that time I was about 40 metres away from the injecting centre. I saw Suzie, who I've known - she's been a beggar at times in my area - and she was against the wall, while two officers stood over her. They were arresting her.

They had found heroin in her possession. I thought to present myself in the situation as a barrister - as somebody who knows Suzie and was willing to provide pro bono assistance for her as she might require it. One of the officers asked me to stand away. Again, I repeated who I was, why I was there. I was told that I was hindering this investigation and that I would be charged if I didn't walk away. I said, "Well, you have a notebook there. Please, could you just take down my phone number and pass it on to Suzie?" I was told, "Go and speak to the other officer," standing away, about five metres away. So I approached the other officer.

I said, "I'm a friend of Suzie's and I would like to provide my phone number so that she might be able to contact me for pro bono assistance." The officer said, "We're here to prosecute people, mate." I was a bit taken aback by this, standing where I was, 40 metres away from the medically-supervised injecting centre. Standing where I was, wanting to provide assistance to an Indigenous Australian and a member of my local community. I was then approached by three members of the public, all of whom were also friends of Suzie's. They were asking me, "What is this world coming to?" What is happening here and what benefit as a tax payer would they be receiving from what was happening in the station, so close to the injecting centre in the epicentres of so many of the problems that Alex and Mick have spoken about?

When one considers that we had three officers conducting this investigation and later that Suzie would have been taken to the police station. Here in New South Wales we have a crisis in terms of the prison population. People are

staying in police stations when refused bail, in some circumstances up to four weeks. Suzie no doubt would have been taken to the police station, would have been charged and because Suzie is somebody I know who sleeps rough would have had very limited community ties and certainly nobody in her immediate family who could put up a surety. Suzie would have had a very strong chance of being refused bail.

Suzie's matter might not be coming before a court if she was to have pleaded not guilty for up to nine months and no doubt, we had the resources of the court, of a Legal Aid solicitor, of the corrections officers who would have had the task of putting Suzie in a truck and transporting her from the police station to the court, from the court back to the police station. When we estimate how much money people had spent when they paid their taxes to effect this particular operation one starts to see the operation of our drug laws in a day-to-day reality of so many people. Because I went last night to try to seek Suzie's permission to use her name, she was not where she normally sleeps one might assume that she is still in custody.

I can say this, if there was an inkling that Suzie was suffering a mental condition she would not be now in a mental institution in New South Wales because to be a forensic patient requires one to hit such a high threshold, given the limited resources. I think that we can safely say that she's not there. I know that she was not where she normally sleeps. Suzie's problem is being played out across this country in so many ways, in so many places, as a result of these drug laws. Whilst we see in so many ways in our discourse, in our debates, we are seeing real progress, for Suzie it hasn't meant much. I thought today I just wanted to tell Suzie's story because again, we're standing only about 400 metres away from where this happened last Thursday.

The CHAIR — Okay, thanks, Paul. Both the report and the comments you've made leave lots of issues for us to discuss and we'll follow through some of those in the time we have with you. If I can start just with one issue, perhaps, and maybe it relates to you, Mick, because it's sort of central or a key issue that comes up in the report is that - it recognises that perhaps politicians respond to expectations or perceived expectations in the community and so there is an issue of how do we change those expectations or perceived expectations to be able to move along a reformist path more aggressively?

Mr PALMER — Yes - more competently, I guess, yes. I think that is the reality. It's a complex problem. It's a wicked problem, as they say, and I fully understand that and appreciate the political difficulties with it. I think part of the answer to that and I think one of the barriers, of course, is the fear in the community. From my own personal communications with a whole range of people including family and friends, the level of knowledge and understanding about the reality of the drug-use situation is very poor. We haven't spent much time in marketing or promoting or explaining the reality of that drug market place, if you like.

You know, I think the reality, in my experience, is that in general terms, drug use falls into two big buckets. One is recreational drug users, most of whom are young people holding down decent jobs who go about productive careers or otherwise live fully productive lives but as young people always do take risks and explore - stretch the boundaries and so on. They represent many of our children, friends and so on. At the other end, you've got problematic drug use. Not many recreational drug users finish up suffering problematic drug use but they may, from time to time, come to the attention of the police. When I practiced at the bar for a couple of years in southern Queensland in the early '80s I found myself appearing for people who were found in possession of cannabis or cannabis smoking in joint houses that they were sharing while surfing at the Gold Coast beaches and the like.

They were charged with use and possession, often as a result of a complaint made by a next-door neighbour. If they were subject to a conviction it was likely to impact on the careers they could otherwise chase: I remember appearing for people who had applied to be police officers, who were waiting for visas to go to the United States, who had applied for the defence forces: convictions for simple use and possession could stop that happening. That's when I first started to think about, "Wow, you know, the penalty here far outweighs the crime in terms of what these young kids are doing. This is just young kids doing things perhaps they shouldn't do, we'd rather they not do but they're always going to do."

We all take risks as young people and I would not have joined the police force if everybody had known everything that I did before I joined, I'm sure, let alone become Commissioner of it. So, I mean, that is the reality of the world in which we live and on the other side almost all - I can't think of an exception, actually, to problematic drug use where the drug use wasn't a response to the problems the person was suffering. They were either, as Alex said, homeless, desperately disadvantaged, suffering mental illness, schizophrenia or other problems and the drug use

was a release from the day-to-day problems in life. Policing has always been dealing with the symptoms rather than the causes, so we tend to arrest people on the symptoms that come to our attention.

It's not our job, a lot of the times, to look at what are the underlying causes for that behaviour to occur. If I can give you one example that I think is really relevant to this: I was a young detective in Darwin. I remember going to a house involving an Indigenous family where somebody had given us advice that two young kids from the family had broken into a corner store and had stolen food. We went to the house and what in fact they had stolen were three or four small crates of pie apple - the sour apple used to make apple pie. We went into the house and the whole family - mum, dad and about four children - were sitting around the table actually eating pie apple out of the tins which mum or dad had opened with a tin opener.

The fridge only had pie apple in it, and in the kitchen in the cupboards, there was no other food at all other than pie apple. The two older kids in the family had simply stolen the food to feed the family. Dad was a hopeless alcoholic. Mum had serious mental health issues. They were a family in deep trouble and I thought, if you looked at this simply as theft, you know, you arrest the kids and walk away but when you stood there as a young detective you thought, these kids are almost good Samaritans. Unless we start to understand some of the reasons why people engage in this behaviour, we're never, ever, going to solve the reasons why the behaviour occurs in the first place.

I think that is what is dramatically missing in terms of our current drug policy approach. There is a lot of reasons why people do things and the more we can explain that to the community. Every time you personalise it, and I'm sure you've all had experiences with this, every time we know somebody who has suffered a drug use problem or we have a family member who commits suicide because of depression, the attitude we have to the problem changes. All of a sudden you understand: it's like meeting a detainee from a refugee camp. You meet them, you realise, "Wow, there is a lot more to these people than I thought there was." All of a sudden you've got a deeper understanding of what the reality of the problem is.

I think that is a challenge for us publicly. I think there has been little political capital spent on trying to explain that, the reality of the situation, to the broader public. I think if we did, it wouldn't be anywhere near the problem we think it is. I think the fear is really a skinny fear, based on almost no knowledge or understanding of the reality of the problem. The more we understood that, the more people realise, "Wow, there has got to be a better way to do business." Everybody commits to the fact that we should be about reducing harms, particularly to the young people in our community, which are the vast majority of the people we're talking about. I just don't think we've spent any capital in really trying to achieve that end, if you like, Mr Chair.

The CHAIR — Alex, yes?

Dr WODAK — Jean-Claude Juncker, who is now the president of the European Commission and previously was the Prime Minister of Luxembourg, said, "We politicians know what we have to do. We just don't know how to get re-elected after we've done that." That's really the nub of the problem in this area but if we look around we can see many examples of political fellowship, where the political leaders have followed the people and we also can see examples of political leadership, where the politicians have been ahead of the community. I can give you two examples here: one is where the Prime Minister and Cabinet in I think December 1983 decided to float the dollar.

There was no debate about floating the dollar at that time: it had been recommended in, I think, the Campbell report previously. But there hadn't been a debate. The Prime Minister and Cabinet knew that they had to do this and it has been the source of a great deal of the prosperity that the Australian people have enjoyed ever since. When on the other side of politics Prime Minister Malcolm Fraser put to his Cabinet that his government should ban tobacco advertising, he was outvoted by his own Cabinet and as Prime Minister he exercised his prerogative of proceeding with a ban on tobacco advertising. That has been a very important part of a very important story: no drug compares with the amount of health damage and economic damage to the Australian people and the Australian economy as tobacco does.

It's greater than the harms of all the other drugs put together and thank you, Malcolm Fraser, for that leadership. So it is possible for leaders to carefully select topics and I put to you that this is a topic that is really ripe for reform here now. 55 per cent of Australian people today - according to a poll carried out by Essential, September 2016 - support regulating and taxing recreational cannabis and there were 50 per cent or greater support coming from men,

women, people who say they vote Liberal, who say they vote Labour, who say they vote Greens - that should be Liberal and National - and also in the three age groups 18 to 34, 35 to 54, 55 plus.

So there would be an opportunity, I would guess - I'm not a politician - for a politician to have enough support to show leadership in that area. That particular reform would underpin a lot of later reforms so I think the answer is pick and choose the issues carefully. It's clear that pill-testing is an area where we need to go fairly quickly and I think we need more medically-supervised injecting centres and there is support, local support, for that - strong support and I think enough support in the community. There is not support for some of the other reforms but I'm sure that will grow as we start moving down the reform path.

The reforms were introduced in Portugal in July 2001, which have been enormously successful, survived the global financial crisis when Portugal suffered very badly in the global financial crisis and the Portuguese government cut a lot of government spending but didn't touch the spending in this area and didn't touch it because it enjoys such strong community support and when - after elections when government has changed in Portugal the incoming government has not changed the policies that were introduced in July 2001. They were introduced after a very strong debate; a debate that was sparked off when some children of prominent Portuguese politicians had unfortunately died from drugs. That is what had started that debate in Portugal.

I know that one of your members of your delegation here today has been to Portugal. That is a very good example of how to manage the process of change.

The CHAIR — All right - other questions?

Ms PATTEN — Yes.

The CHAIR — Fiona will - we'll keep working on it.

Ms PATTEN — Thank you - great, thanks very much. I was really interested in recommendations seven and eight of your report, which was around changing the KPIs for police and also considering how you could save money from - as you called it - unproductive law enforcement areas. I'm just wondering if you could expand on rather than arrests being a KPI, what would you envisage being those alternative KPIs and also where would we be saving money in those unhelpful law enforcement areas?

Mr PALMER — I think the first thing is that not all police forces have KPIs that relate to arrests of specific products.

Ms PATTEN — Okay, yes.

Mr PALMER — I think that is a very negative thing and I think that's always dangerous an area of policing, the moment you set quotas or what are seen to be quotas. There is a bit of an encouragement for you to attempt to make sure you meet it. I mean, it is a very serious issue in traffic policing, so we should really be cautious about the areas in which we make KPIs. The KPIs ought to be focused on those more broader issues, like social stability and safety in local communities. The endeavours ought to be about reducing overall crime rates, reducing the feelings of fear and lack of safety in local communities and on the streets and at the coal face of –

Ms PATTEN — How can you test that, Mick?

Mr PALMER — Well, you can test it in a range of ways: by the number of complaints that are received by people who have been subject to unsafe threats or other behaviour that impacts on them; obviously property crimes that may occur, the level of callouts that police have to issues of social unrest and fighting and disturbances outside licensed premises and other public places around the community: it's really not hard. Australia has a lot of things going for it and we probably in many ways ought to be doing better than we have and I say that as somebody that was in charge of not doing a very good job in many of these areas. So I'm not being wise after the event: we haven't done this as well as we should.

In almost - even the biggest cities, the problem areas are generally pretty small and if you focus police attention to where the problems are worst, in a way that is more scientific than what we do, instead of trying to be all things to all people, which obviously you can't ever really be, we'd probably be a lot more effective than we are. So I think

it's about re-aligning and Commissioners and other people having meaningful discussions with politicians about what should be the aims that we're trying to achieve in this process?

If we really focused on what they are and targeted police activity and visibility - and police visibility, of course, is such a crucial issue in all these issues - not too many people commit crime in the presence of uniformed police officers. The more uniform presence you have in the problem areas of the city, the more safety you'll have in those same areas. It always strikes me that in so many areas where I know and see nightly behaviour that is pretty ordinary, I'm hardly ever seeing uniforms present and I'm thinking, "This is where they ought to be. Why aren't we seeing them?" So I think that's more important than the KPIs.

Ms PATTEN — Yes.

Mr PALMER — I mean, KPIs should be those more general areas of social safety and people's feeling of confidence and so on. Obviously property crimes and complaints are issues that are relevant to that.

Ms PATTEN — Yes.

Mr PALMER — The other issue was in regard to –

Ms PATTEN — Unproductive - yes.

Mr PALMER — Unproductive - well, I believe we should have a clear, standardised decriminalisation of just simple use and possession, so that was not a police problem - two things would happen: that time and effort could be spent on much more meaningful police work. I don't think that money should be moved from policing to something else. I agree with Alex that more money ought to be spent on the health-and-safety aspect of drug use. But there is never going to be enough money to go around in terms of being effective as a police officer or being effective as a police service.

But their activities and use could be much more productively spent, as almost every police officer knows. If it was focused on the higher end of the criminal environment - that's what policing is about, community safety; community safety in the general sense and high-end property crime and violent crime at the other end of the spectrum. That's where the activity should be. The reality is police are more effective now than they've ever been in their history: they have more collaboration, more intelligence sharing, better use of telephone interception listening devices and other technology than has ever happened before.

There are very significant seizures of drugs, arrests of very significant players but at the end of the day we don't make any damn difference. You know, the price doesn't go up, the supply doesn't come down and in an untested and totally unregulated market there are too many people making too much money. In my experience it is not a penalty to a crime that is the deterrent but the chance of getting caught. No-one cares what the penalty is, including it being the death penalty, if they don't think they're going to get caught. I've seen people take terrible risks because they believe they're not going to get caught. The more chance of being caught, the less people are going to take the risk, like roadside breath-testing and speed limitations and so on.

But when you've got a situation like we have here, where the profits are huge and the chances of getting caught are low, we're never going to control the market. Untested markets are what create the problems that we are now dealing with. I mean, to me at the heart of this is the fact that the problems we're now really worried about and are facing are being caused by a current policy.

Ms PATTEN — Yes.

Mr PALMER — So it's not as if these problems occurred and we thought, "We'd better have a drug policy that's really tough." We've had a tough drug policy and this is the outcome of it. We couldn't possibly be satisfied with an outcome on the back of a policy that's been around as long as I've been alive, let alone as long as I've been a police officer. I mean, there must be a better way to do business.

Ms PATTEN — Yes, thanks, Mick.

The CHAIR — Okay, just before we go to next questions, in terms of the timing, of course we are theoretically with A21 just going till 10.45 but then we're going on till 11.30 with the Australian Drug Law Reform Foundation

which of course includes Paul and Alex anyway so I think we'll just continue on till 11.30 and of course you're welcome to stay on, Mick. We'll continue with questions that way if you're happy with that?

Mr PALMER — I'll have to leave a little early because I've got another appointment with Minister Grant but I'll certainly be happy to stay for –

The CHAIR — Okay, all right. Murray had a question and then we'll come back to Natalie and go back and forth a bit.

Mr THOMPSON — Thanks very much, Geoff, and thank you for your contributions here today and in the field. In the Australia21 report, it notes that drugs such as antihistamines and short-acting benzodiazapines carry a much higher risk of road crashes than drugs currently tested for at the roadside, *visa via* cannabis, MDMA or methamphetamine. Is that current?

Mr PALMER — Alex is the best man to answer that, Murray.

Dr WODAK — Yes, it is correct. The three drugs that we test for, that Victoria started with - it was the first jurisdiction in the world to test for in 2004 and by 2011 all jurisdictions were testing for THC for cannabis. Methamphetamine and ecstasy have a small increased risk of a road crash but the other drugs - the short-acting benzodiazapines, the first generation antihistamines and opioids have a much higher risk and account for more road crashes, yet we don't test for them. We have no certainty that the positive test for the three drugs that we do test for correlates at all with impairment. It correlates with the drugs having been in the system at some point. I think the appropriate legal principle here is - I better get this right, I've got two lawyers next to me - is that it's better to let 10 guilty people go free than one innocent person getting punished. The punishments for drug-driving are quite severe. They're out of all proportion to the punishments imposed on people found to be driving in the presence of prescribed concentrations of alcohol.

So I think drug-driving laws really need to be looked at again: in all the years they've been in operation now - up to 13 years in Victoria - we haven't had any independent evaluation to determine whether they actually do reduce road crashes. We should be doing that in Victoria and in other jurisdiction as well. These laws have been in place long enough and we've got at the moment a clear collision that we're heading into where we're allowing lawful use of medicinal cannabis at the moment, still unfortunately on a very small scale, and we're going to have a lot of people fairly soon who are caught driving with positive roadside drug tests for THC after using lawful medicinal cannabis.

People with terminal illnesses or other serious illnesses are using the drug lawfully –

Mr TILLEY — Hang on, hang on –

Dr WODAK — Sorry, I can't hear you.

Mr TILLEY — Medical cannabis, as I understand it, in Victoria it doesn't have delta 9 tetrahydrocannabinol in it.

Ms PATTEN — Yes, it does.

Dr WODAK — It does.

Mr TILLEY — But to a lesser extent.

Ms PATTEN — There is - like, there is low THC, high CBD and then there is for pain relief.

Dr WODAK — It still has it.

Ms PATTEN — It would be the other way.

Dr WODAK — Some forms of medicinal cannabis only have cannabidiol and don't have THC. But this is a field in its infancy but at the moment, medicinal cannabis does have THC in it. There is a variety of different options being used: for example, Sativex; nabiximols, which is the product of GW Pharmaceuticals, have got THC in it.

The CHAIR — All right - Murray was wanting to continue on that line.

Mr THOMPSON — I'll ask a different question now, thanks, Geoff. The most recent Australia21 report, "Can Australia Respond to Drugs More Effectively and Safely," reflected discussions of an eminent group of people and covered a wide-ranging number of matters. On what issues did opinions differ, particularly in terms of solutions?

Mr PALMER — It was almost unanimous in regard to the 13 recommendations and the findings of this report that reflected the views of the meeting, not the views of Australia21 but rather what the meeting discussed and what the meeting as a group found. There was only one of the 17 people who was in a serving position, government position, who thought that he wasn't able to have his name associated with the report. But there was no greater disagreement in regard to the issues.

Mr THOMPSON — Geoff, I've got other questions but I'd like to move it around the table, thank you.

The CHAIR — All right, we'll come back. Natalie, we'll go to you.

Ms SULEYMAN — Thank you for your presentation. I just wanted to ask a question in relation to prescription drugs and you haven't really touched on the users who are, in high numbers, abusing prescription drugs. How would you suggest ways of tackling, I would say, the grave issues that we have with prescription drugs and the overdoses in relation to directly linking with prescription drugs?

Dr WODAK — Well, it's a huge and a growing problem and it's a problem that hasn't received the attention in Australia or in other countries that it deserves to have. We only have to look across the Pacific at what's happened in the United States to realise that we are following the United States. We started after the United States and our problems haven't increased as rapidly as the problems have in the United States but it's still a very significant problem in Australia. In other words, drug overdose deaths from prescription drugs are rising rapidly in Australia and I think we should be very concerned about this. I chaired a group with the Royal Australasian College of Physicians in 2009 on this issue and it's complicated because it involves all nine jurisdictions and at each jurisdictional level it involves the Health Department and other government departments.

Within the Health Department, it involves many sections of the department so it's a sort of a messy problem to try and deal with. Regrettably, the pharmaceutical industry's role in this has been reprehensible. You may be aware that one drug company, Purdue, was fined I think \$600 million by the courts because of its criminal behaviour. What do we have to do about this? I think we need to have somebody in charge. One person or one organisation has to have national responsibility for this issue in Australia. At the moment, the responsibility is spread over many, many different people. Secondly, I think we need to raise the level of awareness in the community and raise the level of awareness among doctors about how serious this is.

We have to convince the community and doctors that the prescribing of prescription opioids for severe, chronic, non-malignant pain is very marginal. It does help some people but there are a lot of people who it has no benefit for and a lot of people it has significant side effects for. So prescribing of prescription opioids needs to be much more discriminating: fewer people, shorter periods, reviewed much more often, lower doses. That can only happen if we have educational campaigns directed at the community and also for doctors. There is also an important role of medicinal cannabis in this.

It may surprise you but a 2014 paper in the journal of the American Medical Association compared drug overdose deaths in states where medicinal cannabis was lawful with states where medicinal cannabis wasn't lawful. The drug overdose death rate was 25 per cent lower in states where medicinal cannabis was lawful compared to the other states. In states where medicinal cannabis had been made lawful earlier, the drug overdose death rate was lower than in states where this had only happened more recently. Since that paper has come out there has been a number of other papers that have come out - about four or five other papers have come out supporting that.

For example, there is a paper that has come out recently showing that patients with severe, chronic, non-malignant pain prescribed prescription opioids who also take medicinal cannabis use lower doses of prescription opioids than people not using medicinal cannabis. So there is also a significant role for accelerating the implementation of lawful, medicinal cannabis in Australia. In my view - and I know my colleagues agree with that - that implementation is occurring in Australia far too slowly. We need to speed that up, partly for medicinal cannabis itself, partly to reduce deaths from prescription opioids. The temptation is always to ratchet-up supply restrictions

and there are calls for on-time prescription monitoring and I think that probably has a role but the history of supply restrictions is not encouraging.

Very often the results are disappointing and very often there are severe, unintended negative consequences that we didn't realise at the time so I would like to see much more emphasis put on reducing demand than reducing supply. But it's something we need to take very seriously. In America, deaths from drug overdose - particularly prescription overdose - are occurring at the level I think now of 39,000 a year and they outnumber deaths from motor car accidents plus AIDS. It's a very significant public health problem in the United States - so significant that it has started reducing life expectancy in middle-aged white males - that population more than other populations because they tend to use prescription opioids more than other populations.

So it's starting to have very significant public health implications in the United States. I don't want things to get as bad in Australia as they've got in the United States.

Mr BODISCO — If I could just make an observation also, from my life as a practitioner barrister working predominantly in the area criminal law, over the last two years I've referred approximately 50 of my clients into drug rehabilitation facilities so I'm in regular contact with the facilities that operate around New South Wales. The average wait to get into a rehabilitation facility for one of my clients who need to get in, because as much as anything else, they want to demonstrate when they're finally up for sentencing that they have taken appropriate steps to rehabilitate themselves - the average wait is up to seven or eight months to get into a public facility.

Those facilities will not take you if you have an addiction to benzodiazepam or as we often call xannies - Xanax pills, sleeping pills. They won't take you if you're addicted to Fentanyl. First issue. Second is that when many of my clients have finally ended up doing their time in jail, they've reported it much easier to break their addictions to crystal methamphetamine or to heroin than they have to break their addictions to the painkillers or sleeping pills. In fact, they are prescribed benzodiazepines in prison because otherwise they have seizures. It's something to remember.

Ms SULEYMAN — I just have one final question.

The CHAIR — Okay.

Ms SULEYMAN — Is it an issue of making the appropriate investment for drug rehab and support services, addiction services, rather than decriminalising drugs?

Dr WODAK — I think we need to do both and can I point out that people talk a lot in Portugal about the changes that were made in reducing penalties and eliminating some penalties. What's not talked about quite so much, but is very important in Portugal, is that it made great efforts to expand and improve its drug treatment systems. So the kind of thing that you've just heard from Paul wouldn't happen in Portugal. People can have better access to vastly improved drug treatment systems so we need to do both. The problem I have with only decriminalising the drug laws without going further and starting to try and regulate the drug supply system - notwithstanding how political difficulties are considerable - I recognise that, I acknowledge that - but the reason I say that we have to do both is that just imagine if the United States during alcohol prohibition in 1902 to 1933 had simply removed the criminal sanctions from the possession and consumption of alcohol and hadn't done anything about providing a legal source of supply? They still would have had Al Capone wandering around and we have to get rid of the Al Capones out of this area and their counterparts.

The black market is more of a problem than the drugs themselves. When heroin is prescribed, pharmaceutical heroin is prescribed by doctors to patients as it is in the United Kingdom, for example, where it is prescribed to patients with a heroin addiction problem, most of them will improve. We now have trials of what's called heroin-assisted treatment that have been conducted in six countries with a combined total of over 1,500 subjects. Those trials have had quite consistent results showing clear benefit for the families and the communities in those countries where it's prescribed. So when pharmaceutical heroin is prescribed by doctors and dispensed by nurses and pharmacists, it benefits individuals and communities.

When it's supplied or prescribed by criminals in a black-market system it hurts those individuals and communities. The problem isn't the drug. The problem is the dispensing, the distribution system, so what we need to change is the distribution system. I say this to you particularly because you're Victorians and it was in your capital city,

Melbourne, almost 20 years ago, August 19 1997, when the Howard cabinet stopped Australia's heroin trial. One of the things we need to do is have heroin trial in Australia. The trial that we should have had in 1997 that was unfortunately stopped - we need to do that now so that this can be an option.

Why it's particularly important is because the people who get heroin-assisted treatment in the half-dozen or so countries - about 10 countries around the world now - that prescribe this as a treatment option. The only people they will consider is a small minority - about 5 per cent or so - of people with severe heroin dependence. They have to have severe dependence and they have to have tried and not benefited from all the other treatments available - so-called treatment refractory people. Those people are particularly important. They're a small minority but they're using prodigious quantities of heroin.

They're accounting for a disproportionate share of the crime committed in the community and presumably also doing a disproportionate share of the recruitment of novice users, so taking those people out of the market and putting them into some kind of treatment is good for them, very good for the community. Switzerland showed this by introducing that system in the 1990s when Australia stopped the trial. Switzerland went ahead with their trial and they now have this treatment for about 1,000 Swiss people, spread throughout the country, and we can see that the Swiss epidemic of heroin use declined significantly during the 1990s and early 2000s after prescription heroin was introduced. We need to follow those countries: Switzerland, Germany, Spain, Netherlands, England, Canada, that have heroin-assisted treatment - Denmark as well.

We need to follow those countries and it's all part of the process of dealing with prescription opioids.

Mr BODISCO — If I could say - the question possibly assumes a binary position in respect to the two ideas of on the one side the criminal justice response and on the other, the public health response. I think that so often the law is like a spider's web here: it captures the small fry but lets the big bumble bees go through. But we also need to look at what it does to the fry: it stigmatises. When somebody is at the point where they are addicted to drugs, it becomes a lifestyle, a career, to fund that addiction. We are at a point as a human where we need support and what the criminal justice response does so often is stigmatise, isolate, divide.

It takes us away from the necessary supports we might hope for, including family, but also clinicians, an enabling community around us to encourage us to do things with our rights; it takes us out of education, breaks us from our jobs and our careers and our forward momentum in life. The criminal justice response so often works against those public health aims. I think when certainly if somebody was looking at an admission into a rehabilitation facility I would say that the better patient - the patient who is more likely to be successful is the one not with the criminal sanction hanging over their head but the one who has decided that they want to make meaningful changes in their life and dependent of that - so just some reflections.

The CHAIR — Okay, we'll go to Martin's questions.

Mr DIXON — Just a comment or observation and a question. You talked about leadership and politicians making brave decisions and, "Yes, Minister," be a brave decision-maker. I think what makes our job easier is if there are people calling for change, you know - especially if it's the tabloid press actually calling for us to - it would make our job a lot easier. So that involves -

Ms PATTEN — Andrew Bolt for us -

Mr DIXON — Some bridges are too far but - I just think to educate the whole community is everybody's responsibility and it makes it so much easier for us to take the steps, perhaps, that need to be taken. My initial question which I wrote down very early but I think has been answered but I just want to confirm this: I think all of you have said really what we're doing is counterproductive. The way things operate now is counterproductive. I thought, well, that's a sweeping statement - what do you mean by that? Paul, is that what you meant by Suzie? You know, she's been arrested. She's gone off to where ever and therefore she is going to come back probably in a worse position because she's been - and in fact the example you've just talked about, she's away from any other supports she might have had whether they be a community, health, family. Is that what you mean? Is that what is meant by being counterproductive?

Mr BODISCO — Yes, and stigmatised to the point where if she was indeed able to get work before, she's less likely now.

Mr DIXON — Okay, yes.

Mr BODISCO — She probably, after all the stress of what she's been through, is - if she is at liberty she's probably taking drugs right now. But there is a political element in terms of I think selling this harm-minimisation message and I think inherent - and I just remind everybody that these (cigarettes) are legal, these will kill half the people that take them up and become addicts –

Dr WODAK — Two thirds.

Mr BODISCO — It's two thirds - these are not encouraged. I mean, I've got a picture on the cover. Inherent, I think, in those who say that we need tough laws on drugs, we need this war on drugs to continue, is this idea that if we don't have the criminal justice response then we're encouraging people to use it. This is the answer, I think, because every day when I have my cigarette I'm reminded about what the consequences can be. I don't go and buy these from the same person who would sell me crystal methamphetamine. I don't go and buy these from the same person who would profit out of a heroin addiction. Therefore, I'm not encouraged because we conflate so many different drugs of different objective seriousness together when we call them all illegal.

I don't have to deal with the black market and those who would profit more out of me being addicted to heroin than they would out of me being addicted to these. I also would be in a position where revenue would be gathered which could go towards funding assistance for me or someone else to get off whatever their demons have taken them to. In that sense, when one looks at what's happened in California and sees where the marijuana industry has grown into a commercial industry the size of wine overnight, one can see that there are substantial revenues that could be gained in respect of that policy change that could ultimately assist me to get off these. It's something else to consider in the way that we message these things to the broader community.

Mr DIXON — Thank you.

The CHAIR — Okay, Bill.

Mr TILLEY — Yes, I just want to concentrate, gentlemen, a little bit - getting off the academic and you know, the intellectual discussion and some of the practical stuff. Now, my colleagues and yourselves have seen some absolute tragic things on our streets and our police stations, our emergency departments, in our custodial facilities. You know, we've seen it but the thing is I don't think there's one of us here that doesn't say that we're not fixing. We're not getting any closer. There is an old copper term, if I may use it - and it's not in the execution of a search warrant but a failure to search is a failure to find.

I prescribe by that but the practicalities of a lot of this stuff - we're talking about impairment in a society. Now, for example, as legislators and public policy makers, I don't think it's necessarily cowardice or not willing but how do we - for those that don't have a substance use, as such, how do we protect as legislators the rest of society and particularly when it comes to driving and operating machinery and in the workplace. Dr Wodak, you did mention about impairment and you're absolutely right. The preliminary oral fluid tests don't test for impairment and I fully know that. In fact, I was one of Victoria's first drug assessors, where you had to actually go out there and get them to walk a line, ask a series of questions, nystagmus and all those types of things.

But, you know, there has been some significant failures in public policy in that regard because if there was a presence of alcohol you didn't worry about any substance. You charge them with the alcohol. But that legislation has since changed so how do we step up gradually to address some of the ailments and the issues in our society? We just can't - I don't think we can just turn around and tomorrow - just holus bolus come into policy that decriminalises it. It's got to be a process and for example, you know, around Australia we can talk about cannabis in particular.

We know in society that over the years with your general organically-grown cannabis - you know, pasture-fed stuff and everything - compared to what is now colloquially-termed as skunk, where it's hydroponically grown, has significant levels of THC and is quite dangerous - as a practitioner, Dr Wodak, would you think that it would be fair to say that if we were looking at this, that we'd address particularly when we're just in isolation talking about cannabis, would we address something in that regard first?

Dr WODAK — Well, there are several different ways of responding to that: one is what Denmark did about 10 years ago. Denmark has nine major parties and they were struggling with this issue as most countries struggle

with this issue and the nine parties met privately and thrashed this issue out and they agreed on a program to respond to this issue in Denmark. All nine parties signed onto that program and then they held a press conference with representatives of the nine political parties and they said, "This is what Denmark is going to do." Denmark has now opened an injecting room, for example, in five of their major cities.

They started - the first country in the world to start heroin-assisted treatment without doing a trial of it: they said, "We're a small country. We can't afford to do a trial on everything. The trials that have been done are enough for us," so they started doing that for the population I described before - severely dependent, treatment refractory. They've adopted a series of policies which all the political parties have agreed to so that's one option and we have an Australian version of that during the HIV epidemic which began with Neil Blewett, the Labour health minister and Peter Baum, the shadow health minister from the coalition side - having a cup of tea together to discuss the HIV epidemic and out of that grew a collaboration which served this country extremely well.

I was present at a meeting in Darling Harbour about 15 years ago where - a HIV meeting - where Neil Blewett and Peter Baum walked in the room together, both now in their retirement, and the room just burst into spontaneous applause for them and it lasted about 15 minutes. You know, people were so grateful for what these patriots had done for their country. Then there is the Malcolm Fraser option for tobacco control which was ramming it down his own party and where there wasn't a widespread call for it. I mean, you guys are in the business of managing political issues. I can't teach you how to do this.

There are several options for us and if we look at the alternative side, drug prohibition wasn't introduced responding to mass protests. There were meetings held in a hotel in Shanghai in 1909 with 13 countries present. Then there was a meeting held privately in the Hague in 1912 and then a meeting in Geneva in 1925 under the League of Nations. There were a series of quiet, private little meetings and out of that grew these top-down, global policies which have turned out to be a disaster. They weren't based on evidence: they weren't based on mass public opinion. They were just driven through the system and now that those mistakes have been made it's getting so hard to get rid of them.

I put it to you, sir, that what we really need is for the politicians to start speaking to the people, explaining that we're in a mess with these policies and we won't overturn them overnight but we will chip away at them and we'll start a process. I think that would be strongly welcome and –

Ms PATTEN — Start with the cannabis as Bill was –

Dr WODAK — I would start with - well, the pill-testing issue is, I think, close to happening. I hope medically is second and let's hope that a third and fourth medically-supervised injecting centre - there is some momentum happening there and I think regulating recreational cannabis, allowing medicinal cannabis to be used, for goodness sake, to relieve suffering for people with terminal illnesses and other serious, medical illnesses. It's all going too slowly and in some cases not going at all. I think discussions, dialogue with the Australian people, explaining, we need to get out of the mess we're in - we've done that before. You guys have done that before with other issues.

I'm going to say something now which may shock and surprise you: that is to say that if we look at where Australia is now, particularly in our economy and in our health compared to other countries, Australia has really done extraordinarily well in the last 40 years. Our health, judged by the conventional parameters that our health is judged by and compared with other countries - we're in the top half-dozen healthiest countries in the world and it's not because we spend more than other countries - we spend 9 per cent of GDP on it - we do it well. Likewise, our economy has grown as we all know - maybe not as much as some people would like but many people live a very comfortable life economically.

Our education standards are slipping but they're still quite high by international standards. Somebody has got to be held responsible for these great achievements. It can only be the political class, which includes the elected politicians and the bureaucracies. You guys have done a great job in those areas. Let's do a great job in this area.

The CHAIR — Okay, yes - Mick, I understand.

Mr PALMER — Thank you very much indeed. Can I just say one thing in regard to what Mr Tilley said –

The CHAIR — Sure.

Mr PALMER — I endorse everything Alex has said. I mean, the violence that's created by people who often seem to be impacted by drugs obviously is a real community concern. Politically that is something you've got to be seen to be addressing. I think there's two issues there that really are important to that consideration: one is that that behaviour is not insignificantly driven by the fact that people are buying untested drugs - completely untested drugs in an unregulated market. They've got no idea what they're buying and many of the people that we find are having these psychotic episodes and people in fact that die from overdoses are dying because what they bought was not what they thought they bought.

There is no control over supply and people obviously buy from shady dealers down back lanes, as a result of which their behaviour goes berserk. So that's one of the reasons for that and the second thing is that in dealing with that I think a simple thing politically and practically to do is to distinguish the use from the behaviour. So you treat the use but you criminally deal with the behaviour, so if I commit violent behaviour as a result of being impacted by drug use, well, don't excuse the behaviour but treat the use so there is some chance that you will rehabilitate me going forward. Where that occurs it occurs very effectively but we don't: we throw the baby out with the bathwater.

There is a way to separate use from behaviour and I think we ought to be focusing on that as part of that transitional journey. As Alex said, it's a step-by-step process. We've got to ease into this but standing still I don't think is an option.

The CHAIR — Okay.

Mr TILLEY — Just before you go there, before you leave - do you have any knowledge whatsoever, because you say there's significantly, the cutting agents in all forms of whatever is being used? Is there any test anywhere in this world that can determine, apart from the presence of whatever they're primarily trying to ingest and apart from giving an indication in a field test - is there any test anywhere in the world that will determine how much of the cutting agent and how good the quality is? Because how can we bring into public policy that you turn around and test your substance and it's full of rubbish? It's more damage.

Mr PALMER — Yes, well, the argument for that is of course to regulate supply, so that you know you're buying it from a regulated supplier that has been government-sanctioned. That is the pure answer to that. Certainly from police evidence - after the event, sadly. Frequently we're finding, for example, the level of potency of a drug, toxicity of a drug, is sometimes six, eight and 10 times that which the person who bought it believed they bought. So they take the dose they normally would have taken: next thing they're dead. I've been involved in a number of cases where that's been the case, where clearly the level of toxicity has been far higher than what was normally the case.

In terms of the other commodities within the drug that might be obviously tainted - they talk about the fact that so many methamphetamines, so many contraband commodities are thrown into the mix - Alex can talk to that, I don't know. But I know that it is frequent. The people involved in this process are about maximising profit and also about maximising your dependency, so the more they can get you to be dependent upon them and come back for a second dose, the more they can make profit from the sale, the more they're going to do what they need to do.

Dr WODAK — No, I agree with that - dose variation is the primary problem. The unreliability of knowing what is being bought but in the case of ecstasy it's the adulterants that are probably often if not always responsible for the deaths. Some of the deaths are due to very high doses that are being sold but again, it simply reflects the fact that this is an unregulated trade and the sooner we can move to regulating that, the better.

The CHAIR — Okay, all right.

Mr TILLEY — Before you move on, Paul, I just want to add again on the record the story that you share with us from Suzie up the Cross, you know - I mean, I've worked up there and yes, I'm often disappointed with the behaviour of some law-enforcers, okay, but never surprised. But in saying that, with the story that you've given to the committee, we know that there's a whole lot of facts that aren't there. Suzie may well have been - would it be fair to say that Suzie may well have been known to the member of the police force at the time, that he may well have been gigging for her?

So often you get - when you're talking to members of the community quite often there has got to be a bit of a public display. Their operational awareness, their risk assessment, they probably didn't know you - but like I said, I'm often disappointed by the behaviours of some of our law enforcers.

Mr BODISCO — I wasn't intending to in any way attack the officers. I think they woke up that day thinking that they were assisting to clean up the Cross. I think they thought that they were taking steps to enforce the laws of the land. One might think that if they were aware that there was criminal activity going on and they chose to turn a blind eye to it that that might be something that might concern a lot of people as well.

Mr TILLEY — Yes, sure.

Mr BODISCO — I think this is going to only ever happen while we have this response and I'm just reminded that Jon Maynard Keynes said: "When the facts change, I change my mind. What do you do?" I think we've seen so often among governments the latter. We're taking I think an approach which the consensus among public health experts has been advocating against for a long time. If I was to look at that time when Neil Blewett and others initiated the needle and syringe programs at that time, I think it would have been a rational approach to think that if you started giving out free or cheap, affordable needles to drug addicts, that you might be increasing the amount of people who are injecting-drug users.

That hasn't happened though. But when you look at the statistics, a good 20 years after that decision was made, and you look at the amount of people in Australia who contracted HIV as a result of injecting drug use, the amount was one half of a per cent. When you looked at other cities around the world - London, it was 50 per cent. Paris it was 60 per cent. The reason why these policy-makers received their 15-minute ovation was because no doubt a lot of the people in that room are able to affirm that lives have been saved as a result of that policy shift. I think that is why we should be guided by the experts.

The CHAIR — Okay, just for a second - we'll keep going in a moment, Alex, if you're okay - we were due to finish with your contribution at 11.30 and then we had invited New South Wales police to address us now but they've declined the invitation so if you're happy we'll continue on till midday, for another half an hour?

Mr BODISCO — I might need to leave soon.

The CHAIR — We'll understand, Paul, if you need to go. You're still able to stay on Alex? Thank you. All right, well, continue with your comment now.

Dr WODAK — I wanted to make two comments about Suzie, who I also know, as someone who lives in that neighbourhood and also saw her when she was seeking healthcare. The two comments are that as Paul mentioned, she is an Indigenous woman and we do have to note that our drug laws - the burden of our drug laws have been borne disproportionately by racial minorities. This is not a recent development: the first drug laws ever passed by Australia parliaments were passed by your parliament, the parliament of South Australia, the parliament of New South Wales in the gold rush days and they were laws which criminalised the smoking of opium.

The only people who smoked opium in the gold-rush days in Australia were Chinese and these were clearly racist, anti-Chinese laws and the same thing happened at the same time in the state of California and in the United States and the province of British Columbia in Canada. So there is a long history of our drug laws unfortunately being motivated by racism or having racist effects. The other thing I would say to you is just as Paul told you how the particular police officers in carrying out what they thought were enforcing our drug laws were in fact seemingly to be going well beyond their legal remit. There is unfortunately a long history of this happening with drug laws around the world and right now we're seeing in the Philippines at least 9,000-10,000 people have been subject to extra-judicial killings under the orders of President Rodrigo Duterte.

Those killings are still going on. He mentioned that in his election campaign. When he won the presidency, even before the inauguration, he publicly called for police to start these killings. They did so and those killings have continued and accelerated since he became president. In a world where we didn't have harsh and punitive drug laws it's unthinkable that the president of the Philippines or any other country would call upon a national campaign of extra-judicial killings. 3,000 people were killed in 2003 in Thailand on the orders of the then-Prime Minister Thaksin Shinawatra. Philippines isn't the only country to have mass extra-judicial killings of people who use or sell drugs.

Unfortunately Philippines is falling into a tradition of - which other countries also share. Our drug laws have very severe and unintended consequences themselves and then they also have huge, indirect consequences and they are often abused themselves.

Mr BODISCO — If I could say, this goes to a question that was asked earlier regarding the statistics: the use of drug detection dogs here in Sydney for a dance party that was held three years ago called Harbour Life - so again now we're talking about 150 metres away from where we saw the arrests of 80 people who were in attendance, all of them for possession of drugs. So the statistics, if one was to look at drug detection dogs here in Sydney would show that 80 arrests occurred that night. I happened to be working as the duty barrister at the Downing Centre about four weeks after that dance party. It happened to be the day return for the court attendance notices for all those people that were arrested at that dance party.

The magistrate came on to the bench and said, "Could it be called out, everybody from Harbour Life who's here who's been arrested? Come into the court now." So 80 people came in and the magistrate asked them all to stand up. He made the sign of the cross and he said, "It's a public health issue. I'm giving you all section 10, no conviction." I can tell you, however, not one of those people would be working in the public service now if they had applied for a job, say, as a school teacher without disclosure of that. None of them would be working as a barrister without disclosure of that. None of those people would have been able to access a visa to the United States via the electronic admission of your visa processing through the consulate.

If they subsequently were to apply for a visa at the consulate they would be waiting more than six months as to whether or not the consular officials would exercise their discretion to allow them to have a visa. Those people all would have had to disclose the fact that they had received this dispensation in so many areas of their working lives. Some of them may have faced exposure in the newspapers and embarrassment that comes with that and some of them would have lost their jobs, because so often we see the process of going before a court as - we rejoice in the tears of a sinner and so disclosure to people who you care about is part of that process.

So I can't tell you with any exactitude about what has happened to those people but I certainly couldn't justify what went on by reference to those statistics, because there is a human story embedded in this and it will continue to happen while we have this approach.

Mr TILLEY — So, Paul, just quickly, you said that only four of the 80 were issued again for possession?

Mr BODISCO — Pardon?

Mr TILLEY — There was only four of those 80 issued –

Mr BODISCO — No, they all –

Mr TILLEY — They were all found in possession? Okay.

The CHAIR — Fiona.

Ms PATTEN — Thank you. I've got a few questions. I'm going to have to be really selective but going back to the notion of taxing and regulating cannabis and I suppose taking that very - well, the drug that has the biggest use out of the illegal market. There has been different models and certainly Colorado has probably been the most advanced model of this but there is significant criticism around the Colorado model. If you were to write, in your own head, have you got a model that would work for taxing and regulating cannabis in Victoria?

Dr WODAK — I'm working on that together with Nick Cowdry, who is the former director of public prosecution of New South Wales; Hal Sterling, who is a retired District Court judge; Helen Gibbon, who is a senior lecturer at UNSW law school and Ben Mostin, who is also a lecturer at the UNSW law school. We're in the process of preparing a model like that. I think that we've got a growing number of models that are becoming available now as more countries and more jurisdictions start to look at this issue of how to tax and regulate cannabis. So different countries have approached it in different ways. So far we've got eight states covering more than 20 per cent of the American population that have already approved the taxation and regulation of cannabis and either implemented it already or are in the process of starting to implement it.

Canada will start taxing and regulating cannabis on 1 July 2018 and will become the first G7 country to do so. Uruguay has already become the first nation to tax and regulate cannabis. That has already started. Geneva and Jamaica have said that they will start taxing and regulating cannabis.

Ms PATTEN — A lot of people have said, "We don't want to go down the alcohol path," so do we be very restrictive about the advertising? Do we be very restrictive about how much people can buy? Obviously we can moderate the price through the taxation model. I'm just trying to get a picture of what we should be considering.

Dr WODAK — Yes - well, I think we ban sales under a certain age and we require proof of age for people who claim to be above that age, modelled on what we do for alcohol. I think we have health warnings on packages.

Ms PATTEN — Do we sell a smokable product or –

Dr WODAK — I would hope people would not be smoking cannabis but would be vaping it - would be inhaling the vapour. I think we should have consumer protection information on the packet: "This packet contains 3.4 per cent THC and 6.2 per cent CBD." That kind of information on the packet. I'd like to see health-seeking information required, so for people who want to stop or cut down and having difficulty doing that, I can ring this phone number or I can go to this website. I would like to see all advertising banned, personally. I would also like to see all donations to all political parties and politicians banned. I don't know whether that's practical but I would like to see it.

I think there are a lot of lessons we can learn from the mistakes that were made with the regulation of alcohol and tobacco that we don't want to see, that I don't want to see repeated with cannabis. Parliaments are going to have to and governments are going to have to wrestle with the issue of pricing. If the price is too high that will simply perpetuate the black market. If the price is too low then that may encourage more use so we want to get the Goldilocks price that's not too hot and not too cold - that's right in the middle and that's going to take a bit of adjustment. We'll only be able to find that out by trial and error and presumably over time that will have to be modified now and then. The income generation is quite considerable from this and so the state of California estimates that they are going to generate over \$1 billion a year and we can start thinking of what we would like to do with \$1 billion. California is putting that into justice reinvestment, to try and get people out of prisons and try and reduce crime in high-crime areas. Colorado has put some of that money into rebuilding their public school system in that state. So there are various options as to how to do that. I think probably the system that will be closest to what we would consider will be what Canada is going to adopt in July next year on their national day, and a particularly tricky issue is what we're going to do about the international treaties.

Ms PATTEN — Yes.

Dr WODAK — There are various options available, including amending the treaties, withdrawing from the treaties or what I suspect Canada will do which is breaching the treaties and saying they're breaching the treaties - the treaties are broken anyway. But I think it's a very important part of drug law reform. Jon Eleckman, the notorious Watergate conspirator, who went to jail for his Watergate crimes and who played a major role in convincing President Nixon to wage a war on drugs to improve his chances of re-election in the 1972 elections said that, "For the time being, marijuana is on this side of the ledger and once marijuana goes over to the other side of the ledger our system of drug prohibition will be threatened."

That's not the only reason to do this but it's one of the reasons to do this, is that when recreational cannabis is taxed and regulated. It will, I think, help us to pursue the reform process much more easily. It is the most widely-used illicit drug and the main reason for starting with cannabis is that it probably accounts for around half or probably more than half of the illicit drug market in financial terms. Getting that - moving that into a regulated and taxed system will reduce a lot of the pressures for corruption amongst our public officers.

Ms PATTEN — Yes.

Mr BODISCO — I just think there is a lot of international experience now and a growing body of reports and evidence around different approaches and we have a unique opportunity to look at the international experience and different policy responses. I personally would be concerned about a model where chemists, say, pharmacists, sold the marijuana for the same reasons that I alluded to when we deal with an illicit market. We conflate different drugs of different types. It becomes the gateway into other types of drugs but I would be concerned about the advertising and the appropriate messaging that we have at the moment with cigarettes. That approach ought to be looked at

with respect to cannabis. When one deals with public messaging, in my view, one should talk to the individual consumer as a rational entity. Somebody who should not be frightened about or scared by claims that, 'hey, if you smoke this joint you'll end up like X person who has lost their job and is now involved in living on the street or whatever', because that is not going to be the experience of most people who take this drug. I think you can target the messages towards young people or towards, say, a woman who is pregnant and might face particular consequences of using that particular drug. The messaging has to be important because for the user it's easy for the message to lose its credibility because most people who try different drugs are not going to face the full weight of the adverse consequences that can happen.

Ms PATTEN — Yes.

Mr BODISCO — So, I think these are messages and these are approaches which have to have a strong evidence base behind them.

The CHAIR — All right - we'll go to Murray for another question.

Mr THOMPSON — Yes, thank you again for your comments. I just note at page 36 of the Australia21 report there is a suggestion from a participant as to how the sales supply of cannabis might take effect and among the matters it suggests I would have labels like, "Smoking this could give you schizophrenia," and it would have help seeking information at such-and-such a number if you feel you can't stop. I just note that there was a Dr Arieti from New York who once noted that no war, no disease, no famine had exacted such a great toll on human life or caused so much suffering as schizophrenia.

In the drug debates there is a discussion regarding the correlation between the ingestion of marijuana and schizophrenia and I'm just wondering if there was such a harm as to be suggested, that has such a great impact upon human life and suffering, why would we sanction the sale of the product?

Dr WODAK — Well, there is still an academic debate about whether cannabis does in fact cause schizophrenia and there are reputable researchers on both sides of that debate. I think it's fair to say that the majority view is that there is a relationship between cannabis use and schizophrenia but it's been observed in a number of countries that the prevalence of cannabis use has increased dramatically from the 1960s, from close to zero to much higher levels that we see today and that the prevalence of schizophrenia has remained the same or gone down, if anything, and that the schizophrenia we see in 2017 is not as severe as the schizophrenia we saw 50 years or so ago.

So that doesn't sit comfortably with the theory that cannabis is a potent cause of schizophrenia. My view is that the benefit of doubt should go to schizophrenia and that until we know for certain we should assume cannabis does cause schizophrenia but when - importantly, when people have tried to estimate how much schizophrenia is caused by cannabis it turns out that the estimates are very low. If cannabis does cause schizophrenia, it causes very few cases. Some estimates are that we would have to reduce cannabis use by 20,000 people to have one fewer case of schizophrenia. So that is all in terms of the cost-benefit analysis but the other part of this is that the cannabis provided by Al Capone is presumably just as much at risk, if not more, of producing schizophrenia than the cannabis that is produced under the authority of her Majesty's government.

If anything, the risk will be less when we have a regulated product which is produced in a very consistent way. So there are a lot of uncertainties about this and in terms of the medicinal use, looking at that briefly, I think it's fair to say that a lot of the medications that doctors prescribe do have some unfortunate, severe side effects and some even produce fatalities now and then. So if we're prescribing medicinal cannabis for medicinal purposes, the occasional case of schizophrenia shouldn't - certainly shouldn't please us but it certainly shouldn't stop us from using it as an option when other conventional medicines have been tried in particularly carefully-selected cases.

When it is used recreationally, we know we can't stop cannabis use. Something like 2 million Australians use cannabis every year. The prevalence of schizophrenia is about 1 per cent of the population so that means there are about roughly speaking 200,000 Australians who have schizophrenia now. Every case of schizophrenia that can be prevented I would certainly welcome but I don't think reducing cannabis use is going to achieve much in terms of reducing schizophrenia because the risk is fairly small, if it is a risk at all. I'm sorry that's a convoluted kind of an answer but I'm trying to summarise a lot of research in a practical way.

Mr BODISCO — If I could just say - to quote Jon Edwards, the Jacobean playwright: "Whether shot by pearls or choked by silk it's all the same." We talk about sanctioning, say, cigarettes and therefore lung cancer, one looks at a lot of suffering. But some good reasons why we are going to effectively sanction by legalising, instead what we do is avoid the illicit market and what goes with that, including with drug enforcement, people having to grow hydroponically their marijuana, which has - and Alex is better placed to inform you about this - but which has an effect on potency and therefore on the prevalence of schizophrenia as a result of the smoking of marijuana.

Mr THOMPSON — Thank you.

The CHAIR — All right - other questions?

Mr TILLEY — Just one quick one. Probably over the years - I don't know whether you may recall, I've asked you a question before, Doctor, just in relation to other treatments - could you share with the committee all these other treatments for opioids and things but what about naltrexone implants?

Dr WODAK — Well, we've had naltrexone implants and their equivalent in the United States. The long-acting, intra-muscular injections - we've had those now in Australia since about 2001 and the evidence base for them is very small. The NHMRC determined that the evidence base for effectiveness and safety wasn't sufficient as to allow the naltrexone implants to be used on a routine basis but they could still be used for research purposes. The major manufacturer of naltrexone implants in Australia, in Perth in fact, has not sought to apply to the TGA to have the drug fully registered.

I'm astonished that the Commonwealth Health Department and several major health departments around the country have taken so little action in terms of the clinicians providing naltrexone implant services, particularly in Western Australia but also in Victoria. There has been a little bit of action in New South Wales. I've seen a number of patients damaged by naltrexone implants, severely ill, admitted to hospital, almost died. There was a coronial inquiry into three naltrexone-implanted deaths in New South Wales which resulted in a practitioner being referred to the psychology board with a recommendation that he be deregistered, which in fact was carried out.

He appealed, he lost the appeal and he is still an unregistered psychologist. So I personally find the whole process abhorrent and it's, to me, a reflection of the war-on-drugs mentality. If this wasn't a population that was so vilified and marginalised and ostracised, it would never have happened. We would never have had a medical intervention that was unregistered and unapproved inflicted on people with rheumatoid arthritis or diabetes. The community and the politicians would have been up in arms to stop that and yet this practice has been allowed to continue around the country and to me, it has a lot of similarities to what happened in Chelmsford Hospital in New South Wales 30 years ago with deep-sleep therapy, which finally was put to an end but after many individuals were damaged and some deaths occurred.

I would like to see this practice ended. It probably will come to an end in any case because of a long-acting form of buprenorphine which is now being introduced which is a monthly injection and that will - that is a registered product which has been properly researched and looks to be effective and safe and I think that is going to make naltrexone implants disappear.

The CHAIR — Okay, you've still got another question? Murray has still got one - another question, yes?

Mr THOMPSON — Yes, I'm happy to share it.

Ms PATTEN — No, no - I've got thousands so I'll - I'm conscious of time.

The CHAIR — Yes, anyway, keep going, Murray.

Mr THOMPSON — Just a brief question - you used the term, "chemical vacation," and there are multiple reasons why people might seek to alleviate pain and - in grief or turmoil. How would you grade the range of drugs in society in terms of their impact and the dangers attaching to them in a batting order of risk, including alcohol, tobacco, tablets, marijuana and other drugs?

Dr WODAK — It's a good question. It's a very difficult question to answer. It's a very obvious question, it's a very important question. I think the best answer I can give you is a paper that was published in the Lancet by David Nutt, who is a very distinguished pharmacologist professor at Imperial College in London and it was

published in about 2011. I'll find the paper and send it to you. He brought together a group of experts and they looked at data from 20 drugs and they tried to answer the question you have just asked in terms of damage to the individual and damage to the community and they produced two different sets of answers.

I'm sure I can't do the paper justice by trying to remember what the 20 drugs were and what their rank order was in the two different questions that they asked themselves. To an extent the amount of harm that a drug causes is also a product of the environment that they are in and if we choose the same drug and distribute it through a black market as I said before, it's much more damaging to an individual and the community than if the same drug is managed by a prescription-controlled - in other words, by doctors and nurses and pharmacists - damage is much, much less. So to an extent it's always an interaction between the intrinsic pharmacological properties of the drug and also the regulatory environment that it enters into.

But I will send you the paper which is not easy to read but it does - it is very clear that alcohol and tobacco are fearsomely dangerous to individuals and communities and amongst the illicit drugs heroin and cocaine are amongst the more dangerous. Cannabis is close to the bottom but there are drugs that are considered in this paper to be less damaging to individuals and communities, like ecstasy and LSD.

The CHAIR — Okay - anything pressing or –

Ms PATTEN — The only other issue that I just would like to possibly get slightly covered, Alex, is the New Zealand model of dealing with new psychoactive substances and while I appreciate that it's not terribly active if maybe you could speak a little bit about the objectives of that model and how it works.

Dr WODAK — Well, the New Zealand model was the psychoactive substances bill, which was passed in the New Zealand parliament on July 11 2013 and came into effect a week later, on July 18. It was passed by a pretty convincing majority: 119 to 1. What the bill did was that it only considered psychoactive substances that hadn't already been prohibited in New Zealand, so they had to be new psychoactive substances. Somebody had to propose to the New Zealand government that a particular psychoactive drug be considered under that bill and they had to pay a significant sum of money to fund the New Zealand government into doing some animal testing to assess the safety or the lack of safety of that drug. They also had to provide the molecular structure of the drug.

Then all of that data was put together and put to a committee that the New Zealand government set up who considered it in detail and then they announced their findings on a website and the findings would either be that the individual who had proposed that drug would now be allowed to sell it or alternatively, that they wouldn't be allowed to sell the drug or the third option was that more time was needed - more testing was needed. So over the course of the next 10 months, 40 drugs were approved and also under the same bill the outlets were regulated and so the number of outlets went from an estimated 3,000 to 4,000 to about 400.

The outlets had to be run by a person of - a fit-and-proper person and they - there were age restrictions about who could enter those premises and I attended a meeting in Wellington where a very senior New Zealand policeman spoke very much in favour of the bill: politicians from three different political parties spoke very strongly in favour of the bill and the bill was very strongly considered. I should mention that the whole bill came into operation while there was a coalition government headed by a national party - the equivalent of our liberal and national party, so a conservative government. Unfortunately, in May 2014 with elections coming up, the bill was suspended.

It's not completely clear to me why the bill was suspended but one of the reasons was certainly the fact that the lone member of parliament who voted against the bill on July 11 2013 had moved another bill which he managed to get the majority of members of parliament to support, to ban animal testing. So the government lost its ability to test drugs. It was found also that the testing system that they had in place was very unwieldy, time-consuming and more expensive than they had bargained for and so that was another reason why the bill has been suspended. The bill hasn't been withdrawn completely. I don't understand parliamentary procedures: you would understand this better than me but the New Zealand government is still trying to figure out how they can bring this bill back and continue its operation. The person responsible - the minister responsible for shepherding that bill through the system in the first place, Peter Dunne - is still actively supporting it as a member of the New Zealand government as a minister with responsibility for that area. Once again our New Zealand friends and colleagues have made history. This is really not just New Zealand history: this is internationally very significant.

If I can say so, to a female member of parliament, I remind you that New Zealand was the first country in the world to give women the vote and once again, they've been ahead of the rest of the world in this kind of area.

Unfortunately, the system is not operational now but New Zealand is trying to bring the bill back and I hope they do. Other countries showed a lot of interest in that bill. I can also provide some comments by Peter Dunne which I'll send to you as well.

Ms PATTEN — Thanks, Alex.

The CHAIR — Good, all right - we've certainly gone a lot longer than we expected with you, Alex. We thank you very much for the time you've made available to us. We have the people that we are expecting to hear from in just five minutes' time, so we might have a quick break now and thank you very much for your contribution wearing your two different hats this morning, and it's certainly been especially helpful for us. Thanks, Alex. We might have a quick break until we resume in a bit over five minutes.

Witnesses withdrew.