LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into supply and use of methamphetamines, particularly 'ice', in Victoria

Melbourne – 4 July 2014

Members

Mr B. Carroll
Mr T. McCurdy
Mr S. Ramsay
Mr J. Scheffer
Mr D. Southwick

Chair: Mr S. Ramsay
Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook
Legal Research Officer: Mr P. Johnston

Witnesses

Mr J. Ryan, Chief Executive Officer, Penington Institute

The CHAIR — I welcome Mr John Ryan to the public hearing of the Law Reform, Drugs and Crime Prevention Committee of the Victorian Parliament. We appreciate that you have already provided a submission and already presented to the committee, but we wanted to ask you back to ask you some questions, given we have now gone into considerable detail of writing chapters and preparing recommendations for our report. We thought it was opportune to rehash some of the work and also, given you have been involved in some of the ice forums across the state, hopefully you will be able to supplement our report.

Before we start I will read you the conditions under which you are presenting to the committee this morning. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Mr RYAN — Yes.

The CHAIR — It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence and will provide a proof version of the transcript at the earliest opportunity so you can correct it as appropriate. I now invite you to make a verbal submission, and then we have a number of questions which we would like to ask. Alternatively, John, given Sandy has provided you with some questions, you might like to respond to those as you see fit.

Mr RYAN — Thank you very much, and thank you for the opportunity to present to you. We have been busy across Victoria dealing with the issue of ice use. It is a challenge right across Victoria, and indeed it is a challenge nationally. It would be wrong to think that it is just a Victorian problem. If one looks internationally it is also a growing problem, so we are not particularly unique. What I think is unique in Victoria is the rapid increase in purity levels since 2011–12, and according to the Australian Crime Commission that is now being seen in other jurisdictions in Australia, particularly in New South Wales and Queensland. In fact we have a local problem, a state problem, a national problem and an international problem with drug use.

In relation to how we should respond to that, I think we can take a leaf from the book of finance in a way, which is diversified investment. If we put all of our eggs in one basket, we are doomed to take a high-risk approach and potentially fail, and to my mind that would suggest that we have a legal framework where methamphetamine is completely illegal and yet people are still using it. We have a fairly affluent society, and there are certainly people who are disadvantaged who are affected by methamphetamine use, but also there are many middle-class people affected by methamphetamine use. It is curiously right across the socioeconomic spectrum, which means that the best prevention has not worked either.

Of course, as we know, drug addiction is a chronic relapsing condition, in which case drug treatment is often not successful on the first occasion, and particularly with the difficulty of addiction to methamphetamine it means that people relapse into use. To my mind that means we need to have a third strand to what is our national drug strategy, which is a harm reduction approach. In the words of a visiting American psychologist, dead addicts do not recover; she put it that bluntly. Of course when people die from drug use, as the overdose numbers from methamphetamine use have been going up dramatically, they leave behind family, friends and a ripple effect of harm in the community. We need to have the third pillar of the national drug strategy, which is harm reduction, protecting people and keeping them alive while their drug use continues so that by the time they grow out of their drug using period they have stayed alive plus they have the least negative consequences possible.

I think that sort of comprehensive approach is the most sensible approach for government, and it has been supported in Australia since the mid-1980s. It has come with different names et cetera, such as Howard's 'tough on drugs', but during the Howard period of being tough on drugs he not only supported increased interdiction but increased funding, for example, for needle and syringe programs. He did that because the evidence was so strong. For example, the evidence in relation to needle and syringe programs is that they prevent HIV, which is a problem that we have not had to face in the injecting drug community in Australia to any great extent, and also hepatitis C. There have been 5500 HIV cases prevented in the last 10 years and 19 000 hepatitis cases. That is an incredible return on investment in terms of health dollars saved and community suffering prevented.

I think that would be the most important thing, which is to stay with the evidence base and to continue with that tradition of effectively a diversified investment. But if one looks at the actual balance of investments in Australia, most of the money is spent on enforcement — more than $1 billion — $500 million on drug treatment and prevention and 2.3 per cent on harm reduction. It is very much a slither of our approach, and one should contemplate whether that is adequate considering the number of people affected by drug use and the number of families who are concerned about their loved ones facing addiction and other drug-related problems. Those would be my opening remarks.

The CHAIR — Thank you. I might open the batting with a couple of questions in respect to the forums that have been conducted by the Department of Justice and yourselves over different areas, and then I will leave it up to the committee to perhaps fill in the other gaps.

We have a summary evaluation from the Department of Justice in relation to the outcomes of the forums they have been conducting across the state. It is not detailed but fairly generic. From the experience you have had in regard to your relationship with those forums and their outcomes, what do you see in relation to prevalence in regional areas and also what the call is for additional resources? I am just making sure that we are filling the gaps in our report and recommendations about what the general need is in the community, particularly in regional areas. Can you give us an insight into your perspective on that?

Mr RYAN — I found it a fascinating experience. Gone are the days when the community was in denial that drug use affects people from all walks of life. I think that is a shift that has happened over the last 15 years in terms of community understanding about drug use. Gone are the days when they thought there was a magic wand that could prevent all drug use problems. I think that has been challenged by the reality that people are experiencing through their social networks and in their local communities. People really do want help in these issues. They particularly want information. There is a general sentiment that there is a dearth of information around drug use.

That is an important challenge which is a role for government, I think, in terms of providing evidence-based information for local communities around drug-use problems, particularly for people who are directly affected but also for people who are just more broadly in the community. In every forum there are people who stand up and describe some absolutely horrendous circumstances they have experienced, particularly in their own immediate family, and there is an incredible level of empathy and sympathy, I think, in the broader audience, or the broader group of people, for that experience and a determination and expectation that people should be helped in relation to these issues. This does not just rely on police. The police are obviously a key part of it, and they will often say that we cannot arrest our way out of this problem — it needs health to step up to the plate, and it needs education to step up to the plate.

In my opinion what is also clear from the forums is that local community ownership of the issue is very important, and that means better local government engagement in methamphetamine-related issues and also better community infrastructure engagement. It is not the case that sporting clubs are immune from methamphetamine-related problems; in a way, sporting clubs should be front and centre in responses, just as employers and employees need to take a role. It is not only unemployed people who are using methamphetamine; it is people who are actually in employment. That is obviously an occupational health and safety risk and a productivity burden for businesses, but it is also actually an opportunity for positive intervention in the community at the local level. I think a

lot of the sentiment from local communities is about trying to find a pathway to better community infrastructure at the local hospital and also throughout the community.

The other significant acknowledgement in the community is that whilst some people use methamphetamine only once or twice, the trajectory into addiction can be very rapid and can take people by surprise. I think that reinforces the need for better education of people at risk or people using methamphetamine and also the people around them so that there is a better understanding of the signs of problematic methamphetamine use and actual community capacity and family capacity to intervene when there are such problems.

Mr SCHEFFER — Thanks very much for your presentation, John, and for coming in. Just at the outset, all of us on the committee, but I am speaking for myself, have acquired a very strong appreciation of the profound seriousness of the effect of methamphetamine on individuals and families and small communities. Having said that, one of the terms of reference we have been asked to look at is also the relationship between methamphetamine use and other licit and illicit drugs, which brings me to the issue of alcohol.

We have had witness after witness tell us that the 2 per cent from the 2010 figures, which I understand is probably going to be qualified in the 2014 figures, from the national health and welfare survey — is a small percentage compared to the 80-odd per cent of people using alcohol and, say, the 15 per cent of those who use it harmfully. We have a huge disproportion of harm from alcohol compared to methamphetamine. That brings me to the forums. They are very well attended for all intents and purposes, and there is big media reporting around it. Do you think that there is a place for having forums like that around alcohol?

Mr RYAN — I am not sure. The alcohol issue is very interesting. Obviously it is the most prevalent drug used in the community, and there is no doubt it provides the biggest health burden — the road toll et cetera. When you go to prison you find that ice is, as one prisoner said to me, the drug of the day, so it is actually feeding prison numbers. Why is it feeding prison numbers? Because of the crime. How does that crime impact on the local community? I think it makes people very conscious and aware of ice-related problems.

Alcohol is in a different category, I think, in that regard, which is that we have had it since white settlement. It is mostly consumed responsibly. There is a proportion of people who run into alcohol problems. We have more to do in relation to alcohol. But whether or not the understanding of alcohol, or the lack of understanding of alcohol, is the same as the lack of understanding of methamphetamines, I do not think so. I think the community is much more savvy about alcohol and its negative risk consequences compared to methamphetamines. So my prediction would be — and in fact the experience has been of a few services that have tried to run alcohol forums — the level of interest is extremely small in comparison. For example, we have had literally hundreds of people in small country towns attending forums on methamphetamines; you might get 20 or 30 who might go to an alcohol forum. Our community understanding and infrastructure and capacity around alcohol is much better than our capacity around ice.

Mr SCHEFFER — What is the relationship between that perception and the media? The reason I mention that is the way it looked to me with the forums. For example, I think you did some 50 forums; a forum would come to a town, and there would be a series of media stories around it — in some cases, we understand, wildly exaggerated, like with Neerim South, for example. These stories would come, then heaps of people would turn up. I have not been to any, but I watched a video of one of them. There are high levels of anxiety — for very good reasons, as I said before; I am not diminishing that in any way — and then a media story afterwards, taking some very strong headlines around ice. Prior to that we were having lots and lots of stories in the media about king hits and people being punched out, a lot of injuries around alcohol, which all seems to have disappeared a bit and ice has kind of replaced it. The context in which people are perceiving this is really important. When you said there is not much interest in alcohol, is that manufactured or is that actually a reality? I appreciate your point about the history of alcohol.

Mr RYAN — Subeditors have a tendency to do alarmist headlines, but I think most of the media reporting has actually been fairly balanced and responsible in relation to ice use. It is a

significant problem in the community, and they have really, for the most part, reflected community concerns in that regard. I am not uncomfortable, broadly, with the media reporting in relation to ice. I think there are some improvements that could be made, such as providing referral information similar to suicide prevention at the end of stories. I think that would be helpful, so that people are prompted to seek help by media articles. Particularly in small communities, where there is I guess heightened surveillance, it does not take many people with ice-related issues to alarm the community, because the networks are so strong. Therefore in small communities I think there is the capacity to be alarmed by it, particularly because often it is the first time in those communities that illicit drugs have been a big problem and there is an enthusiasm to deal with it. I do not think it is necessarily irrational at all.

Mr SCHEFFER — I would not say it was irrational; I am saying it is disproportionate, perhaps.

Mr RYAN — The difficult thing with illicit drugs is that it is very hard to identify how prevalent it is because it is all so secret. The increase in ice use is not reflected in the most recent drug household survey, from 2010, so it is really always going to be very difficult. But having said that, it seems to me that when people stand up in the forums — and I have been to a number of the forums — there is a general acceptance that there is a problem in the community. I was in one focus group in a regional town with young men who were disagreeing on a lot of issues but who agreed that perhaps 50 per cent of the 18 to 25-year-olds had tried ice. Fifty per cent is a huge number. They were disagreeing on a lot of things, and they did not disagree on that.

Mr McCURDY — I have been to a lot of those forums as well, and I was surprised at how many people came out. As you said, it is people with kids just wanting to understand what ice is. I think there is a huge lack of awareness about exactly what it looks like, how you take it and all those sorts of things. My question is: we have seen Project STOP as being voluntary in Australia. Some states in the US, and I am not sure whether it is all states, have made pseudoephedrine a prescription drug. Do you know of any evidence that that works — by making it a prescription drug rather than allowing it to be available across the counter?

Mr RYAN — I do not think there is convincing evidence. It is probably helpful, but interestingly there are always ways around those sorts of interventions. Certainly the innovativeness of people who want to traffic and profit from drugs is always one step ahead of law enforcement because the profits are so extraordinary and people are willing to take the risks to make those profits. My suspicion is that most of the ice in the last while has not been small manufacturing from pharmaceutical diversion but is large-scale importation from overseas.

Mr CARROLL — Thanks, John, for returning to speak to the committee. In your written submission you dedicated a lot of analysis to needle and syringe programs, and I just want to tease that out a bit. You also highlighted that Victoria is the only state that currently does not have a syringe dispensing unit installed as part of its public health program and of harm reduction benefits. I have never been to a needle and syringe program, so how critical are they given we read about them in the papers and that they are sensitive to different communities not wanting them et cetera? How critical are they in harm reduction, and then following on from that what are the benefits of having syringe-dispensing units installed — that they would then add to the program?

Mr RYAN — I think the most important thing to say about the needle and syringe program is that there is no evidence that it increases injecting drug use, and so it is addressing injecting drug use that is already occurring and reducing the harm from that particularly in relation to blood-borne virus prevention. The importance of having access to injecting equipment is complex and difficult because the drug market is 24/7. Methamphetamine use in particular is 24/7 and our service system is mostly 9.00 a.m. to 5.00 p.m., with some extension maybe out to midnight. Obviously methamphetamine use can be something that keeps people going for days on end. They also inject more when using methamphetamines, in which case having a secure dispensing as part of a suite of interventions around unsafe injecting practices is, I think, really important. It is important to provide that access out of hours and also for people who are already injecting but who are too afraid to get to the program. The evidence from interstate is that once you provide an avenue for people to gain access and confidence to then deal with face-to-face services, that that face-to-face

service is really important as a pathway into other health interventions, for example, drug treatment, legal assistance or nursing and medical care.

I think they are very important, because our risk with ice and injecting drug use is escalated in relation to HIV. We are already seeing increased injecting drug use in relation to ice, so people are transitioning from smoking to injecting. That is the worst-case scenario in terms of public health and in terms of blood-borne viruses but also in terms of the severity of the addiction. I think there is a challenge, which is to try to prevent people from using methamphetamine, prevent them from becoming addicted to methamphetamine, but also to prevent them from transitioning from smoking to injecting.

Mr CARROLL — Can I just tease that out? If I am an ice addict who injects — does not smoke it — who lives in Richmond, and I want to get access to a needle and syringe that is clean, where would I go, say, at 9 o'clock at night?

Mr RYAN — At 9 o'clock at night you are in a fair bit of trouble. There is an outreach program that you might be able to have access to if you were savvy enough to have the number and the contacts. You could travel to the Salvation Army in St Kilda if you had a mode of transport, or you could rely on friendship networks. They are about your only options at 9 or 10 o'clock at night. If you are in a small country town, it is likely that you have no options.

Mr CARROLL — The added benefit is, if I did go to one of those facilities, I would have interaction with a public health professional, who could then talk to me about harm reduction, alternatives and counselling support.

Mr RYAN — Yes, that is right. The best system is always that diversified portfolio system, basically, which is to have lots of different layers. One is secure dispensing units. Another layer is well-trained health professionals. Another layer is people who provide access as part of their jobs in country hospitals, community health centres, et cetera. It is a tiered approach. The challenge is to get the sharing of injecting equipment down to zero. Part of that is about trying to prevent people from turning to injecting, but part of it is actually addressing those people who are injecting with health interventions. One health intervention is making sure they have access to sterile injecting equipment.

Mr CARROLL — Is sharing pretty common?

Mr RYAN — It certainly is.

The CHAIR — For the record, Mr Southwick has joined us, and I invite him to ask a question.

Mr SOUTHWICK — My question is around resilience for young people, particularly those who have not been lured into the drug in the first place — resilience to help that young person say no from the very beginning. Within your list of recommendations you talk about specifically curriculum development, e-learning and a whole range of different things targeted, I assume, at our schools. Do you have any further thoughts that you could add around the sorts of strategies we could be looking at to build that resilience for our young people?

Mr RYAN — The old approach in relation to resilience suggests that engagement such as working and engagement in community through sport, through healthy families et cetera is fundamental, and I think ice is disrupting that paradigm, which is to say that engagement in sport in some locations is actually a pathway into ice use because it is so prevalent in some communities, as indeed it is in some professional groupings. If you end up in particular industries, you are at an increased risk of ice use. I think that means it is therefore important to not just have that broader approach to resilience but to drill down to the individual and family level in relation to resilience. Most people who are introduced to ice are introduced by a sibling, a sibling's friend or their own friendship network, so it is very much about having an understanding of what risks people are taking by consuming ice.

There is still a belief amongst a lot of young people that ice is a clean drug, and of course young people often feel rather invincible about things. Heroin might be a dirty drug, but ice is an all right

drug. When people hear about how 'fantastic' the effects of ice are and how high you get on ice and they are yet to experience or observe firsthand the negative consequences of ice, people can be easily convinced that they can use it but not run into trouble. I think that means we need to go back a step and improve people's understanding of how it plays with their brains particularly and how it affects the chemistry in their brains. That is very underappreciated by young people, so they are taking risks through naivety.

A great resilience builder is improving community knowledge and getting families to talk honesty and frankly about this. We have had that in relation to sexual education, safe sex, et cetera. I think we need to have the same fearless and frank conversations in relation to drug use. It is not 'Just say no'; it is about how to say no and also about how to ask for help when you have run into trouble.

Mr SOUTHWICK — Earlier in your submission you talk about awareness campaigns being developed. What would an awareness campaign look like? Who would it be targeted at? How do you build that education element you have just spoken about to ensure that the conversations are being had? When we are having these sorts of conversations, is ice the drug that is the lead-in to the conversation, or are drugs in general part of that, considering the issues we have at the moment with this particular drug?

Mr RYAN — I have heard a number of people say it is easier to get ice than cannabis in some country towns, which is extraordinary. Because of the negative consequences of ice use, I think it should be the lead focus. That is not to say that people do not do polydrug use. There are lots of harms from other drugs. Particularly underreported is the harm from synthetic drugs.

The approach in terms of an education campaign is to very much target and segment the audience. It has to be culturally appropriate so that it is not one size fits all. We have seen from overseas that 'Just say no' education campaigns do not work, so we have to have an element of primary prevention but also a nuanced campaign for early intervention for people who are using but are yet to have slipped into serious use or addiction to ice, and then we have to have other campaigns for people who are using ice problematically and are at risk of transitioning to injecting, for example, and of transitioning to serious addiction to try to pull back that trajectory. The other very important audience is family members who are concerned about ice use in their communities and in particular in their families. My sense is that the best campaigning would be nuanced across all the different cultural groups and also across different ranges of people who are impacted by ice.

Mr SOUTHWICK — You recommended that the Victorian government establish a series of forums for professionals to learn from each other and share national and international experiences. Do you think some of those forums would be part of that resilience training and education element that could be further rolled out?

Mr RYAN — Yes, absolutely. The challenge for all of us is that the drug market moves much quicker than government systems, the health system or the law enforcement system. It is extremely dynamic. Getting people together to talk through those issues and come up with sensible, evidence-based action plans that are accountable to each other and to the community is absolutely fundamental.

The CHAIR — I want to go back and tidy up a couple of issues that you have raised. In relation to syringe and needle vending machines or dispensing machines, has there been an evaluation from other states in relation to the impact of that? What has that been?

Mr RYAN — There have been a number of evaluations, and some of the furphies in relation to secure dispensing units that have been exposed include, for example, are that an increase in injecting drug use has not happened, access by children has not happened and local amenity deterioration has not happened. What has happened has been positive, which is that it has improved access to sterile injecting equipment and it has also improved access to face-to-face service delivery. It is not about disrupting good health professional engagement with injecting drug users; the impact has been to increase engagement with health workers because of improved access to the program. Obviously the introduction of after-hours access to secure dispensing units reduces the risk of sharing injecting equipment through the time cycle.

The CHAIR — We have had a fairly strong argument by another crusader, if I can use that word, in relation to the prevention of use of methamphetamine. I am happy to stand corrected, although I suggest you would be strongly opposed to making available any further opportunities to gain access to needles and syringes for the purpose of injecting illicit drugs. That is something the committee is trying to get its head around in relation to how to move forward with its recommendations.

Mr RYAN — I hope you do not think I am a crusader when you said 'another' crusader.

The CHAIR — No, I did not use the term in relation to you, just with someone else.

Mr RYAN — There is a lot of crusading in relation to drug-use issues, and to be perfectly frank there is a lot of ideological contestation, if that is an apt description. There is a risk of snake oil salesmen, I think, in relation to drug-use issues, which is, 'I have the silver bullet solution. If you stop doing all of that and do what I am suggesting, you'll have a win'. It comes from all sorts of angles, and one of the angles is, 'Let's stop access to sterile injecting equipment'. The only problem with that is it is completely against all of the evidence, and my interest personally and our interest as an organisation is advancing health and community safety in relation to these issues. We are very much focused on the evidence.

I went on the Churchill Fellowship, fortunately, to America and England last year and met with some of the leaders of the recovery movement in America. America has obviously had a very strong drug war since the Nixon years in the early 1970s. The recovery leadership has acknowledged and does acknowledge the importance of harm reduction and the importance of keeping people alive through, for example, access to sterile injecting equipment, and it also acknowledges that there are great opportunities there for people to actually transition from the needle-and-syringe program interface, for example, into recovery and back into the mainstream of the community.

You get people saying that the simple solution is X, Y or Z, which is why I think we need that diversified approach, which is to cover off on risks from a number of angles, knowing full well that there is no simple solution to this. Let us be perfectly honest: we are not going to eradicate drug use ever. There is always going to be alcohol use. There are always going to be some people who are smoking. The evidence is, I think, incontrovertible that we are always going to have some level of illicit drug use. The issue is whether we value all human life and think that people who are negatively impacted or addicted to drugs are worth saving — if their lives are valuable. Personally I think they are, and saying something like, 'We should cut access to sterile injecting equipment' is tantamount to saying, 'Let's let those people go, and in the process let's let all their family and friends be negatively impacted by HIV, hepatitis C or death and addiction'. So I do not buy into anybody saying that they have a silver bullet solution to these issues.

Mr McCURDY — Following on from that, if you have travelled internationally, who can we learn the most from? Is it the Montana project? Is it the Kiwis? Is there anywhere you have seen that is tackling this issue better than others?

Mr RYAN — I have looked very hard around the world. I cannot see anywhere that is really a good model. There is something called the matrix model in America, which is very focused on people's holistic health needs and a pathway out of addiction. Obviously countries like China, America and Myanmar et cetera have very tough law and order approaches. They are often shifting away from that and much more towards the Australian approach. The Republicans in America are pushing a decarceration approach; they think their prisons are too full. It is an absolutely mixed bag. I think the issue is — —

Mr SCHEFFER — What about the Scandinavian countries, which are often held up as the path blazers?

Mr RYAN — Yes, and Singapore, in a way, is probably our nearest neighbour with a very small population that is very wealthy. People travel from one country to another to consume drugs. In Scandinavian countries they move around, including in relation to alcohol. The social welfare

system is incredibly different and incredibly expensive in Scandinavia, and it is not anywhere near ours. But I think there are lessons to be learnt from them in relation to investing in drug treatment and the effectiveness of drug treatment. There are better lessons to be learnt in other jurisdictions in Europe in relation to how to deal with ongoing drug use. They have got an HIV and overdose problem — —

Mr SCHEFFER — Such as?

Mr RYAN — I think Portugal is very interesting in the sense that they have reduced blood-borne virus transmission, they have reduced overall drug use, they have reduced overdose, and they have done it via a legal system. Drug use has become a regulatory issue with intervention from social services — and law enforcement, but social services. They are very much trying to push users into health care and basically into rehabilitation services, and they have been very successful at it in a difficult environment.

Mr SOUTHWICK — Just back to the needle and syringe program, has there been any work done in terms of responsibility for the needles once they are disposed of? I am leading to the argument that if we are suggesting putting machines out and so on, what does that then do for the potential to put more needles out into the market and there being more danger.

Mr RYAN — The evaluations have shown no reduction in local amenity, which includes inappropriate disposal. The challenge is to make sure there are disposal facilities accessible for people who inject drugs, and there is always a disposal container right next to a secure dispensing unit, plus obviously there need to be disposal containers in appropriate places in the rest of the community. The evidence from interstate is that it does not increase inappropriate disposal, and the evidence in relation to needle and syringe programs is that they encourage appropriate disposal of injecting equipment and they actually increase appropriate disposal. In places where there are not needle and syringe programs you often find inappropriate disposal problems are higher.

Mr SOUTHWICK — So people who are off their heads are still expected to appropriately dispose of the syringes.

Mr RYAN — Yes, and mostly they do. For those occasions when they do not the challenge is how we create safeguards in the community, as per every other issue in relation to drugs. That means proper response times by local services, for example, local government or local needle and syringe programs or local businesses to identify the problem and remove it. As a proportion of disposal it is very small, but the scale of injecting drug use in the community is so large that it is a significant issue. I think one discarded needle is a concern, but the risk of blood-borne virus infection from inappropriately discarded needles to members of the public through needlestick injury — there has never been a case of HIV transmission. But nonetheless it creates community concern, and that is why encouraging drug users to disperse appropriately mostly works. On the occasions that it does not, we have to step in and actually clean up.

The CHAIR — On behalf of the committee, I thank you for your time this morning, John. We appreciate it.

Mr RYAN — Thank you.

The CHAIR — Thank you again for your input into this inquiry both through the written submission and also your verbal submissions.

Mr RYAN — Thank you very much.

The CHAIR — I close the public hearing at 9.50 a.m.

Committee adjourned.