T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 5 June 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
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Witness

Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria.

Necessary corrections to be notified to executive officer of committee

The CHAIR — Stefan, thank you for your time this morning. As you are aware, we are working through our third public hearing today in regard to drug law reform. We thank you for the submission you made on behalf of Odyssey House. Clearly we are very interested to learn more about the model and the issues that Odyssey House experiences. We welcome you going through a general summary. You are aware that Hansard is recording what is being said and that soon you will get a draft of Hansard's collection of notes. If you are happy that that is technically correct, that will be part of the public record. I think that is all I need to say. You know you are covered by parliamentary privilege if that is required. If you provide a bit of an overview to us in regard to Odyssey House and the issues as you see them, then we will be interested to follow up with some discussion on that.

Dr GRUENERT — Thank you, Chair and members of the committee, for this opportunity and for the invitation to come and speak this morning. I would like to firstly acknowledge that we are meeting on traditional land of the Wurundjeri people and to pay my respects to their elders, past and present. As some other speakers have outlined, I acknowledge that the issues we are speaking of today disproportionately affect many Aboriginal and Indigenous people all around the world. I declare the commitment of Odyssey House to being part of closing that gap through our reconciliation action plan.

By way of background, I am a registered psychologist, and I have worked for Odyssey House for over 15 years, the last 10 of which have been as the CEO, and I am speaking in that capacity representing that organisation today. I guess I will make a few points from my submission. I certainly welcome questions either as we go or after that. The first thing is really to acknowledge that this is a complex issue that jurisdictions around the world struggle with. There are many degrees of policy along what are pretty broad continuums, and I do not think any particular jurisdiction or country has got it right, although many show elements, I think, of good things that we can learn from.

I would acknowledge that, while Australia does many things well, we can do better in this area of drug policy in particular to reduce the harms, and I would like to speak about some of those things today. One of the challenges we obviously face in moving and changing any drug policy is to bring the community along. I appreciate that often community safety is at the forefront of everyone's mind, and bringing the community along can be challenging when there are many examples of violent crimes and things, particularly with alcohol and ice in the media fairly frequently. It can be quite difficult to come up with rational policy.

I would like to start by saying that Odyssey does support the current three elements of the national drug policy — that is, supply reduction, demand reduction and harm reduction — but we believe that the emphasis needs to shift much more to treatment, demand reduction and harm reduction, with less emphasis on the law enforcement and those legal costs. We believe that we should be targeting our law enforcement costs to much higher level crimes — high-level trafficking and violent crimes associated with drugs — rather than personal and dependent use, and even some low-level dealing to people's peers in their network.

I would like to say I am a firm believer of taking an evidence approach to many things. I think at the moment we are at a crossroads, particularly on drug policy, where for many years we have been using ideology, our own personal anecdotes and motives and sometimes what we think is a commonsense approach to drug policy. I think there is a greater understanding that the evidence does not always align with that. Evidence is a challenge to all of our beliefs because we might all be proven to be wrong, but I certainly support the use of it in this area in particular.

We currently as an organisation do not support the widescale adoption of a legalisation approach in an unregulated way to all drugs. But having said that, I guess there is some room in the middle, which I would like to elaborate on. It is fair to say that there is a spectrum, whether you are talking about legalisation, where drugs are available on every street corner and easily accessible as an unregulated market, or the other end of the spectrum, where you have got hardline prohibition approaches, which is also an unregulated market — a black market. It is our view that both of those extremes actually lead to the greatest harms of drugs. So in a sense there is a U-curve, where the sweet spot in the middle is the area where the fewest harms can be achieved, but at both extremes you have more harm.

Underpinning that notion is our belief that drugs — alcohol and all sorts of drugs — are not necessarily bad. Almost every drug we know has the potential to provide positive benefits to society, whether that be in pain management or whether that be socially and recreationally or whether that be for the treatment of a whole range of conditions and medicines.

It is really important in a world that often tries to enjoy those benefits — during childbirth and in the treatment of ADHD, and we are going to see a whole lot of drugs come out about cannabinoids — we want to make sure that we are able as a society to enjoy the benefits of these drugs and absolutely minimise the harm. So our intention would not be to eradicate drugs but merely to come up with a system of regulation and policies that will maximise their benefits while minimising their harms.

As an organisation the first thing we support is the extension and formalisation in Victoria of decriminalisation such that people are not getting a criminal record, which we know, as a treatment organisation that supports more than 8000 people every year, makes your efforts of achieving recovery and re-entering mainstream society much more difficult. We understand there is a de facto approach to most drugs by most jurisdictions around Victoria, but that is really up to the discretion often of individual officers. We would like to see that extended to all drugs and certainly formalised.

In addition to that I think there is some evidence to suggest that we might take the approach of investigating and exploring some regulated supply of some drugs. Again, because of our desire for an evidence-based approach, I do not see this being done in a radical, kneejerk way. I think we really need an incremental, slow, great evaluation around that. We have seen some examples, particularly in the US around some of the work they have done, and the changes in policy around cannabis where there have been many unintended consequences.

Some of that has been because they have allowed it to become quite unregulated in the same way that we see the unregulated market around alcohol and tobacco, where it is too easily accessible. In the hands of commercial suppliers we see corners being cut. We see the move to a cash economy in many states in the US because of the discrepancies between federal and state laws there. We have seen corners being cut around how it is grown and the use of contraband pesticides and other things and recalls of those drugs, and we see companies cutting all sorts of corners around whatever regulation is there.

The CHAIR — On that score are there any particular states you want to identify that you think have gone down that path to a negative effect or others that seem to be more carefully regulated?

Dr GRUENERT — It is not my area of expertise to distinguish the differences between one state and another. I think one of the difficulties is the conflict between the federal laws and the state laws whereby no state-related entities are actually supplying drugs, so it has been essentially handed over to smaller scale suppliers or some larger commercial suppliers rather than state-endorsed entities. I think that approach is much more likely to lead to fewer harms at the middle of the curve rather than pushing it out to the unregulated side.

I do understand that there have been in some states some small cooperatives and things which seem to be managing the supply and use much more effectively than when it has been handed over to the large entities, but again I am happy to take that on notice and supply some more information if I come across it.

I guess there would be other drugs where we would also be looking to see some trials or movement into that regulated supply, and that may be in the notion of prescription heroin for people who have been very difficult to treat with other forms of pharmacotherapy or other forms of psychosocial support where other things have failed. What we have learned over many years is that there is no one size that fits all and we need a really nuanced approach to different cohorts and different populations. There may be a longstanding group of people resistant to all sorts of other forms of treatment who will require ongoing support where prescribed heroin may be the safest and most effective way of supporting them and helping them perhaps move to better health or even maintain health over time.

One of the reasons we would like to move beyond just decriminalisation is that many of the harms around drugs come from that black market — the unregulated supply — and simply even formally decriminalising drugs in the state of Victoria would not remove that. It would not remove the resources that are going into that criminal world and all the violence and crime that is associated with that. Many users who are dependent on drugs get caught up in that, and certainly that has been our experience of the additional traumas caused to those people over time.

There is a whole range of other things where some changes to law could better support the people we work with and, I think, move towards that sweet spot in the middle. They include, as I have mentioned: the trial of prescribed heroin; needle and syringe programs and expanding those to within prisons; greater access and hours; more integration with other services; and greater expansion of naloxone, in particular making naloxone

more accessible. As a health service we cannot simply go and buy a whole lot of naloxone and have that in our waiting rooms or for staff to carry. The way it is scheduled and prescribed, that is not accessible to us; it needs to be through a GP for someone who is a user of opiates. That, I think, limits its potential for widescale use across the community. We would like to see some reduction in the barriers for securing naloxone for friends, family and health service providers.

We support the trial or the rollout of a medically supervised injecting facility, particularly in areas like Richmond, and also see that as being best integrated within some health services as well. Lastly, there is a range of small, minor associated laws that many of our clients become hindered by and that we would like to see some adjustments to around some of the special circumstances in the act and some Centrelink regulations and changes in strengthening the payday lender laws. Our financial counsellors, of which we employ two at Odyssey House Victoria, have some expertise in this area. They are continually seeing many people for whom a further harm is caused in relation to getting into financial difficulty and the troubles and the barriers they have actually unwinding that difficulty over time to achieve recovery.

They are the key points, I guess, I would like to make, other than potentially acknowledging that there is a belief by many in society — and again these beliefs are not always founded on the evidence — that any liberalisation of drug laws is likely to increase drug use. I think often what is confused, even though there are mixed results around that in many jurisdictions where laws have been changed, is there has not necessarily been a significant increase in use. Sometimes what we see is an increase in the number of people using drugs but not actually the harms associated with those drugs, and that distinction or that nuance is often misunderstood. I think it is important, as I said earlier, that the use of drugs is not necessarily associated with harm but the way in which drugs are used and the regulation around them, those are the things that really matter. I welcome any questions.

The CHAIR — In terms of the last state budget, where an additional $80 million was directed towards alcohol and drug rehab, which gives us another 30 beds, I think, around the state, I am interested to know how Odyssey House feels about that.

Dr GRUENERT — The impact? Yes, sure. So the $80 million was targeted to a range of initiatives, some including access to telephone and counselling support, some giving broader access to the number of people on CCOs — community correction orders — so greater access to treatment in the community. Some of that, the largest proportion, will be directed towards increasing the number of residential rehab beds in Victoria. The previous state budget had included some resources for another 18 to 20 beds, which will be targeted to the Grampians region. This state budget includes $10 million to source some extra properties, understanding that going through planning and getting community support and all of that is quite a long process. Future budgets would then look at the capital involved in constructing new facilities. What we see in this budget is an injection of 30 new beds within existing facilities, where they can be put in, and commitment for a further 60, so 90 over time, to some of those new facilities, and that is particularly in regional areas.

In terms of impact, we are aware that Victoria has half or less than any other state or territory in terms of beds per capita, except for South Australia, where we have a similar amount, and we would need another 250 to 300 beds in Victoria to come up to that benchmark set in other states and territories. Now that is a big change. I understand that Victoria has had a long history with institutionalisation and has been reluctant to go down that residential path. I think it is also important to acknowledge that residential beds, while they are a really important part of the spectrum, are not the only part of the spectrum. I have certainly welcomed the investment over many years in community-based services as well. While Odyssey sees around 600 people in residential services each year, we also see 8000 in the community.

We understand that a period of residential treatment in someone's journey is more likely for them to be able to achieve recovery. It does not have to be at the start, the middle or the end. And for some people who have tried a lighter touch, have tried counselling, residential might be the most suitable and the only thing that is going to help get them through. We do not want to see the investment just at that end, but we certainly welcome this increase. It is going to absolutely make an impact.

We currently have around half of the beds in Victoria and we currently have anywhere between a two and a six-month wait to access those beds, and that is an unavoidable wait. These are people who have access to counselling services, to day programs, to pharmacotherapy programs, whether that is methadone and buprenorphine, and they may have tried all of those. For whatever reason their families need a break from them.

They have not been able to manage enough stability in the community to benefit from those programs and a period of residential treatment is really what they need. Certainly it will make an impact — absolutely.

Mr DIXON — With the decriminalisation of using, what I am picking up is that there is a fairly pragmatic view out there and not a lot of people actually get a criminal record for using. Is that more a symbolic thing? What are the practical implications of it? Probably a minor group are actually being criminalised.

Dr GRUENERT — I think the practical implication is that it takes away the postcode lottery about whether you will get a practical approach, or a reasonable approach, or not. In most cases, particularly for drugs like cannabis, absolutely, you are getting diverted, but with all sorts of other drugs, depending on who you have got and what capacity they have at the time, you may in fact end up with a criminal record and you may in fact have some legal sanctions as a result of being caught with possession of that drug, even as a user. It goes beyond a token approach. I think it formalises it, and it would expand it to other drugs.

But the point you make is an important one I think. Most of the crime and the resources and time of the police is not the result of simple drug possession. It is the crimes associated with drug use. That is not going to change. But a change of emphasis from, I guess, some broader law reform policies that really divert the resources away from the supply reduction side will be that there are more resources available for treatment, and I think that has been the real change in places like Portugal. It is not simply having people whose drug use has been caught diverted out of the criminal justice system. It is really diverting the resources. Over many years we have put more and more into policing. Where treatment is made available, when someone needs it, when they are motivated, it is accessible, and that has really been the impact. That demand reduction is the way we are going to prevent all these other crimes associated with drug use occurring. Certainly the data projected from looking at the forensic system is there are going to be more and more people accessing treatment whose crimes are directly related to their drug use.

Mr DIXON — You said at the start that we need to bring the community along.

Dr GRUENERT — How do we do that?

Mr DIXON — Yes.

Dr GRUENERT — One of the biggest challenges is obviously the stigma, and where we see the biggest impact is when someone either has courage or they have been thrust into the public limelight, whether that be a Prime Minister whose daughter has a heroin issue or whether that be a football star. This is when the public starts to debate it. Even around medicinal cannabis we see that when someone's child is struggling with seizures as a result of epilepsy the community suddenly says, 'Oh, okay, we can see some benefit from these drugs', and that goes back to that other point.

I think we really need to get honest and have those conversations. For example, I have been on the public record saying, 'I don't want to eradicate drugs from society because I want my children to benefit from them in a range of things as medications'. We need to be honest about our own use of drugs, whether that be caffeine or alcohol. It is not the drug use itself but where a combination of underlying social factors takes that drug use from a medicinal use, a social use, to a very harmful use, a dependent use. These are the things we need to change — so a community conversation, some courage from leaders of all types. We see too many police commissioners have those conversations once they leave office. It is that fear — the fear to talk about our own drug use and policies that change. But I honestly think we are at the crossroads now, where even at the United Nations some significant shifts have occurred from some very conservative countries that really understand that the evidence is behind a different approach. And I think families sharing their stories and telling their stories is very powerful.

Mr THOMPSON — Dr Gruenert, thanks for your evidence. You may have heard before about an example that I had to deal with over the weekend — parents who have been trying to find treatment for their son who has had a six-year addiction to synthetic cannabis that is available from a number of shops around Melbourne as incense or some other misdescribed product. What options do they have when there have been 20 emergency department admissions within recent years? He has rolled in and rolled out, sometimes in a state where he can barely walk, and he is given his possessions back, sometimes including the very product that he had been smoking before he went into hospital. What options do the parents have when under a section 81 order it is only

10 to 14 days treatment and the family is of the view that he needs massive daily care to enable him to break his reliance upon this synthetic cannabinoid?

Dr GRUENERT — I would like to make a couple of responses to that question if I might. The first one is that history has shown us whenever we crack down under a prohibitionist approach to drugs what we see is an emergence of newer drugs, often more potent and less understood drugs. For example, with the crackdown on opium we saw heroin emerging. In the 1920s we saw a crackdown on alcohol under Prohibition in the US and many people went away from using lighter alcohol products, such as beer and some wines, to much harder spirits. The same occurred with the move from speed at sort of 10 to 15 per cent — a crackdown on that and you move to ice at 80 to 90 per cent. So whenever we crack down on a drug, including cannabis, what we see is the emergence of other forms, often more pure, more dangerous, and little research around it to understand it, all in the aim of trying to avoid detection or to increase profits for those that are dealing these drugs. So it is much easier to shift and move and make profits on ice then it is on amphetamines at 10 or 15 per cent.

One of the unintended consequences of a prohibition approach and not a regulated supply approach is that you see the emergence of drugs like synthetic cannabis, and you will see a continuing effort of those who manufacture and those who demand those drugs to try and tweak and change the formulas to avoid detection and make it available. We certainly see at Odyssey many harms associated with synthetic cannabis which we are just starting to understand because it is a changing, moving drug that goes under the name of synthetic cannabis. That is the first point I make.

The second point, which really goes to the heart of your question, is what options do we have and what could we have to really get someone like that some help? We know that the current substances misuse act gets rarely used, and it is really only used on very rare occasions where someone is at risk of causing substantial harm to themselves and others. It is not necessarily well understood. There are very few beds and, as you point out, the way it has been set up is a very short passage of treatment. So for many people it does not even come on their radar, or where people have used that service it is a very short-term relief — sometimes just helping someone get through the withdrawal, reducing their tolerance to a drug and then they will be back out on that drug.

I understand one of the previous speakers, Tony Parsons, did speak about the program of research that Magistrate Jenny Bowles had undertaken. We know that the evidence is very strong around mandated treatment if done correctly. We have seen examples where it is done ineffectively like a boot camp or prison, and you are very unlikely to get much success out of that. It needs to incorporate a human rights framework. It needs to be carefully applied, so not for any parent just wanting to send a naughty child or a child that they are anxious or stressed about. It is not an automatic given that they can sanction them into treatment. It should be a very good system of assessment, with judicial oversight to make sure that it is being used wisely but not so many barriers that it is too hard to jump through hurdles.

What we have learned is that the majority of people seeking our support do not come putting their hand up just of their own voluntary nature. They come because there is child protection involvement. They come because their family members have put so much pressure on them and they going to kick them out of home or out of the relationship. They come because their health has deteriorated to such an extent that they end up in an ambulance and emergency and they are referred on.

So many people come in with some coercive pressure or other factor, and in a sense none of those things matter as long as we are getting them into support, even if it is court ordered and they are trying to avoid a prison sentence. They may come in with very low motivation to change, but over time, if that period of support and treatment is long enough, they typically realise, 'Hey, there's something in this. My life is actually better when I'm not on drugs as long as I've got some strategies and supports to medicate, support and manage all of those traumas that my drug use is actually masking or assisting with'.

So a mandated form of treatment, I believe, absolutely has some place in a spectrum, particularly, as Tony Parsons mentioned, where many young people are referred to a voluntary service and they may access it for a few days and simply leave without any sort of accountability or consequences of that. So when voluntary treatment fails for someone who is really out of control and causing harm to themselves, I think the models that she has looked at overseas can form a basis for treatment where at least the front end is secure — where people need to go in and comply — and over time as they step through they can move to a less secure part of that facility where the boundaries are really set by themselves and their desire to get better and get well.

These models have demonstrated success overseas for those people for whom voluntary treatment has failed or who are simply so caught up in their drug use and the benefits that that is giving them in that moment that they cannot see the harm it is doing to themselves and others. So I think we need to move to exploring those sorts of models for that person that you have explored, who may not get into voluntary treatment because the places are not there or there is the two, three or four-month wait list, or for whom at the moment their only option is very short periods of stay which are really not long enough.

The evidence overseas and in Australia suggests that if you have got a whole range of supports around you, a 30-day stint in treatment may be sufficient, and that is the model that private health insurance and many private providers utilise. That only works when you have got sufficient support back in the community from family, GPs, psychologists and others to help you maintain those changes. Otherwise we are typically talking about a 90-day stay in residential treatment for those that are most acute to really break those habits that often have taken many years to develop.

Mr THOMPSON — Thank you, Dr Gruenert. Just by way of brief follow-up then, if the son is discharged onto the streets of East Melbourne tonight at 5.45 and the parents ask me what they can do, without going to the Bowles model, what can they do tonight at 5.45?

Dr GRUENERT — I guess the options available to them are to try and link that person into whatever supports or services are available, notwithstanding that person may have changed, and that may be getting immediate assessment, getting immediate referrals for counselling, and if it is deemed that residential treatment in the public system is what they after, then at least getting them on the waiting list for that. Notwithstanding that, if they have resources, they may have tried other places like day programs, as you have mentioned. They may have tried some private providers, of which there are many popping up to fill those gaps.

We welcome private providers for those who can afford them, because it does ease the pressure on the public system. The real problem, again, has some implications from a legal perspective — that is, there are very few regulations around the treatment provided by a private provider unless it is hospital auspiced. So you might get a good treatment, but you might just get a service that has no active ingredient in its treatment. It merely needs to comply with corporate law and consumer law, but it needs to really provide nothing by any standards to operate in the state of Victoria. So certainly it is a lottery, certainly they are going to be put on wait lists. They might be able to get some access to short-term telephone counselling or face-to-face counselling, but my guess is that for someone whose use has gone over six, seven or eight years and who has tried many times to detox and come through, that they are going to need longer supports, which simply are not going to be available immediately to them.

Mr THOMPSON — The tragedy on our streets.

Dr GRUENERT — And it is one of absolute many. We have some support for those family members who can talk through their own needs and their own struggles on telephone services, but we get contacted multiple times every week by families that are desperate, who would love to chain their children to their beds to prevent them from the harms that they know they are going to be exposed to, and many of those children simply do not make it.

The CHAIR — To follow on from the comments you were just making about private providers and the concern of resi rehab in particular and the lack of regulation, what might a government to do to improve or to ensure that the services are acceptable?

Dr GRUENERT — I think it is probably best done at a federal level with strong advocacy from the states. But I think there are two approaches: one probably requires more resources, and that is my least favourite, probably, approach. I think there is a more practical one whereby any service that is providing drug treatment, or a health service around drug treatment, even in the state of Victoria, should need to be able to provide some record of compliance with some sort of standards or quality management system at their own expense.

The CHAIR — They do not at the moment?

Dr GRUENERT — No.

Mr DIXON — That surprised me.

Dr GRUENERT — All public providers absolutely have to provide evidence of that to receive public funding, but no other providers who take in fee-for-service private money need to provide any evidence at their own expense. Now this could be simply an external audit saying, 'Yes, you've met these quality standards' — whether that is an ISO or a QICs or anything else. That onus would be on them. Obviously there would be some regulation and policing required, but that could be incorporated fairly easily into another body rather than setting up a whole body around this that was resource intensive.

Mr EIDEH — Just a quick one. I want to ask about the misuse of prescription medication. What is your view on the Victorian government's announcement of a real-time prescription monitoring system?

Dr GRUENERT — Sure. I am very supportive of any approach to monitor both the prescription of a whole range of medications and also the dispensing of, and a system that integrates those. There is no doubt that that will reduce some harms, not all of them. But we know from firsthand experience that many of our clients have become skilled at doctor shopping and working the system, and that has been the way of them obtaining all sorts of medications that they have used in non-prescribed ways that have absolutely maintained their addictions and added to the harms, in particular in combination with other drugs, being particularly dangerous.

This will absolutely help to reduce that. It is not going to prevent the whole black market. We know that particularly drugs used in palliative care and cancer treatment end up on the black market. So they have been appropriately prescribed but they have been diverted because someone used part of them — the pain was not too bad and they thought, 'Well, I've got six tablets left; I can make a hundred bucks on these' — or sometimes they are walking out with huge quantities and they are making thousands of dollars. So it is not going to prevent everything, because many are prescribed well and it is not just the same person doctor shopping. In drug policy there is no one thing, there is no one silver bullet that will do; we need a combination of all these things to reduce the harms and find that sweet spot in the middle.

Mr DIXON — Obviously there is literally a captive audience of drug users in jail, and it is not very good, the treatment there. Is there an opportunity to do that better, obviously?

Dr GRUENERT — One of the challenges with an incarcerated population is that when they are mixed with a mainstream population in prison — so a general population — every fibre of your body there is building a wall to protect yourself from prison culture. What we know in drug treatment — in fact in many forms of treatment — is that the number one thing you are trying to do to help people achieve recovery is to work on their relationship skills that are going to help them develop positive social relationships. That is the number one predictor of success in long-term recovery. We can give people houses, we can give them jobs — all of those, again, enhance people's positive social networks, and that achieves long-term recovery. In prison in a general population it is very difficult for people to get real and honest and vulnerable, in a sense, to actually develop the emotional regulation skills, to develop the relationship skills and to be surrounded by a good peer network that is positively working towards that.

So I think any prison program is always a challenge. I think examples where they work best are where there is a precinct of people who have made a commitment to working on their drug use. So there have been some therapeutic communities where the prison officers, the staff, everyone is on board with a treatment program and people are actually able to get real, honest and vulnerable and do that hard work to make the real changes in their relationships, but in a generalist population it is very difficult to do much more than give people some education. They will comply with those courses but we do not see much evidence of behaviour change as a result.

Mr THOMPSON — You mentioned that there have been some unintended consequences at times in relation to drug decriminalisation, noting one example in terms of liberalisation that some of the statistical data may not necessarily be adverse — more people have tried it but it has not led to the harms that are currently being addressed. I was just wondering if you could for the record outline what you saw as being some of the unintended consequences and if any of those are in the more harmful category.

Dr GRUENERT — In some places in Europe, places like Holland, we did not see a large increase in the number, for example, around cannabis and the coffee shops, understanding that that is not a fully unregulated legal market. Of the local users, we certainly saw tourists coming into those areas and so it did increase the night-time entertainment and the volume of people attracted to those areas who would often binge because they did not have access to this in their own areas. But we certainly did not see that amongst those around in Holland

and in Amsterdam in particular where the attraction really diminished because it was available to them. So sometimes there is that. You know, when it is not done uniformly across a large area there is an unintended consequence in that it can be a bit of a honey pot effect to others.

We see in places like Portugal while there was no large-scale increase in numbers, particularly when compared to other countries where the number of people using drugs had increased over time — as you mentioned and as I have mentioned previously — we have seen some increase in the numbers of people using but not necessarily the harms, so that is certainly one consequence that occurs particularly around cannabis where we have seen that.

I think you probably need to go to other examples like alcohol and tobacco to really see some of the unintended consequences when you do not get the regulated supply right and we move too far to that unregulated legalisation approach. So with alcohol in particular when we allowed a lot more licences, a greater density of alcohol licences and greater hours of operation all of the harms associated with alcohol increased in those communities. We saw more hospital admissions. We saw more ambulance call-outs. We saw greater examples of domestic violence. We saw drink-driving incidents increase.

Mr THOMPSON — Are you speaking about Melbourne?

Dr GRUENERT — I am speaking about Melbourne, absolutely. There is very clear data on that, where density, outlets and hours of operation have had a huge impact on the harms. Again with tobacco we have seen the positive benefits, and Australia has a very enviable record. When you make sure that even though we still allow tobacco as a legal drug it is under very controlled conditions, including how we allow people to advertise and the packages they use, the harms can absolutely be reduced and the number of people smoking, combined with education and other programs.

While I would like to see some trials of regulated supply and moving beyond just decriminalisation, I think we would want to learn the lessons from those drugs, proceed with caution and learn the lessons particularly around cannabis in the US, where it has been handed over to profit-making organisations and we are seeing some of those issues emerge that we have seen in the tobacco industry and in the alcohol industry, where corners are cut, where there are recalls of products, where it has been made available more to minors than probably was expected and where that supply has not been as regulated as the authorities wanted, where, while some of the tax take up has been great and a real benefit — and those are the things that have got it over the line politically in those states — some of those tax returns have not been as great as anticipated, particularly because it has become more of a cash culture where people are not using their credit cards and they do not want to use that, because again there are still federal laws in place.

Ms PATTEN — They are not allowed to use credit cards.

Dr GRUENERT — They are not allowed to, absolutely. The federal laws are put in place, so once it moves into a cash economy your opportunity for taxation uptake is always going to be compromised. That was probably an unintended consequence, so some of the returns to schools and other community infrastructure that were hoped for have not been quite as big as they probably should be with the volume that is being sold.

The CHAIR — Thanks, Stefan, for your contribution. Obviously, as I said, you will get a draft of the transcript before long.

Dr GRUENERT — Thank you for the opportunity, and I genuinely wish you all the best in your deliberations. There is a large amount, I am sure, of information to synthesise, and, as I said right at the start, it is complex. There is no perfect answer here, but I think Victoria can certainly do better.

Witness withdrew.